

BOARD OF DIRECTORS

AGENDA AND PAPERS

TUESDAY 13TH OCTOBER 2015

MEETING OF THE BOARD OF DIRECTORS

TUESDAY, 13TH OCTOBER 2015 AT 1.00PM

TRAINING ROOM 3 & 4

A G E N D A

FORMAL BUSINESS

- | | | |
|----|--|----------|
| 1. | Welcome and Apologies | Chairman |
| 2. | Declarations of Interest | Chairman |
| 3. | To receive and approve the Board of Directors minutes of meeting held on 1 st September 2015, BoD action tracker (September 2015) and matters arising
(Attached) | Chairman |

QUALITY & ASSURANCE

- | | | |
|-----|---|---|
| 4. | To receive a Patient story | Director of Nursing and Quality |
| 5. | To review the Integrated Performance Report to month 5 to include:
An overview of the risks associated with Winter Preparedness
(Attached) | Executive Team |
| 6. | To receive a presentation on Cancer Services | Associate Director of Performance and Planning
/ Lead Cancer Clinician |
| 7. | To receive the Patient Experience Annual Report 2014/15
(Attached) | Director of Nursing and Quality |
| 8. | To receive an update on CQC Inspection Preparation | Director of Nursing and Quality |
| 9. | To receive the PLACE Assessment Report
(Attached) | Head of Facilities |
| 10. | To receive a verbal update on 'Speak Out Safely' | Director of Human Resources & Organisational Development |

- | | | |
|-----|--|---------------------------------|
| 11. | To receive a update on Never Events and Serious Untoward Incidents | Director of Nursing and Quality |
|-----|--|---------------------------------|

STRATEGIC DEVELOPMENT

- | | | |
|-----|--|--|
| 12. | To receive the Chief Executive's Report (verbal) | Chief Executive |
| 13. | To receive an update on Governor Matters (verbal) | Director of Corporate & Legal Services |

FOR NOTING & RECEIPT

PLEASE NOTE THESE PAPERS ARE AVAILABLE ON REQUEST

- | | | |
|-----|---|--|
| 14. | To receive the Q1 feedback letter from Monitor | Chief Finance Officer |
| 15. | To receive the minutes of the Quality, Safety and Patient Experience Committee 20 th July 2015 | Director of Nursing and Quality |
| 16. | To receive the minutes of the People and Organisational Development Committee 9 th July 2015 | Director of Human Resources and Organisational Development |
| 17. | Date and Time of Next Meeting: | |

Board of Directors Meeting
Tuesday 8th December 2015 @ Time TBC - Training Room 3 & 4

BOARD OF DIRECTORS

MINUTES OF THE MEETING HELD ON TUESDAY,
1ST SEPTEMBER 2015 at 12.30pm
TRAINING ROOM 3 & 4

		Attendance	
Chairman	Sir D Nichols	☒	
Non Executive Director	Mr A Higgins	☒	
Non Executive Director	Mr J Wilkie	☒	
Non Executive Director	Mr E Oliver	☒	
Non Executive Director	Mrs R Hopwood	☒	
Non Executive Director	Dr E McMahon		☒
Chief Executive	Mr T Chambers	☒	
Medical Director	Mr I Harvey	☒	
Chief Finance Officer	Mrs Debbie O'Neill	☒	
Director of Nursing & Quality	Mrs A Kelly	☒	
Director of Planning, Partnerships & Development	Mr M Brandreth	☒	
Director of Human Resources and Organisational Development	Mrs S Hodgkinson	☒	
Director of Corporate & Legal Services	Mr S P Cross	☒	
Interim Director of Operations	Ms L Burnett	☒	

In attendance:

Mrs C Raggett – Secretary to the Board
 Dr N Laundy, Clinical Lead for A&E
 Ms C Smith, Facilities Manager
 Ms K Townsend, Acute Directorate Manager
 Mr I Bett, Associate Director of Planning and Performance

FORMAL BUSINESS

B62/15 WELCOME AND APOLOGIES

Sir Duncan welcomed all attendees to the meeting.

Apologies were received from Dr McMahon.

Mr Chambers informed the Board that Mr Brandreth would be focussing on the new model hospital work for the next 6 months and that Ms Burnett has been appointed as Interim Director of Operations until the end of January 2016. Ms Burnett will be attending the Board during this time as a non-voting member.

B63/15 DECLARATIONS OF INTEREST

There were no declarations of interest.

B64/15 TO RECEIVE AND APPROVE THE MINUTES OF BOARD OF DIRECTORS' MEETING HELD ON 7TH JULY 2015 AND BOARD ACTION TRACKER AS AT END OF AUGUST 2015

The Board of Directors minutes of the meeting held on 7th July 2015 were received as a true and accurate record.

The Board noted the Board Action Tracker as at end of August 2015.

MATTERS ARISING

There were no matters arising.

QUALITY & ASSURANCE

B65/15 TO RECEIVE A CARERS' STORY

The Board received details from a member of staff's experience as a carer and working full time at the Countess. Ms Smith gave details of the needs of her daughter and how this impacts on both family and working life.

Ms Smith stated that she would not be able to work full time without the support and flexibility of the Countess, her managers and team.

Sir Duncan thanked Ms Smith for her very powerful presentation.

Mrs Hodgkinson added that Ms Smith had inspired many members of staff, some who did not see themselves as carers and who have now sought advice and guidance.

Mr Oliver asked if the Trust was aware of how many staff were official carers. Mr Chambers stated that nationally approximately a third of NHS staff were carers. Mrs Hodgkinson added that the Trust was working on identifying the number of staff who are carers but noted that as staff do not always see themselves as a carer the figures would not be a full picture.

B66/15 TO RECEIVE A PRESENTATION ON WINTER PREPAREDNESS AND ED 4 HOUR TARGET

Ms Burnett, Ms Townsend and Dr Laundry, Clinical Lead for the Emergency Department (ED) gave a detailed presentation on the pressures within the ED and the actions being taken to support the department and winter preparedness.
(Slides sent under separate cover)

In response to a question from Mr Higgins, a discussion took place regarding support for ED in the short term from the CCG and community providers. Mr Brandreth gave details of the work with the CCG and the provisions of beds in the community and how the Trust is able to allocate patients to the beds. Mr Brandreth thanked Dr Laundry and his team for their hard work and added that he had spent 2 shifts in ED shadowing Dr Laundry which had highlighted the demands on Dr Laundry and the team and how the current physical layout of the department did not help clinicians.

Mr Wilkie asked about the recruitment of skilled staff for ED. Dr Laundry stated that staffing recruitment was difficult and that staffing levels would need to be increased in the long term. There is a need for middle grade doctors who can do clinical supervision and recruitment is always being undertaken both nationally and internationally. Ms Burnett added that there are 3 Advanced Nurse Practitioners currently being trained and options being considered for pharmacists and therapists to further support ED.

Sur Duncan thanked Ms Burnett, Ms Townsend, and Dr Laundry for the very informative presentation.

B67/15 TO REVIEW THE INTEGRATED PERFORMANCE REPORT TO MONTH 4 TO INCLUDE: Update on Cancer Performance and Consider and Approve the Trust's Cancer Access Policy

The Board received details on the key issues within the integrated performance report to Month 4.

Mr Brandreth reported that the Trust had achieved the C.Difficile, ED, RTT, cancer targets and the number of cancelled operations has reduced which demonstrated a good operational picture.

Mrs Hodkinson was pleased to report that the appraisal was not at 90.5% with 5 divisions now over the target of 5%.

Mrs Hodkinson gave an update on variable pay as detailed on page 24 of the performance report and it was noted that the People and Organisational Development Committee (POD) was undertaking a review of the spend. Mrs Hodkinson added that Mr Harvey would focus on medical agency spend as part of the High Quality Care Costs Less (HQCL) work and that she and her team will focus

on all other areas of variable pay.

Mrs O'Neill gave an overview of the Trust's current financial position and highlighted the following points:

- The Trust is £274k off plan.
- There is a shortfall on the CRS programme of £503k.
- There is a £1.2m spend on medical agency spend up to end of August 2015.
- Income is above plan for non-elective work and obstetrics, which is offsetting some of the cost pressures.
- There has been some temporary investment in Planned Care to support delivery of the CRS programme.

Mrs O'Neill stated that whilst the Trust was currently off plan, it is still expected to deliver the planned deficit at the end of the financial year.

Mr Wilkie asked about the improvement of long term sickness levels. Mrs Hodgkinson replied that this was due to intervention and the business partners working closely with managers to support staff.

Mrs Hopwood referred to the levels of staff who had received safeguarding training which was under expected levels. Mrs Kelly stated that the inclusion of the safeguarding training levels in the performance report was due to the levels being identified on the Board Assurance Framework. An action plan is in place to improve the level of staff who have received the training.

In response to a question from Mrs Hopwood, a discussion took place regarding the 10% of staff who leave the trust and their reasons for leaving. It was noted that Mrs Appleton-Cairns is reviewing the exit process for staff. Mrs Hodgkinson added that there was some concern around the number of Operating Department Practitioners (ODP) who are leaving the Trust and there were some areas of concern for nursing in the Planned Care division.

Mrs Hodgkinson stated that the reasons for staff leaving the Trust were reviewed at POD and that a 6 monthly workforce report would be brought to Board in December 2015.

In response to a question from Mr Higgins, a discussion took place regarding the levels of recurrent CRS identified to date and it was noted that some recurrent schemes were starting later in the year so would not show a full year of savings recurrently in this financial year.

Sir Duncan congratulated the cancer team for the achievements to date. Sir Duncan asked about the actions being taken to support the Urology team. Mr Brandreth stated that he had personally been involved with Mr Bett and the consultants and that there had been a real understanding and engagement with the clinicians to improve the service for patients.

The Integrated Performance Report for Month 4 was received by the Board.

Update on Cancer Performance

Mr Bett gave an overview of the requirements of the joint letter from the TDA, NHS England and Monitor to the Trust which included the need for the Trust to report weekly on cancer waiting times. Mr Bett confirmed that the Trust had not been asked to submit an improvement plan. The Trust has completed a self-assessment and it was noted that the Trust was compliant against all 8 standards.

Mr Bett presented the Trust's Cancer Operational Policy to the Board for approval, as this had been recently reviewed and updated. Mr Wilkie asked if the Trust's policy was in line with other Trusts. Mr Bett replied that there was nothing different in the policy and added that the policy had been discussed at the regional cancer leads meeting.

In response to a question from Mrs Hopwood, Mr Bett stated that the cancer operational policy was applied to all patients and that agreed to refer to Wales in the policy.

The Board approved the Cancer Operational Policy subject to the change as noted above.

B68/15 TO RECEIVE AN UPDATE OF THE NURSING & MIDWIFERY SAFE STAFFING ESTABLISHMENT REVIEW TO INCLUDE:
Specialist Nurse/Midwifery Review
Midwifery Establishment Review

Mrs Kelly outlined the details of the Nursing and Midwifery Safe Staffing Establishment Review and highlighted the following:

- A review of shift cover on night duty has been undertaken and that there is a need to redistribute workforce at night to where the staff are most needed to support the acuity of patients.
- The care and comfort role has been successful in Planned Care and will now be rolled out in Urgent Care.
- The trust is currently building in 20% cover for nursing staff however, the early work from Lord Carter shows that the Trust benchmarks lower than peers nationally. It was important that the trust manages the risk for annual leave, sickness and training.
- Following the Kirkup Report on Morecambe, the Trust is doing a detailed piece of work in the neonatal unit to ensure that it has the right skill mix of staff.
- A review is being undertaken in the context of workload in urgent care to include the quality and safe care for patients.
- There is some challenge around vacancies in Planned Care in relation to staff leaving the Trust, maternity leave, sickness and the number of students coming from the

University is lower than expected. The Trust is going to Spain to recruit 30 nurses. The Trust is managing the position with bank and agency staff and is meeting the staffing requirements.

In response to a question from Mr Wilkie, a full discussion took place regarding the allocation of 20% cover and the reserves in place for maternity leave which is different to other trusts. It was noted that the Trust provides quality and safe care for patients in which workforce can be flexible to support the acuity of the patient.

In response to a question from Higgins, a further discussion took place in relation to succession planning and the leadership development programme at the Trust.

Mrs Kelly stated that specialist nurses were an important part of the future workforce. The Heads of Nursing are doing a review around this role and a number of actions have already been implemented including upskilling the specialist nurses to support the wards during the winter.

Mrs Kelly stated that following the NICE Guidance issued for midwifery staffing levels, a further review had been undertaken. The staffing levels were currently 29 ladies to one member of staff which was slightly under the national recommendation. Ms Fogarty, head of Midwifery states that there is a shortfall of 3 staff but a further review will undertake in 6 months and staffing levels will then be reconsidered.

In response to a question from Mr Chambers, a discussion took place about the care contact time and now the support from the non-nursing roles for the wards can help ward managers. Mrs Kelly reported that feedback from Ward Managers was that there was a need to clarify the role of supervisory ward manager as there were a number of administrative tasks that could be completed by non-clinical staff.

Mr Oliver reported that he and Mrs Hodgkinson had visited the HR department that morning and that following discussions with the staff, it was not clear on the processes for authorising overtime. Mr Oliver suggested that it may be useful for POD to link into the next nursing and midwifery establishment review in terms of mapping which departments have an overspend and to revisit the paper trail from the ward. Mrs Kelly added that the advantage of the Lord Carter work was the support for e-rostering which would reduce the amount of paperwork.

B69/15 TO RECEIVE DETAILS OF DOCTORS / NURSING & MIDWIFERY REVALIDATION TO INCLUDE ANNUAL MEDICAL APPRAISAL REVALIDATION REPORT

Mr Harvey presented that second annual report for Medical Appraisal Revalidation. It was noted that all doctors have received an appraisal within the new timeframe of 15 months. All processes are also in place and recommendations to the GMC on doctors have been made in a timely manner.

Mr Harvey added that there has been a change from previous years in relation to the numbers of doctors undergoing fitness to practice reviews with the GMC. There have 5 doctors entered into fitness to practice reviews during the last 12 months from the Trust. Mr Harvey stated that there has been a change in the public perception of the GMC as each referral of a Doctor to the GMC is due to a complaint.

Mrs Kelly presented that Nursing and Midwifery Revalidation paper. The revalidation process for all nurses and midwives to undergo revalidation every 3 years will commence in April 2016. Mrs Kelly, as Director of Nursing and Quality is responsible for ensuring that all nurses and midwives are registered and revalidated. There is a lot of work in progress and the revalidation process is also being monitored by POD.

The Trust has completed a self-assessment and this has highlighted that where a nurse does not have a nurse manager, there is an issue as to who should undertake their professional appraisal and revalidation. It was noted that this was a detailed paper and that a lot of work was underway. The POD will receive regular updates on the progress of the revalidation.

Mr Wilkie asked if the process for CPD for nurses was straight forward. Mrs Kelly replied that it was not more than nurses were already completing.

B70/15 TO RECEIVE AN UPDATE ON THE 6 MONTHLY NURSING & MIDWIFERY STRATEGY UPDATE

Mrs Kelly presented the update on progress of the 6 monthly Nursing and Midwifery Strategy to the Board.

In response to a question from Mrs Hopwood, a discussion took place regarding the involvement of the Countess with Betsi Cadwaladr Health Board and their potential redesign of services.

B71/15 TO RECEIVE THE TRUST'S MORTALITY REPORT

Mr Harvey presented the mortality report to the Board and outlined the new process for review of mortality at the Trust and the move to HED clinical benchmarking. Mr Harvey now personally reviews every death in the Trust and then refers cases for further review where appropriate.

Sir Duncan referred to the figures for mortality at weekends and asked if the levels are not due to anything the Trust is doing, what could it be? Mr Harvey replied that this was a national issue however, the levels at the weekend can be lower than in the week on some occasions. Mr Harvey stated that there is a need for clarification from coders as to if there is an issue on documentation and note keeping due to the pressures at the weekend. Mr Harvey is attending the North West Mortality Group October 2015, where the group will receive a presentation

from SHMI and there will be an opportunity for clinicians to discuss the SHMI levels.

B72/15 TO RECEIVE AN UPDATE ON NEVER EVENTS AND SERIOUS UNTOWARD INCIDENTS

Mrs Kelly reported that there had been no never events.

Mrs Kelly reported that there are 4 level 2 investigations currently being undertaken at the Trust and these were being monitored and reviewed at the Quality, Safety and Patient Experience Committee.

STRATEGIC DEVELOPMENT

B73/15 TO RECEIVE THE CHIEF EXECUTIVE'S REPORT (VERBAL)

Mr Chambers gave an update on the following points:

- At the beginning of August 2015, the Trust welcomed 24 newly qualified doctors and they are a welcome addition to team Countess.
- The Trust now teaches 5th, 4th and 3rd year students.
- Following feedback from patients and services users, the new Way Finding Signage has now been installed. The signage has been created with input from Helen Clifton, Public Governor and has been welcomed across the Trust.
- The Trust is holding 3 listening events in September 2015, these events give the public the opportunity to give their views on the Countess of Chester Hospital NHS Foundation Trust.
- Chris Matheson, MP for Chester opened the Trust's new CT scanner in August 2015. The scanner is one of only three in the UK.
- Lord Prior will be visiting the trust on 4th September 2015 to see the work that the Trust is doing in terms of staffing and productivity and in relation to procurement and stores management.
-

B74/15 TO RECEIVE AN UPDATE ON GOVERNOR MATTERS

Mr Cross gave an update on the following points:

- Mr Cross thanked Governors for their continued support and hard work.
- There will be a Council of Governors meeting following the Board meeting, which will include a 'Getting to Know Us' session with the Executive Team.
- The Governor elections are currently underway and there has been a good level of voting to date.
- There is a change to the date of the next Board of Directors meeting which will now be held at 1pm on Tuesday 13th October 2015.
- The Annual Members Meeting will be held at 5pm on Tuesday 13th October 2015.

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FOR NOTING& RECEIPT

B75/15 **TO RECEIVE THE Q1 LETTER TO MONITOR**

The Board received and noted the Q1 letter to Monitor.

B76/15 **TO RECEIVE THE Q4 AND 15/16 ANNUAL PLAN REVIEW LETTER FROM MONITOR**

The Board Received And Noted The Q4 and 15/16 Annual Plan Review Letter From Monitor.

B77/15 **TO RECEIVE THE LETTER FROM MONITOR REGARDING DT SECTOR PLANS AND FINANCIAL CHALLENGE AND THE TRUST'S RESPONSE**

The Board received and noted the letter from Monitor regarding FT sector plans and financial challenge and the Trust's response.

B78/15 **TO RECEIVE THE MINUTES OF THE QUALITY, SAFETY AND PATIENT EXPERIENCE COMMITTEE – 15TH JUNE 2015**

The Board received and noted the minutes of the Quality, Safety and Patient Experience Committee – 15th June 2015.

B79/15 **TO RECEIVE THE MINUTES OF THE PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE – 2ND JUNE 2015**

The Board received and noted the minutes of the People and Organisational Development Committee – 2nd June 2015.

B80/15 **TO RECEIVE THE SAFEGUARDING CHILDREN'S ANNUAL REPORT 2014/15**

The Board received and noted the Safeguarding Children's Annual Report 2014/15.

B81/15 **TO RECEIVE THE DOMESTIC ABUSE ANNUAL REPORT 2014/15**

The Board received and noted the Domestic Abuse Annual Report 2014/15.

B82/15 **TO RECEIVE THE OVERSEAS VISITORS POLICY**

The Board received and noted the Overseas Visitors Policy.

B83/15 **TO RECEIVE THE CORPORATE INFECTION PREVENTION AND CONTROL ASSURANCE – QUARTERLY REPORT (RETROSPECTIVE REPORT BASED UPON MAY 2015 QUARTERLY DATA UPDATE)**

The Board received and noted the Corporate Infection Prevention And Control Assurance – Quarterly Report (Retrospective Report Based Upon May 2015 Quarterly Data Update.

B84/15 **TO RECEIVE THE DETAILS OF THE FREEDOM OF INFORMATION REQUESTS
RECEIVED BY THE TRUST FROM APRIL 2015 – JULY 2015**

The Board received and noted the Freedom Of Information Requests Received by the Trust From April 2015 – July 2015.

B85/15 **DATE AND TIME OF NEXT MEETING**

Tuesday, 13th October 2015 – 1.00pm Education and Training Centre, Countess of Chester Hospital.

BOARD OF DIRECTORS ACTION LOG 2014/15 & 2015/16

Meeting Date	Minute Ref:	Issue	Action	Update	Responsibility	Target Date
07.07.15	B45/15	Review of issues being raised in complaints	Alison Kelly to present Complaints and PALS Annual Report 2014/15 to Board		Alison Kelly	October 2015
07.07.15		Communication to staff and public in relation to Vanguard and the shape, scope and ambition for local and regional health services	Sue Hodgkinson to lead via People and Organisational Development Committee	Following discussion at EDG – this will be led through the System Wide Strategic Leadership Group	Tony Chambers	December 2015

	Action has slipped
	Action is not yet complete but on track
	Action complete
*	Moved with agreement



Integrated Board Report - August 2015

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Appendices:

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**Are we
safe?**

**BAF ref:
CR1, CR2,
CR3, CR6,
CR7, CR10**

Description

Current position/comments

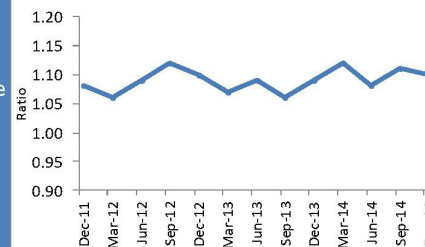
Trend

Target

Mortality
SHMI

Risk adjusted mortality ratio based on number of expected deaths. National published figure from HSCIC.

This measure does not take into account palliative care codes. It provides a complete picture of hospital deaths and includes deaths within 30 days of discharge showing whether the Trust is within the expected range when compared to the quarterly rebased national baseline.



As expected - Blue

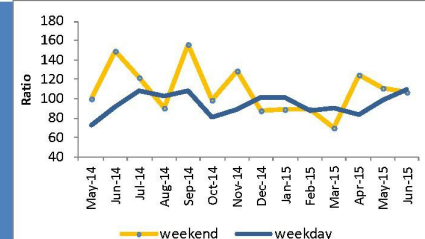
Above expected - Red

Below expected - Green

Mortality
HSMR

Ratio is the number of observed deaths divided by predicted deaths. HSMR looks at diagnoses which most commonly result in death

This measure is based on specific diagnosis groups that account for approx 80% of our inpatients. A ratio of greater than 100 means more deaths occurred than expected, while a ratio of less than 100 suggests fewer deaths occurred than expected.



As expected - Blue

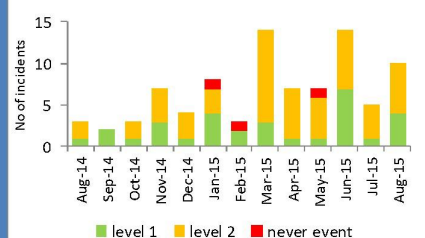
Above expected - Red

Below expected - Green

Serious
Untoward
Incidents

Level 2 severe harm or death to patient. Never events are serious largely preventable pt safety

There were 4 Lvl 1s and 6 Lvl 2s declared. Level 1s - 2 Delays in diagnosis; Missed Pneumothorax; Gas Anaesthesia administered in wheelchair; Level 2s - A patient who died relating to CDiff; an IG breach involving a clinical handover document; A patient not placed on the relevant waiting list for surgery; ED discharge summaries; Adult safeguarding involving a member of staff; Post-op

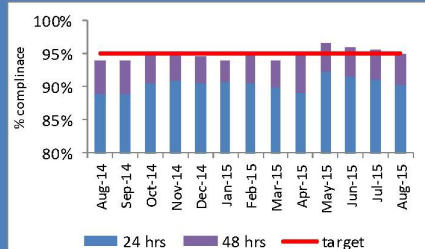


No current target but any Never event highlighted as red in month

Electronic
Discharge
for
admitted
patients

90% of electronic discharges for admitted pts should be sent within 24 hrs, 95% within 48 hrs and all within 2 weeks

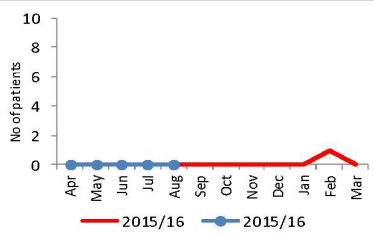
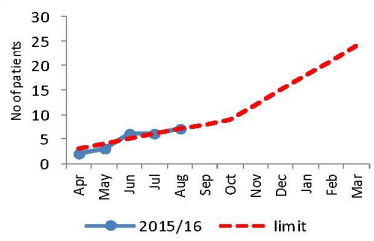
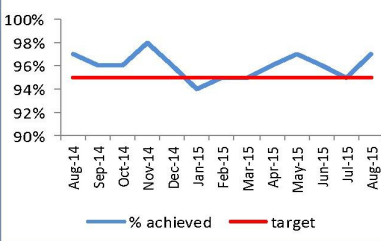
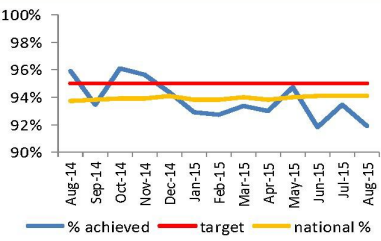
Performance within 48 hours has been narrowly missed for August (94.92%) The performance for this financial year has been revised to reflect working days as reported in the previous year. See page 16 for exception report.



90% within 24 hrs per month

95% within 48 hrs per month

**Are we
safe?**

	Description	Current position/comments	Trend	Target
	Number of cases of hospital acquired MRSA bacteraemia (meticillin-resistant staphylococcus aureus)	The target for MRSA is zero cases within the year. There were no cases in August.		Zero cases for the year
	Number of cases of Clostridium Difficile	A maximum of 24 cases has been set for 2015/16. There was one case for August which is on trajectory for the year to date		24 maximum annual cases exception report if two consecutive months over trajectory
	Based on ward based hand hygiene audits. Each ward is required to submit two audits each month	Performance has achieved since February 2015		95% each month
	Tool to survey a snapshot of harm free patient care. Includes pressure ulcers, falls, catheters, UTIs and VTE	Performance against target fell from previous month. Exception report provided on page 15		Compare to National average Above average - Green Below average - red

**Are we
safe?**

	Description	Current position/comments	Trend	Target																												
Safe Staffing	Actual staffing compared to planned for registered nurses/ midwives and care staff	Safe staffing remains above target. See pages 31 to 33 for detailed safe staffing report	<table><caption>% staff planned/actual</caption><thead><tr><th>Month</th><th>% staff planned/actual</th></tr></thead><tbody><tr><td>Aug-14</td><td>98%</td></tr><tr><td>Sep-14</td><td>97%</td></tr><tr><td>Oct-14</td><td>100%</td></tr><tr><td>Nov-14</td><td>100%</td></tr><tr><td>Dec-14</td><td>99%</td></tr><tr><td>Jan-15</td><td>99%</td></tr><tr><td>Feb-15</td><td>99%</td></tr><tr><td>Mar-15</td><td>98%</td></tr><tr><td>Apr-15</td><td>98%</td></tr><tr><td>May-15</td><td>99%</td></tr><tr><td>Jun-15</td><td>99%</td></tr><tr><td>Jul-15</td><td>98%</td></tr><tr><td>Aug-15</td><td>97%</td></tr></tbody></table>	Month	% staff planned/actual	Aug-14	98%	Sep-14	97%	Oct-14	100%	Nov-14	100%	Dec-14	99%	Jan-15	99%	Feb-15	99%	Mar-15	98%	Apr-15	98%	May-15	99%	Jun-15	99%	Jul-15	98%	Aug-15	97%	>95% per month
Month	% staff planned/actual																															
Aug-14	98%																															
Sep-14	97%																															
Oct-14	100%																															
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May-15	99%																															
Jun-15	99%																															
Jul-15	98%																															
Aug-15	97%																															
DoLS	Number of Deprivation of Liberty applications requested during the quarter	Due to legislative changes in relation to DoLS in March 2014 our practice and criteria for applications in relation to these legal applications has substantially altered thus leading to increases in the numbers required. There is a current focus on education and training in respect of this area which is being closely monitored	<table><caption>No of patients</caption><thead><tr><th>Quarter</th><th>Requested</th><th>Authorised</th></tr></thead><tbody><tr><td>Q1</td><td>10</td><td>5</td></tr><tr><td>Q2</td><td>65</td><td>10</td></tr><tr><td>Q3</td><td>70</td><td>15</td></tr><tr><td>Q4</td><td>55</td><td>20</td></tr><tr><td>Q1</td><td>65</td><td>10</td></tr></tbody></table>	Quarter	Requested	Authorised	Q1	10	5	Q2	65	10	Q3	70	15	Q4	55	20	Q1	65	10	No target for this measure but has to be reported at Board level										
Quarter	Requested	Authorised																														
Q1	10	5																														
Q2	65	10																														
Q3	70	15																														
Q4	55	20																														
Q1	65	10																														
Safeguarding training	% of level 2 training undertaken to be split by training for Adults and Children	he Director of Nursing & Quality is personally focusing on those who are non-compliant. It is essential that both adults and childrens safeguarding training compliance is improved. An exception report is provided on page 17	<table><caption>% of level 2 training</caption><thead><tr><th>Month</th><th>Adult</th><th>Children</th></tr></thead><tbody><tr><td>Jun-15</td><td>30%</td><td>70%</td></tr><tr><td>Jul-15</td><td>30%</td><td>70%</td></tr><tr><td>Aug-15</td><td>30%</td><td>70%</td></tr></tbody></table>	Month	Adult	Children	Jun-15	30%	70%	Jul-15	30%	70%	Aug-15	30%	70%	>80% in month																
Month	Adult	Children																														
Jun-15	30%	70%																														
Jul-15	30%	70%																														
Aug-15	30%	70%																														
Inpatient Falls with harm	Inpatient falls with moderate or above harm	No falls with moderate or above harm for the month of August	<table><caption>No of falls with harm</caption><thead><tr><th>Month</th><th>No of falls with harm</th></tr></thead><tbody><tr><td>Apr</td><td>1</td></tr><tr><td>May</td><td>1</td></tr><tr><td>Jun</td><td>3</td></tr><tr><td>Jul</td><td>3</td></tr><tr><td>Aug</td><td>0</td></tr><tr><td>Sep</td><td>0</td></tr><tr><td>Oct</td><td>0</td></tr><tr><td>Nov</td><td>0</td></tr><tr><td>Dec</td><td>0</td></tr><tr><td>Jan</td><td>0</td></tr><tr><td>Feb</td><td>0</td></tr><tr><td>Mar</td><td>0</td></tr></tbody></table>	Month	No of falls with harm	Apr	1	May	1	Jun	3	Jul	3	Aug	0	Sep	0	Oct	0	Nov	0	Dec	0	Jan	0	Feb	0	Mar	0	Any falls with harm - red Target is zero cases in month		
Month	No of falls with harm																															
Apr	1																															
May	1																															
Jun	3																															
Jul	3																															
Aug	0																															
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Jan	0																															
Feb	0																															
Mar	0																															

Are we effective?

	Description	Current position/comments	13 month rolling trend	Target																																																							
Stroke	Western Cheshire CCG Stroke patients who spend at least 90% of their time in hospital on a stroke unit .	The stroke target was above the standard in July. TIA performance was 100% against the target of 60% . The measure will be one month behind due to clinical coding	<table border="1"><thead><tr><th>Month</th><th>% achieved</th><th>target</th></tr></thead><tbody><tr><td>Jul-14</td><td>75%</td><td>80%</td></tr><tr><td>Aug-14</td><td>85%</td><td>80%</td></tr><tr><td>Sep-14</td><td>80%</td><td>80%</td></tr><tr><td>Oct-14</td><td>85%</td><td>80%</td></tr><tr><td>Nov-14</td><td>85%</td><td>80%</td></tr><tr><td>Dec-14</td><td>75%</td><td>80%</td></tr><tr><td>Jan-15</td><td>80%</td><td>80%</td></tr><tr><td>Feb-15</td><td>80%</td><td>80%</td></tr><tr><td>Mar-15</td><td>90%</td><td>80%</td></tr><tr><td>Apr-15</td><td>85%</td><td>80%</td></tr><tr><td>May-15</td><td>90%</td><td>80%</td></tr><tr><td>Jun-15</td><td>85%</td><td>80%</td></tr><tr><td>Jul-15</td><td>85%</td><td>80%</td></tr></tbody></table>	Month	% achieved	target	Jul-14	75%	80%	Aug-14	85%	80%	Sep-14	80%	80%	Oct-14	85%	80%	Nov-14	85%	80%	Dec-14	75%	80%	Jan-15	80%	80%	Feb-15	80%	80%	Mar-15	90%	80%	Apr-15	85%	80%	May-15	90%	80%	Jun-15	85%	80%	Jul-15	85%	80%	>80% per month													
Month	% achieved	target																																																									
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May-15	90%	80%																																																									
Jun-15	85%	80%																																																									
Jul-15	85%	80%																																																									
Sepsis	National CQUIN. Random sample audit per month on 2 parts.	Part 1 - If identified as a sepsis patient were they screened following local protocol? Only 1 patient identified in sample for Apr and they were screened. May and June = 0 pts were caught in sample with sepsis Part 2 - If a patient identified as 'Red Flag' or 'Severe' sepsis did they receive IV antibiotics within 1 hr of arrival? Two patients identified in June who had received antibiotics	<table border="1"><thead><tr><th>Month</th><th>Part 1</th><th>Part 2</th></tr></thead><tbody><tr><td>Apr-15</td><td>100%</td><td>100%</td></tr><tr><td>May-15</td><td>100%</td><td>0%</td></tr><tr><td>Jun-15</td><td>100%</td><td>100%</td></tr><tr><td>Jul-15</td><td>100%</td><td>100%</td></tr><tr><td>Aug-15</td><td>100%</td><td>100%</td></tr><tr><td>Sep-15</td><td>100%</td><td>100%</td></tr><tr><td>Oct-15</td><td>100%</td><td>100%</td></tr><tr><td>Nov-15</td><td>100%</td><td>100%</td></tr><tr><td>Dec-15</td><td>100%</td><td>100%</td></tr><tr><td>Jan-16</td><td>100%</td><td>100%</td></tr><tr><td>Feb-16</td><td>100%</td><td>100%</td></tr><tr><td>Mar-16</td><td>100%</td><td>100%</td></tr></tbody></table>	Month	Part 1	Part 2	Apr-15	100%	100%	May-15	100%	0%	Jun-15	100%	100%	Jul-15	100%	100%	Aug-15	100%	100%	Sep-15	100%	100%	Oct-15	100%	100%	Nov-15	100%	100%	Dec-15	100%	100%	Jan-16	100%	100%	Feb-16	100%	100%	Mar-16	100%	100%	CQUIN will be awarded if improvement from baseline, Q1, (or maintained if 100%) is demonstrated																
Month	Part 1	Part 2																																																									
Apr-15	100%	100%																																																									
May-15	100%	0%																																																									
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Mar-16	100%	100%																																																									
Acute Kidney Injury	National CQUIN. Random sample of 25 patients who had an AKI alert during their stay 'Did their discharge summary include 4 key items?'	4 key items: *Stage of AKI *Medicine review *Blood tests requested on discharge *Frequency of blood tests post discharge	<table border="1"><thead><tr><th>Month</th><th>Stage</th><th>Med review</th><th>BldTstRqe</th><th>BldTstFreq</th></tr></thead><tbody><tr><td>Jul-15</td><td>100%</td><td>90%</td><td>82%</td><td>85%</td></tr><tr><td>Aug-15</td><td>100%</td><td>95%</td><td>82%</td><td>85%</td></tr><tr><td>Sep-15</td><td>100%</td><td>95%</td><td>82%</td><td>85%</td></tr><tr><td>Oct-15</td><td>100%</td><td>95%</td><td>82%</td><td>85%</td></tr><tr><td>Nov-15</td><td>100%</td><td>95%</td><td>82%</td><td>85%</td></tr><tr><td>Dec-15</td><td>100%</td><td>95%</td><td>82%</td><td>85%</td></tr><tr><td>Jan-16</td><td>100%</td><td>95%</td><td>82%</td><td>85%</td></tr><tr><td>Feb-16</td><td>100%</td><td>95%</td><td>82%</td><td>85%</td></tr><tr><td>Mar-16</td><td>100%</td><td>95%</td><td>82%</td><td>85%</td></tr><tr><td>Apr-16</td><td>100%</td><td>95%</td><td>82%</td><td>85%</td></tr></tbody></table>	Month	Stage	Med review	BldTstRqe	BldTstFreq	Jul-15	100%	90%	82%	85%	Aug-15	100%	95%	82%	85%	Sep-15	100%	95%	82%	85%	Oct-15	100%	95%	82%	85%	Nov-15	100%	95%	82%	85%	Dec-15	100%	95%	82%	85%	Jan-16	100%	95%	82%	85%	Feb-16	100%	95%	82%	85%	Mar-16	100%	95%	82%	85%	Apr-16	100%	95%	82%	85%	Target not agreed. Measure to be agreed by Sept15
Month	Stage	Med review	BldTstRqe	BldTstFreq																																																							
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Mar-16	100%	95%	82%	85%																																																							
Apr-16	100%	95%	82%	85%																																																							
Dementia	National CQUIN. % of patients aged 75 or above asked case finding question within 72 hours of admission	There is a continued achievement of this target	<table border="1"><thead><tr><th>Month</th><th>% achieved</th><th>target</th></tr></thead><tbody><tr><td>Aug-14</td><td>94%</td><td>90%</td></tr><tr><td>Sep-14</td><td>93%</td><td>90%</td></tr><tr><td>Oct-14</td><td>92%</td><td>90%</td></tr><tr><td>Nov-14</td><td>93%</td><td>90%</td></tr><tr><td>Dec-14</td><td>94%</td><td>90%</td></tr><tr><td>Jan-15</td><td>94%</td><td>90%</td></tr><tr><td>Feb-15</td><td>95%</td><td>90%</td></tr><tr><td>Mar-15</td><td>95%</td><td>90%</td></tr><tr><td>Apr-15</td><td>96%</td><td>90%</td></tr><tr><td>May-15</td><td>97%</td><td>90%</td></tr><tr><td>Jun-15</td><td>96%</td><td>90%</td></tr><tr><td>Jul-15</td><td>97%</td><td>90%</td></tr><tr><td>Aug-15</td><td>97%</td><td>90%</td></tr></tbody></table>	Month	% achieved	target	Aug-14	94%	90%	Sep-14	93%	90%	Oct-14	92%	90%	Nov-14	93%	90%	Dec-14	94%	90%	Jan-15	94%	90%	Feb-15	95%	90%	Mar-15	95%	90%	Apr-15	96%	90%	May-15	97%	90%	Jun-15	96%	90%	Jul-15	97%	90%	Aug-15	97%	90%	>90%													
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Jul-15	97%	90%																																																									
Aug-15	97%	90%																																																									

**Are we
caring?**

**BAF ref:
CR1, CR4,
CR6, CR7,
CR10**

	Description	Current position/comments	Trend	Target																																																																						
Friends & Family - % likely to recommend	Would patients recommend service to friends & family. Introduced in 2013 for Inpatients, A&E and maternity.	Outpatient and day case services were introduced from April 2015	<table><thead><tr><th>Month</th><th>A&E</th><th>IP</th><th>Mat</th></tr></thead><tbody><tr><td>Apr-15</td><td>83%</td><td>97%</td><td>94%</td></tr><tr><td>May-15</td><td>86%</td><td>98%</td><td>97%</td></tr><tr><td>Jun-15</td><td>81%</td><td>96%</td><td>96%</td></tr><tr><td>Jul-15</td><td>84%</td><td>99%</td><td>95%</td></tr><tr><td>Aug-15</td><td>83%</td><td>99%</td><td>96%</td></tr></tbody></table>	Month	A&E	IP	Mat	Apr-15	83%	97%	94%	May-15	86%	98%	97%	Jun-15	81%	96%	96%	Jul-15	84%	99%	95%	Aug-15	83%	99%	96%	Target to be agreed with Director of Nursing by Sept 15																																														
Month	A&E	IP	Mat																																																																							
Apr-15	83%	97%	94%																																																																							
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Friends & Family response rate	Number of responses received for IP, A&E and maternity compared to eligible patients	The response rate for inpatients in August underperformed. Exception report on page 18	<table><thead><tr><th>Month</th><th>Response Rate (%)</th></tr></thead><tbody><tr><td>Aug-14</td><td>18%</td></tr><tr><td>Sep-14</td><td>20%</td></tr><tr><td>Oct-14</td><td>18%</td></tr><tr><td>Nov-14</td><td>20%</td></tr><tr><td>Dec-14</td><td>16%</td></tr><tr><td>Jan-15</td><td>25%</td></tr><tr><td>Feb-15</td><td>10%</td></tr><tr><td>Mar-15</td><td>20%</td></tr><tr><td>Apr-15</td><td>16%</td></tr><tr><td>May-15</td><td>20%</td></tr><tr><td>Jun-15</td><td>18%</td></tr><tr><td>Jul-15</td><td>10%</td></tr><tr><td>Aug-15</td><td>8%</td></tr></tbody></table>	Month	Response Rate (%)	Aug-14	18%	Sep-14	20%	Oct-14	18%	Nov-14	20%	Dec-14	16%	Jan-15	25%	Feb-15	10%	Mar-15	20%	Apr-15	16%	May-15	20%	Jun-15	18%	Jul-15	10%	Aug-15	8%	>15% per month																																										
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Feedback	Monthly Trust complaints and formal thank you letters received by the Trust	In August 2015 the Trust received 20 new formal complaints. 90% of all complaints were sent out within time, up from 82% in June. The Chief Executives office received eight formal thank you letters for the month of August	<table><thead><tr><th>Month</th><th>Complaints received</th><th>Average</th><th>UCL</th><th>LCL</th></tr></thead><tbody><tr><td>Aug-14</td><td>20</td><td>20</td><td>35</td><td>5</td></tr><tr><td>Sep-14</td><td>25</td><td>20</td><td>35</td><td>5</td></tr><tr><td>Oct-14</td><td>28</td><td>20</td><td>35</td><td>5</td></tr><tr><td>Nov-14</td><td>28</td><td>20</td><td>35</td><td>5</td></tr><tr><td>Dec-14</td><td>22</td><td>20</td><td>35</td><td>5</td></tr><tr><td>Jan-15</td><td>22</td><td>20</td><td>35</td><td>5</td></tr><tr><td>Feb-15</td><td>22</td><td>20</td><td>35</td><td>5</td></tr><tr><td>Mar-15</td><td>15</td><td>20</td><td>35</td><td>5</td></tr><tr><td>Apr-15</td><td>15</td><td>20</td><td>35</td><td>5</td></tr><tr><td>May-15</td><td>18</td><td>20</td><td>35</td><td>5</td></tr><tr><td>Jun-15</td><td>25</td><td>20</td><td>35</td><td>5</td></tr><tr><td>Jul-15</td><td>25</td><td>20</td><td>35</td><td>5</td></tr><tr><td>Aug-15</td><td>20</td><td>20</td><td>35</td><td>5</td></tr></tbody></table>	Month	Complaints received	Average	UCL	LCL	Aug-14	20	20	35	5	Sep-14	25	20	35	5	Oct-14	28	20	35	5	Nov-14	28	20	35	5	Dec-14	22	20	35	5	Jan-15	22	20	35	5	Feb-15	22	20	35	5	Mar-15	15	20	35	5	Apr-15	15	20	35	5	May-15	18	20	35	5	Jun-15	25	20	35	5	Jul-15	25	20	35	5	Aug-15	20	20	35	5	Complaints to be within expected control limits
Month	Complaints received	Average	UCL	LCL																																																																						
Aug-14	20	20	35	5																																																																						
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Jul-15	25	20	35	5																																																																						
Aug-15	20	20	35	5																																																																						
Mixed Sex accommodation breaches	Number of breaches to the mixed sex accommodation standard for non clinical reasons	There were no breaches to this standard in the month of August	<table><thead><tr><th>Month</th><th>No of breaches</th></tr></thead><tbody><tr><td>Aug-14</td><td>0</td></tr><tr><td>Sep-14</td><td>0</td></tr><tr><td>Oct-14</td><td>0</td></tr><tr><td>Nov-14</td><td>4</td></tr><tr><td>Dec-14</td><td>0</td></tr><tr><td>Jan-15</td><td>0</td></tr><tr><td>Feb-15</td><td>0</td></tr><tr><td>Mar-15</td><td>0</td></tr><tr><td>Apr-15</td><td>0</td></tr><tr><td>May-15</td><td>0</td></tr><tr><td>Jun-15</td><td>0</td></tr><tr><td>Jul-15</td><td>0</td></tr><tr><td>Aug-15</td><td>0</td></tr></tbody></table>	Month	No of breaches	Aug-14	0	Sep-14	0	Oct-14	0	Nov-14	4	Dec-14	0	Jan-15	0	Feb-15	0	Mar-15	0	Apr-15	0	May-15	0	Jun-15	0	Jul-15	0	Aug-15	0	Zero cases per month																																										
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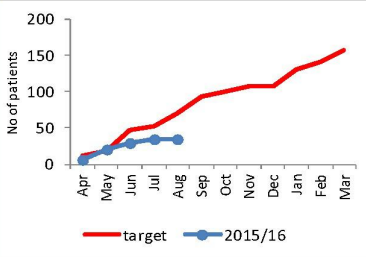
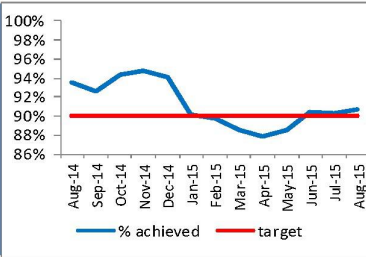
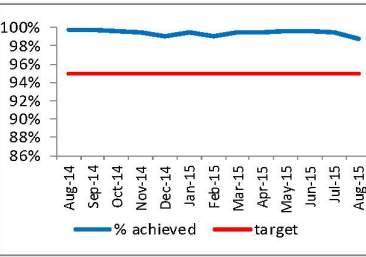
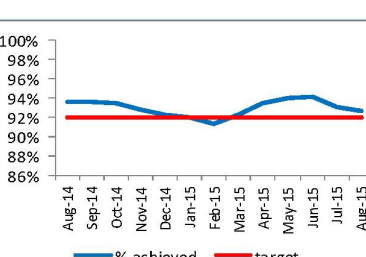
Are we responsive?

BAF ref:
CR3, CR5,
CR6, CR7,
CR8, CR9,
CR10

	Description	Current position/comments	13 month rolling trend	Target																												
Diagnostic 6 week standard	Diagnostic tests to be carried out within 6 weeks of request being received. This is measured on the National DM01 return.	Diagnostics failed the target however did improve in August. See page 19 for exception report.	<table><thead><tr><th>Month</th><th>% achieved</th></tr></thead><tbody><tr><td>Aug-14</td><td>98.5%</td></tr><tr><td>Sep-14</td><td>99.5%</td></tr><tr><td>Oct-14</td><td>99.5%</td></tr><tr><td>Nov-14</td><td>99.5%</td></tr><tr><td>Dec-14</td><td>99.5%</td></tr><tr><td>Jan-15</td><td>99.5%</td></tr><tr><td>Feb-15</td><td>99.5%</td></tr><tr><td>Mar-15</td><td>98.5%</td></tr><tr><td>Apr-15</td><td>96.5%</td></tr><tr><td>May-15</td><td>97.5%</td></tr><tr><td>Jun-15</td><td>95.5%</td></tr><tr><td>Jul-15</td><td>96.5%</td></tr><tr><td>Aug-15</td><td>98.5%</td></tr></tbody></table>	Month	% achieved	Aug-14	98.5%	Sep-14	99.5%	Oct-14	99.5%	Nov-14	99.5%	Dec-14	99.5%	Jan-15	99.5%	Feb-15	99.5%	Mar-15	98.5%	Apr-15	96.5%	May-15	97.5%	Jun-15	95.5%	Jul-15	96.5%	Aug-15	98.5%	99% per month
Month	% achieved																															
Aug-14	98.5%																															
Sep-14	99.5%																															
Oct-14	99.5%																															
Nov-14	99.5%																															
Dec-14	99.5%																															
Jan-15	99.5%																															
Feb-15	99.5%																															
Mar-15	98.5%																															
Apr-15	96.5%																															
May-15	97.5%																															
Jun-15	95.5%																															
Jul-15	96.5%																															
Aug-15	98.5%																															
Cancer 62 day standard	First treatment for cancer within 62 days of urgent referral through GP 2 week referral route. 85% threshold	The position for July has now been finalised at 94.87% with 3 breaches. The provisional position for August is currently 80.53% with 11 breaches, this was a narrow underperformance by 4 breaches. The current position for Quarter 2 is above target at 87.73%. Exception report on page 20	<table><thead><tr><th>Month</th><th>% achieved</th></tr></thead><tbody><tr><td>Aug-14</td><td>75%</td></tr><tr><td>Sep-14</td><td>80%</td></tr><tr><td>Oct-14</td><td>82%</td></tr><tr><td>Nov-14</td><td>85%</td></tr><tr><td>Dec-14</td><td>78%</td></tr><tr><td>Jan-15</td><td>85%</td></tr><tr><td>Feb-15</td><td>85%</td></tr><tr><td>Mar-15</td><td>85%</td></tr><tr><td>Apr-15</td><td>85%</td></tr><tr><td>May-15</td><td>82%</td></tr><tr><td>Jun-15</td><td>85%</td></tr><tr><td>Jul-15</td><td>95%</td></tr><tr><td>Aug-15</td><td>80%</td></tr></tbody></table>	Month	% achieved	Aug-14	75%	Sep-14	80%	Oct-14	82%	Nov-14	85%	Dec-14	78%	Jan-15	85%	Feb-15	85%	Mar-15	85%	Apr-15	85%	May-15	82%	Jun-15	85%	Jul-15	95%	Aug-15	80%	85% per Quarter
Month	% achieved																															
Aug-14	75%																															
Sep-14	80%																															
Oct-14	82%																															
Nov-14	85%																															
Dec-14	78%																															
Jan-15	85%																															
Feb-15	85%																															
Mar-15	85%																															
Apr-15	85%																															
May-15	82%																															
Jun-15	85%																															
Jul-15	95%																															
Aug-15	80%																															
Cancer 31 day standard	Patients receiving first definitive treatment within 1 month of cancer diagnosis. The threshold is 96%.	The 31 day standard continues to achieve	<table><thead><tr><th>Month</th><th>% achieved</th></tr></thead><tbody><tr><td>Aug-14</td><td>97.5%</td></tr><tr><td>Sep-14</td><td>97.5%</td></tr><tr><td>Oct-14</td><td>98.5%</td></tr><tr><td>Nov-14</td><td>98.5%</td></tr><tr><td>Dec-14</td><td>98.5%</td></tr><tr><td>Jan-15</td><td>98.5%</td></tr><tr><td>Feb-15</td><td>99.5%</td></tr><tr><td>Mar-15</td><td>99.5%</td></tr><tr><td>Apr-15</td><td>98.5%</td></tr><tr><td>May-15</td><td>98.5%</td></tr><tr><td>Jun-15</td><td>97.5%</td></tr><tr><td>Jul-15</td><td>99.5%</td></tr><tr><td>Aug-15</td><td>97.5%</td></tr></tbody></table>	Month	% achieved	Aug-14	97.5%	Sep-14	97.5%	Oct-14	98.5%	Nov-14	98.5%	Dec-14	98.5%	Jan-15	98.5%	Feb-15	99.5%	Mar-15	99.5%	Apr-15	98.5%	May-15	98.5%	Jun-15	97.5%	Jul-15	99.5%	Aug-15	97.5%	96% per Quarter
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Jul-15	99.5%																															
Aug-15	97.5%																															
Cancer 2 week standard	Patients referred from GP with suspected cancer should have their first appointment within 14 calendar days	Performance against this standard continues to be achieved.	<table><thead><tr><th>Month</th><th>% achieved</th></tr></thead><tbody><tr><td>Aug-14</td><td>97.5%</td></tr><tr><td>Sep-14</td><td>98.5%</td></tr><tr><td>Oct-14</td><td>97.5%</td></tr><tr><td>Nov-14</td><td>96.5%</td></tr><tr><td>Dec-14</td><td>94.5%</td></tr><tr><td>Jan-15</td><td>96.5%</td></tr><tr><td>Feb-15</td><td>96.5%</td></tr><tr><td>Mar-15</td><td>96.5%</td></tr><tr><td>Apr-15</td><td>95.5%</td></tr><tr><td>May-15</td><td>95.5%</td></tr><tr><td>Jun-15</td><td>96.5%</td></tr><tr><td>Jul-15</td><td>96.5%</td></tr><tr><td>Aug-15</td><td>96.5%</td></tr></tbody></table>	Month	% achieved	Aug-14	97.5%	Sep-14	98.5%	Oct-14	97.5%	Nov-14	96.5%	Dec-14	94.5%	Jan-15	96.5%	Feb-15	96.5%	Mar-15	96.5%	Apr-15	95.5%	May-15	95.5%	Jun-15	96.5%	Jul-15	96.5%	Aug-15	96.5%	93% per Quarter
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Jul-15	96.5%																															
Aug-15	96.5%																															

Are we responsive?

BAF ref:
CR3, CR5,
CR6, CR7,
CR8, CR9,
CR10

	Description	Current position/comments	Trend	Target
Cancellation due to no beds	Hospital cancellations due to no beds	There were no cancellations of patients due to no beds in August. At this stage we continue to achieve the target of returning to 2012/13 levels. Please note this does not include patients cancelled due to no Critical Care bed which is being tracked separately		Internal target based on 2012/13 levels
RTT admitted pathways	Percentage of completed pathways for English patients closed within 18 weeks. The threshold is 90%.	Achieved in August. Only the specialities of General Surgery, Ophthalmology and Oral Surgery were under the 90% target		90% per month
RTT non-admitted pathways	Percentage of non-admitted pathways for English patients closed within 18 weeks. The threshold is 95%.	All specialties continue to meet the 95% target for non admitted pathways		95% per month
RTT incomplete pathways	Percentage of incomplete pathways for English patients within 18 weeks. The threshold is 92%.	Overall performance continued to be met. Only General Surgery and Oral Surgery were under the 92% target		92% per month

Are we responsive?

BAF ref:
CR3, CR5,
CR6, CR7,
CR8, CR9,
CR10

Description

Current position/comments

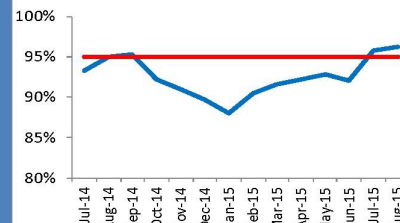
13 month rolling trend

Target

A&E 4
hour
standard

Maximum wait time of 4 hours in A&E from arrival to admission, transfer or discharge. Target of 95%.

Performance has achieved in August which is the second month consecutively. A number of key actions have been actioned by A&E staff

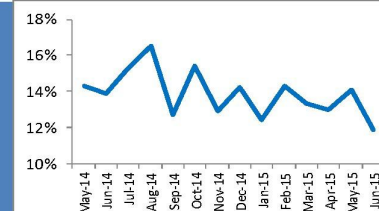


>95% per month

Readmission
rate

Number of emergency readmissions within 28 days. Excludes patients with diagnosis of cancer, nephrology, obstetrics

This is a new metric monitored on the board assurance report from April 2015

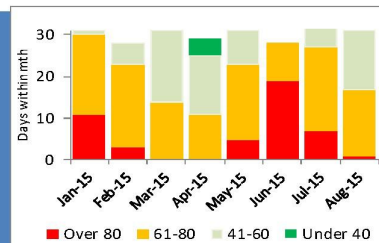


Target to be agreed in Sept 15

Medically
optimised
patients

Number of days within the month where there are medically optimised patients within acute beds

Improvement have been seen in the last two consecutive months. This is reflective in the improved A&E standard in July and August and therefore no exception report has been provided



Less than 40 medically optimised patients within acute beds each day (target agreed with CCG)

Number of
Intermediate
care beds

Number of intermediate care beds in use in the Community

Work is underway to develop the metric to measure and monitor from September 2015

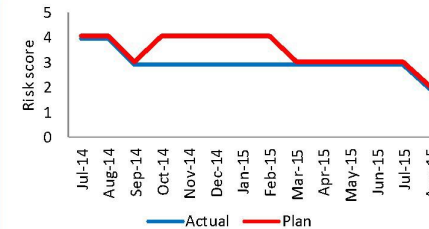


Description Current position/comments

**Financial
Sustainability
Risk Rating**

Monitor's
(independent
regulator)
measure of
financial risk

Monitor has changed its Risk Assessment Framework (RAF). There are now two additional metrics, and a new 'over-ride' which limits the overall rating to a 2 in circumstances where one (or more) of the metrics is a 1.
Under the new RAF our actual (and plan) falls to a 2. Early indications are that this will not impact on the current Monitor regulatory approach

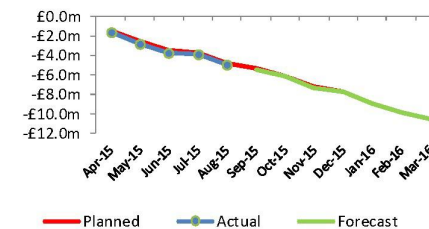


A score of 2 each month (NB: this is a restated target following the changes to the RAF)

**Normalised
net
surplus/
deficit**

Net income
and
expenditure
after
adjusting for
hosted
services and
impairments

Planned deficit YTD is £4.8m and we are reporting adverse performance against this of £223k. Efficiency schemes are off plan by £512k at M5, contributing to this overspent position. Pressures continue within Medical and Nursing agency spend. Over achievement of income to date has been able to partly offset some of these expenditure pressures. Exception report on page 21

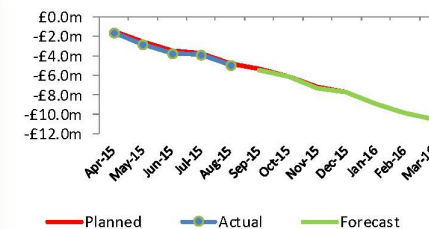


As Plan

**Forecast
Normalised
net
surplus/**

Forecast net
income and
expenditure
after
adjusting for
hosted
services and
impairments

At this stage of the year, we are still planning to deliver the £10.5m deficit plan, despite the current overspend against plan, as there are sufficient levels of contingency within reserves to mitigate the current financial pressure.

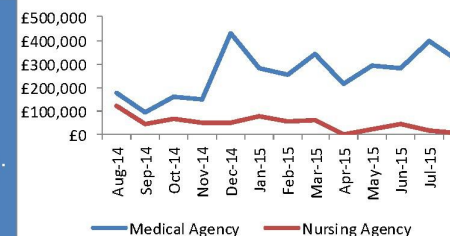


As Plan

**Agency
spend**

Planning
improvements
in productivity
and efficiency

Medical Pay is currently overspent by £352k, due to agency costs in excess of those anticipated. Agency medical expenditure YTD is £1,502k (9% of the total medical spend). Nursing Pay is currently £261k overspent, however this is largely offset by additional PbR income. Agency nursing expenditure YTD is £85k (0.5% of total trained nursing spend)



Target not agreed for Medical Agency. For Nursing Agency, spend capped at 3% of total trained nursing spend from Q3.

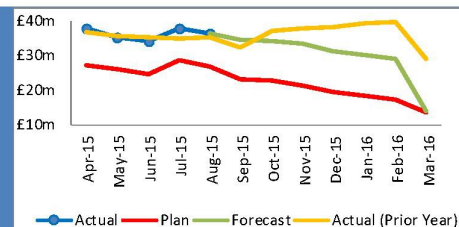
**Are we
well led?**

Description Current position/comments

Cash

Cash on
deposit <3
month
deposit

The closing cash balance at the end of August was £36m which is £9m above plan. This is due to the receipt of the monthly payment on account from West Cheshire CCG, offset by the increase in debtors, and slippage in the capital program.

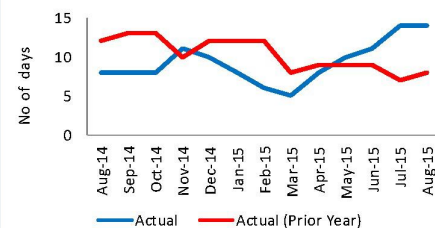


£27m

Debtor Days

Debtor Days:
Trade
Debtors
divides by
income x 365

Debtor days has stabilised this month, but remains high due primarily to:
- continued over-performance on contract; billed quarterly in arrears, creating a short term increase in debtors;
- continuing issues with Wirral FT;
- failure to agree remaining amounts due from host CCG and specialist commissioners relating to prior year.



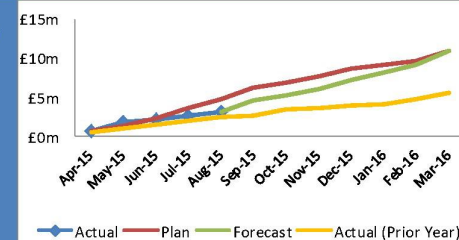
No target
defined

Capital Expenditure

Capital
expenditure
performance
against plan /
forecast out-
turn

Capital expenditure is £1.6m behind plan, due to slippage with purchasing medical equipment and completing backlog maintenance.

It is anticipated that this will 'catch up' and so the forecast out-turn remains at £10.9m.



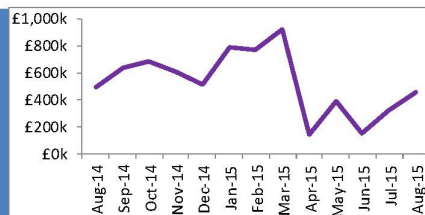
£4.7m

Description Current position/comments

**CRS
In Year**

Planning improvements in productivity and efficiency

Against the £6m annual efficiency target, as at M5, £2,343k (39%) in CRS savings have been achieved with £2,087k (35%) identified as either Green or Amber rated schemes and £1,570k (26%) Red or Black rated schemes. As at M5 the under achievement against the CRS savings plan is giving a £512k adverse variance. Exception report is available on page 22

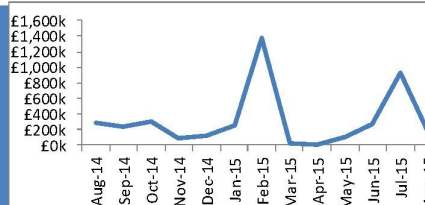


No deviation from plan

**CRS
Recurrently**

Planning improvements in productivity and efficiency

Recurrently £1,504k (25%) in CRS savings have been achieved with £3,319k (55%) identified as either Green or Amber rated schemes and £1,177k (20%) Red or Black rated schemes. Please note detail in the Exception Report on page 22

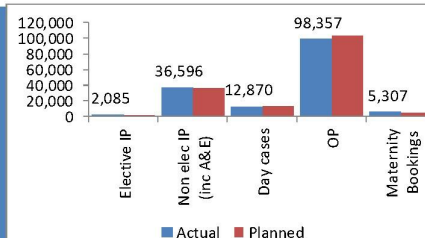


No deviation from plan

**Contract
performance
Activity Numbers**

YTD Contract performance against Trust Planned activity (English & Welsh)

Numbers continue to be above plan on elective activity and A&E attendances in the month of August. The anticipated reduction in antenatal and maternity activity has not materialised resulting in a favourable variance. However, activity numbers are below plan on daycase, outpatient and emergency activity in month.



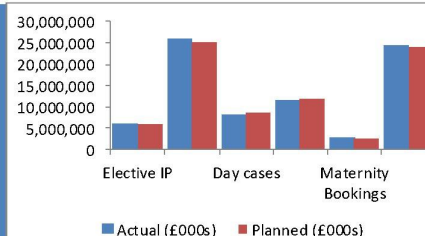
Actual Activity should be greater than Planned activity

**Contract
performance
Financial Value**

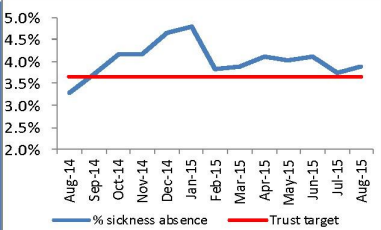
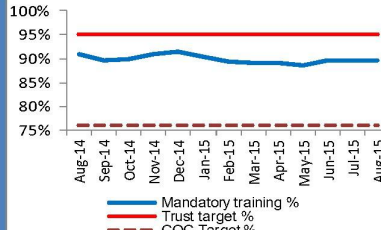
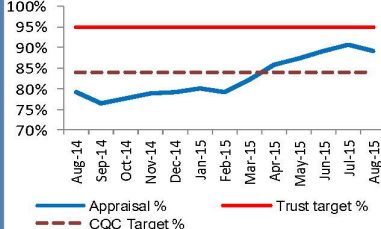
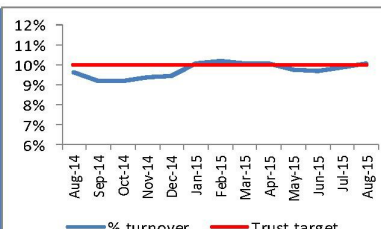
YTD Contract performance against Trust Planned Value (English & Welsh)

At the end of month five, the financial value is £1,229k above plan year to date as follows:-

Elective IP	+£204k
Non-Elective IP	+£1,019k
Daycase	-£398k
Outpatients	-£462k
Maternity	+£359k Non PBR
	+£507k



Actual Value should be greater than Planned Value

	Description	Current position/comments	13 month rolling trend	Target
Sickness absence	% sickness absence. Monthly rate excludes Comfort zone and Bank staff	Trust wide attendance management levels increased in August to 3.88% from the July figure of 3.73%. The rolling 12 month average is 4.04% exceeding the Trust target. There was a reduction in short term absence from 1.99% to 1.93%, with the increase coming from the long term absences increasing from 1.76% to 1.95%. Exception report on page 23		Below 3.65% per month
Mandatory training	Mandatory Training Monthly Rate Excludes Comfort Zone, Bank Staff, Staff on long term sick & mat. leave.	Compliance with Mandatory Training position remains static this month. Current compliance rate of 89.7%, which exceeds the CQC target (76%) but is below the Trust target (95%). When taking into account those already booked to attend, the Trust is just below the 95% Trust target. Exception Report on page 24		95% per month <i>The CQC target is 76% (the CQC take the results from the Staff Survey)</i>
Staff with completed appraisal	Appraisal Monthly Rate Exclusions as above and also excludes staff with less than 1 years service.	The level of appraisal compliance has reduced marginally, achieving 89.1% in August. This still exceeds the CQC target (84%) but remains below the Trust target (95%). Exception report on page 25		Above 95% per month <i>The CQC target is 84% (the CQC take the results from the Staff Survey)</i>
Staff turnover	Turnover Rate Based on the previous 12 months and on permanent staff only. Rate should be under the	Staff Turnover is 0.07% above the target of 10%, against an establishment of 3319 wte. The breach equates to 1.9wte leavers above the target. Due to this small number above target no exception report has been provided at this time. Should performance deteriorate further then an exception report will be provided.		Below 10% per month

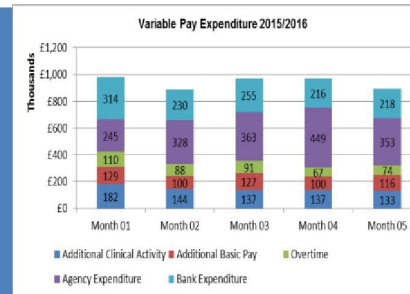
**Are we
well led?**

Description Current position/comments Breakdown by type by month Target

Variable
pay

Variable pay
spend
(Agency,
ACA, Basic
Pay, Bank &
Overtime
expenditure)

Medical agency spend showed a significant variance in month, with vacancies & gaps in rotas impacting in across of specialties (including Plastics, Rheumatology, Anaesthetics). Overtime & bank usage continue to improve in the level of spend and a presentation will be provided to Exec Team in Sept recommending changes in controls and process. Exception report on Page 26



To deliver £4.5m
pay related CRS
savings.

EXCEPTION REPORT

Indicator: Safety thermometer

Description:

The percentage harm free is currently below the national level. This is a point prevalent survey conducted once a month based on ward participation. The numbers may vary on a monthly basis. The table shows the number of patients on this snapshot on this one day within the month that were shown to have the identified harms.

Proposed actions:

It is disappointing that the August Safety Thermometer results illustrating a significant drop in performance. Analysis of the data has revealed non-compliance of data collection by a number of areas as well as incidences of catheter related infections and VTE in particular. The Director of Nursing has reviewed this and a new process of quality assurance is being implemented to ensure correct data collection is in place. In addition to this, the Heads of Nursing will be integrating the Ward's performance into existing KPI's in a view to demonstrating improvement.

Forecast for improvement:

Q1	Q2	Q3	Q4

Historic data:

Trust % harm free

		Aug14	Sep14	Oct14	Nov14	Dec14	Jan15	Feb15	Mar15	Apr15	May15	Jun15	Jul15	Aug15
Harm Free		93.84	93.68	95.68	93.80	95.00	91.60	91.91	91.23	92.45	93.98	92.00	93.40	91.91

Number of harms plus sample and survey size

Pressure Ulcers - All		12	20	15	20	13	25	18	27	16	18	23	23	11
Pressure Ulcers - New		5	6	4	5	5	9	9	9	1	7	8	9	5
Falls with Harm		3	2	0	2	1	4	4	0	0	1	6	3	1
Catheters & UTIs		0	3	0	1	1	1	1	1	5	5	8	0	3
Catheters & New UTIs		0	3	0	1	1	1	0	1	3	4	5	0	2
New VTEs		3	3	4	2	1	4	12	13	8	4	3	2	7
All Harms		18	27	19	25	16	34	33	40	29	26	36	27	19
New Harms		11	14	8	10	8	18	23	22	12	16	21	13	14
Sample		292	427	440	403	320	405	408	456	384	432	450	409	235
Surveys		13	19	19	18	14	18	18	21	18	20	21	20	13

Lead:

Sian Williams, Deputy Director of Nursing & Quality

Executive Lead:

Alison Kelly, Director of Nursing & Quality

EXCEPTION REPORT

Indicator: E-Discharge

Issue:

Both measures regarding e-discharge within 24 and 48 hours are currently not achieving the target. This issue is in a number of specialties.

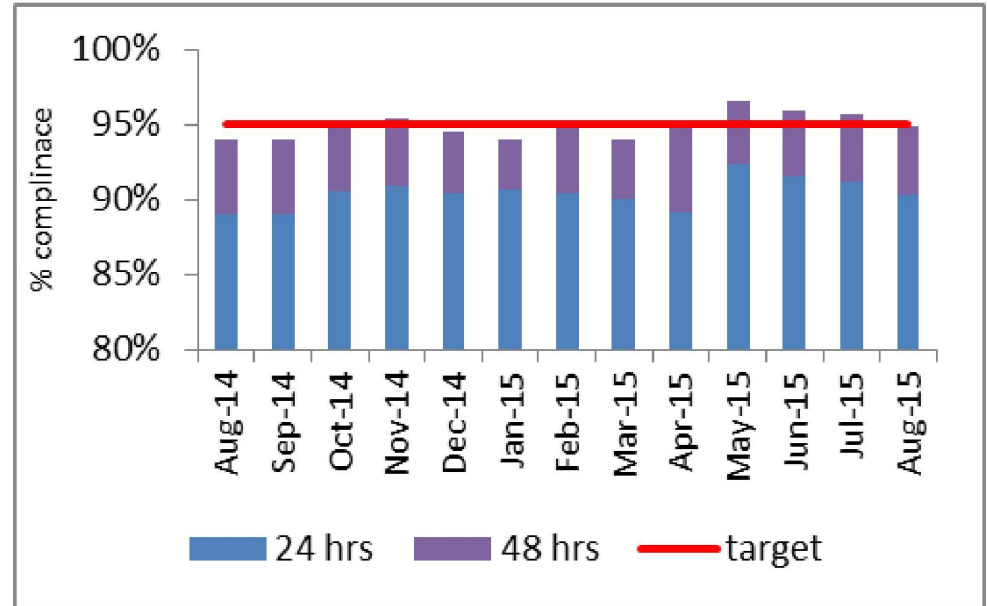
Proposed actions:

Performance continues to be monitored both on a daily basis by Divisions and weekly within the Operational Performance Group chaired by the Director of Operations. A Clinically led Task and Finish has been agreed to address issues that remain in relation to performance against this target.

Forecast for improvement:

Q1	Q2	Q3	Q4

Historic data:



Lead: Divisional Directors
Executive Lead: Mark Brandreth, Deputy Chief Executive

EXCEPTION REPORT

Indicator: Safeguarding training for Children

Issue:

The Trust must maintain at least 80% compliance with groups 1,2,3 and 4 safeguarding children training, the current exception is group 2 which is below the required level of compliance.

Proposed actions:

Children:

Group 2 staff must complete their training by completing the level 2 Safeguarding Children (secondary care) eLearning module. Training has to be completed every 3 years. Our ongoing action plan has included a monthly report from HR regarding compliance and subsequent briefings to staff regarding the need to complete their training. In addition some face to face group 2 training sessions have taken place. We have designed a written information pack. The CoCH Safeguarding Strategy Board is overseeing this action plan. We are confident that we will improve compliance.

Adults:

A number of actions identified including -

- Review of Prevent TNA to focus WRAP on those most in need building on TNAs from other health agencies

- Inclusion of Prevent Brief in Safeguarding Adult training for those not captured at induction

- Direct contact to all teams within CoCH to flag non-compliance with adult safeguarding training and direct to training materials

- Direct contact will be reviewed after a quarter and those teams still not compliant

- Adjustments are being made to Mandatory training to trial Safeguarding Adult sessions in workshop format

- An internal internet based MCA and DoLS session with in house video examples is to be built to make MCA and DoLS more accessible to Clinical staff

Forecast for improvement:

Q1

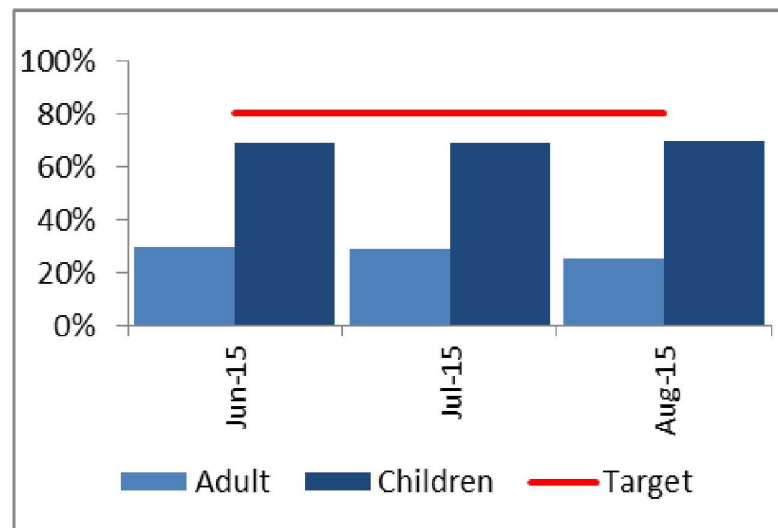
Q2

Q3

Q4



Historic data:



Lead:

Sian Williams, Deputy Director of Nursing & Quality

Executive Lead:

Alison Kelly, Director of Nursing & Quality

EXCEPTION REPORT

Indicator: Friends & Family response rate

Issue:

The response rate for inpatients is particularly low for July and August and this is due to a change in the questionnaire template provided to patients. The Trust system currently used at no charge comes to end this year. In December the Trust will have to invest in a new system to collect this data.

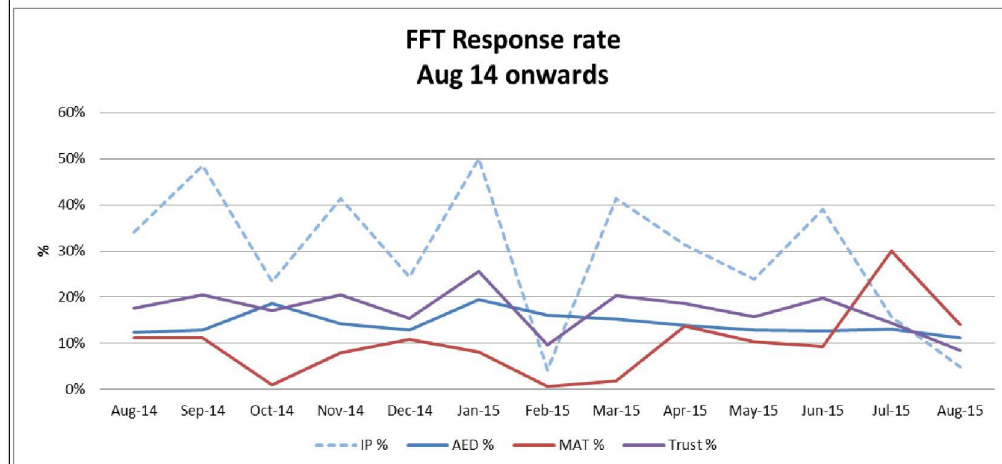
Proposed actions:

There have been continued issues with provision of new FFT forms available to the clinical areas which has demonstrated poor response rates across the Trust, however, this is now resolved. However, a greater focus is still required on patients being made aware of the opportunity to respond. In light of this, a Trust wide action plan is being finalised following specific plans from the Emergency Department, Outpatient Department and Maternity service. This plan will be monitored through the Patient Experience Operational Group. The Trust is liaising with the NHS England (north) FFT Lead who is providing support to the Trust to increase compliance with this national requirement. The Trust has also have recent challenge from commissioners in respect of current performance, the Trust action plan will be shared with commissioners when finalised.

Forecast for improvement:

Q1	Q2	Q3	Q4

Historic data:



Lead:

Sian Williams, Deputy Director of Nursing & Quality

Executive Lead:

Alison Kelly, Director of Nursing & Quality

EXCEPTION REPORT

Indicator: Diagnostic 6 week wait

Issue:

The diagnostic 6 week standard has been breached for six consecutive months due to issues within the echocardiography service. This includes workload across the echo service, workforce, process and systems and issues with equipment.

Proposed actions:

The improvement trajectory is on plan in relation to reducing the number of patients waiting over 6 weeks. We have recruited to a number of vacancies and the actions to reduce inappropriate referrals has been successful. There has been a significant decrease in the number of breaches and the staff continue to monitor the data and implement escalation processes should there be any deterioration in the position

Forecast for improvement:

Q1	Q2	Q3	Q4

Historic data:

English - Number of Exams > 6 weeks

Month End Snapshot	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15
Magnetic Resonance Imaging		1		3	1	1	1		1	2	3	1	6
Computed Tomography								3	1		1	5	7
Non-obstetric ultrasound	44	5			15			1	1	1	8		
Audiology - Audiology Assessments		2	1	1					1			1	6
Cardiology - echocardiography	24	2	2	1	4	6	3	51	114	84	130	96	42
Respiratory physiology - sleep studies								1					
Colonoscopy						1							
Flexi sigmoidoscopy													
Cystoscopy	12	6	2	10	2	9	1	16	11	5	7	8	4
Gastroscopy								5					
Total patients waiting	3329	3506	3614	3567	3662	2774	3193	3798	3317	3236	3353	3729	3887
% < 6 weeks	97.70%	99.54%	99.9%	99.6%	99.4%	99.4%	99.8%	98.0%	96.1%	97.2%	95.4%	97.0%	98.3%

Lead: Richard Baird, Lorraine Burnett, Linda Fellowes (Divisional Directors)
Executive Lead: Mark Brandreth, Deputy Chief Executive

EXCEPTION REPORT

Indicator: 62 day cancer performance

Issue:

The position for July has now been finalised at 94.87% with 3 breaches. The provisional position for August is currently 80.53% with 11 breaches, this was a narrow underperformance by 4 breaches. The current position for Quarter 2 is above target at 87.73%.

The PTL has slightly increased by 9 patients since the previous month and has now remained stable since June. The area of concern to performance remains the number of patients over 62 days in Upper GI as this was the main reason for the narrow underperformance in Q1.

Proposed actions:

Urology

Urology performance has improved resulting in only one breach in July. There are still a small number of patients waiting above 62 days which potentially will result in further breaches in the future, but overall the position is improving. Actions continue which include:

- New consultant started in post in September which will result in additional capacity for results clinics and outpatient capacity.
- Consultants have all increased their existing clinic capacity for initial outpatient appointments
- Lead Clinician reviewing waiting list on weekly basis
- Revised draft prostate pathway has been completed and requiring final approval from CCG which will improve time to first diagnostic.

Upper GI

Despite significant improvement concern remains in the number of patients over 62 days. Improvement meetings are continuing with clinicians in UGI to improve performance with the main focus of addressing the outpatient capacity shortfall. Actions include:

- Business case approved for additional UGI consultant which will provide increased outpatient and diagnostic capacity. Advert out for locum consultant in the interim
- Lead clinician to review longest waiting patients and agree any urgent action to ensure timely appropriate clinical intervention
- Lead clinician to review breaches for the last two years to identify any further pathway improvements

Forecast for improvement:

Q1	Q2	Q3	Q4

Historic data:

Monthly and quarterly performance and number of patients over 62 days on PTL

Month	62 day performance (%)	Numbers over 62 days
Oct-14	79.31	219
Nov-14	88.57	159
Dec-14	80	164
QUARTER 3	82.29	
Jan-15	76.67	138
Feb-15	86.05	81
Mar-15	87.04	84
QUARTER 4	82.8	
Apr-15	86.21	88
May-15	82.86	86
Jun-15	79.83	55
QUARTER 1	82.94	
Jul-15	94.87	49
August 15 (Provisional)	80.53	58
QUARTER 2	87.83	

Speciality	Above 62+ Days on PTL 28/08/15
Breast	1
Colorectal	2
Gynaecology	3
Haematology	1
Head and Neck	7
Lung	9
Skin	1
Upper GI	28
Urology	6
TOTAL	58

Lead: Ian Bett, Associate Director of Performance & Planning
Executive Lead: Mark Brandreth, Deputy Chief Executive

EXCEPTION REPORT

Indicator: Normalised Net Surplus / Deficit

Issue:

At the end of month 5, there is an adverse performance against plan of £223k.

Pay:

There are pressures relating to Medical and Nursing pay covering sickness, maternity and vacancies.

Non pay:

CRS underachievement accounts for £512k of the variance.

However there are activity related pressures resulting in overspends on drugs of £205k, outsourcing of £78K and medical & surgical equipment of £92k that are not fully offset by the PBR funding received for the over performance on activity. Further analysis is required.

Pressures are also highlighted in relation to expenditure on furniture & computers of £120k and consultancy of £39k which are being fully investigated and analysed.

Income:

Income is significantly over plan reducing the overall deficit. This is predominantly relating to obstetric income and the corporate element of PBR funding.

Forecast:

At this stage in the financial year, we are still planning to deliver the £10.5m deficit plan since there are sufficient levels of contingency within reserves to mitigate the current level of financial pressure. However this forecast assumes that the Divisions / Departments will deliver on the CRS schemes that have been identified and it is important that any risks to this delivery are highlighted at the earlier opportunity to ensure further actions can be taken to mitigate any resulting financial pressures.

Proposed actions:

Divisions / departments have worked up action plans which will now be reviewed by the Chief Finance Officer in budget holder meetings for those areas with the greatest overspend.

Further progress on developing and working up key milestones and savings for the CRS schemes that have been identified in conjunction with the PMO to ensure delivery on track. Additional support has been secured to work with the Planned Care Division to improve their CRS plans.

Executive leads have been identified to review and reduce variable pay and non pay. Please see further details under CRS exception report.

Forecast for improvement:

Q1	Q2	Q3	Q4

FINANCIAL PERFORMANCE AS AT 31ST AUGUST 2015 - KEY VARIANCES

	Year to Date £000s
Nursing	261
Medical	352
Other Pay	(117)
PBR Funding allocated to Divisions	(107)
TOTAL PAY	389
Drugs	205
Furniture, Office & Computers	120
Outsourcing	78
Med & Surgical Equipment	92
Consultancy	39
Other Non Pay	65
PBR Funding allocated to Divisions	(4)
TOTAL NON PAY	595
CRS	512
INCOME	(1,273)
GRAND TOTAL	223

EXCEPTION REPORT

Indicator: CRS in Year & Recurrently

Issue:

The CRS has not been delivered as planned as at month five. This is primarily due to a shortfall in the number of schemes identified resulting in a shortfall of delivery to date. There has also been some slippage in the start dates of some schemes. The target delivery profile is based on historical delivery trend resulting in a month 5 target of £1,988k. The amount achieved is £1,476k resulting in underachievement of £512k at the end of month five. Currently there is a risk of non delivery of £1.57m of the Efficiency Plan (relating to Red & Black schemes). Please see action plan below.

Proposed actions:

The Director of HR is leading a group tasked with reviewing all aspects of variable pay for the Trust, to include additional clinical sessions paid, overtime, outsourcing etc. The Director of Corporate Affairs & Legal Services, is leading a group tasked with reviewing all aspects of non pay expenditure for the Trust, to include drugs, furniture & computers, maintenance etc. The Divisions / Departments report monthly at QFWG on progress against green, amber and red rated schemes and pipeline work. The PPD department is ensuring all PIDS are completed and key milestones delivered. The organisation is currently working with DoH and Lord Carter in relation to support for further efficiency savings opportunities with plans currently being drawn up. The High Quality Care Costs Less (HQCL) work streams are also focusing on delivery of the recurrent CRS. Additional capacity has been made available to the Planned Care team to support further development and delivery of the CRS.

Forecast for improvement:

Q1	Q2	Q3	Q4

2015/16 EFFICIENCY PROGRAMME PERFORMANCE AS AT AUGUST 15

IN YEAR							
Division / Department	2015/16 In Year CRS Target	Achieved	Outstanding	Green	Amber	Red	Pipeline
Planned Care	£ 2,200,000	£ 556,934	£ 1,643,066	£ 241,059	£ 318,714	£ 172,500	£ 910,794
Urgent Care	£ 2,200,000	£ 460,460	£ 1,739,540	£ 392,705	£ 700,527	£ 195,532	£ 450,777
D&P	£ 580,000	£ 256,769	£ 323,231	£ 24,220	£ 20,500	£ 31,000	£ 247,511
Estates & Facilities	£ 520,000	£ 239,074	£ 280,926	£ 19,930	£ 54,000	£ 13,000	£ 193,996
Nurse Mgmt	£ 36,000	£ 27,500	£ 8,500	£ 3,657	-	£ 4,843	-
Medical Photography	£ 3,000	£ 3,000	-	-	-	-	-
Comms & Engagement	£ 3,000	£ 3,000	-	-	-	-	-
Corporate Clinical	£ 8,000	£ 8,254	-£ 254	0	-	-	£ 254
IM&T	£ 200,000	£ 43,772	£ 156,228	£ 50,975	-	-	£ 105,253
HR	£ 107,000	£ 11,000	£ 96,000	£ 24,000	£ 14,500	£ 52,000	£ 5,500
Trust Administration	£ 28,000	£ 7,500	£ 20,500	£ 1,635	£ 9,888	£ 500	£ 8,477
PPD	£ 20,000	£ 19,453	£ 547	£ 547	-	-	-
Finance	£ 55,000	£ 55,000	£ 0	-	-	-	-
Procurement	£ 40,000	£ 40,000	-	-	-	-	-
Central	-	£ 611,228	-£ 611,228	£ 210,000	-	-	-£ 821,228
TOTAL	£ 6,000,000	£ 2,342,943	£ 3,657,057	£ 968,726	£ 1,118,129	£ 469,375	£ 1,100,826

2015/16 EFFICIENCY PROGRAMME PERFORMANCE AS AT AUGUST 15

RECURRENT							
Division / Department	2015/16 Recurrent CRS Target	Achieved	Outstanding	Green	Amber	Red	Pipeline
Planned Care	£ 2,200,000	£ 420,598	£ 1,779,402	£ 313,946	£ 419,848	£ 400,000	£ 645,608
Urgent Care	£ 2,200,000	£ 385,327	£ 1,814,673	£ 632,084	£ 1,494,804	£ 253,653	£ 565,868
D&P	£ 580,000	£ 332,247	£ 247,753	£ 64,000	£ 38,000	£ 150,000	£ 4,247
Estates & Facilities	£ 520,000	£ 234,199	£ 285,801	£ 22,817	£ 146,000	£ 80,000	£ 36,984
Nurse Mgmt	£ 36,000	£ -	£ 36,000	-	-	£ 2,747	£ 33,253
Medical Photography	£ 3,000	£ 3,000	-	-	-	-	-
Comms & Engagement	£ 3,000	£ 3,000	-	-	-	-	-
Corporate Clinical	£ 8,000	£ 254	£ 7,746	-	-	-	£ 7,746
IM&T	£ 200,000	£ 46,272	£ 153,728	£ 84,752	-	-	£ 68,976
HR	£ 107,000	£ 11,000	£ 96,000	£ 10,000	£ 82,500	£ 57,500	£ 54,000
Trust Administration	£ 28,000	£ 3,500	£ 24,500	-	£ 9,888	-	£ 14,612
PPD	£ 20,000	£ 483	£ 19,517	-	-	-	£ 19,517
Finance	£ 55,000	£ 23,938	£ 31,062	-	-	-	£ 31,062
Procurement	£ 40,000	£ 40,000	-	-	-	-	-
Central	-	-	-	-	-	-	-
TOTAL	£ 6,000,000	£ 1,503,818	£ 4,496,182	£ 1,127,599	£ 2,191,040	£ 943,900	£ 233,643

2015/16 EFFICIENCY PROGRAMME PERFORMANCE - MOVEMENT - IN YEAR & RECURRENT

IN YEAR							
	2015/16 In Year CRS Target	Achieved	Outstanding	Green	Amber	Red	Pipeline
July	£ 6,000,000	£ 1,936,926	£ 4,063,074	£ 1,139,934	£ 1,368,884	£ 494,449	£ 1,059,806
August	£ 6,000,000	£ 2,342,943	£ 3,657,057	£ 968,726	£ 1,118,129	£ 469,375	£ 1,100,826
Movement		£ 406,017	-£ 406,017	£ 171,208	-£ 250,755	-£ 25,074	£ 41,020
RECURRENT							
	2015/16 Recurrent CRS Target	Achieved to date	Outstanding	Green	Amber	Red	Pipeline
July	£ 6,000,000	£ 1,317,522	£ 4,682,478	£ 1,148,708	£ 2,402,366	£ 973,153	£ 158,251
August	£ 6,000,000	£ 1,503,818	£ 4,496,182	£ 1,127,599	£ 2,191,040	£ 943,900	£ 233,643
Movement		£ 186,296	-£ 186,296	£ 21,109	-£ 211,326	-£ 29,253	£ 75,392

EXCEPTION REPORT

Indicator: Monthly Sickness Absence rate

Issue:

The Trust wide absence rates remained comparatively steady during August 2015. There was a minor reduction in short term absence this month with a reduction in Gastrointestinal conditions, however there was an increase of 21.30% in depression, anxiety, stress, mental health conditions (13.33WTE). Other Musculoskeletal conditions remain the highest reason for long term absences increasing in month by 19.44% (20.66WTE) and short term absences (8.63WTE). The remaining increases in long term absences are as a result of ENT (3WTE) and Pregnancy related (2 WTE). The absence rates across the region are currently averaging 4.2% as highlighted by EWIN regional benchmarking data with this Trust running at 4.04%.

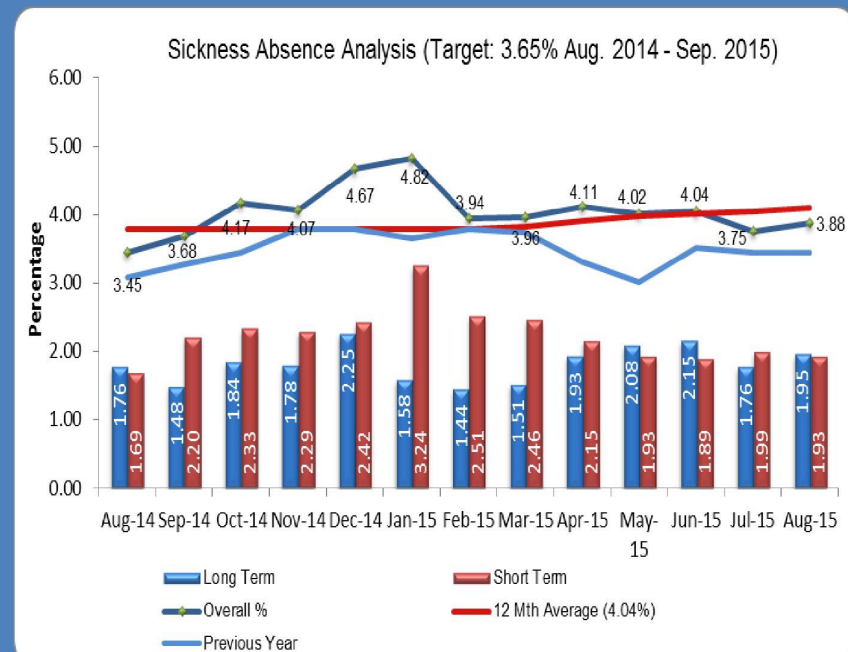
Proposed actions:

The Health and Well Being Strategy actions and progress will be provided in an update to the Board planned for December 2015. Wider good health promotions continue including resilience education, mental health training for managers, lifestyle sessions, fit camps and dietary/nutritional advice sessions. Hot spot analysis is continuing & the review of the Attendance Management Policy has resulted in some revisions to the policy and a thorough update of the managers guidance on handling attendance matters. Whilst the policy has not yet been finalised, the joint group of Staff Side & Management representatives presently have some challenges in relation to gaining common agreement on the % threshold/target and which absences count towards thresholds. A short period of time is being provided to assimilate further information before a joint final paper is presented to the Executive Directors Group. Once finalised, the new policy will be rolled out via training sessions with managers and a relaunch of the Policy will take place.

Forecast for improvement:

Q1	Q2	Q3	Q4

Historic data:



Lead:

Dee Appleton-Cairns, Deputy Director of HR

Executive Lead:

Sue Hodgkinson

EXCEPTION REPORT

Indicator: Mandatory Training Completed In The Last 12 Months

Issue:

The level of Mandatory Training completed remains static again this month. This exceeds the CQC target (76%) but remains below the Trust target of 95%. An additional measurement is partial compliance where staff who are non-compliant but are booked onto future programmes is standing at just below 95%, almost achieving the Trust target. Local Induction increased slightly to 86.5% which remains below the Trust target of 95%.

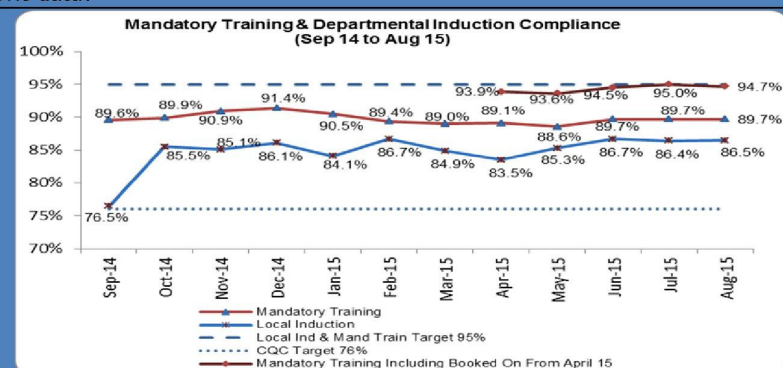
Proposed actions:

The Learning & Development team and those who participate in the Mandatory Training programmes have created additional capacity to ensure access is open to as many staff as possible. In addition, a review of what elements of mandatory training should be provided is being finalised for the Autumn, with review and approval to be undertaken by a future People & Organisational Development Committee. Performance continues to be escalated to the Director of Human Resources & Organisational Development where continuous improvements are not being observed.

Forecast for improvement:

Q1	Q2	Q3	Q4

Historic data:



Mandatory Training Table for August 2015

Position	Division	Compliance
1	Corporate Clinical	100.0%
2	COCH & WUTH Collaboration	98.3%
3	Human Resources	96.4%
4	Facilities	93.5%
5	Planned	91.9%
6	Diag, Therapies & Pharmacy	91.1%
7	Estates	90.2%
8	Corporate Non Clinical	88.7%
9	Finance & Performance	87.2%
10	Urgent Care	86.1%
11	Nurse Management	83.3%
Trust Total		89.7%

Local Induction Table for August 2015

Position	Division	Compliance
1	COCH & WUTH Collaboration	100.0%
2	Corporate Non Clinical	100.0%
3	Estates	100.0%
4	Facilities	100.0%
5	Nurse Management	100.0%
6	Planned	97.2%
7	Diag, Therapies & Pharmacy	92.6%
8	Human Resources	87.5%
9	Urgent Care	79.8%
10	Finance & Performance	76.9%
11	Corporate Clinical	0.0%
Trust Total		86.5%

Lead: Linda Walker, Head of Learning & Development
Executive Lead: Sue Hodgkinson

EXCEPTION REPORT

Indicator: Appraisals Completed In The Last 12 Months

Issue:

Performance against the appraisal target of 95% reduced marginally to 89.1%, which is anticipated to be due to annual leave during the August period.

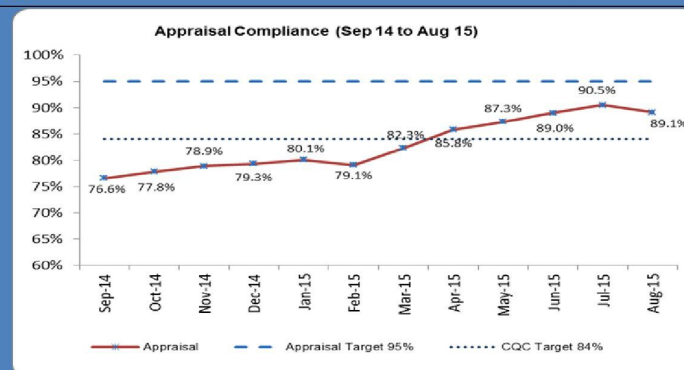
Proposed actions:

Significant emphasis on the importance of appraisal completion remains within Stocktake discussions. Close monitoring continues and where there are no signs of improvements, discussions will take place with the Director of HR & Organisational Development. Work continues on the appraisal agenda, the Appraisal process, quality and compliance with further review taking place at People & Organisational Development Committee (September 2015). This will also form a strand of the culture strategy and associated action plan in order to maintain the importance and profile.

Forecast for improvement:

Q1	Q2	Q3	Q4

Historic data:



Appraisal Table for August 2015

Position	Division	Compliance
1	Estates	100.0%
2	Human Resources	97.9%
3	COCH & WUTH Collaboration	96.3%
4	Planned	96.3%
5	Facilities	93.5%
6	Corporate Non Clinical	90.7%
7	Finance & Performance	89.3%
8	Diag. Therapies & Pharmacy	88.9%
9	Urgent Care	80.1%
10	Corporate Clinical	78.6%
11	Nurse Management	74.3%
Trust Total		89.1%

Lead: Linda Walker, Head of Learning & Development
Executive Lead: Sue Hodgkinson

EXCEPTION REPORT

Indicator: Variable Pay

Issue:

To deliver the £4.5m required savings in relation to pay related CRS plans in 15/16, increased focus is being placed on the reduction of variable pay spend across the Trust. Sue Hodgkinson, Director of HR & OD, is the Executive Lead.

				M&D Vacancies	Urgent Care	Planned	Total
				CONSULTANT	1	1	2
				SPECIALTY DOCTOR	1	1	2
				SPR	2	4	6
				TRUST SPR		1	1
				SHO		9	9
				TOTAL	4	16	20
N&M Vacancies (FTE)	Urgent Care	Planned Care	Total				
N&M Registered	6.00	32.16	38.16				
Support Staff	2.00	5.12	7.12				

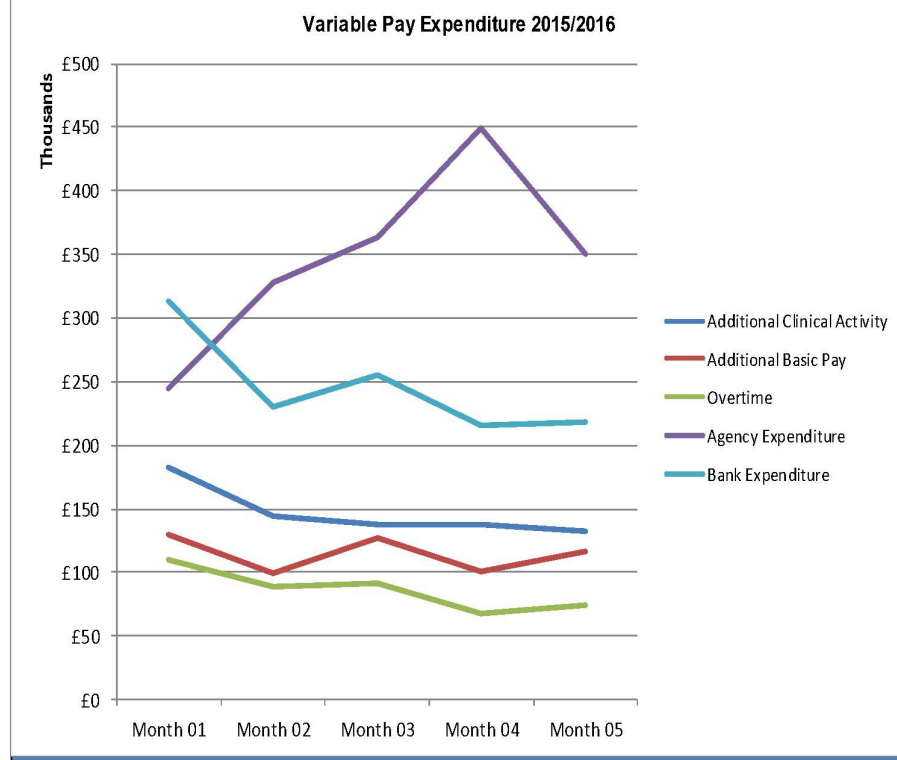
Proposed actions:

Detailed position presented to Finance Sub Committee. Paper to be presented review at EDG w/c 21/09/15 detailing data analysis undertaken, issues identified and proposed recommendations & controls. Key concern relates to Agency spend, with increased gaps in both medical and planned care nursing. Developing communication to wider organisation. MIAA review on Medical agency spend & controls received and will form part of action plan in relation to the High Quality Care Costs Less Programme. People & Organisational Development Committee reviewing delivery in detail.

Forecast for improvement:

Q1	Q2	Q3	Q4

Historic data:



Lead:

Richard Baird, Jane O'Neill, Martin Godfrey, Diane Holder

Executive Lead:

Sue Hodgkinson

Appendix 1 – Safe staffing

Countess of Chester Hospital 		Aug-15							Statement of actions to ensure safe staffing levels
Specialty	Ward	Registered Nurses/Midwives			Care Staff			All staff	
		Planned monthly hours	Actual monthly hours	%	Planned monthly hours	Actual monthly hours	%	% planned hours staffed	
Paediatrics	30	2668.5	2633	98.7%	713	754	105.8%	100.2%	
Obstetrics	32	1782.5	1826	102.4%	1426	1242	87.1%	95.6%	
Labour Ward	CLS	4278	4263	99.6%	870.5	842	96.7%	99.2%	
Stroke Unit	33	2668.5	2435	91.2%	2356	2517.5	106.9%	98.6%	
Care of the Elderly	34	2050.5	1996.5	97.4%	2650.5	2539.5	95.8%	96.5%	
General Surgery	40	1426	1379.5	96.7%	465	469.5	101.0%	97.8%	
General Surgery	41	1354	1129	83.4%	746	584	78.3%	81.6%	
Cardiology	42	1955.5	1922.4	98.3%	1612	1705	105.8%	101.7%	
Care of the Elderly	43	2081.5	1962	94.3%	2697	2847.5	105.6%	100.6%	
General Surgery	44	2141.5	1748	81.6%	2170	1948.5	89.8%	85.7%	
Urology/Trauma and Orthopaedics	45	2141.5	1999	93.3%	2511	2610	103.9%	99.1%	
Respiratory Medicine	48	2622	2338	89.2%	1767	2440	138.1%	108.9%	
Gastroenterology	49	1924.5	1903.5	98.9%	1953	1960.5	100.4%	99.7%	
Haematology/Resp Medicine	50	2296.5	2130.75	128.1%	1953	2502	128.1%	109.0%	
Respiratory Medicine	51	2030.5	1855	91.4%	2170	1928.5	88.9%	90.1%	
General surgery	52	2327.5	1927	82.8%	1798	1805	100.4%	90.5%	
Surgery	53	1583.5	1363	86.1%	713	1258.5	176.5%	114.2%	
General Surgery	54	2869.5	2507.5	87.4%	2325	2423.75	104.2%	94.9%	
Acute Medicine	AMU	4087	3875	94.8%	2170	2225.5	102.6%	97.5%	
Cardiology	CCU	2436	2162.5	88.8%	372	535.5	144.0%	96.1%	
Rehabilitation - EPH	Diamond	1955.5	1343	68.7%	2170	2156.5	99.4%	84.8%	
Rehabilitation - EPH	Emerald	1255.5	1169.5	93.2%	2015	2242.5	111.3%	104.3%	
Rehabilitation - EPH	Ruby	1488	1468.5	98.7%	2743.5	2356	85.9%	90.4%	
Critical care medicine	ICU	9269	8918.5	96.2%	1085	773.5	71.3%	93.6%	Managing staffing on staff to occupancy basis, proactive recruitment monitoring
Neonatal	NNU	3041	2783	91.5%	1426	1165	81.7%	88.4%	
Total		61065.5	56405.15	92.4%	42164.5	43078.25	102.2%	96.4%	

Caring for patients who require 'one to one' support continues. The Trust is working in a collaborative to look at improving the guidance of enhanced support at ward level. This is an ongoing piece of work. The Hospital has performed its bi-annual staffing paper, the results of which has been presented to the boards and has been published on its web site. There are still a number of Registered Nurse vacancies. Members of the senior nursing team now have agreed dates to return to Spain for further recruitment of at least 30 nurses. We are also strengthening our links with the Spanish Nursing Universities.

		Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Paediatrics	30										
Stroke Unit	33										
Care of the Elderly	34										
Women's Unit	40										
General Surgery	41										
Cardiology	42										
Care of the Elderly	43										
General Surgery	44										
Urology/Trauma and Orthopaedics	45										
Gastroenterology	49										
Haematology/Resp Medicine	50										
Respiratory Medicine	48										
Short Stay	51										
General surgery	52										
Surgery	53										
General Surgery	54										
Acute Medicine	AMU										
Cardiology	CCU										
Rehab - EPH	Diamond										
Rehab - EPH	Emerald										
Rehab - EPH	Ruby										

Critical care medicine	ICU										
Neonatal	NNU										
Obstetrics	32										
Labour Ward	35										

Key	
>105%	
95% to 105%	
<95% to 90%	
<90%	

Monitoring of the use of one to one and the need for additional hours or current workforce

Hours available match the patient acuity

Daily-Shift review

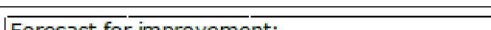
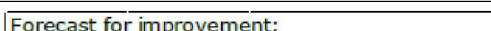
Daily-Shift review resulting in staff movement if needed- escalation guidance triggered

Appendix 2 Changes to report

Please note the following changes to the report from the previous month.

Forecast for Improvement

The forecast for improvement for areas that are currently not meeting performance standards have been reviewed since last month. This was done to ensure that all areas of improvement are coordinated and meet the strategy of the Trust. The following table provides a summary of the forecast for improvement for the remainder of the year. These will now be included each month as a summary of the forecasts provided.

Area of underperformance (Exception report provided)	Improvement trajectory
E-Discharge	Forecast for improvement: Q1 Q2 Q3 Q4 
Diagnostics	Forecast for improvement: Q1 Q2 Q3 Q4 
62 day Cancer	Forecast for improvement: Q1 Q2 Q3 Q4 
18 weeks (Admitted pathway)	Forecast for improvement: Q1 Q2 Q3 Q4 
A&E 4 hour standard	Forecast for improvement: Q1 Q2 Q3 Q4 
Normalised net surplus/deficit	Forecast for improvement: Q1 Q2 Q3 Q4 
CRS delivery	Forecast for improvement: Q1 Q2 Q3 Q4 
Sickness Absence	Forecast for improvement: Q1 Q2 Q3 Q4 
Appraisals	Forecast for improvement: Q1 Q2 Q3 Q4 
Mandatory Training	Forecast for improvement: Q1 Q2 Q3 Q4 
Variable Pay	Forecast for improvement: Q1 Q2 Q3 Q4 

Amendments to measures/performance report since last month:

Are we safe measures:

- Weekend mortality added to the 'Mortality HSMR' measure
- A new 'Safeguarding training' measure added
- 'Inpatient falls' measure replaced by 'Inpatient falls with harm'

Are we caring measures:

- 'Complaints' measure retitled as 'Feedback'

Reporting Mechanisms

Further clarification on measures not included within the Board Report and the associated committees for which they will now report to are clarified in the table below.

Area	Metric	Date Added/deleted	Committee to take responsibility for metric	Comment
Quality & Safety	Care Metrics	May-15	QSPEC	
Quality & Safety	Dementia questions 2 & 3	May-15	QSPEC	Question 1 remains on report as a metric
Quality & Safety	Litigation, Claims & Inquests	May-15	QSPEC	
Quality & Safety	VTE	May-15	QSPEC	
Quality & Safety	Hospicom responses	May-15	QSPEC	
Quality & Safety	Healthwatch Enter & View visits	May-15	QSPEC	
Quality & Safety	Advancing Quality CQUINs	May-15	QSPEC	National CQUINs on report and other metrics escalated as appropriate
Quality & Safety	Mental Capacity Assessments & DOLs	May-15	QSPEC	
Quality & Safety	CDiff lapses in care	May-15	CDG	Part of Monitor reporting requirements
Operational performance	Cancer targets	May-15	CDG/Cancer performance group	14 day, 31 day and 62 day standards shown on report and others will be reported by exception
Operational performance	Ambulance handovers	May-15	CDG	Report by exception
Operational performance	No of referrals	May-15	CDG	
Operational performance	Monitor table – summary of performance	May-15	CDG	
Finance	Performance against IN-YEAR monitor Plan for various metrics	Not currently included in May's draft Board Report	Finance Committee	
Finance	Forecast out-turn for various metrics	Not currently included in May's draft Board Report	Finance Committee	
HR		Metrics that have been reviewed to be agreed at People & OD committee	People & OD committee	

Board of Directors

Subject	Patient Experience Annual Report						
Date of Meeting	13 th October 2015						
Author(s)	Geraint Jones, Complaints Manager Sian Williams, Deputy Director of Nursing						
Presented by	Alison Kelly, Director of Nursing & Quality						
Annual Plan Objective No.							
Summary	Receiving feedback from our patients is fundamental to improving our services. It is important that we feedback to our staff the excellent feedback we regularly receive as well as demonstrating learning from the negative feedback that we sometimes receive. This report illustrates the wealth of feedback gained from our patients and their families and articulates actions going forward						
Recommendation(s)	The Board is asked to: note the contents and to support the actions being taken forward						
Risk Score	N/A						
FOIA Status: <i>FOIA exemptions must be applied to specific information within documents, rather than documents as a whole. Only if the redaction renders the rest of the document non-sensical should the document itself be redacted.</i> Applicable Exemptions: ▪ Prejudice to effective conduct of public affairs ▪ Personal Information ▪ Info provided in confidence ▪ Commercial interests	Please tick the appropriate box below: <table border="1"> <tr> <td>☒</td><td>A. This document is for full publication</td></tr> <tr> <td>☐</td><td>B. This document includes FOIA exempt information</td></tr> <tr> <td>☐</td><td>C. This whole document is exempt under the FOIA</td></tr> </table> IMPORTANT: If you have chosen B. above, highlight the information that is to be redacted within the document, for subsequent removal. Confirm to the Trust Secretary, which applicable exemption(s) apply to the whole document or highlighted sections.	☒	A. This document is for full publication	☐	B. This document includes FOIA exempt information	☐	C. This whole document is exempt under the FOIA
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Patient Experience Report (Complaints) 1 April 2014 – 31 March 2015

Summary

This report provides an overview of all formal complaints, concerns and comments received by the Trust during 2014/15. The report also identifies trends and outlines the learning from complaints.

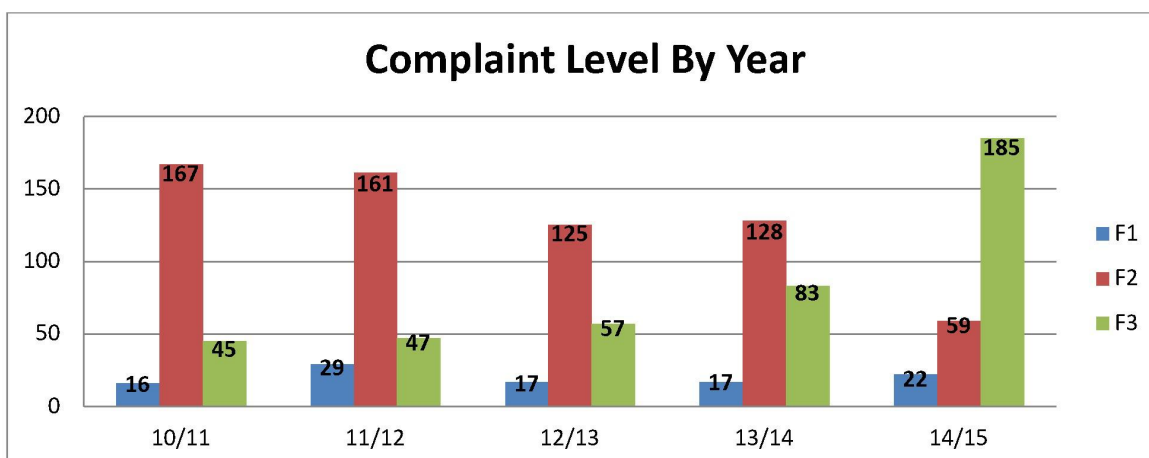
The Trust aims to acknowledge all complaints within 3 working days and respond to all complaints within the initial timescale agreed with the complainant. On receipt of each complaint, an assessment is undertaken which determines the level of investigation required and possible timescale for response. This ensures that the investigation is both proportionate to the severity of the complaint and the related risks. Factors taken into consideration include the complexity of the complaint, number of departments or external organisations involved, whether a serious untoward incident has occurred and the potential for a legal claim.

Complaints

In 2014/15 the Trust received 266 new complaints. Of these, the Trust investigated 228 complaints, a rise of 13% from the previous year. The remaining 37 complaints could not be investigated as they were either 'out of time', written consent was not provided, or the complaint related to another NHS organisation.

Level of complaints investigated during 2014/15

Level	No. of complaints
Low level complaints (usually simple, non-complex complaints)	22
Medium level complaints (usually contains several issues relating to clinical care)	59
Complex complaints (may involve several departments or more than one organisation, it may be a serious untoward incident or may have the potential for legal action)	185



The Trust recognises there are lessons to be learned from every complaint received. As can be seen in the above table, there has been an increase in the number of complaints received in year. There has also been a significant increase in 2014/15 in the number of complex complaints received following the publication of the Clwyd/Hart report and the continued public and media interest in the way treatment and care is provided in the NHS following the Francis Report. These complex cases now often involve several different specialities, or more than one NHS Trust. As a result the length of time taken to investigate complex complaints has increased.

Each complaint is also risk assessed by estimating the likelihood of recurrence and the potential harm.

Complaints and Risk grading 2014/15

Since 2013/14 the Trust has triangulated incident reporting, complaints received and claims, in order to improve the way we investigate concerns about treatment and care.

66 complaints had one or more clinical incidents logged, compared to 44 complaints in 2013/14. Of the 185 complaints graded as moderate to high risk, 59 of these were reported as an incident. This demonstrates that the level of incident reporting for moderate to high risk complaints remains low.

Following investigation, 72 complaints were upheld (27%), 65 were partially upheld (24%) and 115 were not upheld (43%). A further 14 complaints are not included in these figures as they either remain open for further investigation or were incorrectly recorded due to data entry errors.

Formal complaints by clinical speciality

Speciality	No. & Trend	Speciality	No. & Trend
Emergency Medicine	26 ↓	Acute Medicine	19↑
Obstetrics	18↓	Orthodontics	2↓
Orthopaedics	21↓	Breast	5↑
General Surgery	31↑	Fertility	1=
Elderly Medicine	22↑	Gastroenterology	8↑
Ophthalmology	6 ↓	Pain Management	1↓
Urology	12 ↑	Radiology	5↑
Vascular	18 ↑	Therapies	1↑
ENT	8 =	Plastics	2↓
Respiratory Medicine	8 =	Clinical Haematology	1 =
General Medicine	5 ↓	Cardiology	10↑
Paediatrics	11↑	Diabetes	3 =
Gynaecology	16 ↑	Rheumatology	2↑
Stroke	4↑		

General Surgery overtook Emergency Medicine as the speciality that received the most complaints in 2014/15, which is unsurprising given that this figure includes Upper GI, Colorectal and Bariatric complaints. Emergency Medicine was the speciality with the next highest number of complaints, followed by Elderly Medicine and Orthopaedics. These are particularly high volume specialities and the serious nature of many patients' presenting conditions traditionally

results in higher complaints figures in these specialities. Of note is the rise in complaints relating to the following surgical areas: Urology, Vascular Surgery, and the Gynaecology service. The rise in Vascular Surgery complaints can be explained by the establishment of the SMART Centre and the increase in Vascular Surgery on site. It should also be noted that many of the surgical complaints related to capacity issues, including the number of postponed outpatient and surgery appointments, and dissatisfaction with the length of time that patients had waited for their appointments.

It is, however, encouraging that the number of complaints received relating to Orthopaedics, Obstetrics, and Ophthalmology have reduced this year. This demonstrates that the measures put in place by the respective services outlined in previous reports have been effective.

Changes implemented over the last 12 months include:

- ENT clinicians have been reminded that they can access 2 different types of Fine Needle Aspiration service on the same day that they see the patient
- The Trust is developing diversion techniques for dementia patients with input and support from patients' families
- A new Falls policy, which includes a revised falls risk assessment, was introduced
- All Consultants, middle grade doctors and all Band 6 and above nursing staff working in the Emergency Department have been trained to fit Ryles' tubes
- Refresher training has been provided to all Consultants with regards to obtaining written consent from patients prior to surgery
- The Stroke Pathway has been reviewed and updated
- Steps have been taken to ensure that the Orthopaedic team has a robust process to discuss clinical audit and research proposals as a team in a formal meeting. Orthopaedic staff have been reminded of how to progress audit and research, the differences between the two processes, and to follow Trust policies.

Complaints by category

The top 5 trend categories identified in the formal complaints remained the same as in previous years, namely:

- Clinical treatment (e.g. concerns relating to diagnosis and treatment, known complications of treatment, missed fractures)
- Communication
- Delay in receiving an appointment
- Delay in treatment
- Nursing care (e.g. hygiene, pressure area care, falls, continence)

As confirmed in the previous annual report, the Medical Director receives a copy of every complaint involving a clinical element. All complaints relating to nursing staff are seen by the Director of Nursing and Quality, or her deputy, and all nursing complaints are reviewed during staff appraisals. Complaints training is also provided during induction training for new nursing staff.

Formal complaints by key category (as a complaint may contain several issues the total number will exceed the number of letters received)

Category	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	Trend
Medical care	84	94	102	87	137	98	↓
Nursing care	51	54	44	52	65	57	↓
Attitude of staff	32	43	35	28	23	26	↑
Communication	25	27	23	28	22	95	↑
Waiting time	12	16	9	13	25	2	↓
Confidentiality	1	7	3	2	2	1	↓
Privacy & Dignity	4	7	9	5	1	4	↑
Admission Arrangements	2	5	5	1	8	4	↓
Postponed operation	12	12	6	2	5	21	↑
Discharge Arrangements	14	8	20	21	4	31	↑

It is of note that the number of complaints that involve issues relating to medical treatment has dropped significantly. However, there have been significant rises in the number of complaints relating to communication, postponed surgery, and discharge arrangements. Complaints about staff attitude and nursing staff appear to have settled to the levels seen in previous years. Although the number of complaints has increased in year, it should be noted that the Trust treated 425,000 patients in this time, and the number of complaints compared to activity remains extremely low.

Actions and learning from complaints

Lessons learnt from complaints are disseminated through:

- Ward Safety briefings
- Mortality & Morbidity meetings
- Rolling half days
- Ward Managers' Meeting
- Discussion at Divisional Governance meetings
- Individual debriefing/staff appraisal
- Training and education sessions with staff groups
- Case presentations to medical and nursing staff
- Feedback to patients and relatives
- Families have been invited to give feedback on the experience at ward managers' meetings, nurse induction training, and via 'Patient Stories' to the Trust Board
- The Deputy Director of Nursing also monitors the Hospicom service which provides real-time feedback on treatment and care by service users.

The Head of Complaints & PALS meets with Heads of Nursing to discuss trends and monitor action plans until complete. Going forward this year, we will continue to provide complaints reports to Divisional Boards, which will include Themes and Trends, on a monthly basis.

The Head of Complaints & PALS also meets on a regular basis with the Head of Risk & Patient Safety and the Head of Legal Services to discuss trends, common themes, and share learning from complaints.

The PALS and Complaints team, together with the Education & Learning Department and Equality & Diversity Manager, developed an innovative game, "Who Cares?" which is used as part of the Trust's Customer Care training for all staff. The game, which launched in Autumn 2012, challenges participants to engage in discussion about a wide range of customer care issues and to consider how their behaviour, communication and actions can impact upon patient care, their experience and the reputation of the Trust. In addition, the Head of Complaints and PALS has run Complaints Awareness courses to new nurse starters during their induction training. Also, for the first time Complaints Awareness training was provided to Junior Doctors (FY1 and FY2 grades). Arrangements are in place for a similar course to be run for doctors in training in 2016.

Parliamentary & Health Service Ombudsman

Where a patient or relative is unhappy with the Trust's response to their complaint they may refer their complaint to the Parliamentary & Health Service Ombudsman for investigation.

On receipt of the complaint, the Ombudsman's office will make an initial assessment following which they will decide whether further investigation is required. Following this assessment the Ombudsman may:

- Ask the Trust to undertake further steps to try and resolve the complaint;
- Close the case, if they are of the view that the Trust has addressed all issues adequately; or
- Decide to investigate the case

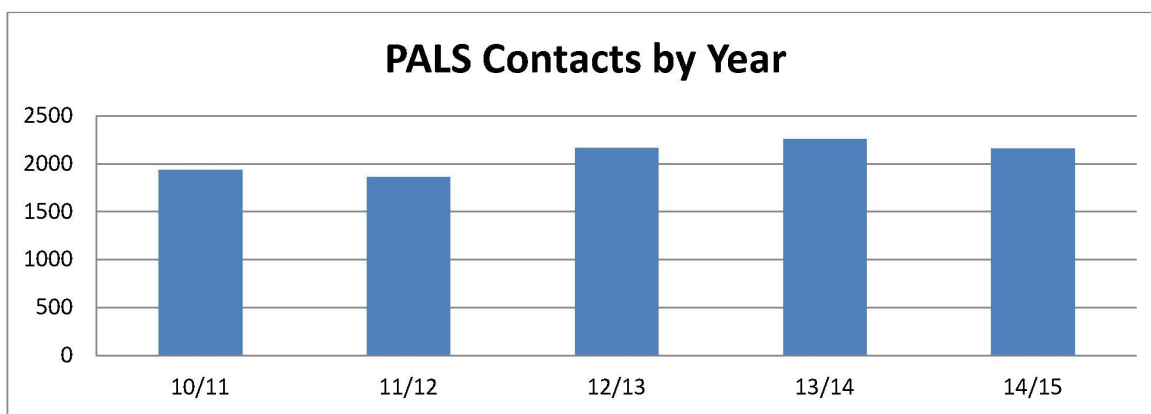
In 2014/15 the Ombudsman increased the number of investigations undertaken nationally from 300-400 cases per year to approximately 4000 cases per year. Therefore, the number of Ombudsman investigations relating to this Trust is likely to increase in the coming year and thereafter.

During the year, the Trust received notification of 6 referrals to the Ombudsman compared to 4 referrals in 2013/4. In 4 cases the Ombudsman was satisfied that the Trust had undertaken a thorough investigation, and did not uphold any aspect of these complaints. The Trust is waiting to hear the outcome of the 2 outstanding investigations.

Patient Advice and Liaison Service (PALS)

The Patient Advice & Liaison Service (PALS) provides a dedicated and accessible service dealing with queries and concerns raised by patients, their relatives and carers by providing on the spot help and advice.

During 2014-15, there were 2,158 PALS contacts via the PALS Helpdesk. These range from requests for information to enquiries and concerns about treatment and care. This demonstrates a decrease of 4% from the previous year.



PALS Story

Patient very happy with the service she received in the Emergency Department. Patient felt that staff were very professional, friendly and helpful. Patient advised that she felt comfortable and cared for at all times. Staff were superb.

Method of contact with PALS

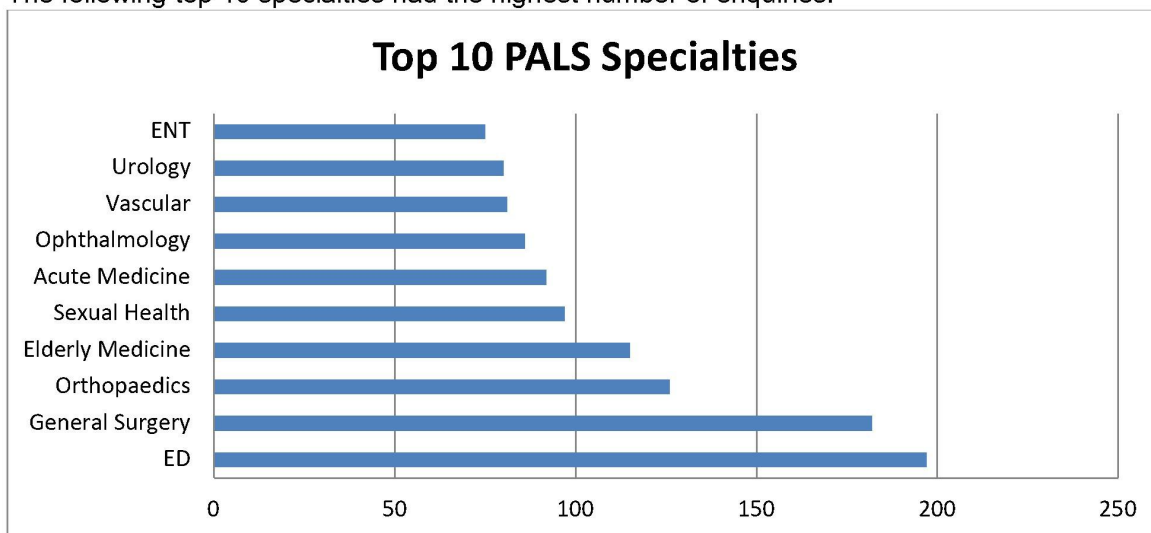
The PALS Helpdesk is the first point of contact for patients and relatives wishing to raise concerns about their care. The majority of these are by telephone (38%) followed by positive comment cards (18%).

PALS Story

Patient unhappy with level of communication with himself and his wife. Patient felt that he and his wife were given conflicting information about his condition which led to his wife becoming alarmed. Apology provided for distress experienced. Patient advised that he received the correct information but that this was subject to change depending on how he responded to treatment. PALS Advisor has fed back to department so that staff are aware of need to ensure clear and consistent communication at all times.

PALS Contacts by Specialty

The following top 10 specialties had the highest number of enquiries:



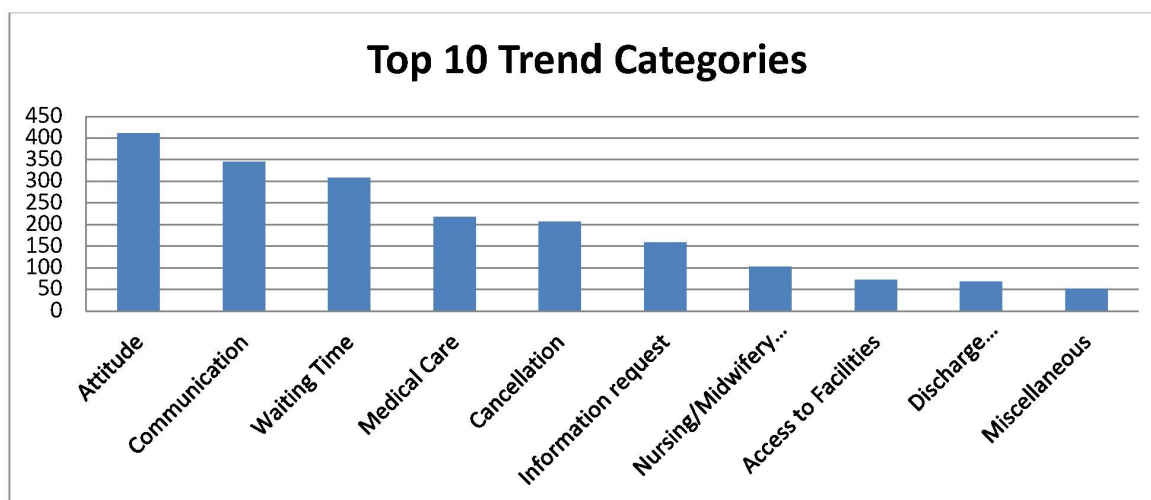
PALS Story

Patient was unhappy that baby changing facilities were not clearly signposted.

Comments forwarded onto Head of Facilities, who immediately made arrangements to improve the signage and increase the baby changing areas in the main hospital.

Type of issues raised via the PALS Help desk

The top 10 trend categories were as follows:



PALS story

Patient was unsure about the procedure regarding the delivery of his medication. He became very frustrated as he could not get an answer regarding this. Patient was assured that his prescription has been faxed to the company supplying his medication. Phone number for company given so that patient can contact company directly. Patient happy with outcome.

Compliments and Comments

The Trust's comments card system received a total of 652 comments during the year, a decrease of 16% from the previous year. 387 (59%) of these complimented the organisation in a variety of ways, particularly the attitude of staff and the care and treatment provided.

Positive comments include:

- *"Excellent service. You cannot improve on perfection!" (Ward 54)*
- *"Excellent service. Hearing clinic – staff and specialists are really at the top. BAHA has turned my life around" (Audiology)*
- *"Excellent service. Couldn't have asked for better. Treated perfectly" (Ruby Ward, Ellesmere Port Hospital)*
- *"First time in hospital at 74. Could not fault. All staff brilliant. Felt like royalty. Food was lovely" (Acute Medical Unit)*

- *“Excellent service. Depth of relevant questioning and sympathetic discussion with the team were far greater than previously experienced or possible with own GP or Consultant. Conclusion and action plan as summarised by doctor were much appreciated and I left hopeful that beneficial steps are possible in helping me manage and reduce my falling problems” (General Medicine)*
- *“Excellent service. My husband and I were very impressed by the kindness shown when he attended for a chest x-ray. He is very disabled and help was given from the time we arrived at reception to having his x-ray taken” (Radiology)*

238 (37%) comments received related to areas where that the service users felt there was room for improvement. These largely related to waiting times in clinic or the wait to receive an appointment, communication and general delays.

All comment cards received are forwarded to departments for their attention and action and common themes are included in a newsletter displayed on the ‘Your Hospital...Your Views’ notice boards and on the Trust’s website.

Suggestions for service improvement include:

- *“Unable to contact Appointments Hotline in order to reschedule an appointment” (Appointments Office)*
- *“Insufficient seating for all patients and their partners in the Antenatal Clinic” (Maternity Unit)*
- *“Good service but had to wait for notes, hence long appointment” (Westminster Eye Centre)*
- *“Unsatisfactory service. Appointment cancelled. Did not receive letter cancelling appointment. Travelled some distance (Maxillo Facial Unit Out Patients)*
- *“Communication - Not informed of protected meal times when visiting” (Ward 44)*
- *“Poor service. We waited a long time in a cramped waiting area but hardest was struggling through the doors with a large wheelchair and no one around to help. These doors need to be automatic” (Outpatients 4)*

Social Media

The Complaints and PALS Department also receives comments via the Trust’s Communication Department from the Trust’s Facebook and Twitter accounts. Where possible, a PALS Advisor will contact the person who has posted the message to either thank them for their kind comments, or offer to investigate their concerns and provide them with a response. The number of contacts using social media in 2014/15 has increased and is expected to grow in future as public use of this medium continues to grow.

Patient Information Websites

The Complaints and PALS Department also responds to comments left on the Trust pages on the NHS Choices and the Patient Opinion websites. Where possible, a PALS Advisor will contact

the person who has posted the message to either thank them for their kind comments, or offer to investigate their concerns and provide them with a response. The number of contacts using patient information websites in 2014/15 has also increased and is expected to continue to grow in future as public awareness of this medium increases.

NHS Choices Feedback

Good choice for cataract op.

I am so glad I chose the Westminster Eye Centre for my recent cataract operation. I went for an assessment on a Wednesday and I was offered the procedure on the following Saturday morning. I was amazed and delighted.

It is 3 weeks since the operation and there has been a very noticeable improvement in my vision. I was fortunate not to experience any of the possible discomforts after the op. which were described in the notes I was given.

I would like to place on record my sincere thanks to the surgeon and their team and to all the staff in the Eye Centre who looked after me with great professionalism and care.

Visited in March 2015. Posted on 23 March 2015

Thank You Letters

In addition, to all the positive comments and personal letters of thanks and cards received by staff, 83 letters of thanks (up 13% from 2013/14) were sent by patients and relatives to the Chief Executive. All are acknowledged in writing and distributed to departments and staff.

Actions Going Forward

The Trust's Complaints Procedure is being refreshed to take into account 'best practice' in complaints handling, as well as building on the Patients Association 'Good Practice Standards for NHS Complaints Handling' and the Parliamentary and Health Service Ombudsman's 'Principles of Good Complaints Handling'.

The Trust is also arranging to meet with representatives from the Parliamentary and Health Service Ombudsman's Office later in the year to discuss 'best practice' in complaints handling and how to further improve our complaints handling.

This will provide the Trust Board with the necessary assurance that the Trust's Complaints and PALS Department is fit for purpose and able to manage complaints and enquiries to the highest possible standards.

The Board is asked to note the contents and approve this report.

Report compiled by:

Geraint Jones
Head of Complaints & PALS
September 2015

Board of Directors

Subject	Patient Led Assessment of the Care Environment (PLACE) report - 2015						
Date of Meeting	13 th October 2015						
Author(s)	Margaret Allen, Facilities Manager Barbara Stoakley, Deputy Facilities Manager						
Presented by	Alison Kelly, Director of Nursing & Quality						
Annual Plan Objective No.							
Summary	The 'PLACE' annual assessment of the patients' environment took place on 15 th & 28 th April 2015 regarding the Countess site and on 4 th June 2015 for Ellesmere Port Hospital site. The assessment is conducted by a team of patient representatives and healthcare staff, inspecting the cleanliness, food, privacy & dignity and maintenance of the environment. The criteria included are not standards but they do represent those aspects of care which patients and the public have identified as important. This paper provides CoCH (including EPH) recent 2015 assessment results and actions to improve areas identified within the assessment. Results have seen a slight deterioration at the Countess site, conversely EPH has illustrated excellent results, details are contained within this paper.						
Recommendation(s)	The Board is asked to: note the contents and to support the actions being taken forward						
Risk Score	N/A						
FOIA Status: <i>FOIA exemptions must be applied to specific information within documents, rather than documents as a whole. Only if the redaction renders the rest of the document non-sensical should the document itself be redacted.</i> Applicable Exemptions: ▪ Prejudice to effective conduct of public affairs ▪ Personal Information ▪ Info provided in confidence ▪ Commercial interests	Please tick the appropriate box below: <table border="1"> <tr> <td>☒</td> <td>A. This document is for full publication</td> </tr> <tr> <td>☐</td> <td>B. This document includes FOIA exempt information</td> </tr> <tr> <td>☐</td> <td>C. This whole document is exempt under the FOIA</td> </tr> </table> IMPORTANT: If you have chosen B. above, highlight the information that is to be redacted within the document, for subsequent removal. Confirm to the Trust Secretary, which applicable exemption(s) apply to the whole document or highlighted sections.	☒	A. This document is for full publication	☐	B. This document includes FOIA exempt information	☐	C. This whole document is exempt under the FOIA
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PLACE – Patient Led Assessments in Care Environments

1 Background

A patient-led assessment of the care environment (PLACE) is the system for assessing the quality of the hospital environment, which replaced Patient Environment Action Team (PEAT) inspections from April 2013. The annual PLACE assessment applies to all hospitals delivering NHS funded care, including day treatment centres and hospices. Information will be used in the CQC's Intelligent Monitoring (IM) process. IM is an analysis used to inform the CQC's new inspection programme about which Trusts could be prioritised for inspection.

PLACE assessments put patient views at the centre of the assessment process, and use information gleaned directly from patient assessors to report how well a hospital is performing in the areas assessed – privacy and dignity, cleanliness, food, general building maintenance and dementia. The dementia assessment has to be completed in all areas where dementia patients may be present. The only exempt areas are paediatric areas and maternity. It focuses entirely on the care environment and does not cover clinical care provision or staff behaviour.

Most importantly, patients and their representatives make up at least 50 per cent of the assessment team, which will give them the opportunity to drive developments in the health services they receive locally. CoCH undertakes quarterly internal PLACE assessments to ensure standards are maintained.

2 Assessment timetable, areas covered and interim results

The assessments for the Countess of Chester Hospital NHS Foundation Trust and Ellesmere Port Hospital were completed as follows:

2.1 4th June 2015 at Ellesmere Port Hospital

Two teams, as per PLACE guidelines, consisted of four patient assessors with representatives from Health watch and four Trust personnel both clinical and non-clinical. The Facilities manager gave an oversight of the assessment prior to the inspection to make all assessors aware of the changes to the paperwork. An external validator was present and this was reciprocated with Wirral University Teaching Hospitals PLACE assessments.

The areas covered were:

- Ward areas
- Outpatient areas
- Communal Areas
- External areas
- Food

2.2 15th and 28th April 2015 at Countess of Chester Hospital

Two teams (each day) as per PLACE guidelines. On 15th April 2015 there were four patient assessors with representatives from Trust assessors and Healthwatch and four Trust personnel both clinical and non-clinical. On 28th April 2015 the team consisted of six patient assessors with representatives from Trust Assessors and Healthwatch and six Trust personnel both clinical and non-clinical. There was also an observer present on this date from the Department of Health who had requested to attend this hospital. An external

validator was present and this was reciprocated with Wirral University Teaching Hospitals PLACE assessments.

The areas covered were:

- Ward areas
- Outpatient areas
- Communal areas
- External areas
- Food
- A&E

3.0 Results – overall impression

Both sites scored well with very positive comments from patient assessors.

Healthwatch and patient assessors expressed a wish to be further included in practical audits and also to be involved in implementing some of the improvements required following the audits.

3.1 First Impressions question

“Based on your first impressions on entering the ward, how confident are you that the environment in this ward supports good care?”

The majority of areas resulted in a score of:

Very confident = A

Or confident = B

3.2 Last Impressions question

“Having carried out the PLACE assessment on this Ward, how confident do you now feel that the environment in this ward supports good care?”

All areas resulted in a score of:

Very confident = A

Or confident = B

The Summary Statements completed by the Patient Representatives as part of the Patient Assessment Summary Sheet read as follows:

15th April 2015

“This is a 30 year hospital which meets the challenge of maintaining the fabric of the building with many modern additions. Patients seemed to be content and well cared for. Staff seemed caring and well-motivated. Food service is good with a good choice and awareness of dietary requirements.

28th April 2015

This is a thirty year old building with modernisation taking place in stages. Patients are treated with dignity and respect. Food served is considered to be very good.

4th June 2015 Ellesmere Port

Ellesmere Port Hospital is an old building (101 years) which faces considerable challenges in maintaining the fabric of the building; however the standards of cleanliness are high. The food is excellent and hot at the point of delivery.

4.0 National Results

Results were published nationally on the 11th August 2015 and were as follows:

4.1

Countess of Chester Hospital					
Assessed Areas	Cleanliness %	Food %	Privacy & Dignity %	Condition, Appearance & Maintenance %	Dementia
National average	97.57%	88.49%	86.03%	90.11%	74.51%
CoCH	98.18%	86.14%	78.35%	88.79%	66.86%

4.2

Ellesmere Port Hospital					
Assessed Areas	Cleanliness %	Food %	Privacy & Dignity %	Condition, Appearance & Maintenance %	Dementia
National average	97.57%	88.49%	86.03%	90.11%	74.51%
EPH	98.32%	94.31%	90.45%	91.30%	71.30%

Results comparisons can be found in Appendix 1 and 2

4.3 Average National Score

Apart from cleanliness in 2015 each assessment area scored at the Countess of Chester was slightly below the national average. Ellesmere Port Hospital scored above the national average in all elements (apart from the new dementia domain which was 3.21% below) However, the combined site/CoCH % score was:

- Cleanliness – 98.25%
- Food – 90.22%
- Privacy & Dignity – 84.40%
- Condition, Appearance & Maintenance – 90.05%
- Dementia -69.08%

Nationally this demonstrates that we are in the top 20% of Trusts for cleanliness, which is excellent. An action plan has already been developed (and some actions already completed) which will be monitored via the PLACE Committee. The Director of Nursing & Quality is the

Exec Lead for PLACE and will be supporting the teams in progressing actions. Estates and Facilities walkabouts have continued with the Director of Nursing & Quality and relevant managers.

4.4 Privacy Dignity and Wellbeing

The assessment of Privacy Dignity and Wellbeing includes infrastructural/

The score for Countess site was 78.35% and Ellesmere Port was 86.73%. Marks were lost due to the fact that the majority of the wards in the Countess do not have a separate treatment room nor a day room. On the assessment day wards 43 and 47 were observed to be very cluttered. In the reception areas of Emergency Department and Westminster Eye clinic it was observed there were insufficient seats at busy times. A negative response was given to the question relating to people being able to hear conversations at reception desks between staff and patients.

4.5 Dementia

The Dementia assessment focusses on flooring, décor and signage, but also includes such things as availability of handrails and appropriate seating, and to a lesser extent food. All questions asked in this area required a yes/no response. This domain draws heavily on the work of the Kings Fund and Stirling University. The items included in the assessment do not constitute the full range of issues requiring assessment which, in total, are too numerous to include. However they do include a number of key issues and organisations are encouraged to undertake more comprehensive assessments using one of the recognised environmental assessment tools available.

This is the first year the dementia assessment has been undertaken and the Countess received a score of 66.86%, whilst Ellesmere Port Hospital was 71.30%.

During the assessment it was observed that not all toilets had both text and picture signs and that toilet doors were not painted in a single colour to distinguish them from other doors. There are handrails in the majority of toilets that are a colour that contrasts with the floor and walls but no toilet seats of a contrasting colour.

Another area that marks were lost in was the lack of prominent signs displaying the ward and hospital name, the lack of a large face clock visible in all areas, the day and date not being visible and doors and handles to staff areas not being painted the same colour as the walls. Another negative response was the inability to remove or cover mirrors in the bathrooms.

5.0 Recommendations

Ellesmere Port Hospital should be congratulated on achieving very positive results however it is disappointing that the overall score for the Countess were not as good. Some actions are very easy to rectify with others requiring a more strategic decision linked with the Trusts Estates Strategy. The attached action plan identifies all the actions being taken forward and are being monitored via the PLACE Committee

The Board of Directors is asked to note the results and content of this paper and to support ongoing actions

Margaret Allan, Facilities Manager
Barbara Stoakley, Deputy Facilities Manager
September 2015

COCH - Patient Led Assessment of the Care Environment P.L.A.C.E.
Action Plan 2014

PLACE 2015			
COCH Comments			
Actions raised	Who Leads	Comments	Completion by:
Ward 32			
1 broken shower head	Estates	COCH Plumbers	Complete.
Grouting needs replacing in showers	Estates	COCH Joiners	In progress
Room 9 and kitchen - drafts from windows	Estates	WASP	Complete.
Some plug holes need sealant replacing	Estates	COCH Plumbers	Complete.
Ward 50			
Broken ceiling tile	Estates	COCH Joiners	Complete
Soap dispenser off wall in bathroom	Estates	COCH Joiners	Complete
No emergency pull cord in toilet	Estates	COCH Assistant	In progress
Bathroom behind nurses station used as storage area	Ward Manager		in progress
Some staff not wearing ID badges	Ward Manager		in progress
Ward 60			
No handrails anywhere on the ward - general circulation corridors	Estates	Obtain quotation from Harrison and Thompson	TBA
Only 1 patient toilet	Estates	COCH Property Services	
Ward 53			
Entrance cluttered	Ward Manager		
Picture missing on female toilet	Estates	COCH Joiners?	
Leaflets missing	Ward Manager		in progress
Handrail on wrong side and chairs against it	Estates	COCH Joiners	Difficult to reposition.
Ward 40			
Corridor outside needs attention - notices removed and gaps left	Estates	COCH Decorator	Redecorated completely
Corridor to ward scuff marks	Estates	COCH Decorator	Redecorated completely
Corridor outside seemed subdued	Estates	COCH Decorator	Redecorated completely
Laminated notices stuck with sellotape	Ward Manager		

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Actions raised	Who Leads	Comments	Completion by:
Ward 43			
Patient commented that staff are great but there are not enough of them	Director of Nursing		
Broken sanitiser outside ward (reported 09.04.15)	Estates		Complete
Internal décor tired - needs updating	Estates	Access to be provided by Nurse Management	
Hole in floor outside A Bay	Estates	B J Watts Flooring	30/10/2015
Bed space in C bay lots of equipment in it	Ward Manager		In progress
1 bathroom with walking frame and patient equipment	Ward Manager		In progress
Paper signs stuck with sellotape	Ward Manager		In progress
Sign relating to computer on fire hose	Ward Manager		In progress
Rusty bin in H bay by the door	Ward Manager		In progress
Cluttered space between and around beds	Ward Manager		In progress
Patient commented that too hot previous day lack of fans	Ward Manager		In progress
Hazard tape on entrance to side room F	Estates	B J Watts Flooring	30/10/2015
Door bashed by reception desk	Estates	COCH Joiners	30/11/2015
Sanitiser dispenser missing by reception desk	Estates	COCH Joiners	Complete
Missing ceiling tile and wall under window needs attention	Estates	COCH Joiners	Complete
Permanent sign required for exit door - (push door)	Estates	Cowens/COCH Joiners	30/10/2015
Entrance A bay doors bashed	Estates	COCH Joiners	30/11/2015
Taps different in bays and toilets	Estates	Clinical/Non Clinical Taps (HTM)	N/A
Ward 44			
Clutter of personal computers by bed	Ward Manager		in progress
Assisted bathroom behind nurse base / drip stands, 1 commode, 4 dressing trolleys stored in there (toilet is used)	Ward Manager		in progress
Shower fittings rusty	Estates	COCH Joiners	Complete
Pull cords not all sanipull	Estates	COCH Assistant	In progress
Ward 47 - AMU			
Bathroom 5 not sanipull	Estates	COCH Assistant	In progress
Lots notices with sellotape	Ward Manager		In progress
Sign taken off wall - big gap	Estates	COCH Joiner/Decorator	Complete
How are we doing and staffing levels not completed	Ward Manager		completed
Chairs stacked all over ward	Ward Manager		in progress
Patient surrounded by visitor chairs	Ward Manager		in progress
Very cluttered	Ward Manager		in progress
Patient surrounded by cylinders	Ward Manager		in progress
Cluttered ward	Ward Manager		in progress

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Emergency Department			
Too many confusing signs difficulty for people with literacy problems - signage needs improving	Matron		in progress
Wall requires replastering	Estates		
Tape on doors	Matron		in progress
Plugs hanging down	Estates		
Car park machine - notice peeling	Security		
Broken chair in waiting area	Estates	COCH Joiners	Complete
Notice on bin requires renewing	Matron		in progress
Eye room -notice stuck with sellotape	Matron		in progress
Marked ceiling tiles	Estates	COCH Joiners	Complete
Children's toilets ceiling tiles marked,wires hanging from ceiling	Estates	COCH Joiners	30/10/2015
Floors in cubicles - cracked round edges of coving (flooring on plan to be replaced later this year)	Estates	B J Watts Flooring Access	Access Issues
Communals (stairs lifts corridors)			
2 broken ceiling tiles outside Oncology	Estates	COCH Joiners	In progress
ENT waiting area vinyl gone on seats - material showing through	Estates	COCH Alan Dunn	
Seating all same height in ENT and main entrance	Estates		
When exit lifts no indication in front to indicate direction to go in	Estates	Signage review Alan Dunn	Complete
No signs inside lifts	Estates	Signage review Alan Dunn	
Stains on floor outside HSDU	Estates/Facilities		
Lots of scuffs on walls in corridors	Estates	Corridors to be painted as part of new signage installation	
Stained and broken ceiling tiles	Estates	COCH Joiners	In progress
3 leaks by ward 41	Estates	COCH Joiners	Complete
ENT Waiting Area trip hazard rubber lifting	Estates	B J Watts	30/11/2015
No signage from bridge	Estates	Signage review Alan Dunn	In progress
Roof covered in weeds by old bike park	Estates	COCH Joiners	Complete
Externals			
Road markings require refreshing	Estates	Henry Williams	18/10/2015
Build up of cigarette ends at edge of car parks and on grass	Estates		
Plan in cases on footpaths - not clear and not up to date	Estates	Part of signage review	

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Actions raised	Who Leads	Comments	Completion by:
Westminster Eye Clinic			
Sellotape and notices over sinks	Ward Manager		in progress
Lack of sanipull cords	Estates	COCH Assistant	In progress
Lump under floor a strip of flooring requires repair	Estates	B J Watts	30/10/2015
Seats are material in waiting area can't clean effectively	Ward Manager		in progress
Burst chairs	Ward Manager		In progress
Clutter in waiting area	Ward Manager		In progress
OPD 3			
Toilet roll holder broken in OPD3 disabled toilet	Estates	COCH Joiner	Complete
Hazard tape on floor by reception.	Estates	B J Watts	30/10/2015
All leaflet boxes empty	Dept Manager		In progress
No handrails	Estates	Obtain quotation from Harrison and Thompson	Site visit complete.
Disabled toilet ceramic requires replacement	Estates	COCH Plumbers	30/11/2015
Toilet seats not different colours	Estates	COCH Plumbers	30/11/2015
Therapies			
Some seats in waiting room - cracked upholstery	Comissioning Mgr		in progress
Paediatric OPD			
Signs laminated but stuck with sellotape	Dept Manager		in progress

KEY

	COCH Staff
	Contractor

EPH - Patient Led Assessment of the Care Environment P.L.A.C.E.
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EPH Comments			
Actions raised	Who Leads	Comments	Completion by:
Communals			
Scuff on walls, chipped door frames, floor bubbling	Estates		
Sanitiser dispenser missing	Estates		
Some indication required that floor slopes in main corridor	Estates		
Bedframe and broken recliner chair stored outside lift	Matron		
Lighting dull in staircase	Estates		
Wall stained by heater	Estates		
Trunking in disabled toilet badly stained	Estates		
Healthy Aged Centre			
Curtain sliders required on rail in therapy room	Estates		
Sellotape residue on trunking	Domestics		
Toilet seats not blue (handrails are dementia assessment)	Estates		
Hazard tape on floor in corridor	Estates		
Marks on floor in day room	Estates		
Commode stored in shower room	Ward Manager		
Emerald			
Some areas need replastering and painting	Estates		
Window ledges require painting	Estates		
Linen Trolley not covered	Ward Manager		
Ruby			
Stains on floor by fire exit	Estates		
1 bathroom with a floor that is not non slip	Estates		
Bathroom used as storage area inappropriate	Ward Manager		
Ward Cluttered	Ward Manager		
Yellow bin bags being used	Matron		
Toilet seats not blue (handrails are dementia assessment)	Estates		
Old stained chair stored in annexe	Ward Manager		
Diamond			
Bathroom used as storage area inappropriate	Ward Manager		
Bed bumpers used in pod areas	Ward Manager		
Physiotherapy			
Seat covers material unable to clean effectively	Estates		
Equipment not stored away	Head Physio CWP		
Radiology			
Decor very tired	Estates		
Seating unable to be cleaned effectively - stains evident	Dept Manager		
Linen not covered	Dept Manager		
Lots of paper notices stuck with sellotape	Dept Manager		
Stains on floor by blood clinic door	Estates		