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Warrington and Halton Teaching Hospitals NHS Foundation Trust

WHH Board of Directors Meeting Part 1

Wednesday 27 November 2019
10.00am-1.00pm
Trust Conference Room

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NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Warrington and Halton Hospital NHS Foundation Trust
Agenda for a meeting of the Board of Directors held in public (Part 1)

Wednesday 27 NOVEMBER 2019 time 10.00am -13.00pm
Trust Conference Room, Warrington Hospital

Pre-election period – The Trust have been to be aware that the pre-election period is effective from 6th November, 2019 until 13th Decmeber, 2019. With this in mind, the Board agenda and papers have been reviewed and have been confined to matters that need a board decision or require board oversight.

REF BM/19	ITEM	PRESENTER	PURPOSE	TIME	
BM 19 11 102	PRESENTATION /PATIENT STORY 15 Minutes – Medical Care			10.00	N/A
BM/19/11/ 103	Welcome, Apologies & Declarations of Interest	Steve McGuirk, Chairman	N/A	10.15	Verb
BM/19/11/ 104 PAGE 4	Minutes of the previous meeting held on 25 September 2019	Steve McGuirk, Chairman	Decision	10:17	Encl
BM/19/11/ 105 PAGE 17	Actions & Matters Arising	Steve McGuirk, Chairman	Decision	10:20	Encl
BM/19/11/ 106 PAGE 18	(a) Chief Executive's Report (b) Summary of NHS Providers Board papers (c) NHSE/I Feedbeck September 2019 System Assurance Meeting	Simon Constable Chief Executive	To note	10:25	Enc
BM/19/11/ 107	Chairman's Report	Steve McGuirk, Chairman	Update	10:40	Verb

Quality People Sustainability

BM/19/11/ 108 PAGE 31	Integrated Performance Dashboard M7 Assurance Committee Reports	All Executive Directors	Assurance + Note	10.50	Enc
(a) PAGE 86+95	- Quality Dashboard including o Monthly Nurse Staffing Report, August + September 2019				Enc
(b) PAGE 103	- Key Issues report Quality and Assurance Committee 5.11.2019	Margaret Bamforth, Committee Chair			Enc
(c) PAGE 108	People Dashboard - Key Issues Strategic People Committee 18.09.2019 + 20.11.2019	Anita Wainwright Committee Chair			Enc
	- Sustainability Dashboard				Enc
(d) PAGE112+115	- Key Issues Finance and Sustainability Committee 23.10.2019 + 20.11.2019	Terry Atherton, Committee Chair			
(e)	- Key Issues Audit Committee (21.11.2019 - verbal)	Ian Jones, Committee Chair			

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Quality

BM/19/11/ 109 PAGE118	Learning From Experience Report Q2 *(slides in supplementary papers)*	Kimberley Salmon-Jamieson Chief Nurse	To note	11.45	Enc
BM/19/11/ 110 PAGE122	Director Infection Prevention + Control (DIPC) Quarterly Q2 Report	Kimberley Salmon-Jamieson Chief Nurse	To note	11:50	Enc
BM/19/11 111 PAGE139	Care Quality Commission (CQC) update	Kimberley Salmon-Jamieson Chief Nurse	To note	11:55	Enc
BM/19/11/ 112 PAGE171	Mortality Review (Learning from Deaths) Q2 Report	Alex Crowe Acting Executive Medical Director	To note	12:05	Enc

Sustainability

BM/19/11/ 113 PAGE186	Q2 Progress on Carter Report Recommendations and Use of Resource Assessment	Andrea McGee Director of Finance + Commercial Development	To note	12:10	Enc

People

BM/19/11/ 114 PAGE224	GMC - Re-validation Annual Report (def from Sept) *(Annual Report in supplementary papers)*	Alex Crowe Acting Executive Medical Director	To note	12.15	Enc
BM/19/11/ 115 PAGE234+250	Guardian of Safe Working Q1 (def from Sept) + Q2 report	Alex Crowe Acting Executive Medical Director	To note	12:20	Enc
BM/19/11 116 PAGE 259	Engagement Dashboard - 6 month report	Pat McLaren Director of Community Engagement + Fundraising	To note	12:25	Enc
BM/19/11/ 117 PAGE267	FTSU Update following FTSU Month	Kimberley Salmon-Jamieson Chief Nurse	To note	12:35	Enc
BM/19/11/ 118 PAGE 270	Flu Vaccincations Update	Michelle Cloney Director of HR & OD	To note		Enc

GOVERNANCE

BM/19/11/ 119 PAGE 276	Strategic Risk Register + BAF *(BAF in supplementary papers)*	Simon Constable Chief Executive	Approval	12:45	Enc

MATTERS FOR APPROVAL

	ITEM	Lead (s)				
BM/19/11/ 120	Charities Commission Checklist *(in supplementary papers)* For Approval	Pat McLaren Director Community Engagement + Fundraising	Committee	Charitable Funds Committee		
			Agenda Ref.	CFC/19/09/33		
			Date of meeting	12.09.2019		
			Summary of Outcome	Approved		
			Agenda Ref.			
			Date of meeting			
			Summary of Outcome			

	Any Other Business	Steve McGuirk, Chairman
	Date of next meeting: Wednesday 29 January 2020 , 10.00am Trust Conference Room	

Copies of Trust Board papers can be found on the WWH Website at:
https://www.whh.nhs.uk/about-us/how-we-work-our-board-and-governors/board-meetings-and-papers

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NHS Warrington and Halton Hospitals NHS Foundation Trust

Warrington and Halton Hospitals NHS Foundation Trust
Minutes of the Board of Directors meeting held in Public (Part 1) on Wednesday 25 September 2019
Trust Conference Room, Warrington Hospital

Present	
Terry Atherton (TA)	Deputy Chair, Non-Executive Director (Chair)
Mel Pickup (MP)	Chief Executive
Simon Constable (SC)	Deputy Chief Executive and Joint Executive Medical Director, WHH and Bridgewater CHFT
Kimberley Salmon-Jamieson (KSJ)	Chief Nurse
Chris Evans (CE)	Chief Operating Officer
Andrea McGee (AMcG)	Director of Finance and Commercial Development
Michelle Cloney (MC)	Director of HR + OD, WHH and Bridgewater CHFT
Anita Wainwright (AW)	Non-Executive Director
Ian Jones (IJ)	Non-Executive Director / Senior Independent Director
In Attendance	
John Culshaw (JC)	Head of Corporate Affairs
Alex Crowe (AC)	Medical Director, Director of Medical Education + Clinical CIO
Lucy Gardner (LG)	Director of Strategy
Phillip James (PJ)	Chief Information Officer
Dan Moore (DM)	Deputy Chief Operating Officer
Donna Hargreaves (DH)	Executive Assistant (Minutes)
Dr Anne Robinson (AR)	Associate Medical Director Patient Safety (Patient Story)
Apologies	
Steve McGuirk (SMcG)	Chairman
Pat McLaren (PMcL)	Director of Community Engagement + Fundraising
Margaret Bamforth (MB)	Non-Executive Director
Cliff Richards (CR)	Non-Executive Director
Observing	
Norman Holding	Public Governor
Alison Kinross	Public Governor
Laura Botea	Good Governance Institute
Max Barbour	Civica
Gilly Graham	Civica

BM/19/09/	Patient Story KSJ introduced AR who provided details of a recent incident regarding a patient with Downs Syndrome and the lessons learned following the incident and how the Trust is learning and taking the agenda forward to ensure all patients with a Learning Disability are fully supported at all times. The Chair thanked AR for her attention and bringing this information to the attention of the Trust Board.
BM/19/09/78	**Welcome, Apologies & Declarations of Interest** The Chair opened the meeting and welcomed colleagues. The Chair welcomed Laura Botea from the Good Governance Institute and Max Barbour and

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DRAFT

NHS Warrington and Halton Hospitals NHS Foundation Trust

	Gilly Graham from Civica who would be observing the Trust Board meeting. Apologies noted above. There we no declarations made in relation to the agenda.
BM/19/09/79	**Minutes of the meeting held 31 July 2019** The minutes of 31 July 2019 were agreed as an accurate record.
BM/19/09/80	**Actions and Matters Arising. Action log and rolling actions were noted.** Page 6, BM/19/07/60 – Chief Executive's Report: Urgent Treatment Centre – it was noted that following a challenge from the Trust on the decision making process of a previous procurement process, a further full procurement process is now live and the Trust will be bidding. At this point, on behalf of the Trust Board, the Chair offered thanks of appreciation to MP for her tremendous stewardship of Warrington and Halton Hospitals NHS Foundation Trust (WHH) during the time she has been Chief Executive Officer. He acknowledged that there was now an excellent new Executive Team in place. He added that at the Trust's annual 'Thank You' awards to be held on 4 October 2019, there would be an opportunity for MP to receive thanks from staff and the Trust collectively. The Chair wished MP every success in her new role at Chief Executive Officer of Bradford Teaching Hospitals NHS Foundation Trust.
BM/19/09/81	**Chief Executive's report** The CEO provided an update on matters for the Board to note since the last meeting both nationally and locally. Rapid Diagnostic Centre – MP reported that the Trust had been successful in their Expression of Interest to be part of the first wave for the development of a Rapid Diagnostic Centre (RDC) in the Cheshire and Merseyside Cancer Alliance CMCA) area. This RDC will also provide services in other areas across Cheshire and Merseyside. Summary of NHS Provider Board papers – noted. Cheshire and Merseyside Health and Care Partnership Board – MP reported that a new Chair is being sought, Sir Duncan Nichol is the interim Chair. It is anticipated that the recruitment process will have been completed by the end of October. It will be a robust decision-making process with a variety of stakeholders being involved. This timeline will be in line with the requirement to submit the long term plan by 27 September 2019. It represents a bottom up aggregate of the plans that are safe, effective and sustainable which will meet increased demand. The long term plan is due 1 November 2019. MP stated that there will be specific emphasis on prevention of ill health within the plan which will be key aspect of it. Three key priorities have been identified: Cardiovascular Disease (CVD), zero suicide and no harm from alcohol. They will be signed off by the System Management Board at a meeting being held on 26 September 2019. The Chair asked how these three key priorities had been identified. MP responded that it was well recognised and accepted that these were the three most high risk areas. So it had been decided not to confine to just a primary care – our approach across Cheshire and Merseyside is to aim to make more improvement, for example, making every contact count. It is an all-encompassing strategy which include Cheshire Fire Service – who can identify arythmias in people's homes via new technology, ie a multi-sectorial approach to help people. Financial Recovery Plan for 2019/20 – MP reported that a new whole system approach is being taken locally to avoid change to the net control total which includes Bridgewater

	Community Healthcare NHS Foundation Trust, Clinical Commissioning Groups (CCGs) and other stakeholders. This will set the scene for a long term plan. Interim Arrangements for Chief Executive support to WHH – MP advised that this was her last Trust Board with WHH, her last day in the Trust would be 17 October 2019 and she would commence her new role in Bradford on 1 November 2019. Simon Constable would be the Acting Chief Executive Officer from 1 November 2019. The recruitment process for MP's replacement will begin on 30 September 2019 and interviews will take place on 12 November 2019. MP thanked the Board and Executive Team and the 4,000 staff who made up WHH for their support over the last nine years. The Board, in turn, convey their thanks to MP.
BM/19/09/82	**Chairman's Report** The Chair highlighted the following for note: - The Chair, on behalf of the Trust's Chairman, Steve McGuirk, (SMcG) endorsed the timeline of the recruitment process for a new Chief Executive for WHH as outlined by MP.
BM/19/09/83 *(a)*	**IPR Dashboard** The Board were asked to note the reports that had already been received by the Board sub-committees and these were to be taken as read. Monthly Nurse Staffing Report July 2019 for noting: the key highlights were noted and that 7.5% demonstrates the Trust's current good overall position of Care Hours Per Patient Day (CHPPD). July and August 2019 had shown a drop in staffing and mitigating actions were taken to rectify it. A deep dive has been requested to identify the reason for the drop, which, in part, could be due to an increase in sickness absence levels. The report has been to the Strategic People Committee (SPC) for assurance. KSJ reported that the Trust now has a potential 45 new staff due to arrive in the next 2-4 weeks. CE asked in terms of sickness absence levels, were there any drivers as to knowing why the levels were high to identify mitigating actions? KSJ responded that she had met with ward managers to identify themes. KSJ has a meeting with MC this week to share the outcomes. AW added that a full discussion had taken place at the last SPC meeting on staffing levels. MC reported that one of the mitigating actions is a programme that has been endorsed by NHS Improvement (NHSI) highlighting the wellbeing of the Trust's staff. As a result, a diagnostic has been carried out which will report through SPC. It has been identified that one of the key areas for recruitment is around clinical staff – Healthcare Assistants (HCA)s. At the Operational People Committee (OPC) a Task and Finish Group has been set up which is being led by John Goodenough, Deputy Chief Nurse, to identify how this staff group is being supported. A series of actions are being taken forward which have been signed off by OPC. Quality measures: MP asked KSJ to provide an update on variances in some of the performance figures; (i) details of the Never Event report; (ii) Medication Safety, when will medicines reconciliation reach the target of 80% and (iii) whilst the Friends and Family Test covers the Inpatient sector, where does Outpatients Friends and Family fall? i. KSJ responded that the Trust reported a Never Event in August 2019 relating to a wrong site interscalene block being performed using ultrasound on a patient scheduled for surgery. Immediate actions were implemented following review and the investigation is underway. A governance process will be followed to understand what happed and to put in place the necessary new procedures. AW asked when would key feedback be

	provided? KSJ responded that a report would go to a future Quality Assurance Committee. SC added that if anything urgent is identified, it will be brought to the November Trust Board. i. KSJ reported that the target is 80% March 2020 for medicines reconciliation and the Pharmacy Department has a plan to reach 40.1% medicines reconciliation pre-January 2020. This ? increasing support in ED. The planned implementation of electronic prescribing and medicines administration (ePMA) and 7 day on ward pharmacy service will support an increase in pharmacy ward staffing levels, leading to improvements in medicines reconciliation figures and prescribing and therefore patient safety. i. KSJ provided a personal example of the technical difficulties that a visitor to Outpatients is experiencing and not being able to provide feedback for the Friends and Family feedback. She reported that the Trust will be meeting with the company that provides the tracker reports to rectify the problem and also to widen the communication opportunity for visitors to Outpatients. AW alluded to previous problems that have been experienced. KSJ acknowledged there had been and assured that there will be an increase in the frequency of meetings with the provider so that a more timely resolution of problems can be actioned.
(b)	Quality Assurance Committee Chairs Key Issues Report (3.09.2019) – noted. SC referenced the Quality Dashboard and VTE and that mitigations are in place to achieve compliance. Access and Performance measures – Ambulance Handovers: CE reported that the Trust will be part of the 19/20 collaborative with the North West Ambulance Service (NWAS) to improve ambulance handovers. Previously NWAS have achieved a reduction of 8 minutes in handover times which equates to an additional 39 emergency vehicles being available in the system. At present the Trust is currently is performing well in respect of both 30-60 minutes and 60 minute + handover times. The NWAS initiative of last winter has now been extended to a further eight organisations with WHH being one of these. The collaborative will commence from November 2019. Super Stranded: MP asked what plans were in place to address the escalation of Super Stranded Patients. CE acknowledged that the Trust has seen a peak in numbers and is currently not hitting the trajectory, however this is a national and regional trend having recently been discussed at the Mid-Mersey AEDB. There have been a number of contributory factors including, reduction of 11 beds on B3, long term sickness within the Integrated Discharge Team (IDT) and the impact of the summer period and reduction of care hours within the domiciliary care provider market. CE assured MP that there is a six week recovery plan in place to mitigate these issues. Breast Symptomatic: The cohort of patients within this standard is relatively small hence this can be subject to fluctuation in performance. Patient choice over the summer period has caused the standard not to be achieved although this has recovered from August 2019 and is on track for achievement in September 2019. Cancelled Operations: The rebooking of elective operations within 28 days post cancellation has not been achieved for 5 months. On review there is no trend within specialties and have been driven by a variety of factors including; patient choice, operator annual leave,

	equipment availability and estates issues. There is a cancelled operations group in place tracking this standard with increased monitoring via the performance review group on a weekly basis. People measures: MC was asked to provide an update on a recovery plan and variable costs to address deterioriation in workforce indicators and mitigations in place to improve. MC explained that one of the main initiatives has been a piece of work to identify how the Trust can best support its agency and bank infrastructure. In 2017, the Trust reviewed its internal processes against NHSI best practice guidance and as a result of which a centralised process has been established in the last 12 months. A Premium Pay Spend and Review Sub Group reports as part of the premium pay dashboard into the Finance and Sustainability Committee. An example of this has been the reduction of 3% agency administrative costs by changing our Direct Engagement provider to Plus Us from Liaison through the Trust's procurement process. Further work is being carried out at the request of the Executive Team to support the Trusts system recovery plans and a deep dive aligned to the Pay section with the NHSI/E Grip and Control Checklist was being conducted. MC gave assurance that measures and processes are in place and that any additional controls would be intended to enhance, rather than replace current approaches. MP asked for assurance that the work to produce a recovery plan is collectively owned. MC replied that SC, CE and KSJ all report back regarding trends of bank and agency spend via the Premium Pay Spend and Review Sub Group and they welcome the deep dive exercise. TA and AW were assured that the Premium Pay Spend and Review Sub Group produces clear data tracking results that feed into FSC. AMcG acknowledged that the Trust is an outlier in terms of its bank and agency spend in achieving its controls total. The deep dive exercise is welcomed and will inform how the 3 and 5 Year Plans will be achieved. AW added that Christine Samosa, Cheshire and Merseyside Strategic Workforce Lead, Health and Care Partnership, had attended a Strategic People Committee and provided a picture of the broader workforce strategy and the context in where the Trust is. Copy of Christine Samosa's presentation to be circulated. KSJ emphasised the importance of moving at pace to reduce costs, supporting teams to make the right decisions and having a significant plan in place for safety.
(c)	Strategic People Committee Chairs Key Issues (18.09.2019): AW asked that the presentation from Christine Samosa, Cheshire & Mersey Health and Care Partnership be circulated. The Key Issues Report will be circulated at the next Trust Board. Finance + Sustainability Measures: IJ asked about the phasing of the agency ceiling noting a reduction from month 7 shown on page 59 of the IPR report. AMcG explained that the Trust had agreed an investment regarding recruitment of permanent staff. Quarter by quarter, the agency spend is profiled to reduce each quarter as permanent staff are recruited. MP asked with regard to sustainability, what is the approach being taken, in particular, to action the recovery plan? AMcG explained that the Trust is working collaboratively with Bridgewater and Warrington and Halton CCGs on system sustainability. Andy Davies the Accountable Officer at Warrington and Halton CCGs is the lead for the development of the local system sustainability plan. The collective mitigated risk has reduced to £11.6m of which the Trust is

	£2.3m. This includes a number of actions that include a review of agency rates and usage, additional scrutiny of non pay expenditure and additional controls relating to recruitment of non clinical posts. An initial show and tell session has been held to share plans and identify opportunities with a further meeting to be arranged. The Chief Executives and Accountable Officer and Executives will be meeting regularly to agree and then monitor delivery of a sustainability workplan. • **The Board noted, reviewed and discussed the report.** • **The Board approved the change to the 2019-20 Capital Programme.**
(d)	Finance + Sustainability Committee (FSC) Chairs Key Issues, 21.08.2019 + 18.09.2019). As Chair of FSC, TA had no additional issues to highlight to discussions earlier.
(e)	Audit Committee (AC) Chairs Key Issues, 1.08.2019) As Chair of AC, IJ had no additional issues to highlight.
(a)	Monthly Safe-staffing reports July and August 2019. KSJ was pleased to report that significant improvements have been made in the overall nursing establishments enabling the Trust to meet the SafeCare acuity establishments of 688.37 WTE. The actual number of staff in post is currently 576.74, leaving the number of nurse vacancies across the Trust at 111.63 which is an improvement of 22 WTE from the previous six month review. The Trust has an ongoing Nursing Recruitment and Retention Plan which continues to deliver. The collaborative work with NHS Improvement has seen an improvement in turnover from 14.99% in November 2018 to 12.81% in May 2019. The funding of £50k has now been received to support the development of the clinical infrastructure in the Trust in collaboration with Chester University. The SafeCare Census results indicate the Trust is in a positive position with regard to acuity of patients. The Birthrate Plus Acuity Tool used for a review of a two week sample of census data recorded of staffing levels to meet acuity which was performed between 11-21 March 2019, demonstrates a ratio of 1:28 which is good. This exercise will be repeated next year to ensure the Trust is within The Royal College of Midwives (RCM) recommended target of 85% staffing levels. AMcG endorsed the positive results demonstrated on the Trust's acuity levels in midwifery. SC referenced the Trust being in its second year of ward accreditation and asked if there was any correlation between that and staffing levels now being experienced. KSJ responded that there are three key areas that directly correlate: leadership, sickness and staffing. TA added that the Nurse Staffing Bi-Annual Report showed that good progress has been made. • **The Board noted and reviewed the report.**
BM/19/09/84	**Learning From Experience Q1 Report 2019/2020** The report relates to implementation of the Trust's Learning Framework. It is quarterly integrated 'Learning from Experience' (LFE) report. It focuses on the learning from incidents, complaints, claims and inquests over Quarter 1, 2019/2020 (April – June). Incident reporting - a decrease in incident reporting, improved incident reporting to be progressed and a number of measures to be put in place to support improved and timely reporting of all incidences, including collaborative working with Bridgewater to scope out Purchasing Datix IQ, which allows staff to digitally dictate incidents and thereby would

	increase reporting. Open incidents progress to timely resolution continues to be monitored through M2O. Trauma External review – Report in November PSCE high level briefing when complete. Pressure Ulcer Collaborative to support continued reduction in PUs Decrease in falls - no falls linked to harm in Q1, monitoring continues. Deep dive to be undertaken relating to Cardio incidents, reported to November PSCE and QAC HLB in January 2020. • **The Board noted and approved the contents of the report.** • **Received assurance that the Learning from Experience process continues within the organisation.** • **The presentation of the data is included within the slide deck provided.**
BM/19/09/85	**Care Quality Commission (CQC) Action Plan** The Chief Nurse (KSJ) outlined the CQC Action Plan and update and highlighted the key elements, namely: • There are 60 actions across 35 recommendations made by CQC • There are no 'Must Do' actions or regulatory breaches – there are 53 actions relating to 'Should Do' recommendations • Current compliance of the CQC action plan is outlined in the report. KSJ advised that all actions will be monitored by the Moving to Outstanding Steering Group which will report into the Executive Team, the Quality Assurance Committee then to the Board. AW referred to the change in the governance plan structure on page 5 of the report. KSJ replied that the reporting mechanisms will not change and oversight will be captured, for example, leadership will be monitored within the Well Led meeting. SC added that existing meetings will be utilised to look at the Key Lines of Enquiry (KLoEs) to ensure the Trust develops actions to progress it to outstanding. A Moving to Outstanding Framework is in development which will self-assess the Trust against the KLoEs. This framework will be considered by the Board at a future meeting. MC reported that as part of the work plan for SPC, feedback will be provided on any people-related items. In addition, feedback will be provided on use of resources. IJ thanked KSJ for a useful update. KSJ provided assurance that this agenda item will be reported to each Board meeting. AC confirmed that the 60 actions across the 35 recommendations made by CQC will be raised at the appropriate meetings including Patient Safety. He added that the Trust's Digital Strategy will be an important enabler in the achievement process with 45% of medicines re-ablement by March 2020 which is part of a phased business case aligned to the Trust's CQC action plan. **The Board discussed and noted:** • **The CQC action plan progress and update** • **Urgent and Emergency Care action plan progress** • **Revised governance structure for CQC Moving to Outstanding**
BM/19/09/86	**Director Infection Prevention +Control (DIPC) Q1 report and Annual Report (latter contained in the Supplementary Binder)** IJ asked about the Norovirus. The Chief Nurse (KSJ) responded that wards were closed. KSJ

	reported that the Trust was significantly affected by Norovirus during April and May. Plans are being made for this year. The annual report was taken as read. • **The Board reviewed, discussed and noted the report, the exceptions reported and the progress made.**
BM/19/09/87	**Learning From Deaths** The Executive Medical Director / Deputy Chief Executive (SC) provided an outline of the report and the improved presentation of information. He reported that Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital Mortality Indicator (SHMI) are within the 'as expected' range. However, following analysis of the data, the MRG indicated an excess number of deaths in diagnosis groups of R Codes and Chronic Obstructive Pulmonary Disease & Bronchiectasis and had requested focussed reviews be undertaken to obtain and share learning. Reports for these work streams will be available from October 2019. Co-morbidity documentation and coding shows an improvement. IJ queried the upward trend shown in SHMI. SC replied that, statistically, the Trust is in a relative position to other organisations and remains within the 'as expected' range for the year and caution should be deployed in interpreting absolute numbers within the confidence intervals. He added that we know how clinical coding can affect how data is shown as well as how consultant episodes are described and stressed the importance of triangulating data with other outputs, including the Structured Judgement Reviews through MRG. Although our data for deaths associated with 'problems in care' is in single figures, work is continually in progress to reduce this further. AC added that through the Mortality Review Group, one of the changes is with regards to sign and symptom recording performance and data capture and to record common working diagnosis to tidy up cleanliness of the data demonstrated in the graphs. He reported that following testing, a pilot would commence in November. SC reported that looking to the future, further improvement in the Trust's processes will be necessary in line with national guidance, a Medical Examiner role will need to be in place by the end of the financial year. This will also include ever more structured engagement with bereaved families to ask if they have any concerns relating to a death. The Trust has recently received guidance on the process and a report will be taken to the Executive Team as to how to progress. TA acknowledged the Assurance Statement that provided the Board with **Moderate** assurance learning from deaths, but emphasised the importance of keeping this in front of us. • **The Board discussed and noted the contents of the briefing paper.**
BM/19/09/88	**Quarterly Progress on Carter Report Recommendations+ Use of Resources Assessment (UoRA)** The Director of Finance and Commercial Development (AMcG) provided a summary of the progress report. The Trust continues to develop and improve its Use of Resources both internally and in collaboration with system-wide partners. The Use of Resources group is developing a work plan which will feed into the Trust's Moving to Outstanding agenda. AMcG reported that the Trust had received a UoRA rating of 'Requires Improvement'. The

	report highlighted a number of areas where improvement can be made including: Sickness Absence, Corporate Service Costs, Agency Ceiling, DNA rate and Financial Balance. However, the report noted positive areas including: Clinical Productivity, Delayed Transfer of Care, Pathology, Pharmacy, Non-pay Costs, Collaboration and use of Technology. The Trust had met with NHS Improvement/Employers (regulators) to discuss figures for nursing and Allied Health Professionals that had proved very helpful. Meetings with the regulators continue. A work plan has been developed and reports are submitted to the Moving to Outstanding group. The Trust is looking to refresh the UoRA data in Model Hospital by October 2019. KSJ reported that a deep dive analysis for the Weighted Activity Unit (WAU) for Allied Health Professionals is taking place. PJ added that from a statistical/digital aspect, it will be important to understand where to focus efforts in re-aligning data. • **The Board noted the contents of the report and the progress being made.**
BM/19/09/89	**ePMA (Electronic Prescribing & Medicines Administration) Business Case** PJ outlined the key issues of the proposal for a two week rapid deployment window in November 2019 (since amended to a 4 week window with no change to the documented resource and investment). Additional capital funding of £65k is requested for 2019/2020 and additional capital funding of £20k for 2021/2022. Revenue funding requested relating to the capital charges has increased by £11k in 2019/2020 and £14k in 2020/2021. The funding requested for 2019/2020 is available from within the capital contingency. The funding requested for 2020/2021 will be ring-fenced within the capital programme for 2020/2021. • **The Board approved the additional investment in the ePMA scheme.**
BM/19/09/90	**Nurse Staffing Bi-Annual Report November 2018-May 2019** Key points for the Committee to note: - Band 5 Nursing Vacancies at the time of the report are at 109 vacancies, currently 72 nurses have accepted a job offer with WHH and are due to commence by the end of Sept. The drop out rate is normally circa 40% on accepted offers however we currently have 50 nurses who we know are joining us, through keeping in touch events and regular ward contact in the months leading up to commencement of employment. - HCA vacancies – Proactive recruitment campaigns over the last 6 months have reduced the overall number of HCA vacancies in May 2019 to 25 WTE, which is significant given the investment and number of posts we had to fill over 80 post filled in the last 6 months. - SafeCare Census results were taken over a 4 week period (22nd April – 19th May). The SafeCare WTE requirement is 688.37 with 576.74 WTE staff currently in post giving a shortfall of 111.63 WTE which represents the total number of RN and HCA vacancies at the time of the report (which is an improvement of 22 WTE from the previous 6 month review). - The Trust continues to be part of the national retention collaborative programme with NHS Improvement (NHSI). The Trust has identified and are working on our retention priorities for 2019; (i) Work life balance; (ii) Continued professional development; (iii) Recognising and Valuing Experience (RAVE); (iv) Developing and empowering line managers - The aim of the collaborative is to reduce RN Turnover by 1.5% over the next 12 months

	from a baseline rate of 14.99% commencing in November 2018. The turnover in May 2019 is 12.81% a reduction of 2.18% to date. Progress against the NHSI Retention and Collaborative Plan, is reported through Strategic People Committee. - The Trust had been successful in 2 bids for monies; £20k as our Deputy Chief Nurse is leading a Preceptorship piece of work across C&M for Trusts to look at 'Best In Class' and £50k to scale up student nurse placements over the next 18 months. - In response to query raised by CR, RB explained the feedback had been positive from 1, 2 and 3 year students in relation to support received as part of the CLIP model and this had resulted in staff wanting to remain at WHH post registration. • **The Board noted the contents of the report.**
BM/19/09/91	**Freedom to Speak Up Bi-Annual Report** The Chief Nurse (KSJ) stated that the purpose of the report was to update the Board on the activity of the Freedom To Speak Up (FTSU) Team. She drew the Board's attention to Table 1 of the report which indicated 8 disclosures in 2019/2020 and table 2 which grouped the types of disclosure for that period. It was noted that there is currently no national data available for Q1 or Q2 2019/2020 to compare the Trust data to. KSJ reported that the group is reviewing new ways to promote the FTSU service and October is national FTSU month. During October the team plans to have stalls on both site (Warrington and Halton) and to visit the wards. It was noted that Jane Hurst, Deputy Director of Finance and Freedom to Speak Up Guardian was meeting regularly with IJ who is the Freedom to Speak Up Champion. • **The Board noted the progress of Freedom To Speak Up.**
BM/19/09/92	**GMC Survey Trainee results 2018-19** The Deputy Medical Director (AC) summarised the content of the Junior Doctor/Trainee Engagement update report. Each year the General Medical Council (GMC) carries out the National Training Survey. This is a very good informative comparative tool to highlight areas of good practice in medical education as well as areas that might need further attention or improvements. The Trust secured a 100% completion rate for the survey for those placed in WHH at the time in which the survey was running. The report covered areas including key elements, actions required, measurements/evaluations, objectives agreed, monitoring/report routes, timelines and recommendations. AC reported that the overall direction of travel was good with reduction in category concerns (from 9 to 6) with only category 1 concerns remaining. In addition, there was a 20% reduction in red flags and 30% reduction in pink flags. AW reported that this work had been discussed at SPC and it is good news to hear plans moving in the right direction. AC added that the Trust is waiting on a visit from the Dean. • **The Board acknowledged the significant progress that has been made in Medical Education and noted the content of the GMC Survey Trainee Results 2018-2019.**
BM/19/09/93	**Flu Programme 2019** MC reported that the 2018 programme had been very successful with an uptake level of 86.7% of frontline staff against a target set by CQUIN of 75%. A different approach is being taken this year. There is a possibility that the Trust may be requested to provide an opt-out feedback form, however, to date, this request has not been received. The vaccine batches

	will be received by the Trust on 26 September, 1 November and 8 November. AW commented on the gap between the issues of the batches of vaccine. MC replied that this was due to production issues. Monthly returns will be submitted to Public Health England. A full evaluation of the Flu Programme will be conducted in April 2020. SC stressed the importance of the success of uptake for patient safety. LG asked if the Trust shares its good practice with other organisations, for example, our partners and GPs? MC replied that information is shared at Cheshire and Merseyside Health meetings, the Trust also has a robust communications plan both on social media and internally. **The Board:** • **Noted the evaluation of the Flu programme 2018** • **Committed to achieving the ambition of 100% of healthcare workers receiving the vaccine** • **Agreed on a Board Champion for the Flu Campaign 2019** • **Noted the outline of the Flu Programme 2019**
BM/19/09/94	**Strategic Risk Register and Board Assurance Framework (BAF)** Head of Corporate Affairs (JC) explained the proposed changes to the BAF for Board approval which had been approved at the Quality Assurance Committee on 3 September 2019. - One new risk proposed for escalation to the BAF – Risk ID 701 Brexit: the risk rating was previously reduced, however, a regional NHSE/I roadshow on 11 September 2019 attended by Deputy Chief Operating Office, EPRR (Emergency Preparedness, Resilience and Response) Lead and representatives from Procurement and Pharmacy reported on improvements made in national procurement of alternative delivery routes. However, the key concern is the planned exit date coinciding with the start of the winter period and its consequences. **The Board agreed the escalation.** - Proposal to de-escalate Risk ID695: failure to meet NHS Cervical Screening Programme Standards. KSJ is satisfied that this risk can be de-escalated to the Corporate Risk Register. TA queried the governance aspect of this change, JC advised that the de-escalation was discussed at both the Risk Review Group and Patient Safety and Clinical Effectiveness Committee. • **The Board reviewed, discussed and approved the changes and updates to the Board Assurance Framework and Strategic Risk Register.**
BM/19/09/95	**Request to amend Constitution – Trust name change** JC reported on behalf of PMcL. The Foundation Trust has been working to move to Teaching Hospital status for the past two years, following initial approval from the Council of Governors to commence the process. • **The Board noted the approval by the Council of Governors with remaining approval awaited from the NHSI Regional Director.**
BM/19/09/96	**Emergency Preparedness, Resilience + Response Assurance (EPRR) 2019-2020** CE reported that as part of the NHS England EPRR framework, providers and commissioners of NHS funded services must show they can effectively respond to major, critical and business continuity incidents whilst maintaining service to patients. In line with the requirements of the 2019-2020 EPRR assurance process, the Trust has undertaken the annual

	self-assessment against the NHS EPRR core standards. Out of the 64 core standards, the Trust is fully compliant with 61, and partially compliant with 3 standards but with evidence of progress towards full compliance. The Trust has achieved an overall compliance level of 'Substantial' which is an improvement from last year's rating. TA asked CE to pass on the Board's thanks to Emma Blackwell, the Trust EPRR Lead for this successful result. • **The Board noted the 'substantial' compliance rating achieved by the Trust.**
BM/19/09/97	**EU Exit preparation** DM reported on a meeting he had attended chaired by Professor Keith Willett, Strategic Commander for EU Exit at NHS England and Improvement. The meeting highlighted clear directions of travel and actions to ensure mitigating plans are in place. DM explained that the advice from the meeting was that the NHS is thought to be more prepared because of the delay since March 2019, however, the timing of Brexit going into winter poses a greater operational risk. Therefore, the net risk hasn't changed since the original March date. The main area of concern is with the resilience of local supply chains. DM confirmed that the Trust's Brexit Working Group continues to meet and is working through a communications plan. The recently attended workshop referenced in agenda item BM/19/09/94 has provided guidance at a national level. Planning is now taking place to capture local issues and a report will be submitted to the October Trust Operational Board. MP referenced the Local Authorities getting involved in system conversations, has there been some local activity in this respect? DM replied that a gap had been identified in this area and the Trust is now linking with system partners with the intention of adopting a co-ordinate approach. IJ asked what proportion of the Trust's staff had applied for 'Settled Status'? MC replied that the Trust had been part of the Settle Status pilot. She assured the Board that the Trust will continue to support staff who wish to apply for Settled Status and will encourage them to seek the appropriate advice. However, MC acknowledged that there was significant concern due to the continued national uncertainty about the exit date. AMcG reported that with regard to Model Hospital data, she had recently checked our status regarding holding of stock, and the Trust is in the median bracket, therefore, could be classed as higher risk as it does not stockpile medicines. LG asked what assurance do we have from our suppliers? DM replied that each of our areas know who they are meant to escalate to/link centrally in terms of co-ordination which is being done at a regional and national level through Professor Willett and his team. TA emphasised that the Trust needs to work with its local system partners in this respect. • **The Board discussed the update and noted the associated risk had been re-escalated to the Board Assurance Framework.**
	Matters for Approval
BM/19/09/98	**Risk Management Strategy Annual Report + Revised Strategy** — **The Board approved the report.**
	Director Infection Prevention + Control Annual Report — **The Board approved the report.**
BM/19/09/100	**Council of Governors Terms of Reference** — **The Board approved the report.**
BM/19/09/101	**Cycle of Business for Approval** • **Charitable Funds Committee** — **The Board approved the report.**

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D R A F T

Warrington and Halton Hospitals NHS Foundation Trust

BM/19/05/57	**Any Other Business** On behalf of his Executive Team colleagues, SC wished MC well in her new role, he thanked her for her wise counsel and challenges where appropriate which provided assurance for patients and staff alike. SC also thanked her personally for support.
	Next meeting to be held: Wednesday 25 September 2019

Signed …… Date …….

Chairman ……..

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Warrington and Halton Hospitals NHS Foundation Trust

BOARD OF DIRECTORS ACTION LOG

AGENDA REFERENCE:	BM/19/11/105	SUBJECT:	TRUST BOARD ACTION LOG	DATE OF MEETING	27 November 2019

1. ACTIONS ON AGENDA

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
BM/19/05/50	29.05.2019	Engagement Dashboard	Future 6 monthly reports to include breakdown of numbers and sources of FOI requests.	**DCE + Fundraising**	**27.11.2019**		On November Board	

2. ROLLING TRACKER OF OUTSTANDING ACTIONS

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
BM/18/07/57		Junior Doctor/Trainee Engagement update Trello)	6 mth update presentation.	**Medical Director**	**27.11.2019**		14.01.2019. Deferred to March 27.03.2019. Referred to future BTO 29.05.2019. Update to September Board to include results from GMC survey results. 06.09.2019. Deferred to November Board 18.11.2019. Deferred to January Board	

3. ACTIONS COMPLETED AND CLOSED SINCE LAST MEETING

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status

RAG Key

	Action overdue or no update provided		Update provided and action complete		Update provided but action incomplete

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NHS Warrington and Halton Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/19/11/106**			
SUBJECT:	**Chief Executive's Briefing**			
DATE OF MEETING:	27th November 2019			
AUTHOR(S):	Simon Constable, Chief Executive			
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Chief Executive			
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will…Always put our patients first through high quality, safe care and an excellent patient experience.	✓		
	SO2 We will…Be the best place to work with a diverse, engaged workforce that is fit for the future.	✓		
	SO3 We will...Work in partnership to design and provide high quality, financially sustainable services.	✓		
LINK TO BAF RISK:	All			
EXECUTIVE SUMMARY *(KEY ISSUES):*	This report provides the Trust Board with an overview of matters on a range of strategic and operational issues, some of which are not covered elsewhere on the agenda for this meeting.			
PURPOSE: *(please select as appropriate)*	Information ✓	Approval	To note	Decision
RECOMMENDATION:	The Board is asked to note the content of this report.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None			

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NHS Warrington and Halton Hospitals NHS Foundation Trust

SUBJECT	Chief Executive's Briefing	AGENDA REF:	BM/19/11/106

1. BACKGROUND/CONTEXT

This report provides the Trust Board with an overview of matters on a range of strategic and operational issues, some of which are not covered elsewhere on the agenda for this meeting.

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

2. KEY ELEMENTS

2.1 Briefings shared with the Board since the last meeting

- DH Health Infrastructure Plan
- Briefing on the 2019 political party conferences
- The Queen's Speech 2019
- NHS Provider letter to the Prime Minister in relation to Annual Pension Tax Allowance
- WHH Safety Summit Programme November 2019
- Winter Letter from Pauline Philip DBE, National Director of Emergency and Elective Care NHSE/I and Bill McCarthy, Executive Regional Director (North West)

2.2 Key issues

2.2.1 Introduction

I am honoured to accept the appointment as Chief Executive of WHH, announced 14th November 2019 following ratification by our Council of Governors.

This is my first Trust Board briefing as Chief Executive and I will be submitting a written report henceforth. My report will highlight some key issues at the time of writing that may or may not be covered in other standing items or the cycle of business.

2.2.2 New radiology equipment

We are delighted to be one of 70 trusts earmarked to receive new cancer screening equipment. This is a major investment which will support detecting cancers much earlier when they are easier to treat. This is a key pillar of the NHS Long Term Plan, and sits well with our involvement as a Rapid Diagnostic Centre as well as the development of a new cancer diagnostic standard. It also is benefical to the non-elective pathway in terms of modern and efficient scanning. The exact amount of funding is yet to be determined. Replacement of our aging CT and MR equipment was already part of our capital programme.

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2.2.3 Change to the Trust Name

The work on 'Teaching' status has been progressing over the past two years and in that time we have received both regional and national recognition for the work we have done in diversifying our workforce. We have considerable university and college affiliations with formal teaching programmes in place for a wide range of staff groups beyond traditional medical education, including nursing, allied health professionals, health scientists, nurse associates and many more. In addition, we have an enviable apprenticeship and work experience programme which is helping provide learning and development for our own staff as well as providing that vital first step to young people wanting to get on the NHS career ladder.

The Trust's Council of Governors ratified the amendment to the Foundation Trust Constitution to reflect the change to the Trust's name to reflect the achievement of 'Teaching' status. Henceforth, the Trust will be known as: "*Warrington and Halton Teaching Hospitals NHS Foundation Trust*."

2.2.4 Governor Elections

The Trust held Public and Staff Governor Elections between 12th September and 8th November 2019.

Five constituencies were elected to with unopposed candidates:

a. Public - Appleton, Farnworth, Hough Green, Halton View, Birchfield – Coin McKenzie (Re-elected)
b. Public - Birchwood, Rixton and Woolston – Anne Robinson (re-elected)
c. Public - Lymm, Grappenhall, Thelwall – Janice Hall
d. Public - Norton South, Halton Brook, Halton Lea – Dave Marshall
e. Staff - Clinical Scientist or Allied Health Professional – Louise Spence (re-elected)

Two constituencies were contested:

a. Public - Culcheth, Glazebury and Croft, Poulton North – Keith Bland MBE (re-elected)
b. Staff - Nursing & Midwifery – Lesley S Mills

No candidates were nominated for five Constituencies and remain vacant:

a. Public - Bewsey and Whitecross, Fairfield and Howley
b. Public - Broadheath, Ditton, Hale, Kingsway, Riverside
c. Public - Rest of England and Wales
d. Staff - Medical & Dental
e. Staff – Support

2.2.5 Strategic Alliance with Bridgewater Community Healthcare NHS Foundation Trust

We continue to work closely with our Bridgewater colleagues to further develop an integrated care offer for acute and community services in the boroughs of Warrington and Halton consistent with the NHS Long Term Plan. Both trusts have been part of an NHS

Improvement transformational change leadership programme with the final session in York in November.

2.2.6 System Working

We had our first System Assurance Meeting with NHSE/I on 30th September 2019 where we were held to account as a system for performance across all domains. For the purposes of this forum, the system constitutes ourselves, Bridgewater and NHS Warrington and NHS Halton CCGs. The first meeting was very positive, with a focus on care quality and service delivery. We have together submitted a system financial recovery plan up to 2023/2024, with a weekly CEO oversight meeting and a Programme Management Office established to oversee the key programmes of improvement work that traditionally would have sat in the organisational silos of CIP/QIPP.

2.2.7 Emergency Access Performance

NHSE/I has undertaken a round of "Winter Stocktake" calls with all North West trusts to understand common challenges and the overall position. Winter appears to have started early for all of us across the North West. We are deploying winter capacity in the shape of Ward K25, being a large brand new facility with up to 18 beds. Our strategy for winter is prioritising assessment capacity for Same Day Emergency Care, though a 24/7 Combined Assessment Unit in the existing GPAU footprint, as we develop plans for a new assessment plaza in Appleton Wing adjacent to ED.

2.2.8 Innovation and Improvement

On 20th November 2019 I attended the launch day of the NIHR Applied Research Collaboration for the North West Coast (ARC NWC). The themes are a) improving population health, b) person centred complex care, c) equitable place based health and care and d) health and care across the life course. All of this is very consistent with the NHS Long Term Plan and our priorities locally and we need to make sure we are fully engaging with this programme of work through our Quality Academy, and linking in with other resources such as the Innovation Agency and the universities.

We have our second Patient Safety Summit on 26th November 2019 bringing learning from incidents, claims and complaints across the Trust. The improvement themes for this year are caring for patients with learning disability, end-of-life care and the role of human factors in Never Events.

2.2.9 EPMA

Electronic Prescribing and Medicines Administration through our Lorenzo EPR has commenced deployment across Warrington Hospital in November, having successfully being trialled in Halton Hospital. After significant planning, this is in a series of stages with appropriate clinical, pharmacy and IT support to ensure safety and effectiveness. It has started in the Burtonwood Wing wards. The early feedback is positive with reports that administration of oral medication is more efficient. We also expect to see efficiencies in TTO medications as well as there being no need to rewrite prescriptions for long-stay patients. EPMA has always been regarded as the important missing link in our Lorenzo EPR implementation.

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NHS Warrington and Halton Hospitals NHS Foundation Trust

2.2.10 Award Ceremonies

The last couple of months has seen several successful award ceremonies. We had our *Thank You Awards* on 4th October 2019 which has been described as our best yet. The ambition is to progress this even further next year to be even more inclusive. Event planning has already started. We will however have a challenge to find a suitably sized venue within the boroughs.

The Chairman and I also attended the *Warrington Guardian Inspiration Awards* on 14th November 2019 with the whole community of Warrington celebrating some extraordinary things in all walks of life, including sports, education and neighbourhood heroes. The Trust was well represented with our Emergency Department winning the Hospital Heroes award with Micke Hearne from the security team and our Breast Screening Team worthy runners up. Our hospital charity was delighted to receive Charity of the Year and our youngest Charity ambassadors Ruben and Elena won Junior Charity Champions.

There was also a fantastic win for WHH at the Burdett Trust National Nursing Retention Awards in London on 19th November 2019. We were one of just eight trusts recognised in these prestigious awards, winning the 'Best Career Planning and Development Offer' award and was also highly commended for 'Best Use of Data (to inform nurse recruitment and retention initiatives). The Burdett Trust recognised the progress in reducing nurse turnover rates which is down by 3.22% since November 2018 and the increasing number of internal promotions. This was also recognised by the CQC in its July report: "The Trust has introduced a number of alternative nursing roles including 28 advanced care practitioners and 4 nurse consultants. This ensures the workforce is adaptable and assists in covering hard to fill roles, as well as providing innovative career pathways".

Finally, our Forgot-Me-Not unit garden was visted by Royal Horticultural Society judges visited in the summer and have awarded it 'Outstanding' Garden in the Community. This has been made possible by work from volunteer Pete, Jane Bradbury, Governor Alison Kinross as well as Keith our Gardener.

2.2.11 Staff Recognition

Team of the Month 1 (August): RTT Team

The RTT Team worked additionally for two months to ensure that the vital RTT national standard was met, meaning patients received their treatment in a timely manner. The RTT team provided the CBUs with appropriate information to comply with the patient access policy for patients with multiple cancellations. The RTT Team have tracked patients to make sure clinical decisions were made pushing for diagnostic tests to be done and chasing clinical notes so that the patient was progressed quickly to their next required encounter.

Team of the Month 2 (August): Catering Department

The team developed a dementia friendly snack box to include a range of finger foods. The team ensured that 5 out of 5 food hygiene scores were achieved from the local authority

assessment. Also, during the recent national concerns about listeria the team made over 600 sandwiches a day in house and at short notice.

Team of the Month (September): Discharge Unit Team
The Discharge Unit Team have raffles to raise money for newspapers and activities for the patients while they wait in the Discharge Unit. They support each other by changing shift patterns at short notice always putting the patients first in challenging situations.

Employee of the Month (September): William Brunt, GPAU Porter
Billy is one of the first and last people patients see on the unit as he always greets them with a smile and talks to them to reduce stress and fear levels. Billy read the newspaper everyday to a blind lady who was on the unit and took the time to help her with her meals. Billy makes everyone's day brighter and is always looking to help and improve patients experience.

3. RECOMMENDATIONS

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

Summary of board papers – statutory bodies

NHS England and NHS Improvement board meeting – 26 September 2019

For more detail on any of the items outlined in this summary, please find the full agenda and papers available online. NHSE/I has also published their final recommendations to Government and Parliament for an NHS Integrated Care Bill. You can read our On the Day Briefing here.

Chairs and Chief Executive's report

- Baroness Dido Harding has stated that NHSE/I will be writing to all provider chairs and lead governors of Foundation Trusts and will set out a development framework for NHS provider chairs.
- Simon Stevens laid out plans to better support frontline staff. NHSE/I will be allocated £150 million of professional development funding for nurses and other health professionals.
- NHSE/I is considering a broader service redesign to relieve performance pressures on primary care and is exploring community pharmacy reform.

Digital First Primary Care consultation outcome

- Dr Nikki Kanani and Ed Waller gave a verbal update setting out details surrounding the consultation.
- NHSE/I want to offer Digital First Primary Care by 2020/21, with a focus on using technology to improve an individual's ability to look after themselves.

Clinically-led review of NHS access standards

- There was an update on the clinically led review of NHS Access Standards.
- In an effort to improve mental health parity, in line with physical care, NHSE/I is testing the approach to urgent community mental health services and access within one hour to liaison psychiatry services.

Operational, quality and financial performance update

- The chief financial officer, Julian Kelly, explained they were more materially worried about the financial position of the commissioner sector rather than providers.
- At the end of month four, NHS commissioners and providers were off plan by £75m. (This figure was not disaggregated).
- Roughly a third of providers are failing to meet their financial plans, while many appear to be exceeding their anticipated trajectories.
- While commenting little on the provider sector, NHSE/I highlighted that it wants to explore how more funding can be released within trusts to spend on capital backlogs for next year. However, Julian Kelly suggested this will only happen if trajectories are met by trusts. Julian confirmed the board would receive more information on capital funding at its next meeting.

Care Quality Commission board meeting – 18 September 2019

For more detail on any of the items outlined in this summary, please find the full agenda and papers available online

Executive team update

- In August, the CQC changed the Adult Social Care (ASC) Provider Information Return (PIR) from a pre-inspection information request to an annual one. CQC has improved the questions on the PIR based on user research, and will monitor if this improves information collection and the way it is used in CQC regulation.
- Improving regulation in closed environments: Phase 2 of the Restraint, Seclusion and Segregation thematic review is currently underway. The CQC will be focusing on rehabilitation and low secure mental health wards, and care services for people with learning disabilities. They will also be looking children's secure and residential services in collaboration with Ofsted.
- Upcoming publication: Urgent and Emergency Care survey. The survey is an independent measure of people's experiences of major A&E, urgent care centres and minor injury units.
- The CQC has commissioned two independent reviews.
  - David Noble is leading a review on the 2015 Whorlton Hall inspection, and the subsequent decision not to publish that inspection.
  - Prof Glynis Murphy is chairing the wider independent review of regulation of Whorlton Hall.

Q1 Performance report

- In July, Primary Medical Services and Hospitals continued to achieve over 90% of inspections undertaken in line with CQC commitments.
- Notable improvement in ASC performance. Inadequate and Requires Improvement inspections continue to be delivered within KPIs.

Change portfolio quarterly update

- As set out in their Portfolio Build 2019/20, CQC maintain that they have made good progress in delivering their change and improvement ambitions. These include:
  - Completion of three user-focused digital technology initiatives
  - Ongoing delivery of CQC resource strategy based on total portfolio demand and working with internal and external partners to develop an overarching engagement strategy for change and transformation

Health Education England board meeting – 17 September 2019

For more details on any of the items outlined in this summary, please find full agenda and papers available online

CEO Update

- HEE has been undertaking targeted activity to increase student uptake of Learning Disability Nursing (LDN) apprenticeships and pre-registration allied health professional (AHP) programmes.
- HEE note that a number of AHP programmes are threatened by reductions in application numbers and are working with the Office for Students to support initiatives designed to address this challenge.

Supporting patient safety through Education and Training

- 17 September sees the first World Health Organisation 'Work Patient Safety' day, HEE has responded to this and launched a report – Supporting Patient Safety Through Education and Training
- HEE plan on creating the first national patient safety syllabus, with associated educational resources and infrastructure by end of March 2020.

EU Exit

- This briefing outlines the key risks identified for HEE, including securing workforce (deemed higher risk) and contracts with EU based suppliers, HEE has not identified issues here which require further action. Funding requirements arising from EU Exit were considered a known challenge. In 2019/20 HEE has secured funding for backfilling any staff seconded to support DHSC emergency planning and response teams.

Talent for care and apprenticeships

- The Talent for Care Strategic Framework was established in 2014 and focusses on developing the healthcare support workforce.
- Responding to the LTP recognition that NHS organisations are community 'anchors', HEE aim to support the NHS to have a workforce which reflects the community it serves. The key areas of activity that HEE are committed to are:
  - Diversity, Inclusion and Participation
  - Preparation for Work (including the Princes Trust)
  - Apprenticeships
  - Volunteering

Summary of board papers – statutory bodies

Care Quality Commission - 16 October 2019

For more detail on any of the items outlined in this summary, please find the full agenda and papers available online

Executive office update

- The CQC has published its annual statutory report to parliament on the state of health and social care
- Since May 2019, the CQC has rated inadequate and placed into special measures 12 sites which admit people with a mental health problem, learning disabilities and autism.
- The CQC recently published a joint statement from members of the cross-regulatory group on online primary care, 'Online primary care – response from the regulators' on what they are doing to address the issues that exist within the system.
- The Chief Operating Officer provided a verbal update on the 2020/21 fees scheme. The CQC notes that it is now at full cost recovery, which means all activity costs now come from provider fees. The CQC usually amends its fee scheme every year, but for 2020/21 has agreed not to. They hope that this will allow providers to have some budgetary stability and allow the CQC to consider a longer term strategy.
- David Noble, who is leading the review focusing on how CQC dealt with concerns that arose in relation to the regulation of Whorlton Hall, has delayed his investigation. Delivery of his report is now planned for CQC's November board meeting.

Freedom to Speak Up Guardian annual report

- The CQC has published its second annual speak up report, which covers the 16 months since the first report in June 2018. The report highlights the need for wider education and training in speaking up and speaking up well.
- The report also notes results from three surveys; the 2018 CQC staff survey, the Truth to Power survey and the recent 2019 Pulse survey. 42% of staff at the CQC felt that "it was safe to challenge the way things are done in CQC". The Truth to Power survey highlighted that fear of being perceived negatively was the biggest reason given for not speaking up. Additionally, the 2019 Pulse survey found that 87% of staff were aware how to raise an issue at the CQC, and 53% felt they would be listened to.

Healthwatch England update

Healthwatch England's report provides an update on its engagement with local communities on key topics such as the long term plan (LTP) and the clinical standards review. Headline themes from a survey of 30,000 people include:

- Feedback suggests the best way to demonstrate that the long term plan is improving quality of care is by fixing some of the issues in accessing primary care.
- People accept that health services might be delivered further from home, but want all their recovery and ongoing healthcare support to be kept local.
- People place an emphasis on the importance of prevention, and want services that do more to proactively help them to stay well.

Health Education England – 15 October 2019

For more detail on any of the items outlined in this summary, please find the full agenda and papers available online

HEE stakeholder survey

- HEE commissioned Ipsos MORI to undertake a survey on stakeholder perceptions. Key findings from the presentation include:
  - HEE is seen as 'fragmented' and stakeholders are looking for greater consistency in both working relationships and messages.
  - Stakeholders, particularly NHS trusts feel that HEE could do more to engage them earlier and thought that HEE could do more to understand experiences at the front line.
  - Stakeholders thought HEE played a key role in both development of new roles and drafting of the interim NHS people plan

Freedom to Speak Up

The Freedom to Speak Up Guardians (FTSUG) now includes staff wellbeing alongside whistleblowing. HEE has successfully developed contact officers to support HEE's drive to improve staff experience.

Finance and performance

- The financial position of HEE as of 31 August 2019, along with an update on budget setting following the spending review announcement in September, were presented to the board. Key points include:
  - Five HEE programme budgets are £0.7m overspent and admin budgets are £0.9m overspent.
  - Following the outcome of the spending round, HEE is determining the parameters, allocation methodology, and monitoring for the new £150m CPD funding. They are also planning the best utilisation of the £60m additional funding toward people plan priorities.
- The latest performance figures were presented, including:
  - HEE is on track to achieve its target of 650 additional midwifery training places.
  - GMC training survey shows 79.3% for overall satisfaction of training, reversing the declining trend.

Talent for care and apprenticeships

At the September meeting the HEE board affirmed its commitment to working with stakeholders to assist the NHS in adapting and developing its employment, education, training and volunteering practices to improve the socio-economic wellbeing and health outcomes of local populations. HEE will work with the Princes Trust, Project Choice, Step into Work and Movement to Work to encourage the development of these outcomes.

Nursing associate evaluation

HEE commissioned an independent evaluation of the introduction of the role of nursing associates. Key findings include:

- Trainees see the programme as a stepping stone to nursing and an opportunity to go to university that might otherwise not be possible due to family and financial circumstances.
- 85% of trainees surveyed felt prepared to enter the workforce as a nursing associate.

Our ref: NWGU85

NHS and NHS Improvement – North West
Regatta Place
Summers Road
Brunswick Business Park
Liverpool
L3 4BL

16 October 2019

Dear Colleagues

Re: Warrington & Halton System Assurance Meeting

Thank you for attending the Warrington & Halton system assurance meeting on 30 September at Warrington & Halton Hospitals NHS Foundation Trust, which I trust you found both constructive and supportive. Please can I take this opportunity to thank the trust for hosting and I would also like to thank all attendees for their frank and open contribution.

Quality and Operational Performance

- We discussed a range of issues under the theme of quality. We noted your update on medicines reconciliation, including the governance arrangements as part of your 'moving to outstanding' committee. We also discussed work to review and improve the community paediatric pathway.

- We note that spinal services remain suspended and that the trust and commissioners are engaging with work across the Cheshire & Merseyside Health & Care Partnership to work up the new clinical model.

- We discussed the uptake of annual health checks for people with learning disabilities, and noted your plans to promote and incentivise these within primary care, but also to engage with a wide range of partners to increase uptake.

- We would like to thank the system for its excellent response in supporting women affected by the closure of One to One Midwives services.

- In terms of urgent and emergency care we recognised that performance against the A&E four hour standard has improved month on month year to date and that you are ahead of trajectory. However as winter approaches, the challenge will be to sustain this improvement. On Long Length of Stay (LLoS), the weekly average of beds occupied by adult patients for 21+ days has been increasing steadily (125 as at week commencing 30 September) since July, and the ambition of 95 is not currently on track to be achieved. We discussed some of your mitigations for this, and would expect that your winter plans also address how this ambition will be delivered. We understand that you have developed a system wide winter plan that you believe all partners can stand behind and that this is currently being peer reviewed ahead of submission. Please could you ensure that your winter plan is submitted to us by Friday 25 October. We recognised that ambulance handover times and the number patients with a LoS of 21+ days had both come under increased pressure in the last few weeks but

acknowledged that the trust was taking action to address both areas, which will strengthen patient flow for the system.

- In terms of planned care, we note that the trust continues to achieve the 92% standard for referral to treatment, the 1% diagnostic standard and the 62 day cancer standard.

Finance

In terms of the system financial challenge, there is a clear expectation that both system and organisational plans are delivered. We discussed the level of financial risk across the system as outlined in the Financial Recovery Plan update that was submitted on 13 September, that shows a financial gap of £11.6 million. Alongside the Month 6 return, the system is to submit the list of schemes/mitigations to close the £11.6m financial gap. We agreed that you would submit an updated Financial Recovery Plan and the list of schemes/mitigations to the Regional Director of Finance by 16 October in line with Month 6 and this will be discussed at a follow up system financial recovery meeting. In preparing this updated plan, the system should make best use of all available benchmark financial improvement information such as Model Hospital operational productivity, GIRFT, prescribing, Continuing Health Care spend etc to support the identification and implementation of mitigations. In addition, given the scale of the financial gap, the system collectively needs to consider implementing further short term expenditure controls and NHSI/E Regional finance colleagues will work with the CCGs and the Trusts in assuring compliance with the application of the Financial Grip and Control Checklists.

Segmentation

- As stated during the meeting, it is our intention to engage with you primarily as a system delivery partner, however, recognising the regulatory dimension of the discussion, please note that we do not intend to make any change to the current segmentation ratings for the Trusts or the CCGs present at the meeting.

Next Steps

- Please ensure that your final agreed winter plan is submitted to englandcm@nhs.net no later than Friday 25 October 2019.

- Your updated FRP should by now have been submitted to the Regional Director of Finance alongside your month 6 return Wednesday 16 October 2019.

Yours sincerely

Graham Urwin
Regional Director of Performance & Improvement
NHS North West

NHS England and NHS Improvement

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REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/19/11/108**	
SUBJECT:	**Integrated Performance Report Dashboard**	
DATE OF MEETING:	27th November 2019	
AUTHOR(S):	Marie Garnett – Head of Contracts and Performance	
EXECUTIVE DIRECTOR SPONSOR:	Alex Crowe, Acting Medical Director Kimberley Salmon-Jamieson, Chief Nurse & Director of Infection Prevention & Control Michelle Cloney – Director of Human Resources & Organisational Development Andrea McGee - Director of Finance & Commercial Development Chris Evans - Chief Operating Officer	
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future. SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.	x x x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): ***(Please DELETE as appropriate)***	#115 Failure to provide adequate staffing levels in some specialities and wards. #134 (a) Failure to sustain financial viability. #134 (b) Failure to deliver the financial position and a surplus #224 Failure to meet the emergency access standard.	
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The Trust has 63 IPR indicators which have been RAG rated in October as follows: **Red: 17 (from 16 in September)** **Amber: 13 (from 14 in September)** **Green: 32 (from 33 in September)** **Non RAG Rated: 1 (from 0 in September)** Quality areas highlighted for improvement are Friends and Family Test for ED, Healthcare Acquired Infections for MRSA, Mixed Sex Accommodation Breaches, Incidents and Medication Safety. Never Events - In October 2019, the Trust identified and reported an incident relating to bilateral dynamic hip screw procedure in Warrington theatres, where an incorrectly sized implant was used. The CQC has been advised. The investigation into this is in progress. A debrief was undertaken with	

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	immediate actions identified. It should be noted that whilst the Friends and Family Test for ED has not met the Trust internal standard, the recommendation rate is comparable to other organisations across the Cheshire and Mersey footprint and an ED action plan is being monitored via the ED Improvement Committee. The Mixed Sex Accommodation breaches are patients who are awaiting step down from the Intensive Care unit. Where appropriate, patients are cohorted within the unit to minimise the impact, however it is noted that patient feedback is consistently positive and environmental changes to create additional side rooms are being progressed. Open Incidents are monitored with progress tracked weekly via the Trust Meeting of Harm and though Trust Operational Board. Whilst there has been an increase noted, specifically with Integrated Medicine and Urgent and Emergency Care CBUs, there is a proactive focus to ensure timely closure. The Governance team is supporting the CBUs with the uploading of evidence to the Datix system where appropriate. The implementation of ePMA and 7 day on ward pharmacy service commenced in November. This will support an increase in pharmacy ward staffing levels leading to improvements In medicine reconciliation performance and prescribing, therefore improving patient safety. The remaining quality indicators are Green / Amber and are on track as a result of work plans that are monitored and aligned to each quality indicator to ensure continual improvement supported where necessary by Trust QI collaborative programmes. The Trust deficit for the period ending 31 October 2019 is £3.3m, which is £0.3m better than plan. The actual control total (excluding Provider Sustainability, Financial Recovery and Marginal Rate Emergency Tariff funding) is £11.6m which is £0.1m better than plan.

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	The Trust has received formal notification of the extension of working capital loans which were due to expire in 2019/20. These loans have been extended into 2020/21.			
PURPOSE: ***(please select as appropriate)***	Information	Approval	To note X	Decision
RECOMMENDATION:	The Trust Board is asked to: **1.** Note the contents of this report. **2.** Note the changes to the 2019/20 capital programme.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.			

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REPORT TO BOARD OF DIRECTORS

SUBJECT	Integrated Performance Report Dashboard	AGENDA REF:	BM/19/11/108

1. BACKGROUND/CONTEXT

The RAG rating for all 63 (previously 65 reported to the Board in August*) indicators from November 2018 to October 2019 is set out in **Appendix 1**. The Integrated Performance Dashboard (**Appendix 2**) has been produced to provide the Board with assurance in relation to the delivery of all KPIs across the following areas:

- Quality
- Access and Performance
- Workforce
- Finance Sustainability

*Please note that Cancer 14 days and Breast Symptomatic standards have been removed from this version of the IPR as they are not reportable during the pilot of the 28 day faster diagnostic standard.

2. KEY ELEMENTS

In month, there has been a movement in the RAG ratings outlined in **Table 1**:

Table 1: RAG Rating Movement

	September	October
Red	16	17
Amber	14	13
Green	33	32
Other	0	1
Total:	63	63

Due to validation and review timescales for Cancer, the RAG rating on the dashboard for these indicators is based on September's validated position. VTE has not been RAG rated in month as this indicator is reported as a quarterly position.

The dashboard has been refreshed to show improvement actions in addition to narrative. In order to incorporate this information, the descriptions of the indicators has been moved from the dashboard to **Appendix 3**.

Statistical Process Control (SPC) charts and narrative have been added to the IPR dashboard, **Appendix 4** contains further information on these charts.

Quality

Quality KPIs

There are 5 indicators rated Red in October, the same number as September.

The 4 indicators which were Red in September and remain Red in October are as follows:

- Incidents – there were 52 open incidents over 40 days old at the end of October, increased from 40 at the end of September against a target of 0. There was 1 never event reported in month relating to an incorrect implant, an investigation is underway.
- Healthcare Acquired Infections (MRSA) - there were two MRSA cases reported in August 2019, therefore this indicator will be Red for the remainder of the year. There was no MRSA cases reported in month.
- Medication Safety – 29.00% of patients had medicines reconciliation within 24 hours in October, increased from 27.00% in September against a target of 80.00%.
- Friends & Family Test (ED and UCC) – the Trust achieved 78.00% in October, the same as September's position, against the Trust target of 87.00%.

There is 1 indicator which has moved from Green to Red in month as follows:

- Mixed Sex Accommodation Breaches (MSA) – there were 6 Mixed Sex Accommodation Breaches reported in October (all within critical care), increased from 0 in September, against a target of 0. There is a zero tolerance threshold for this indicator.

In September (as at the end of Q2), the VTE indicator was Red, however this indicator is not RAG rated in October as VTE is reported as a quarterly position.

There is 1 indicator which has moved from Amber to Green in month as follows:

- Continuity of Carer – the Trust achieved 32.00% in October, increased from 29.00% in September against a target of 30.00%.

Access and Performance

Access and Performance KPIs

There are 5 Access and Performance indicators rated Red in October, the same number as September.

The 5 indicators which were Red in September and remain Red in October are as follows:

- A&E Waiting Times 4 hour national target – the Trust achieved 80.04% excluding walk ins in October, decreased from September's position of 81.95%, against a target of 95.00%.

- Ambulance Handovers 30>60 minutes – there were 117 patients who experienced a delayed handover in October, increased from 85 in September against a target of 0.
- Ambulance Handover at 60 minutes or more – there were 36 patients who experienced a delayed handover in October, decreased from 45 in September against a target of 0.
- Discharge Summaries % sent within 24 hours – the Trust achieved 88.93% in October, increased from 86.47% in September against a target of 95.00%.
- Super Stranded Patients – there were 113 super stranded patients at the end of October, decreased from 131 at the end of September against a trajectory of 95.

PEOPLE

Workforce KPIs

There are 4 indicators rated Red in October, a the same number as September.

The 4 indicators which were Red in September and remain Red in October are as follows:

- Sickness Absence – the Trust's sickness absence rate was 5.48% in October, increased from 5.26% in September against a target of less than 4.20%.
- Bank/Agency Reliance – the Trust reliance was 11.56% in October, decreased from 12.54% in September against a target of less than 9%.
- Monthly Pay Spend – was £16.7m against a budget of £15.8m in October.
- Agency Shifts Compliant with the Cap – 38.03% of shifts were compliant with the Cap in October, decreased from 40.03% in September, against a target of over 49%.

SUSTAINABILITY

Finance and Sustainability KPIs

There are 3 indicators rated Red in October, increased from 2 in September.

The 2 indicators which were Red in September and remain Red in October are as follows:

- Capital Programme – to date the actual spend is £3.8m which is £4.0m below the planned spend of £7.8m. This is due to an underspend against the Kendrick Wing Fire Scheme, Estates and Medical Equipment schemes.
- Better Payment Practice Code (BPPC) – the challenging cash position results in a monthly performance of 39% which is 56% below the national standard of 95%.

There is 1 indicator which has moved from Amber to Red in month as follows:

- CIP Recurrent Savings – the forecast for recurrent cost savings is 44% in October, decreased from 59% in September against a target of 90%.

There is one indicator which has moved from Green to Amber in month as follows:

- Agency Spending – the Trust is at 104% against the agency spending ceiling in October which has increased from 98% in September.

The Income, Activity Summary and Use of Resources Rating Statement as presented to the Finance and Sustainability Committee is attached in **Appendix 5**.

The Trust has signed up to a break even control total. The Trust is currently achieving plan however the current mitigated forecast is £2.3m variance from plan. Key risks are CIP delivery, remaining cost pressures within diagnostics and medical staffing, agency usage and winter capacity costs. The Trust is working with system partners on a system recovery plan and has been reporting progress to NHSE/I. Should the plan not be delivered, the PSF and FRF of c£17m (for the period 1st April 2019 to 31st March 2020) is at risk as achievement is based upon delivery of the plan each quarter. An adverse variance from plan may mean the Trust would need to request a loan. Further mitigations are therefore required.

The Trust has received formal notification of the extension of working capital loans which were due to expire in 2019/20. These loans have been extended into 2020/21.

Capital Programme

There were a number of changes to the capital programme in month which are summarised in **Table 2**.

Table 2: Month 7 changes to the 2019/20 capital programme.

Scheme	Value £000
Additional Funding Required	
ED Patient Monitoring Equipment (1)	81
Cell Washer (1)	7
Intra Aortic Balloon Pump (1)	49
Cardiology Systems Upgrade (1)	92
Outdoor Play Area (2)	36
Bladder Scanner (2)	9
Sub total	**274**
Funded by	
Contingency	(229)
Charitable Funds	(45)
Sub total	**(274)**
Total	**0**

(1) Emergency approval by the Director of Finance & Commercial Development.
(2) Funded by Charitable Funds

There are 2 estates schemes (Halton Hospital Phase 1 and 6 Facet Survey) that are in total forecasting a underspend of £90k. This underspend has been transferred to contingency to support future emergency requests. The contingency is now £0.2m.

To date the planned spend is £7.8m and the actual spend is £3.8m. This results in a £4.0m

under spend which is due to a combination of underspends across all areas but mainly the Kendrick Wing Fire.

On 15 October 2019 NHSI/E notified all Trusts that additional national funding was available to replace imaging equipment that was 10 years old (or older) on 31 March 2019. The funding is available to replace any CT scanner, MRI scanner and mammography equipment. The Trust bid for a CT scanner (due for replacement in 2019/20), a MRI scanner (due for replacement in 2020/21) and a mobile breast screening van. The Department of Health has announced that the Trust has been successful in securing funding and is awaiting confirmation regarding which machines have been funded.

Once the level of funding for diagnostic equipment has been confirmed the capital programme will be reassessed and funding will be redirected as appropriate. The programme will be closely managed to ensure the Trust maximises the capital funding currently available.

The Board is requested to note the changes to the 2019/20 capital programme.

An updated capital programme is attached in **Appendix 6**.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

The KPI's that are underperforming are managed in line with the Trust's Performance Assurance Framework.

4. ASSURANCE COMMITTEE

The following committees provide assurance to the Trust Board:

- Finance and Sustainability Committee
- Audit Committee
- Quality & Assurance Committee
- Trust Operational Board
- Strategic People Committee
- KPI Sub-Committee

5. RECOMMENDATIONS

The Trust Board is asked to:

1. Note the contents of this report.
2. Note the changes to the 2019/20 capital programme.

Appendix 1 – KPI RAG Rating November 2018 – October 2019

	KPI	Performance Improvement Direction	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sept 19	Oct 19
	QUALITY													
1	Incidents	↓ (Incidents over 40 days old)	↑	↓	↓	↓	↓	↑	↑	↑	↑	↑	↓	↑
2	CAS Alerts	↓ (Alerts not actioned in time - 0)	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
3	Duty of Candour	↓ (In month compliance)	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
4	Adult Safety Thermometer	↑ (In month compliance)	↑	↔	↓	↓	↑	↔	↑	↓	↑	↓	↑	↓
5	Children Safety Thermometer	↑ (In month compliance)	↑	↔	↓	↑	↔	↓	↑	↔	↔	↔	↓	↑
6	Maternity Safety Thermometer	↑ (In month compliance)	↓	↑	↓	↑	↓	↓	↑	↓	↑	↓	↑	↓
7	Healthcare Acquired Infections - MSRA	↓ (MRSA cases in month)	↔	↑	↓	↔	↔	↔	↔	↔	↔	↑	↔	↔
8	Healthcare Acquired Infections – Cdiff	↓ (Cdiff cases in month)	↓	↓	↑	↓	↑	↔	↓	↑	↔	↑	↓	↑
9	Healthcare Acquired Infections – Gram Neg	↓ (Gram Neg cases in month)	↓	↑	↑	↓	↓	↑	↑	↓	↓	↓	↑	↓
10	VTE Assessment		↓	↔	↑	↓	↑	↓	↓	↓	↑	↑	↓	
11	Total Inpatient Falls & Harm Levels	↓ (No. of inpatient falls in month)	↓	↑	↓	↓	↑	↓	↓	↓	↓	↑	↑	↓
12	Pressure Ulcers	↓ (No. of pressure ulcers in month)	↑	↑	↑	↓	↑	↑	↓	↑	↔	↓	↑	↑
13	Medication Safety	↓ (Medicines reconciliation within 24 hours)							↓	↑	↑	↑	↔	↑
14	Staffing – Average Fill Rate	↑ (% staffing fill rates in month)	↑	↓	↑	↓	↓	↑	↑	↑	↓	↓	↑	↑
15	Staffing – Care Hours Per Patient Day								↔	↓	↔	↓	↑	↑
16	Mortality ratio - HSMR	(Based on Ratio)	↑	↓	↓	↑	↓	↓	↑	↓	↑	↓	↔	↓
17	Mortality ratio - SHMI	(Based on Ratio)	↑	↔	↑	↓	↑	↓	↑	↔	↑	↔	↔	↓
18	NICE Compliance	↑ (compliance in month)	↑	↑	↓	↑	↑	↓	↑	↓	↑	↑	↓	↑
19	Complaints													
20	Friends & Family – Inpatients & Day cases	↑ (% recommending the Trust)	↑	↑	↓	↑	↔	↓	↑	↔	↓	↑	↑	↓
21	Friends & Family – ED and UCC	↑ (% recommending the Trust)	↓	↑	↓	↑	↑	↑	↑	↓	↔	↑	↓	↔
22	Mixed Sex Accommodation Breaches	↓ (Number of breaches)	↓	↔	↑	↓	↓	↑	↓	↑	↓	↑	↓	↑
23	Continuity of Carer	↑								↓	↑	↑	↓	↑
24	CQC Insight Indicator Composite Score	↑ (Trust Score)	↔	↔	↓	↔	↔	↔	↔	↔	↔	↔	↑	↔

Appendix 1 – KPI RAG Rating November 2018 – October 2019

	ACCESS & PERFORMANCE													
25	Diagnostic Waiting Times 6 Weeks	↑ (% Monthly Performance)	↑	↓	↑	↑	↔	↔	↓	↑	↑	↑	↓	↑
26	RTT - Open Pathways	↑ (% Monthly Performance)	↓	↓	↑	↓	↓	↓	↑	↓	↑	↓	↑	↑
27	RTT – Number Of Patients Waiting 52+ Weeks	↔ (Number of breaches – 0)	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
28	A&E Waiting Times – National Target	↑ (% Monthly Performance)	↓	↓	↓	↑	↑	↓	↑	↑	↑	↑	↓	↓
29	A&E Waiting Times – STP Trajectory	↑ (% Trajectory Performance)	↓	↓	↓	↑	↑	↓	↑	↑	↑	↑	↓	↓
30	A&E Waiting Times – Over 12 Hours	↓						↔	↔	↔	↔	↔	↔	↔
31	Cancer 14 Days*	↑ (% Monthly Performance)	↓	↑	↓	↓	↑	↓	↓	↑	↓	↑		
32	Breast Symptoms 14 Days*	↑ (% Monthly Performance)	↓	↓	↑	↑	↓	↓	↑	↑	↓	↓		
33	Cancer 31 Days First Treatment*	↑ (% Monthly Performance)	↓	↑	↔	↔	↔	↓	↑	↓	↑	↑	↑	↓
34	Cancer 31 Days Subsequent Surgery*	↑ (% Monthly Performance)	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
35	Cancer 31 Days Subsequent Drug*	↑ (% Monthly Performance)	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
36	Cancer 62 Days Urgent*	↑ (% Monthly Performance)	↑	↓	↓	↑	↓	↔	↑	↓	↓	↓	↓	↑
37	Cancer 62 Days Screening*	↑ (% Monthly Performance)	↔	↓	↑	↓	↑	↓	↑	↑	↓	↑	↓	↑
38	Ambulance Handovers 30 to <60 minutes	↓ (Number of patients)	↓	↑	↓	↓	↓	↑	↓	↑	↑	↓	↓	↑
39	Ambulance Handovers at 60 minutes or more	↓ (Number of patients)	↓	↑	↓	↓	↓	↓	↓	↑	↓	↓	↑	↓
40	Discharge Summaries - % sent within 24hrs	↓ (% Monthly Performance)	↓	↓	↑	↑	↓	↑	↓	↑	↑	↓	↓	↑
41	Discharge Summaries – Number NOT sent within 7 days	↔ (Number of patients)	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
42	Cancelled Operations on the day for a non-clinical reasons	↓ (Number of Cancellations)						↔	↓	↓	↑	↓	↑	↓
43	Cancelled Operations– Not offered a date for readmission within 28 days	↓ (Number of Cancellations – not rebooked))	↓	↔	↑	↓	↔	↑	↔	↔	↑	↓	↓	↔
44	Urgent Operations – Cancelled for a 2nd time	↓						↔	↔	↔	↔	↔	↔	↔
45	Super Stranded Patients	↓ (Number of patients)	↑	↑	↓	↑	↑	↓	↔	↓	↑	↑	↑	↓

Appendix 1 – KPI RAG Rating November 2018 – October 2019

	KPI		Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sept 19	Oct 19
	WORKFORCE													
46	Sickness Absence	↓ (% Monthly Performance)	↑	↑	↑	↓	↓	↓	↓	↑	↑	↓	↓	↑
47	Return to Work	↑ (% Monthly Performance)	↓	↓	↓	↓	↓	↓	↓	↓	↑	↓	↓	↓
48	Recruitment	↓ (Average Number of Days)	↓	↔	↑	↓	↓	↓	↓	↓	↑	↑	↓	↔
49	Vacancy Rates	↓ (% vacancy Rate)						↓	↓	↓	↑	↓	↓	↓
50	Retention	↑ (% staff retention)						↑	↓	↑	↑	↑	↑	↑
51	Turnover	↓ (% staff turnover)	↑	↓	↓	↑	↓	↑	↑	↑	↑	↓	↓	↑
52	Bank & Agency Reliance	↓ (% reliance on bank/agency)						↓	↑	↑	↓	↑	↓	↓
53	Agency Shifts Compliant with the Cap	↑ (% compliant agency shifts)						↑	↓	↓	↓	↑	↓	↓
54	Monthly Pay Spend (Contracted & Non-Contracted)	↓ (% of budget spent)	↓	↑	↓	↓	↑	↓	↓	↓	↑	↓	↓	↑
55	Core/Mandatory Training	↑ (% Monthly Performance)	↑	↑	↓	↓	↓	↑	↑	↓	↑	↓	↓	↑
56	PDR	↑ (% Monthly Performance)	↑	↓	↑	↓	↑	↓	↓	↑	↓	↓	↑	↑
	FINANCE													
57	Financial Position	↑ (Cumulative against plan)	↑	↓	↓	↑	↑	↑	↓	↓	↓	↓	↓	↓
58	Cash Balance	↑ (Balance against plan)	↔	↔	↔	↔	↔	↔	↑	↑	↑	↓	↓	↓
59	Capital Programme	↑ (Performance against plan)	↓	↓	↓	↓	↓	↑	↓	↑	↓	↓	↓	↑
60	Better Payment Practice Code	↑ (Monthly actual against plan)	↓	↔	↑	↓	↓	↑	↑	↓	↔	↔	↔	↑
61	Use of Resources Rating	↑ (Rating against plan)	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
62	Agency Spending	↓ (Monthly planned vs actual)	↓	↓	↓	↑	↑	↑	↓	↔	↑	↓	↓	↑
63	Cost Improvement Programme – Performance to date	↑ (Monthly vs target)	↑	↑	↓	↓	↔	↔	↑	↑	↑	↑	↑	↑
64	Cost Improvement Programme – Plans in Progress (In Year)	↑ (Monthly vs plan)	↓	↑	↓	↓	↔	↔	↔	↔	↓	↑	↓	↑
65	Cost Improvement Programme – Plans in Progress (Recurrent)	↑ (Forecast)						↑	↑	↑	↑	↓	↓	↓

*RAG rating is based on previous month's validated position for these indicators.

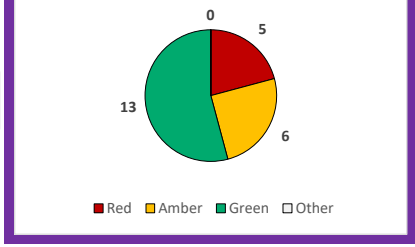
Warrington and Halton Hospitals NHS
NHS Foundation Trust

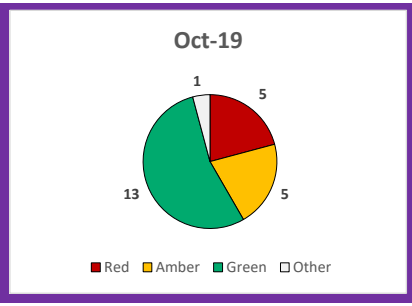
Integrated Dashboard - October 2019

Appendix 2

Key Points/Actions

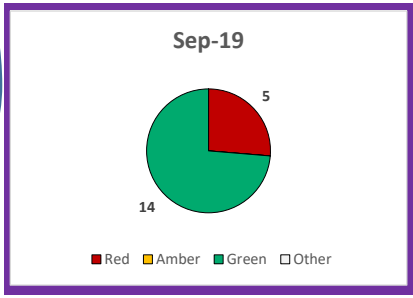
Quality Improvement

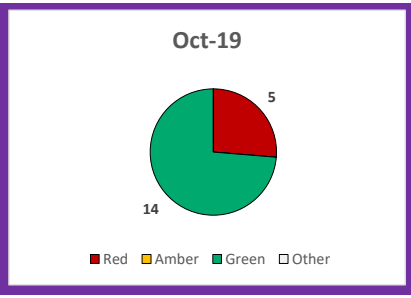




There are 441 open incidents that required review and sign off. Compliance in month in relation to Duty of Candour remains 100%. All thresholds in the 3 categories of the Safety Thermometer have been achieved. The Trust is above trajectory for MRSA having 2 YTD against a target of 0 and is performing within targets for; CDI 29 against a target of 44 in year; E-Coli 32 against a target of 47 in year. A reduction of 24.2% is noted for inpatient falls as of October 2019 compared with the same reporting period for 2018/19. The Trust has had a total of 39 category 2 & 3 pressure ulcers YTD and is on target to achieve the 10% planned reduction in pressure ulcers from 57 in 2018/19. There were 6 mixed sex accommodation breaches in October.

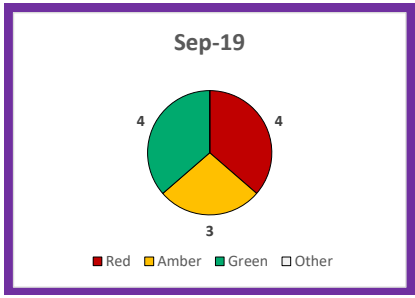
Access & Performance

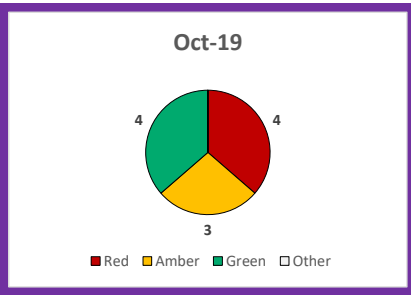




In October 2019, 14 out of the 19 indicators were RAG rated as Green. The Trust has continued to achieve the RTT and the 6 week diagnostic standards in month. The Trust did not meet the 4 hour A&E standard; however the improvement trajectory was met. The number of ambulance handover delays for 60 minutes plus has reduced. All cancer standards were met (based on the September 2019 position). Discharge summaries sent within 24 hours continues to be challenging, however there has been improvement. The number of cancelled operations remains low at 0.30% with no cancellations not rebooked within 28 days and no urgent operations cancelled for a 2nd time. The number of super stranded patients has reduced to 113 as at the end of October.

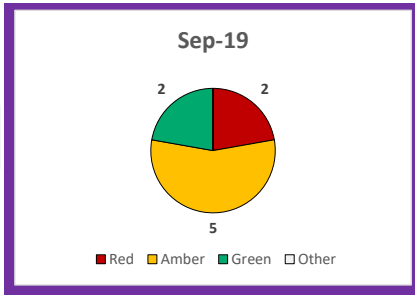
Workforce

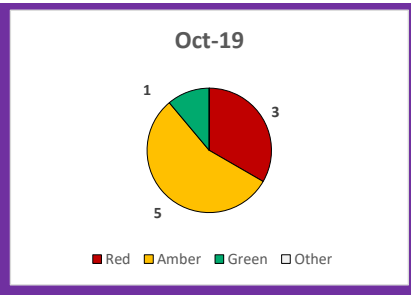




Trust sickness absence in month was 5.48%. Return to work compliance was 78.57%; timeliness of completion is being addressed. Recruitment timeframes over the 12 month rolling period at an average of 61 days. Turnover at 10.97% and Retention at 89.19% remain positive. Bank and Agency reliance is above target at 13.81%. Core Skills Training compliance continues to be positive at 90.86%. PDR compliance is below the target in month at 77.50%, progress at CBU/Department level will be monitored and managers held to account in Operational People Committee. Agency shift compliance pay cap is at 38.03%.

Finance





In the month, the Trust recorded a surplus of £0.5m resulting in a year to date deficit of £3.3m which is £0.3m better than plan. The year to date control total (excluding Provider Sustainability, Financial Recovery and Marginal Rate Emergency tariff funding) is an £11.6m deficit which is £0.1m better than plan. Year to date income is £3.2m above plan, expenditure is £2.9m above plan and non operating expenses are on plan. Capital spend is £3.8m which is £4.0m below the planned capital spend of £7.8m. Annual saving schemes identified are £6.6m which is £0.9m below the £7.5m annual target, and to date savings achieved are £3.1m which is £1.0m above the planned savings. At month end, the cash balance is £1.4m which is £0.2m better than plan. The year to date performance against the Better Payment Practice Code is 39% which is 56% lower than the 95% target. The Trust has recorded a Use of Resources Rating of 3.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Key:
Single Oversight Framework
Care Quality Commission
Trust Strategy

Quality Improvement - Trust Position

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?

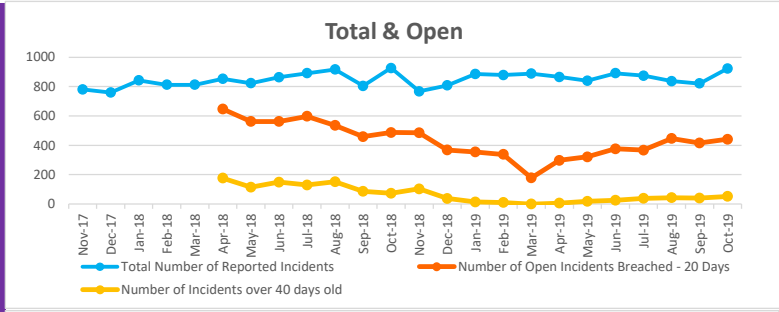
Patient Safety

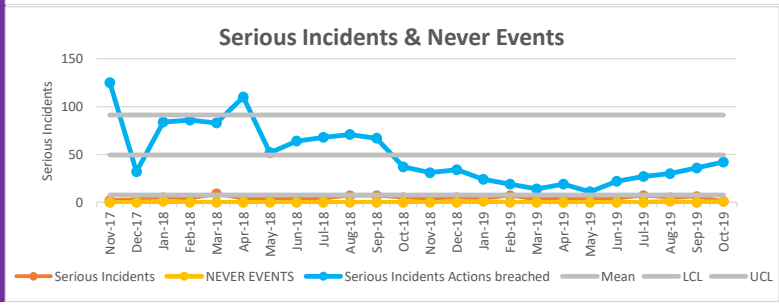
Incidents

Red: Open incidents outside 40 day timeframe
Amber: Open incidents between 20 - 40 days old.
Green: Open incident within timeframe of 20 days.

SOF CQC

There were 52 incidents over 40 days old open in October 2019.





There was 1 Serious Incident reported in October 2019 which was a Never Event in relation to an incorrect implant being inserted, an investigation is underway.
Internal Variance Plan:
There were 52 incidents over 40 days old open in October against a target of 0. Each CBU and specialty receives a dashboard with up to date incidents information.

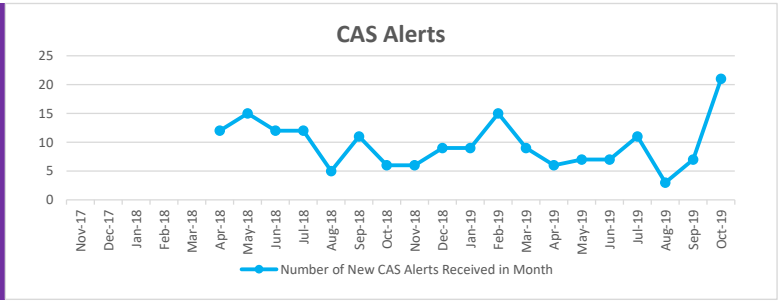
The Trust 'Reporting to Improve' campaign continues with over 200 managers now trained on the use of Datix for incident reviewing. Training and support for this will continue as required.

Concise RCA investigations are now reviewed and signed off at the Weekly Executive Meeting of Harm in line with the approach for Serious Incident Investigations.

CAS Alerts - Green - All relevant CAS Alerts actioned within timescales Red - Applicable CAS Alert not actioned within the timescale.

CQC

There were 21 new CAS Alerts received in month. There were no CAS alert actions which breached the timescale in month.



The Trust received 21 CAS alerts in month with no breaches.

There is ongoing monitoring and oversight at the Health and Safety and Patient Safety and Effectiveness Sub Committees in relation to CAS alerts.

Warrington and Halton Hospitals NHS
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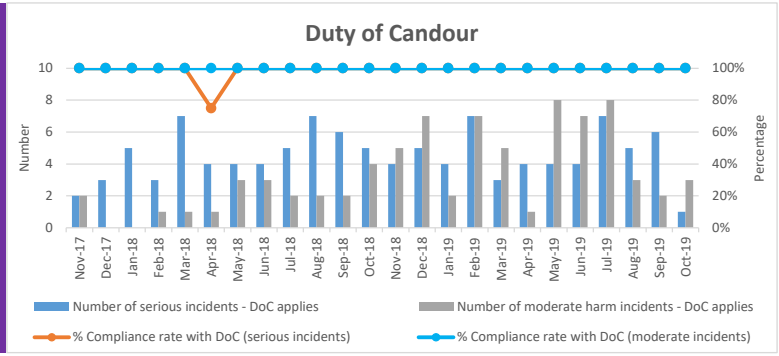
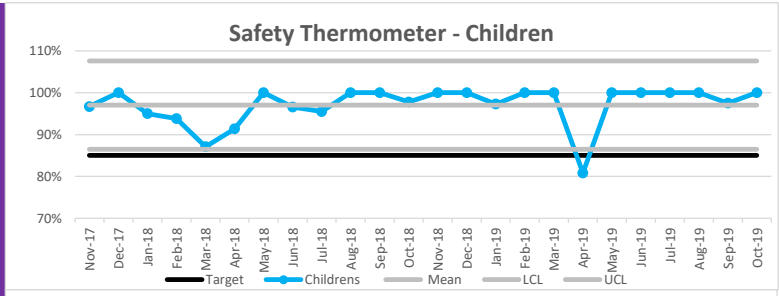
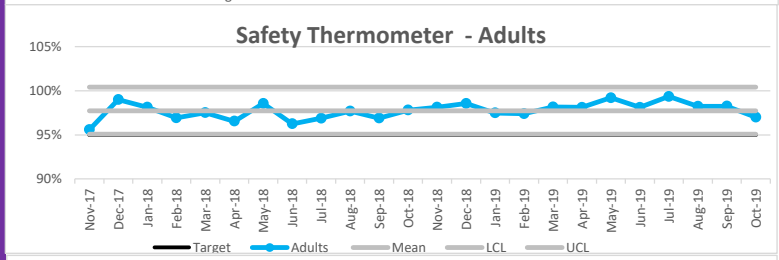
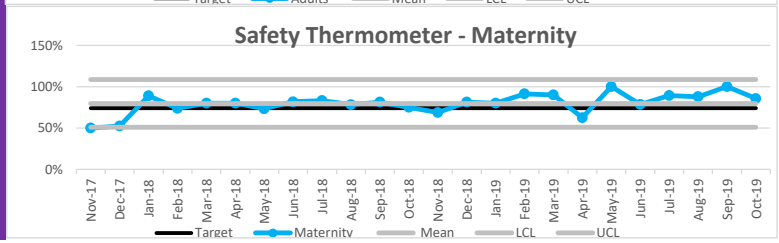
	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Duty of Candour Red: <100% Green: 100%	The Trust achieved 100% for Duty of Candour in month.		Compliance with Duty of Candour remains in line with Trust policy and continues to be supported through monitoring via the Datix system with oversight by the clinical governance department in relation to all correspondence/contact. National Trajectory: The Trust is performing in line with the national trajectory of being 100% compliant.	There is weekly scrutiny and monitoring in place with the Deputy Director of Governance and Quality.
Childrens Safety Thermometer Red: Less than 80% Amber: 81% to 84% Green: 85% or more **Adult Safety Thermometer** Red: Less than 90% Amber: 90% to 94% Green: 95% or more **Maternity Safety Thermometer** Red: Less than 70% Amber: 70% to 73% Green: 74% or more	The Trust achieved 97% on the Adult Safety Thermometer, 100% on the Children's Safety Thermometer and 85.70% on the Maternity Safety Thermometer in month. SPC - These indicators are within common cause (expected) variation.	  	All areas of the Safety Thermometer are above the threshold. Adult - 97% - 6 VTE, 5 CAUTI, 3 Pressure Ulcers & 1 Fall. Children's – 100% Maternity – 85.7% - 2 Infections & 2 babies with low APGAR scores. National Trajectory: All areas of the safety thermometer are performing above the national trajectories; Adults is 7% above, Children's is 20% above and Maternity is 15.7% above the trajectory.	There is ongoing monitoring and oversight at the Health and Safety and Patient Safety and Effectiveness Sub Committees.

Warrington and Halton Hospitals NHS
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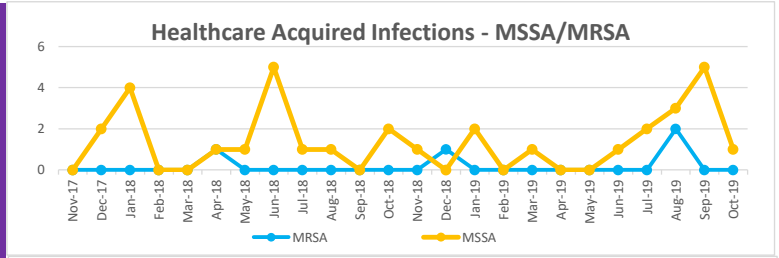
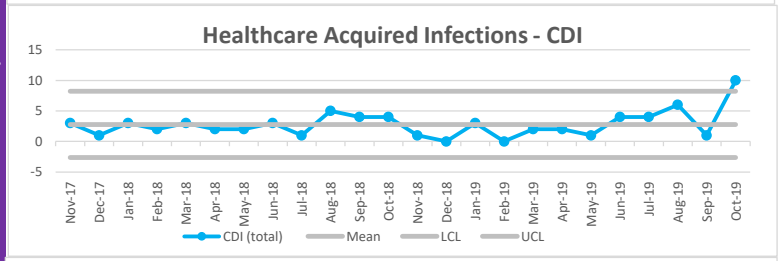
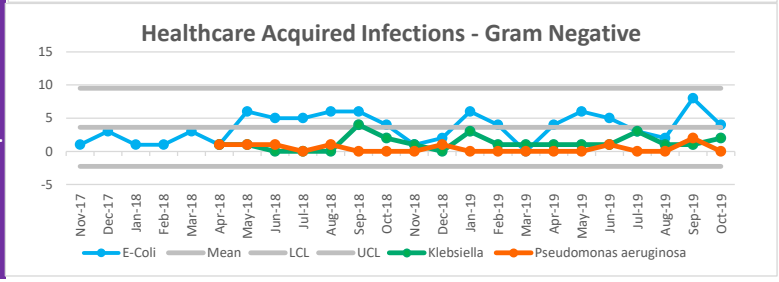
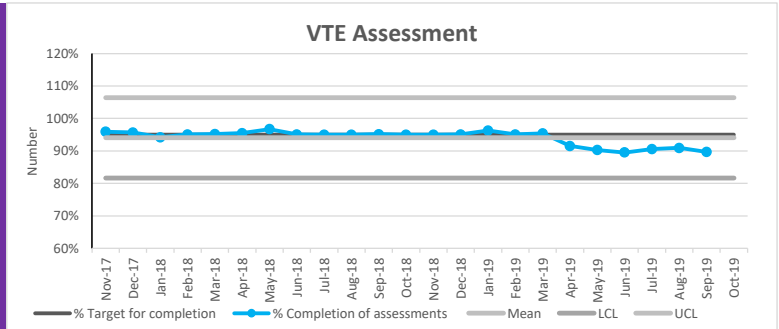
Healthcare Acquired Infections **MRSA** **Red: 1 or more** **Green: 0** **Healthcare Acquired Infections** **C-Difficile** **Red: 44+ per annum** **Green: Less than 44 per annum** **Healthcare Acquired Infections - Gram Negative** **E-Coli** **Red: 47+ per annum** **Green: Less than 47 per annum**	**Performance for April - October 2019** **MRSA bacteraemia cases - 2 cases YTD (reported in August 2019)** **12 MSSA bacteraemia case** **29 C. difficile cases YTD include community onset/healthcare associated and hospital onset cases.** **32 E. coli bacteraemia cases reported YTD.** **10 Klebsiella bacteraemia cases YTD.** **3 P. aeruginosa bacteraemia cases YTD.** **No targets set for MSSA; Klebsiella, P. aeruginosa bacteraemia cases.** **SPC - these indicators are within common cause (expected) variation.**	  	**The Trust is over trajectory for MRSA bacteraemia cases. Areas for improvement noted in relation to urinary catheter care.** **National Trajectory: The Trust is above trajectory for MRSA having 2 cases YTD against a target of 0. The Trust is performing within target for other areas, CDI 29 against a target of 44 in year; E-Coli 32 against a target of 47 in year. There are no targets set for MSSA; Klebsiella, P. aeruginosa bacteraemia cases. The Trust is working with AQuA on the GNBSI reduction programme.**	**Quality improvement collaborative action plans are in place with agreed tests of change. Focus areas include urinary catheter care and ANTT training; patient hand hygiene and hydration. Education on the UTI pathway is underway, this is linked to the CQUIN which is reviewing antimicrobial resistance in lower UTIs.**
VTE Assessment **Red: <95%** **Green: 95% or above based on previous months' figures due to timescales for validation of data**	**The Trust achieved 90.40% for VTE assessments on average in Q2 2019.** **SPC - VTE is within common cause (expected) variation.**		**The Trust achieved 90.40% for VTE assessments on average in Q2 2019.** **National Trajectory: The Trust is 4.6% below the 95% target for VTE. From October to March 2020 the Trust has aligned the VTE audit process with the GIRFT framework for further oversight on quality.**	**There are actions in relation to VTE. Focussed work with clinical teams to improve compliance with the VTE electronic risk assessment processes. Escalation supported by the Deputy Medical Director is now in place to ensure ongoing actions are completed.**

Warrington and Halton Hospitals NHS
NHS Foundation Trust

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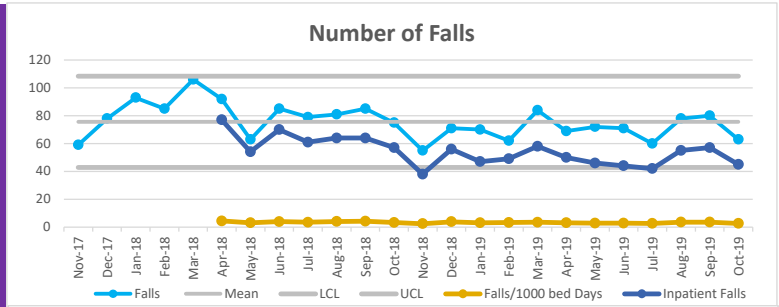
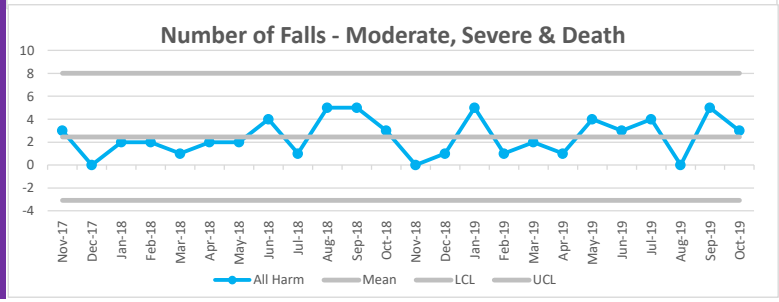
Quality Improvement - Trust Position

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Total number of Inpatient Falls & harm levels Red: <10% decrease from 18/19 Amber: 10-19% decrease from 18/19 Green 20% or more decrease from 18/19	There were a total of 63 falls in the month; of which 45 were inpatient falls. SPC - Falls are within common cause (expected) variation.	 	The Trust recorded no major harm incidents as a result of falls in October 2019. A reduction of 24.2% is noted for inpatient falls as of October 2019/20 compared with the same reporting period for 2018/19. Internal Variance Plan: The Trust has achieved a reduction of 24.2% in month against a target of 20%.	A QI collaborative project continues with clinical areas of focus and nominated leads identified. There is a CQUIN relating to Falls which is underway. Innovation walk arounds are underway with progress reported through the Trust Falls Steering Group which is overseen by the Patient Safety and Effectiveness Sub Committee.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Key:

Single Oversight Framework SOF

Care Quality Commission CQC

Trust Strategy S

Quality Improvement - Trust Position

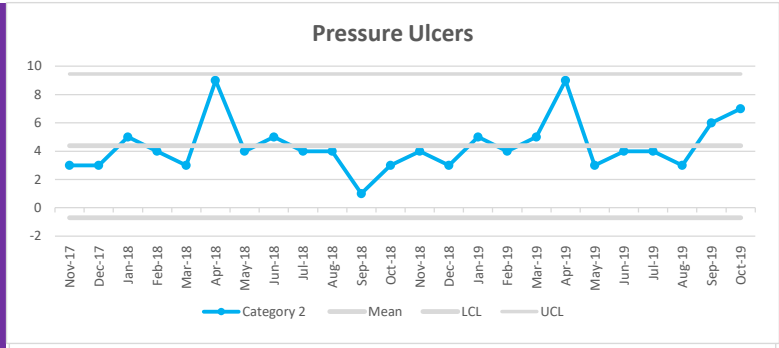
Pressure Ulcers
Based on 57 in 2018/19
Red: 4% reduction or below
Amber: 5%-9% reduction
Green: 10% reduction or above.

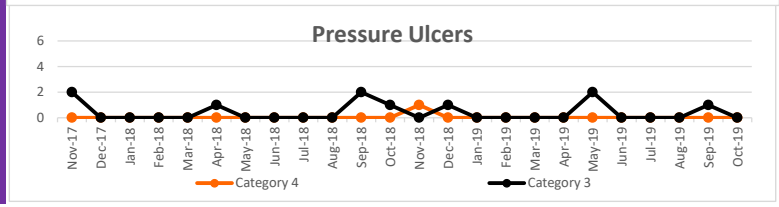
Trust Performance

CQC

There were 0 hospital acquired Category 4 pressure ulcers, 0 Category 3 pressure ulcers and 7 Category 2 pressure ulcers reported in month.
SPC - Pressure ulcers are within common cause (expected) variation.

Trend





What are the reasons for the variation and what is the impact?

There is evidence of variation in accuracy of risk assessments and ongoing monitoring in change of patients condition. There have been instances where there has been a delay in obtaining or upgrading pressure relieving mattresses. The Trust has seen high performance on wards such as B3 with no PUs for over 200 days and A2 no PUs for over 100 days.
Internal Variance Plan: The Trust has had a total on 39 category 2 & 3 pressure ulcers YTD. We are currently on target to achieve the 10% reduction planned from the 57 pressure ulcers in 2018/19.

How are we going to improve the position (Short & Long Term)?

The Quality Improvement collaborative work is ongoing with good progress being made in areas of innovation. Tests of change have commenced and innovation walk arounds are underway, updates are reported through the Trust Tissue Viability Steering Group which is overseen by the Patient Safety and Effectiveness Sub Committee.

Pressure ulcer prevention face to face training continues with additional training in the clinical areas where necessary.

Warrington and Halton Hospitals NHS
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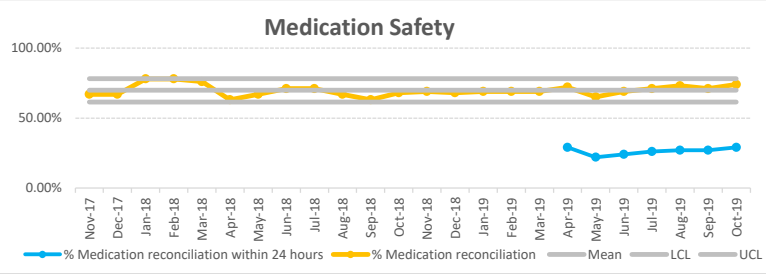
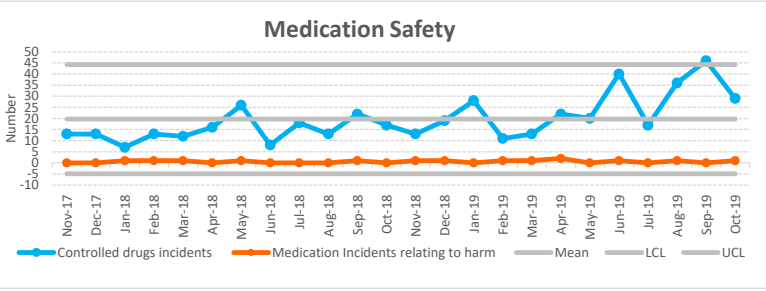
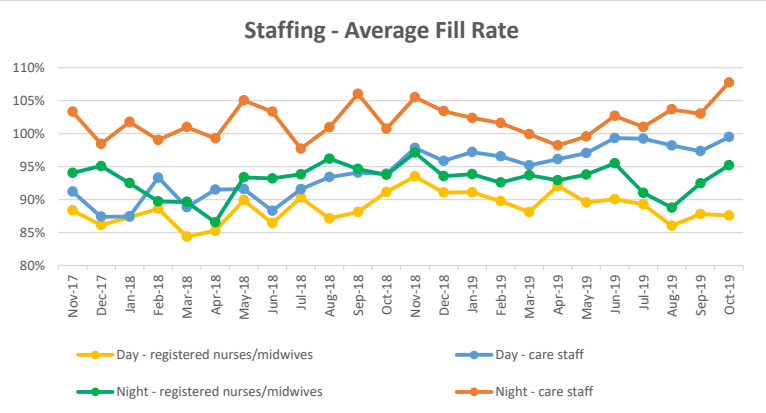
Trust Strategy

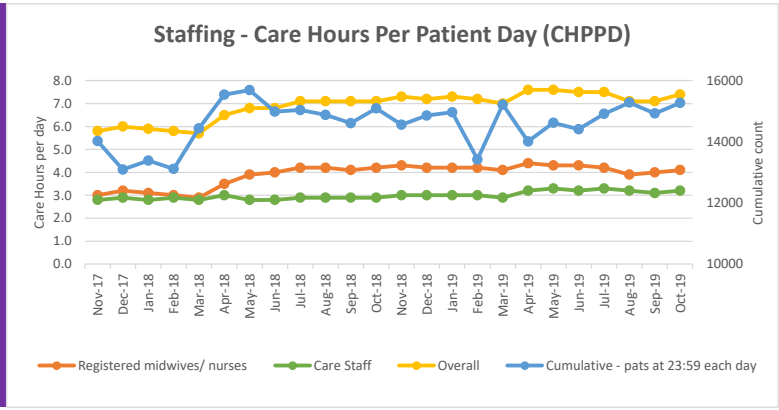
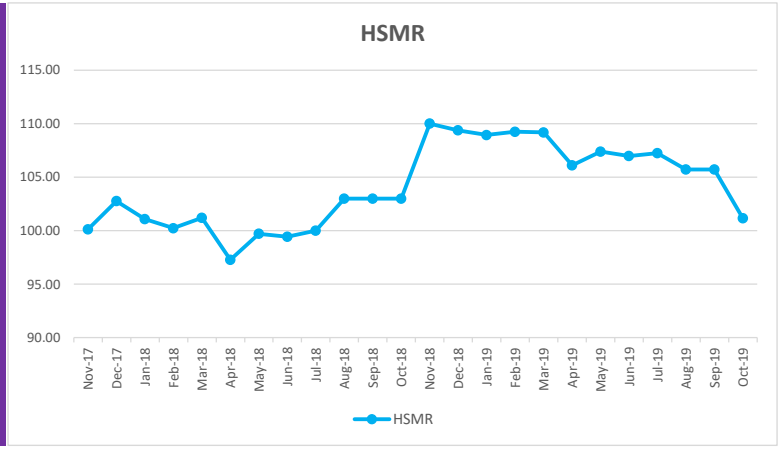
Quality Improvement - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Medication Safety Reconciliation within 24 hours **Red: below 60%** **Amber: 60% - 79%** **Green: 80% or above**	Medication Reconciliation within 24hrs was 29% in October 2019. There was 1 incident of harm relating to medication safety in month. SPC - There is special cause variation present in control drug incidents.	 	With regards to medicines reconciliation, this has increased to 29%. Internal Variance Plan: The Trust is below the 80% target we have set, achieving 29% in month. The implementation of phase 1 of the pharmacy 7 day service will improve medicines reconciliation significantly. Implementation of seven day service pharmacy has commenced, which included a pharmacist situated within ED.	The implementation of ePMA and 7 day on ward pharmacy service commenced in November*, this will support an increase in pharmacy ward staffing levels leading to improvements in medicines reconciliation figures and prescribing and therefore patient safety. *At the time of preparing this report 5 wards have commenced using ePMA in Warrington with further wards scheduled throughout November.
Staffing - Average Fill Rate **Red: 0-79%** **Amber: 80-89%** **Green: 90-100%**	In month the average staffing fill rates were: Day (Nurses/Mwife) 87.57% Day (Care Staff) 99.47% Night (Nurses/Mwife) 95.21% Night (Care Staff) 107.74%		The Trust is achieving over 95% for Care Staff, both Day and Night. Nurses and Midwives for Day and Night is consistently over 85%. National Trajectory: The Trust is above trajectory for all areas except Staffing fill rates for Day (Nurses / Midwives) which was 2.43% below trajectory. Any individual ward that falls below 90% provides mitigation to ensure it is safe and that high quality care is consistently delivered in those areas.	The Trust has recruited 45 WTE nurses, which have all now commenced in post; this should have a positive impact on the fill rate from November onwards. The Trust continues to make progress in the Trust wide Recruitment and Retention Strategy which will improve the positon further.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Key:
Single Oversight Framework (SOF)
Care Quality Commission (CQC)
Trust Strategy (S)

Quality Improvement - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Staffing - Care Hours Per Patient Day (CHPPD) Red: Below 6.0 Amber: 6.0 - 7.8 Green: 7.9 or More	In month, the average CHPPD were: Nurse/Midwife: 4.1 hours Care Staff: 3.2 hours Overall: 7.4 hours		The overall Trust CHPPD has increased by 0.3 to 7.4. National Trajectory: The Trust is 0.5 behind the national target of 7.9 for CHPPD. This continues to be monitored monthly by the Senior Nursing Team.	Ward staffing levels continues to be systematically reviewed, which includes Planned vs Actual staffing levels. These are reported monthly as part of the Unify submission and any ward that falls below 90% provides mitigation to ensure safe, high quality care is consistently being delivered in those areas. The Trust has recruited 45 WTE nurses, which have all now commenced in post; this should have a positive impact on the CHPPD rate from November onwards.
Mortality ratio - HSMR Red: Greater than expected Green: As or under expected	The HSMR ratio in month was 101.16.		The most recent HSMR/SHMI ratios are within the expected range and have shown a decrease on the previous month. Work continues at Mortality Review Group to undertake deep dives and continuation of Standard Judgement Reviews. National Trajectory: The Trust is within the expected range for HSMR and is currently at 101.16 in comparison to our peer group who average at 100.24.	The Ward Round Accreditation will review the quality of documentation which impacts on these results. Focussed reviews are underway where the Trust is an outlier. Work in relation to improving coding, working diagnosis and finished consultant episodes, all of which impact on the mortality data, are underway.

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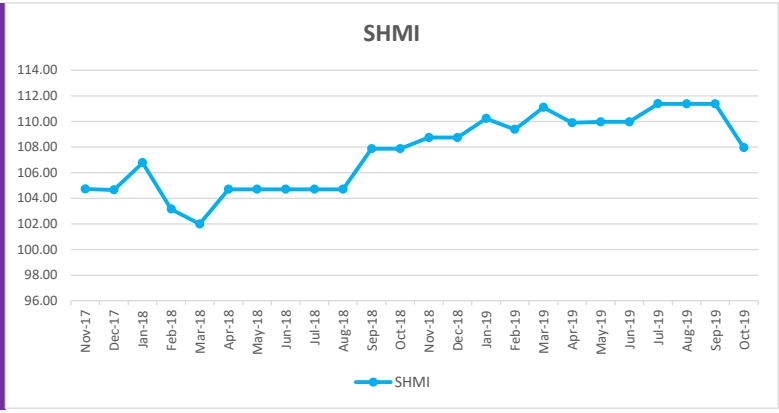
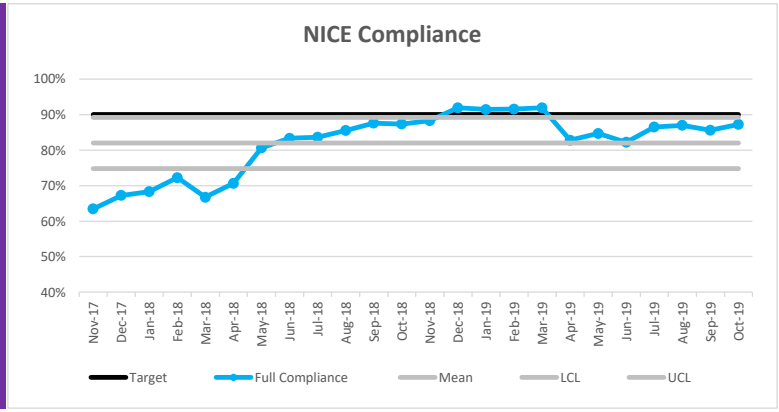
	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Mortality ratio - SHMI Red: Greater than expected Green: As or under expected	The SHMI ratio in month was 107.95.		The most recent HSMR/SHMI are still within the expected range and have shown a decrease on the previous month. Work continues at the Mortality Review Group to undertake deep dives and continuation of Standard Judgement Reviews. National Trajectory: The Trust is within the expected range for SHMI and is currently at 107.95 in comparison to our peer group who average at 103.23.	The Ward Round Accreditation will review the quality of documentation which impacts on these results. Focussed reviews are underway where the Trust is a outlier. Work in relation to improving coding, working diagnosis and finished consultant episodes, all of which impact on the mortality data, are underway.
NICE Compliance Red: Below 75% Amber: 75% to 89% Green: 90% or Above	NICE Compliance was 87.26% in month. SPC - there is evidence of special cause variation.		The overall Trust compliance level is 87.26%, the Trust is implementing an action plan to reach the agreed target of 90%. Internal Variance Plan: The Trust is 2.74% below the 90% target however we are on track to achieve this target by April 2020 through targeted work with the CBUs.	The Trust is currently risk assessing all partial compliance NICE Guidance to ensure that any risks are elevated to the risk register with robust action plans in place to ensure compliance. This is reported to Patient Safety and Effectiveness Sub Committee.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Key:
Single Oversight Framework (SOF)
Care Quality Commission (CQC)
Trust Strategy (S)

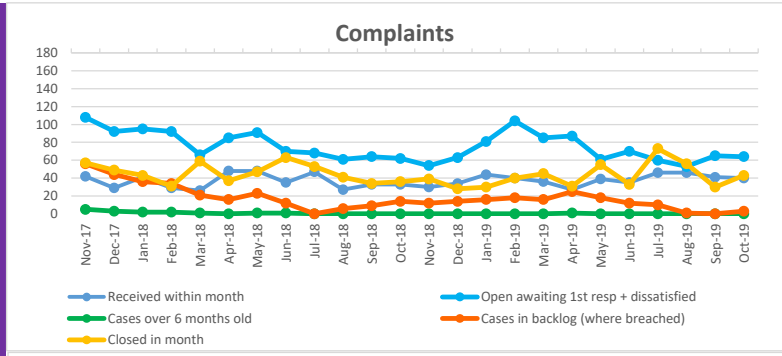
Quality Improvement - Trust Position

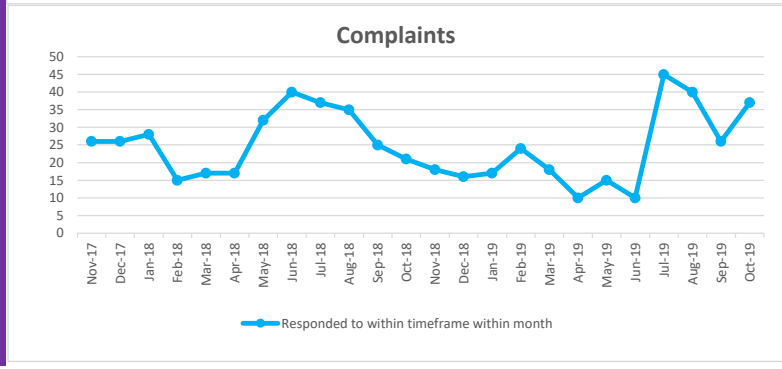
Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?

Patient Experience

Complaints
Red: Complaints over 6 months old/69% or less responded to within the timeframe
Amber: No complaints over 6 months old, 70% - 89% responded to within the timeframe
Green: No backlog, 90% responded to within the timeframe.

The Trust has continued to implement the Quality Account target of 90% complaints responded to within agreed timescales. In October 2019 there are 3 complaints in backlog.





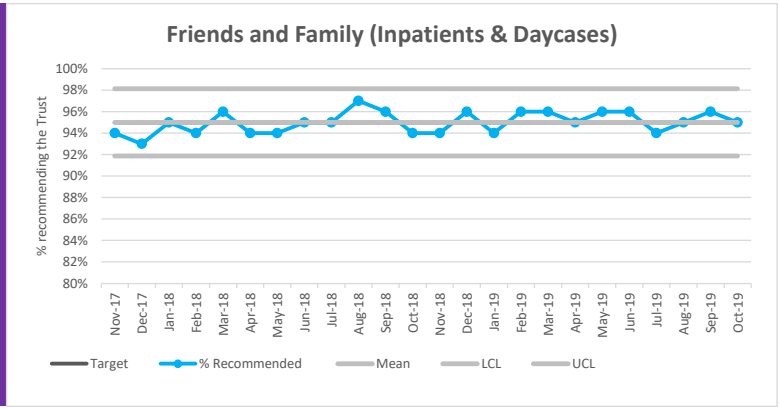
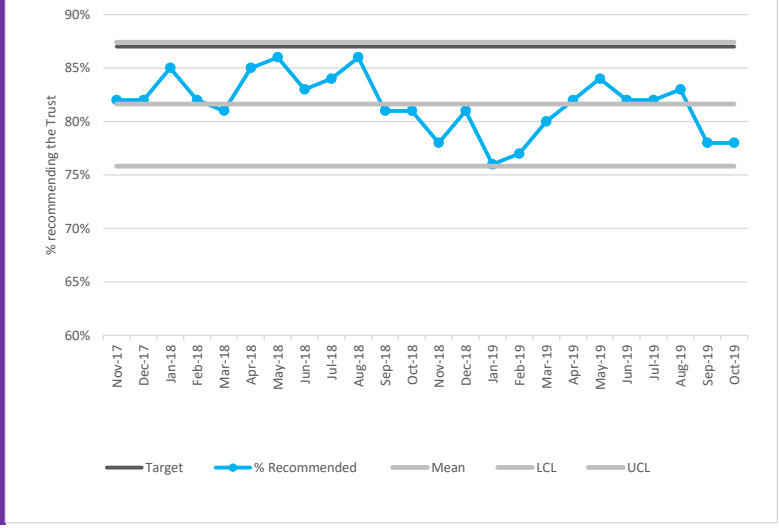
Timeliness of complaints during October was 86% which is nearing our target of 90% by April 2020. There is a quality priority for 2019/20 which is aligned to the Quality Strategy to improve timeliness of responses to complaints, this is monitored via the Trust dashboard and is reported to Quality Assurance Committee.
Internal Variance Plan:
The Trust is 4% below the 90% target but is on track to achieve target by April 2020 through targeted work with the CBUs.

There has been a reduction in the number of breaches across the Trust. The Complaints team continue to work closely with CBUs in order plan each case and maintain this position. Performance is monitored via the Chief Nurse and the Deputy Director of Governance and Quality at the weekly meeting of harm.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Key:
Single Oversight Framework
Care Quality Commission
Trust Strategy

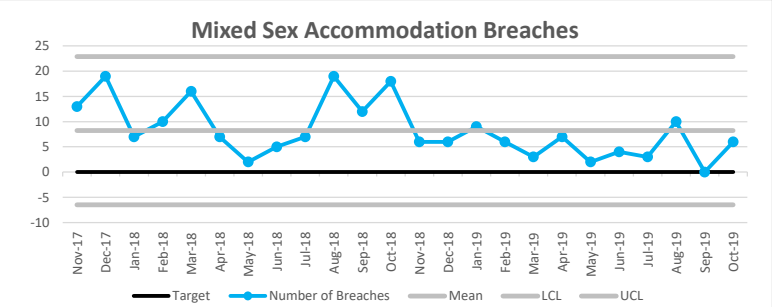
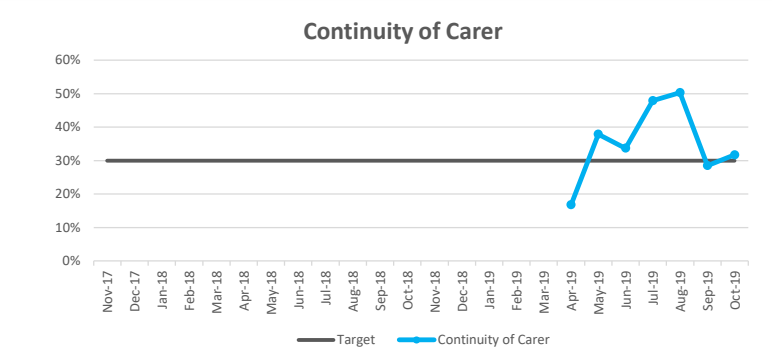
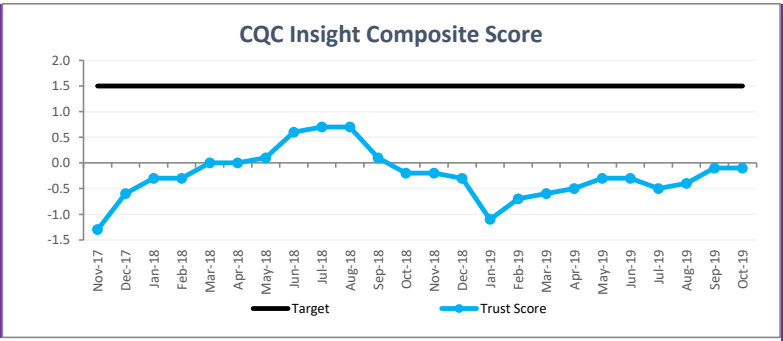
Quality Improvement - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Friends and Family (Inpatients & Day cases) Red: Less than 95% Green: 95% or more	The Trust achieved 95% in month. SPC - FFT Inpatients is within common cause (expected) variation.		The Trust achieved a 95% recommendation rate against a target of 95%. National Trajectory: The Trust is achieving the national trajectory.	The Trust has met the target set of 95% recommendation rate at 95% for the 2nd month in succession. Response rate is consistently above 30% each month. CBUs provide high level briefing paper to Patient Experience Subcommittee monthly since August 2019 and FFT feedback response and recommendation rates continue to be monitored and through Quality Metric reports.
Friends and Family (ED and UCC) Red: Less than 87% Green: 87% or more	The Trust achieved 78% in month. SPC - FFT ED & UCC is within common cause (expected) variation.		The Trust achieved 78% recommendation rate against a target of 87%, which is consistent with the previous month. ED ACU recommendation rate increased 3% in October to 65% and this will continue to be monitored. The response rate was 17.6%, which is within the expected range at WHH but concerns regarding patients being unable to respond to text messaging has been escalated to Healthcare Communications, the Trust's FFT provider. Internal Variance Plan: The Trust is below our internal target of 80%. A deep dive has commenced to review the data and the Deputy Chief Nurse is reviewing the contractual arrangements and the denominator that the Trust is measured on.	Alternative methods of gathering feedback within UEC are being explored, such as online via Ipads to increase the chance of real time or near real time feedback. In April 2020 new FFT recommendations will be launched which will focus on the actions taken to improve the patient experience as opposed to the response and recommendation rates.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Key:
Single Oversight Framework
Care Quality Commission
Trust Strategy

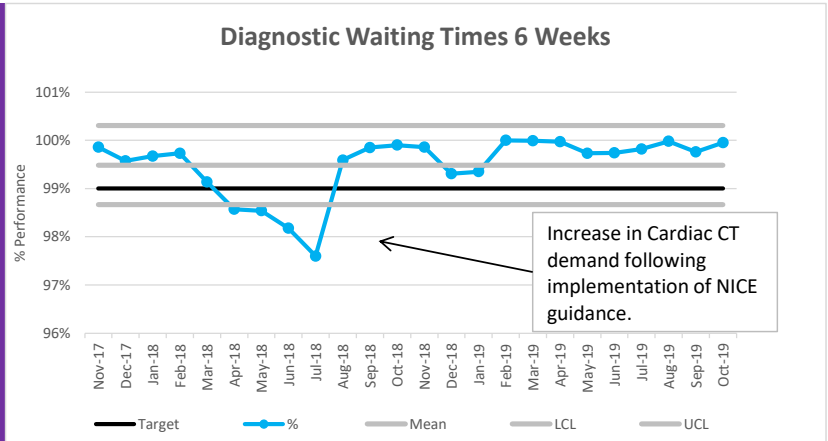
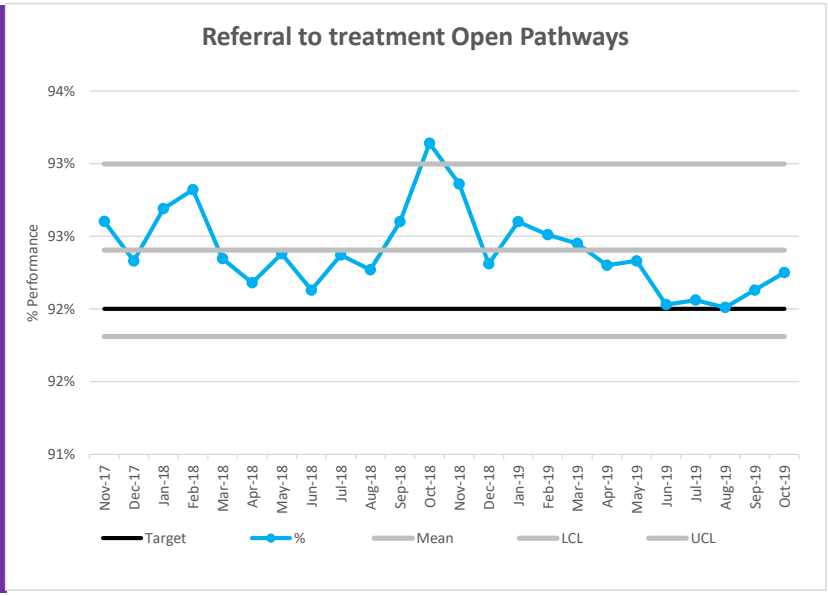
Quality Improvement - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Mixed Sex Accommodation Breaches Red: 1 or more Green: Zero	There were 6 mixed sex accommodation breaches reported in month. SPC - Mixed Sex Accommodation Breaches are within common cause (expected) variation.		There were 6 MSA breaches in October. National Trajectory: The Trust is above the national target of 0 by 6. In comparison to the 100 beaches in 2018/19 we have had 32 for 2019/20 year to date. A direct comparison to this months data last year was 18 breaches compared to the 6 in October 2019/20.	All breaches are in the Intensive Care Unit. Patients are cohorted to minimise breaches and step down is expedited as soon as is practicable. Patient experience continues to be rated highly.
Continuity of Carer Green: 30% or Above Amber: 20% - 29% Red: below 20%	The target percentage for women being booked onto a continuity of carer pathway in 2019 is at least 20%. The target by March 2020 is over 35%, and from March 2021, the target is over 51%. The Trust achieved 31.7% in October 2019.		The Trust achieved 31.7% in October 2019 against a target of 30%. Internal Variance Plan: The Trust is surpassing the target of 20% for the year 2019/20, but will need to increase to at least 35% by March 2020.	Plans to expand the service offer by in-reaching into Ingleside Birth Centre to offer services to care for these women as they would currently have to book in with services in Bolton for continuity of care. The Trust is currently liaising with the CCG regarding accessible funding for innovative care and is developing a business case for a CoC team for women with mental health issues or previous traumatic birth experiences.
CQC CQC Insight Composite Score Red (inadequate): <-3 Amber (req improvement): >-2.9 - 1.5 Green (good/outstanding): >1.5	The Trust CQC Insight Composite Score is -0.1.		Areas where the Trust has improved are in; Patient-led assessment of environment for dementia care, Proportion of reported patient safety incidents that are harmful, Safety Culture, Staff Engagement, Digital scores and Inpatient response rate.	The Moving to Outstanding Steering Group has been established to track and oversee the Trust response to the CQC inspection report and the Moving to Outstanding Framework within the organisation.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Key:
Single Oversight Framework
Care Quality Commission

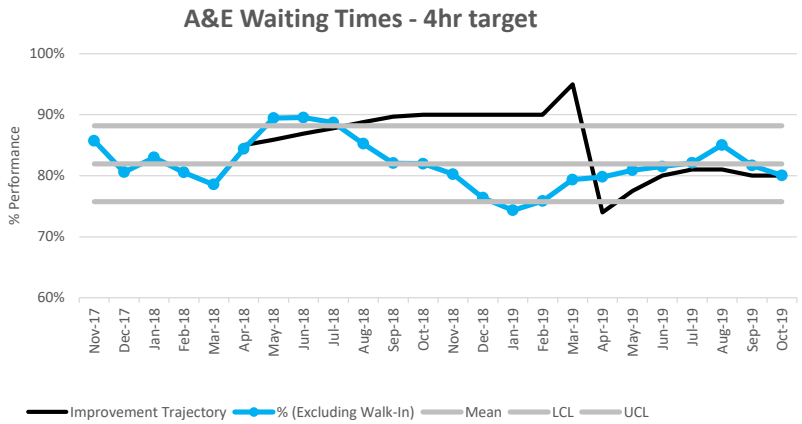
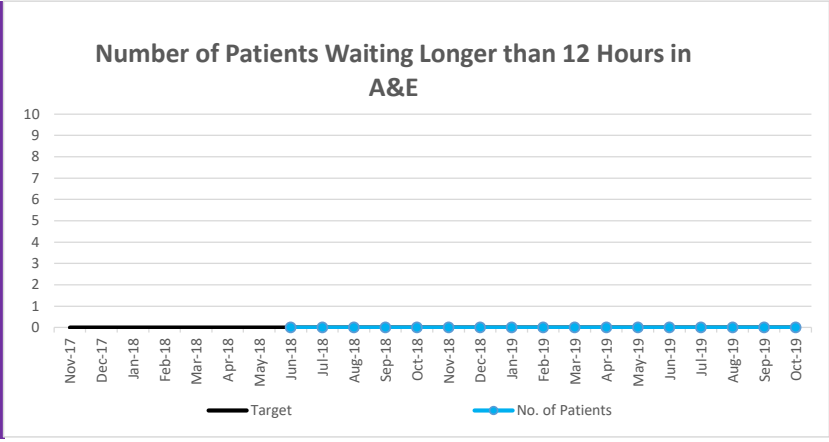
Access & Performance - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Diagnostic Waiting Times 6 Weeks Red: Less than 99% Green: 99% or above	The Trust achieved 99.95% in month. SPC - There has previously been evidence of special cause variation for Diagnostic Waiting Times however this has stabilised.		The 6 week diagnostic target was achieved in October 2019 and has been consistently achieved over the last 12 months, although pressures have increased whilst maintaining capacity within all modalities. This continues to be monitored on a daily basis with appropriate actions being taken to sustain this standard.	Maintain compliance against the diagnostic waiting times standard.
Referral to treatment Open Pathways Red: Less than 92% Green: 92% or above RTT - Number of patients waiting 52+ weeks Green = 0, otherwise Red	The Trust achieved 92.25% in month. SPC - RTT pathways are within common cause (expected) variation. The Trust has consistently achieved this standard.		The Trust continues to achieve the 18 week referral to treatment target, achieving 92.25% in October 2019 against a target of 92%. Trajectories have been developed for 2019/20 to maintain focus within all sub-specialties. The MSK team have developed a recovery plan for T/O and Specialist Surgery have one in place to address paediatrics. Both specialties aim to achieve compliance by the end of March 2020. This is being monitored weekly by the Performance Review Group.	WHH has consistently delivered the RTT standard over the last 45 consecutive months, and has not incurred any 52 week wait breaches. October 2019 has seen an increase in the numbers on the waiting list which is above the trajectory position. This is mainly related to an increase in referrals in the month as the team had already accounted for the non-uptake of WLI due to national pension issues. A deep dive review has been undertaken and an action plan completed. The RTT standard along with the Trust waiting list size is being monitored on a daily basis to ensure actions instigated are achieving as expected.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Key:
Single Oversight Framework SOF
Care Quality Commission CQC

Access & Performance - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Four Hour Standard - National Target Red: Less than 95% Green: 95% or Four Hour Standard Waiting Times - STP Trajectory Red: Less than trajectory	SOF CQC The Trust achieved 80.04% excluding walk ins in month. SPC - There is special cause variation present in the Four Hour A&E standard.		Performance against the ED emergency access continued to be challenged throughout October, however the performance excluding Widnes Walk-In activity met the agreed trajectory of 80.0%, achieving 80.04% in October 2019. Factors contributing to this include unavailability of assessment capacity (GPAU & ED Ambulatory) due to increased need for in-patient capacity.	A CQC action plan around Urgent Care has been developed and is monitored via the Urgent & Emergency Care Improvement Committee.
The number of patients who has experienced a wait in A&E longer than 12 hours from the decision to admit. Green = 0 Red = > 0	SOF There were 0 patients waiting longer than 12 hours in A&E in month.		The Trust has achieved the standard in not having any patients wait longer than 12 hours from the decision to admit in October 2019. This has been consistently achieved over time.	Maintain compliance against the 12 hour standard from decision to admit.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Key:
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Care Quality Commission

Access & Performance - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Cancer 14 Days Red: Less than 93% Green: 93% or above	This indicator has temporarily been removed from the Trust IPR due to the pilot for the 28 day faster cancer diagnosis standard.			
Breast Symptoms 14 Days Red: Less than 93% Green: 93% or above	This indicator has temporarily been removed from the Trust IPR due to the pilot for the 28 day faster cancer diagnosis standard.			

Warrington and Halton Hospitals NHS
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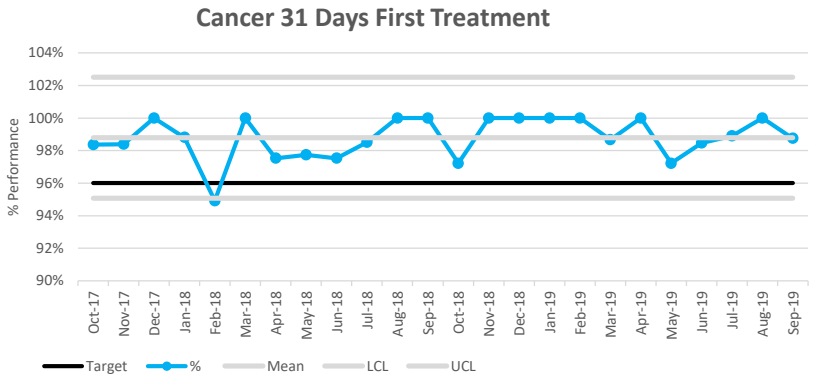
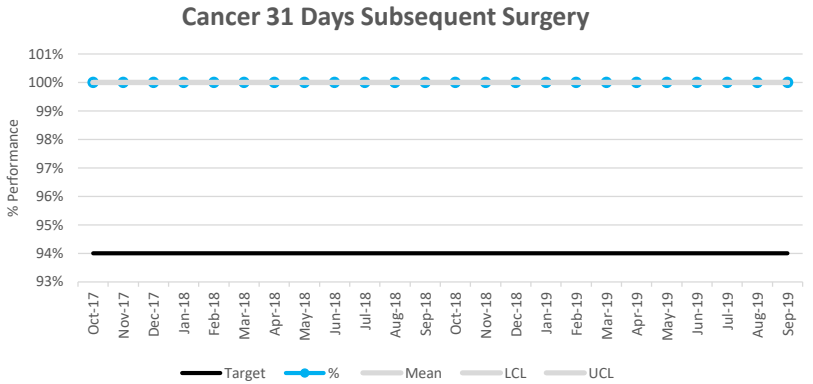
Access & Performance - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Cancer 31 Days First Treatment Red: Less than 96% Green: 96% or above	The Trust achieved 98.79% in September 2019. SPC - Cancer 31 days is within common cause (expected) variation.		The Trust achieved 98.79% in September 2019.	Maintain compliance against the 31 day first treatment standard.
Cancer 31 Days Subsequent Surgery Red: Less than 94% Green: 94% or above	The Trust achieved 100% in September 2019. SPC - Cancer 31 days surgery is within common cause (expected) variation. The Trust has consistently achieved this standard.		The Trust achieved 100% in September 2019.	Maintain compliance against the 31 day subsequent treatment (surgery) standard.

Warrington and Halton Hospitals NHS
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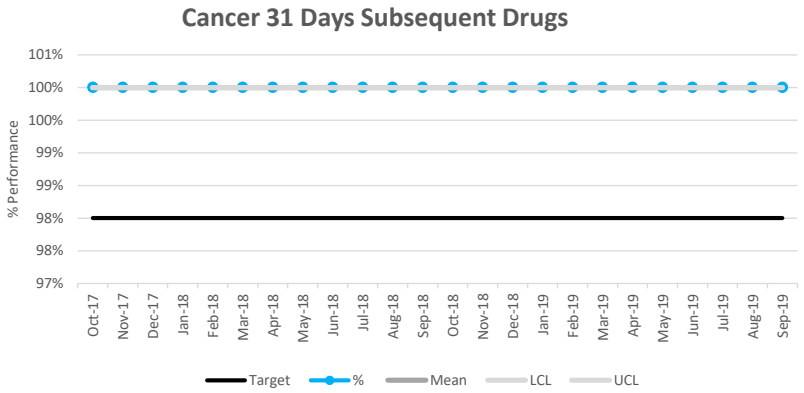
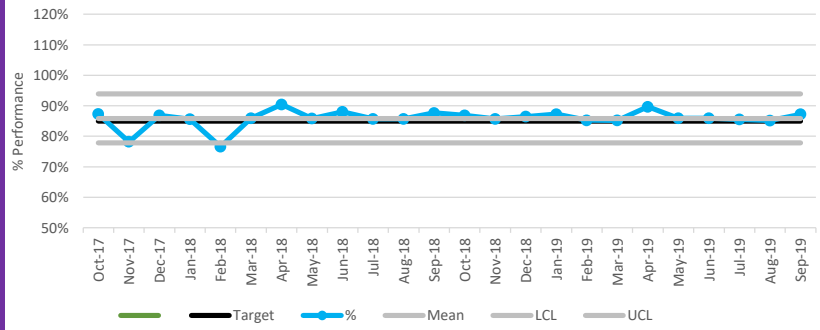
Key:
Single Oversight Framework
Care Quality Commission

Access & Performance - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Cancer 31 Days Subsequent Drug Red: Less than 98% Green: 98% or above	The Trust achieved 100% in September 2019. SPC - Cancer 31 days drugs is within common cause (expected) variation. The Trust has consistently achieved this standard.		The Trust achieved 100% in September 2019.	Maintain compliance against the 31 day subsequent treatment (drug) standard.
Cancer 62 Days Urgent Red: Less than 85% Green: 85% or above	The Trust achieved 87.23% in September 2019. SPC - Cancer 62 days urgent is within common cause (expected) variation.		The Trust achieved 87.23% in September 2019.	Maintain active monitoring of all pathways to maintain compliance against the 62 day standard. Positively, this standard has consistently achieved which has only been possible through full engagement with the CBU Teams and supportive leadership via the Cancer Team.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

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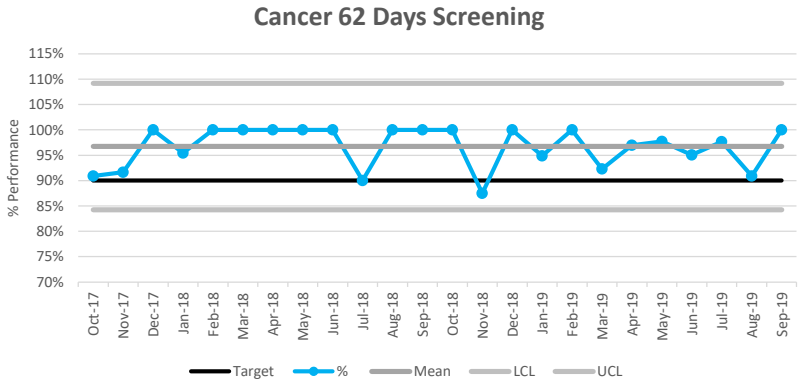
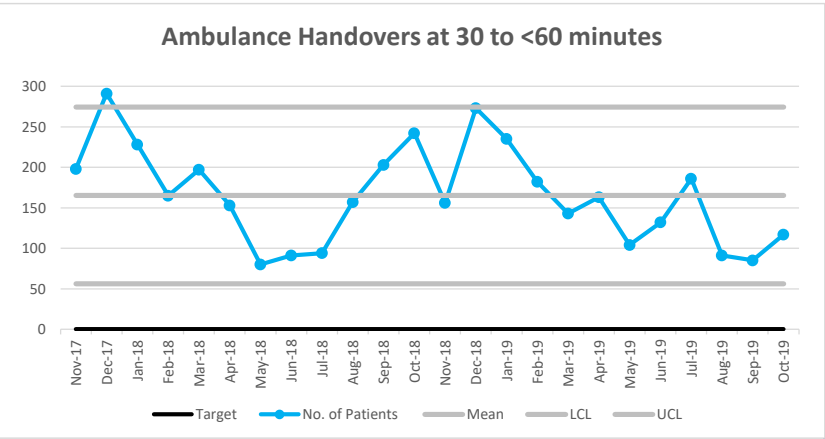
Care Quality Commission

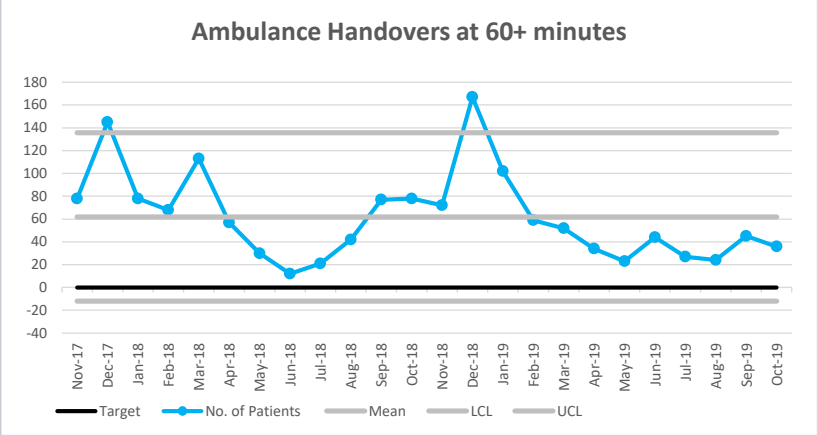
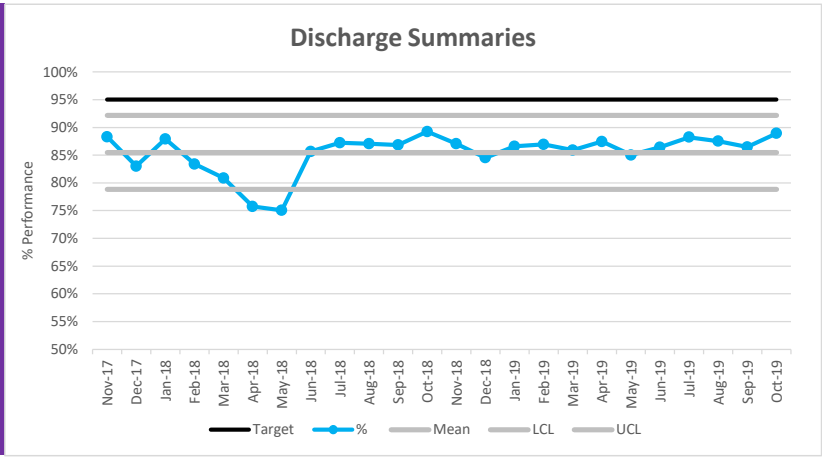
Access & Performance - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Cancer 62 Days Screening Red: Less than 90% Green: 90% or above	The Trust achieved 100% in September 2019. SPC - Cancer 62 days Screening are within common cause (expected) variation.		The Trust achieved 100% in September 2019.	Maintain compliance against the 62 day screening standard.
Ambulance Handovers 30 to <60 minutes Red: More than 0 Green: 0	There were 117 patients waiting between 30 and 60 minutes for handover in month. SPC - There has previously been special cause variation present for Ambulance Handover Times however this has stabilised.		Ambulances handovers remained challenging in October 2019 with a decline in performance for 30-60 min and improvement 60+ minute delays. The operational team continues to focus on maintaining and further improving performance by ensuring flow in the hospital is optimised thus allowing ambulances to off load in a timely manner.	The Trust is participating in an NWAS collaborative to improve handover times throughout the winter period. This commenced in November 2019.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Key:
Single Oversight Framework
Care Quality Commission

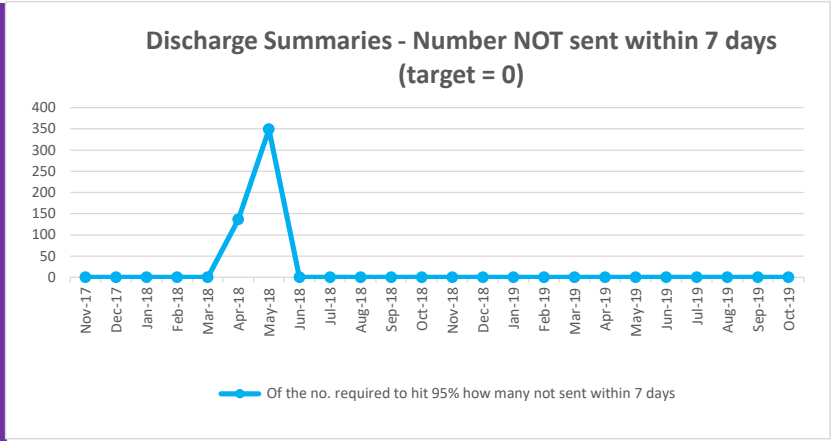
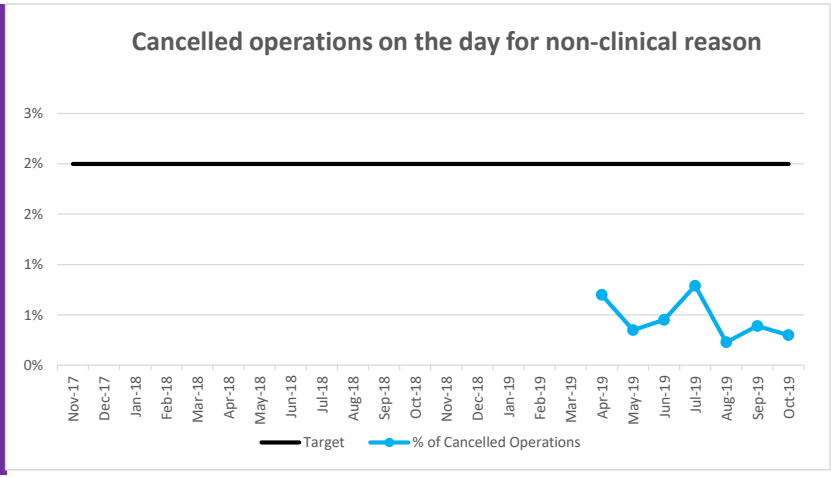
Access & Performance - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Ambulance Handovers at 60 minutes or more Red: More than 0 Green: 0	There were 36 patients waiting over 60 minutes for handover in month. SPC - There has previously been special cause variation present for Ambulance Handover Times however this has stabilised.		Ambulances handovers remained challenging in October 2019 with a decline in performance for 30-60 min and improvement 60+ minute delays. The operational team continues to focus on maintaining and further improving performance by ensuring flow in the hospital is optimised thus allowing ambulances to off load in a timely manner.	The Trust is participating in an NWAS collaborative to improve handover times throughout the winter period. This commenced in November 2019.
Discharge Summaries - % sent within 24hrs Red: Less than 95% Green: 95% or above	The Trust achieved 88.93% in month. SPC - There has previously been special cause variation in Discharge Summaries however this has stabilised.		The Trust continues to monitor compliance across all CBUs. This is monitored via the weekly PRG & monthly KPI meetings. An SoP has been in place however, this is being reviewed in conjunction with the medical teams to ensure effective processes are embedded.	This standard remains challenging for the Trust with performance remaining static in recent months. Although an SoP has been in place, a review has been requested via the monthly KPI forum in conjunction with the medical team to improve current processes and drive improvement.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Key:
Single Oversight Framework
Care Quality Commission

Access & Performance - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Discharge Summaries - Number NOT sent within 7 days Red: Above 0 Green: 0	There were 0 discharge summaries not sent within 7 days required to meet the 95% threshold.		The Trust achieved compliance against the 7 day discharge summary standard in October 2019.	The Trust KPI group will continue to monitor at CBU level to maintain performance against this standard.
Cancelled Operations on the day for a non-clinical reason Red: > 2% Green: < 2%	0.30% operations were cancelled on the day for non clinical reasons in month.		The Trust cancelled 0.30% of operations on the day for non-clinical reasons. Benchmarking would suggest that although the Trust continues to maintain a zero tolerance to cancellations, a rate of less than 2% compares favourably.	A dedicated sub-group of the Theatre Productivity Group to focus on reducing cancellations on the day remains in place focusing on the escalation process, reporting and validation. A deep dive into non-clinical cancellations to inform actions has been undertaken which is supporting improvement.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

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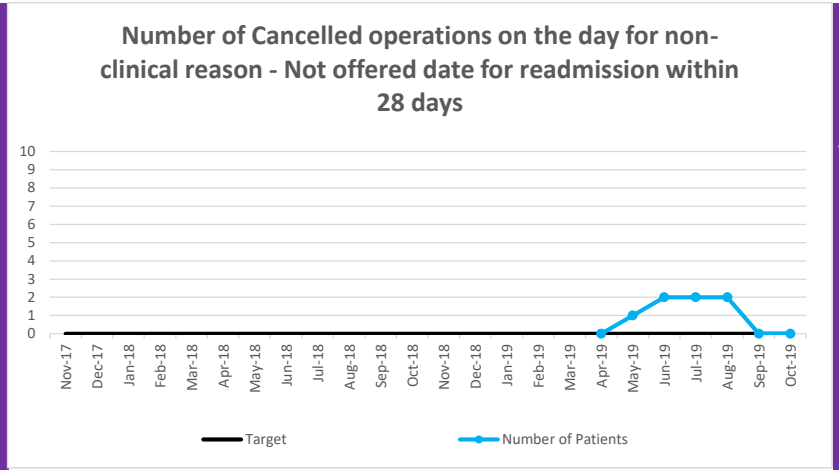
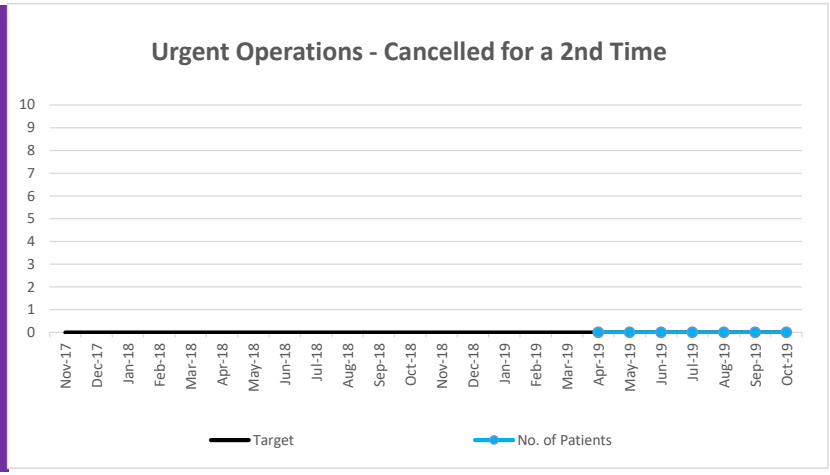
Care Quality Commission

Access & Performance - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Cancelled Operations on the day for a non-clinical reason - Not offered a date for readmission within 28 days of the cancellation Red: Above zero	There were 0 cancelled operations on the day for non clinical reasons in month, where the patient was not booked in within 28 days.		The Trust did not incur any breaches of the 28 day readmission standard within October 2019. This sustains the positive performance in the month of September 2019.	Maintain compliance against the 28 day readmission standard. Monitored via weekly PRG and monthly KPI meetings.
Urgent Operations - Cancelled for a 2nd Time Green = 0 Red = > 0	There were 0 urgent operations cancelled for a second time in month. The Trust has consistently achieved this standard.		This is an additional standard to enhance monitoring of cancelled operations.	Maintain the standard that operations are not cancelled for a second time.

Warrington and Halton Hospitals NHS
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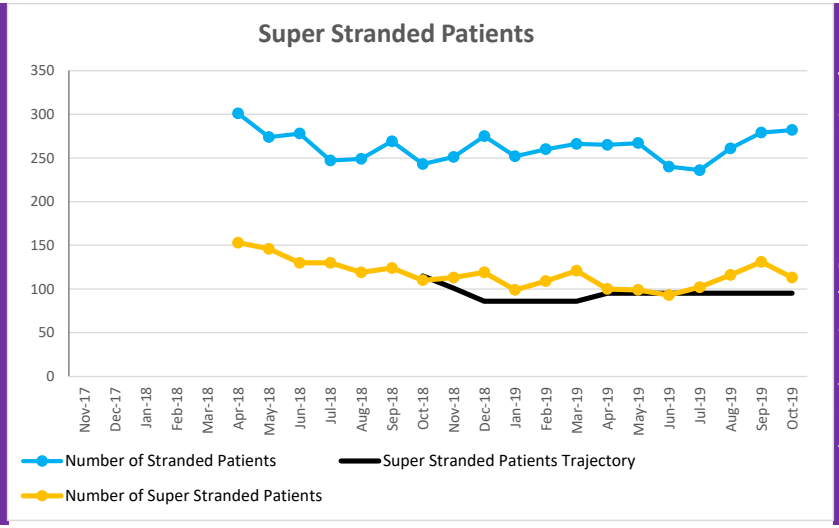
Access & Performance - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Super Stranded Patients Green: Meeting Trajectory Red: Missing Trajectory	There were 282 stranded and 113 super stranded patients at the end of the October 2019.		The numbers of patients categorised as super stranded patients improved in October however remains challenging. The previously reported staffing issues have improved; however, the domically care market has not seen the increase in workforce availability as expected. There has been a renewed drive to progress towards the required 40% reduction in long lengths of stay in line with the NHSI trajectory.	There has been a renewed drive in October including a Multi-Agency Discharge Event (MADE) to progress towards the required 40% reduction in long lengths of stay in line with the NHSI trajectory. Whilst the position is below trajectory, sustaining and this improvement is essential; the learning from this event is being embedded into the Trusts Long Length of Stay sustainability plan. In preparation for the winter, based on the successful MADE events, these will be followed by further corporately led Where Best Next events in December 2019 and January 2020.

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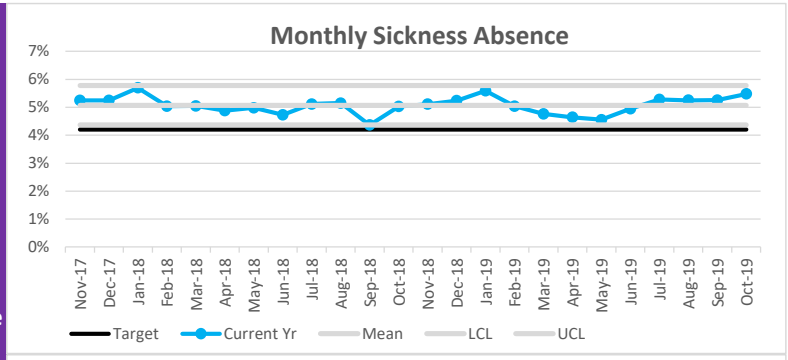
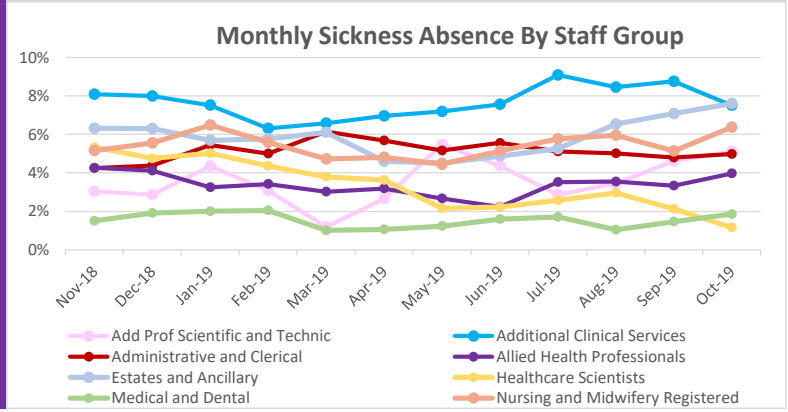
	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Sickness Absence Red: Above 4.5% Amber: 4.2% to 4.5% Green: Below 4.2%	The Trust's sickness absence was 5.48% in month. SPC - Sickness Absence is within common cause (expected) variation.	 	Sickness absence has increased in month. This is in line with seasonal trends, however absence is higher than the same period in the previous year. There continues to be high sickness absence amongst the Additional Clinical Services staff group. There has also been a significant increase in the Estates and Ancillary staff group in recent months. Mental health and Musculoskeletal health remain key reasons for sickness absence.	The HR&OD team have used the NHSE/I endorsed Health & Wellbeing Partnership framework to undertake a high level gap analysis in order to identify immediate actions to improve attendance. A number of initiatives are being piloted using a PDSA approach as advocated in the framework. A full impact evaluation will be undertaken in January 2019, which will feed into a Trust-wide employee engagement and wellbeing strategic plan including a detailed wellbeing diagnostic and health needs assessment of the workforce. In addition, the Trust is investing in a employee assistance programme which will enable the Occupational Health team to implement a four tier mental health provision, including the introduction of Schwartz rounds in Q3/4.

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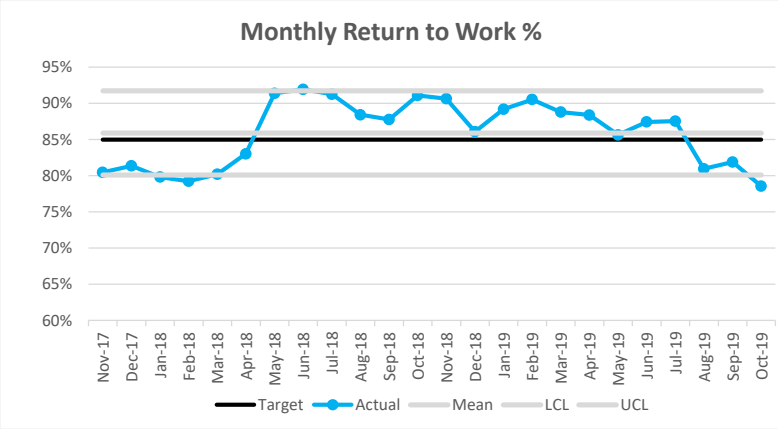
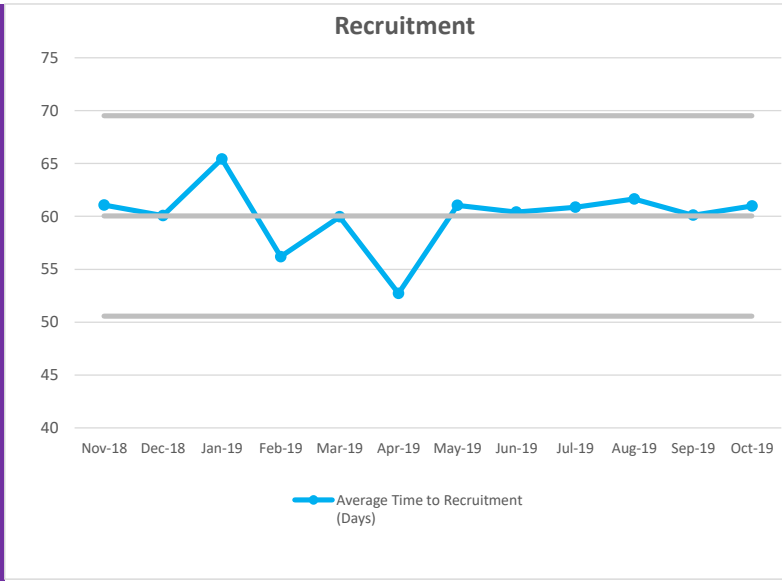
	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Return to Work Red: Below 75% Amber: 75% to 85% Green: Above 85%	The Trust's return to work compliance was 78.57% in month. SPC - There is evidence of special cause variation for Return to Work compliance.		The late and retrospective recording of return to work interviews impacts on the monthly reporting position. Local spot checks have confirmed that return to work interviews are being completed but not recorded in a timely manner.	A review of essential manager training has been completed and now includes information about the importance of the timeliness of policy application. The revised training also includes a session on 'Difficult Conversations' to help managers feel confident in completing RTWIs and to get the best out of the interviews. There is 1:1 Coaching by the HRBP team with line managers on an ongoing basis.
Recruitment Red: 76 days or above Amber: 66 to 76 days Green: 65 days or below	The average number of working days to recruit is 61, based on the last 12 months average. SPC - Recruitment time is within common cause (expected) variation.		Average time to hire has remained below the 65 day standard.	Improving recruitment processes and reducing time to hire – a task and finish group has been set up to review our current processes, in order to identify and suggest improvements. The group are currently working with recruiting managers and new employees to understand their perceptions of the current process. The group is also reviewing the diversity and inclusivity of our recruitment processes. Feedback collected from new employees in general praises the seamless process, with the overwhelming request to offer a flexible approach to collecting information. In the longer term, we plan to work with IM&T colleagues to improve the on-boarding system for our new candidates - moving it online.

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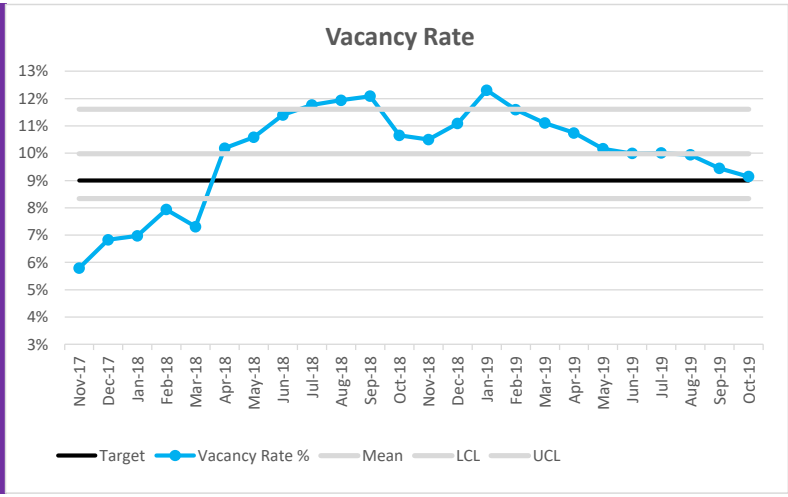
Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Trust vacancy rate was 9.14% in month. SPC - there is evidence of special cause variation for Vacancy Rates.		The continued reduction in vacancy rate is linked to improved retention/turnover and overall improvements in average time to hire.	The Trust's Recruitment and Retention Group continue to focus on opportunities to increase attraction and recruitment through work streams such as the development of the 'Work at WHH' website, improved recruitment open days, career clinics and international recruitment. In addition, the Workforce Redesign Group has an overview of the Workforce Planning process which supports CBUs to identify opportunities to utilise their workforce differently in order to address labour market challenges.

Vacancy Rates

Red: 11% or Above
Amber: 11% to 9%
Green: 9% or Below

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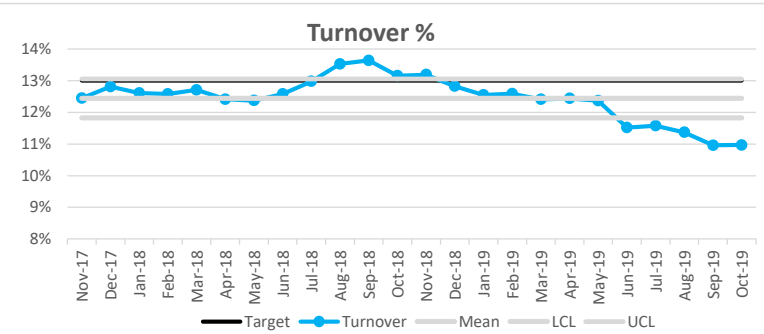
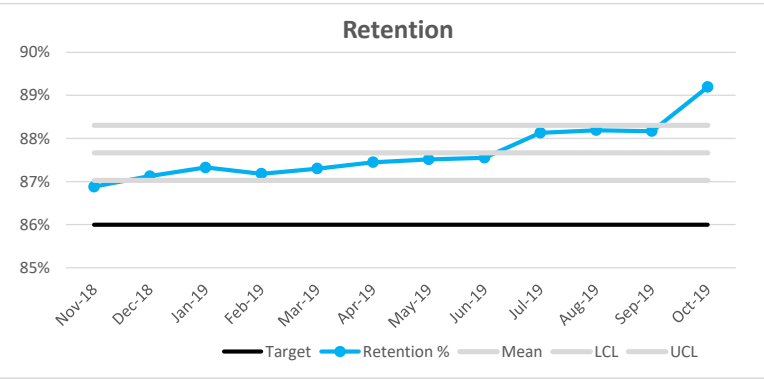
	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Turnover Red: Above 15% Amber: 13% to 15% Green: Below 13%	Trust turnover was 10.97% in month. SPC - There is evidence of special cause variation for Turnover.		Turnover has remained below target (positive) . This is linked to improved employee engagement (as evidenced by the 2018 Staff Survey results and pulse check survey results) and to the work commenced as part of the NHSI Retention Programme.	The programme of work to implement the NHSI nursing retention programme and roll out to other staff groups includes: • Improve our workforce's ability to achieve a better work life balance through promoting what we offer and reviewing our processes/policies. • Support our staff to explore and pursue career progression within the Trust. Careers cafés have been set up throughout the year promoting development and career opportunities. • The promotion of the Recognising and Valuing Experience (RAVE) role/initiative. • Develop and empower our Line Manager's to retain their staff through developing our managers. • Developing the R&R Champions role, so they are able to support our Manager's in both Recruitment and Retention. • Improving our retire and return options/promotion through the Pre-Retirement courses
Retention Red: Below 80% Amber: 80% to 85% Green: Above 86%	Trust Retention was 89.19% in month. SPC - There is evidence of special cause variation for Retention.			

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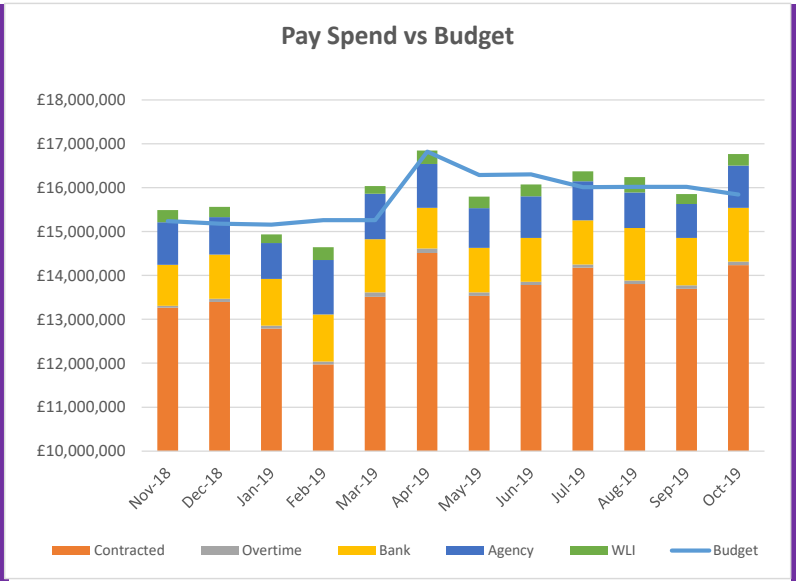
	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Pay Red: Greater than Budget Green: Less than Budget	Trust pay was £0.1m above budget in month.		Total pay spend in month was £16.76m against a budget of £15.8m Contracted pay spend was £14.23m and the remaining £2.53m was spent on temporary staffing including agency, bank, overtime and WLIs.	Additional controls and challenge around pay spend have been identified, to support a reduction in premium pay: • Monthly deep dives into Nursing Agency, supported by NHS Professionals; • Enhanced ECF process for non-clinical vacancies; • Expanded ECF process for some temporary staffing pay spend; • Implementation of Cheshire and Mersey Rate Cards; • Implementation of consistent additional hours rates for Medical Staff; • Introduction of Patchwork Medical Bank system; • Review of all long term locums, led by the Chief Operating Officer; • Review and action of pay elements within NHSI/E Grip and Control Checklist.

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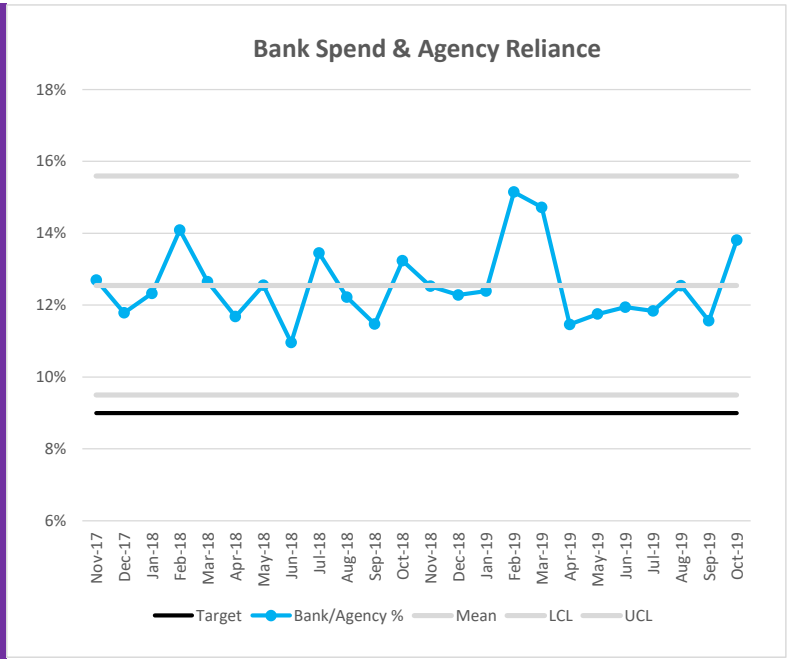
Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
UoR Bank and Agency Reliance reduced to 13.81% in month. SPC - Bank/Agency reliance is within common cause (expected) variation.		The most common reason for temporary staffing usage across all staff groups is vacancy.	The Bank and Agency team has refined the agency booking processes, currently being managed through a centralised team. Since the central team went live cost avoidance of £338k has been achieved, based on negotiated rates, recruitment onto the bank, removing the requirement for an agency worker and a lower admin fee for using +US agency engagement system. Actions outlined above relating to nursing attraction, recruitment and retention will positively impact this indicator, as substantive posts are filled. In order to reduce agency spend through increased bank fill rate, a business case has been approved to work with Patchwork, a provider of specialist Medical Bank Management software. The ambition is to increase Medical bank fill rates to 60% to 80%.

Bank and Agency Reliance

Red: 11% or Above
Amber: 11% to 9%
Green: 9% or Below

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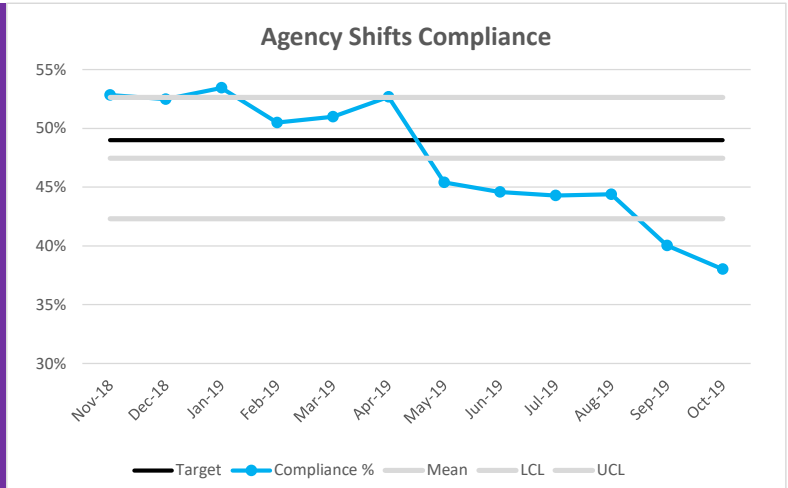
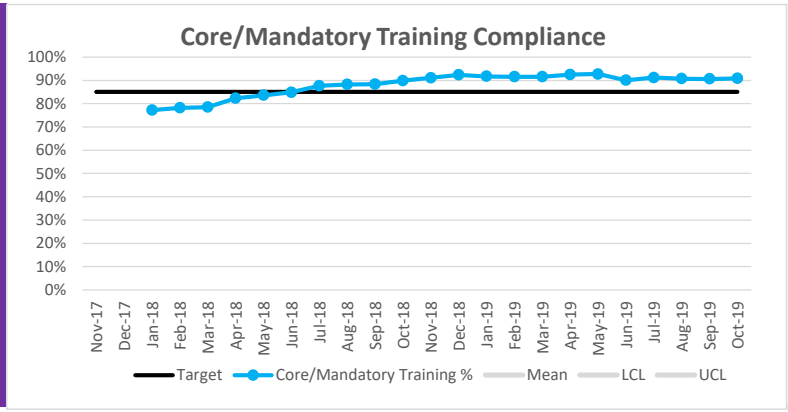
	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Agency Shifts Compliant with the Cap Red: below 49% Green: above 49%	38.03% of shifts were compliant with the NHSI Price Cap. SPC - Agency shift compliance is within common cause (expected) variation.		The majority of shifts that are not compliant with the NHSI Price Cap relate to Medical and Dental agency bookings.	As described above the central bank and agency team continue to negotiate rates down towards the NHSI Price Cap compliance, however 98% of Medical shifts worked are above the Price Cap, compared to 42% of Nursing shifts and 57% of AHPs/Scientific shifts. The national compliance is currently 49%. Increasing medical bank usage will support improving the compliance. The Trust is part of the Cheshire and Mersey Collaborative group, which has been working to create a new rate card (Medical and Dental Staff) for implementation across the region. Whilst these will initially be higher than the cap rates, there will be a step change towards the cap rates.
Core/Mandatory Training Red: Below 70% Amber: 70% to 85% Green: Above 85%	Core/Mandatory training compliance was 90.86% in month.		Mandatory Training compliance has remained above target (positive) since June 2018. The Trust approach to Mandatory Training has been reviewed and expectations clarified. Compliance with Mandatory Training has now become 'business as usual' for staff and managers.	Compliance with Mandatory Training is closely monitored at CBU/Department and topic level via Educational Governance Committee and by Subject Matter Experts.

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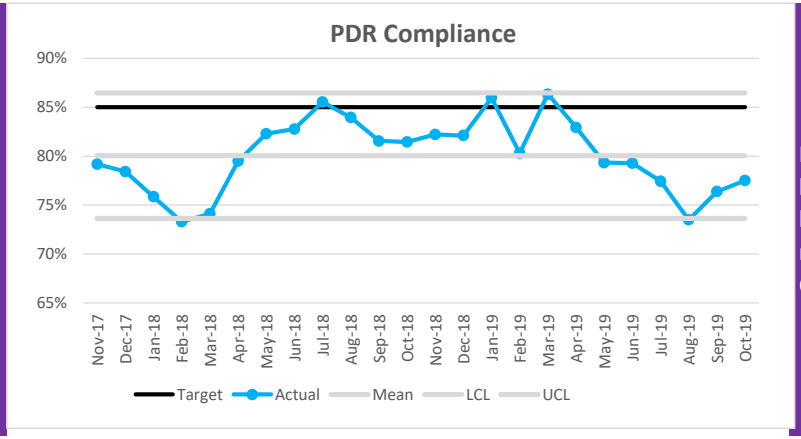
PDR Red: Below 70% Amber: 70% to 85% Green: Above 85%		PDR compliance continues to be below the Trust target, although has increased in month, reflecting communications at CBU and Departmental level.	HR Business Partners continue to work with the CBU managers to further improve PDR compliance. A new appraisal tool has been drafted with engagement from staff across the workforce, the focus is on little paperwork, big conversation. This will be piloted in November 2019 using a Plan Do Study Act (PDSA) test of change cycle.
PDR compliance was 77.50% in month. SPC - there is evidence of special cause variation for PDR compliance.			

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Finance & Sustainability - Trust Position

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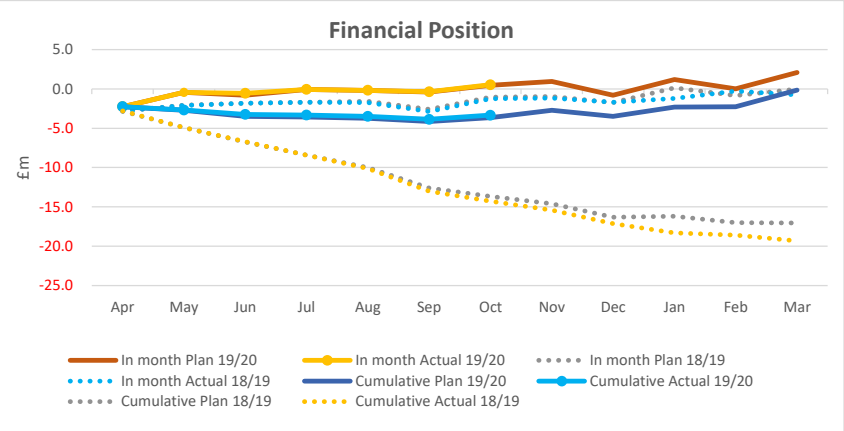
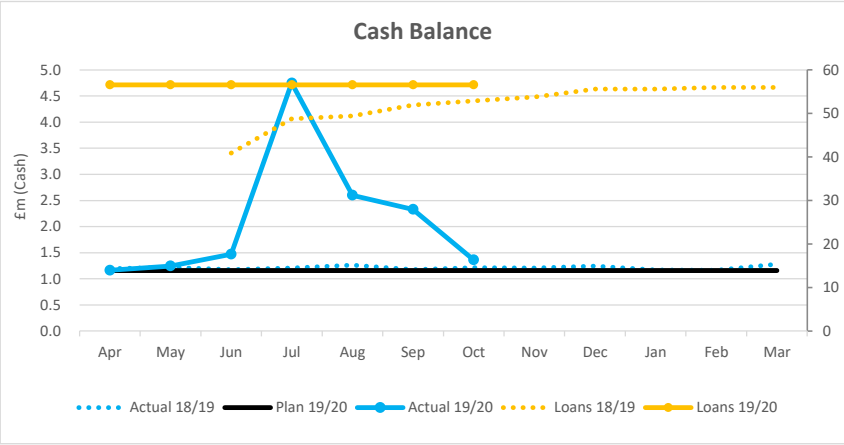
Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Financial Position Red: Deficit Position Amber: Actual on or better than planned but still in deficit Green: Surplus Position		The cumulative deficit of £3.3m is £0.3m better than plan. The monthly control total (excluding Provider Sustainability, Financial Recovery and Marginal Rate Emergency Tariff funding) is a £11.6m deficit which £0.1m better than plan.	The Trust continues to work with commissioners and providers across the local healthcare system to develop a recovery plan. The Trust continues to drive improvements by working closely with CBUS and Corporate Divisions to manage financial performance.
Cash Balance Red: Less than 90% or below minimum cash balance per NHSI Amber: Between 90% and 100% of planned cash balance Green: On or better than plan		The current cash balance of £1.4m is £0.2m better than plan.	To support all CBUs and Corporate Divisions to improve the operating position which will result in improved cash position. Cash is monitored on a daily basis and an annual cash plan is supported by a rolling 13 week plan. All debtors are actively pursued to support liquidity.

The actual surplus in the month is £0.5m which reduces the year to date deficit to £3.3m.

The current cash balance is £1.4m (equates to circa 2 days operational cash).

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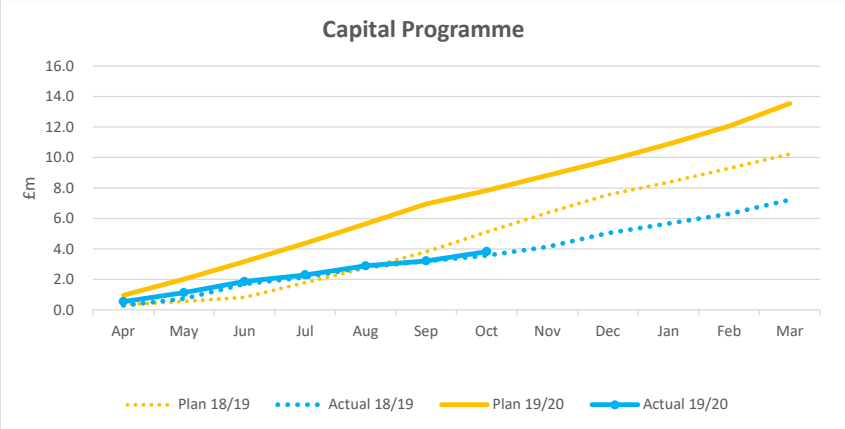
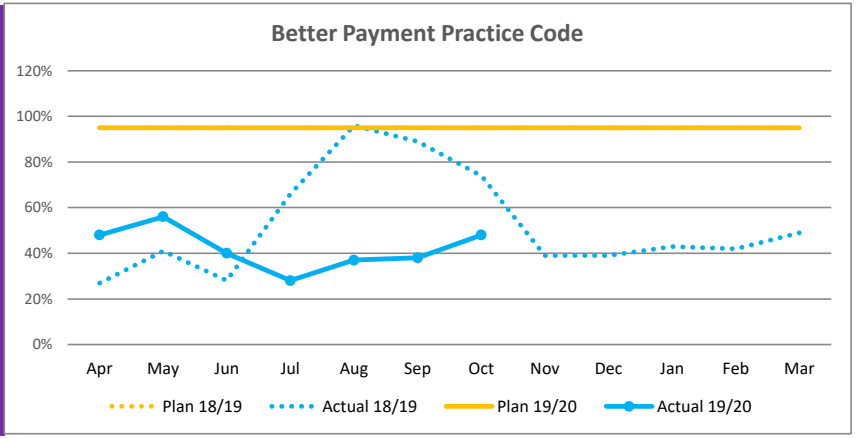
Capital Programme Red: Off plan <80% - >110% Amber: Off plan 80-90% or 101 - 110% Green: On plan 90%-100%			
UoR SOF The actual capital spend in the month is £0.6m which increases the year to date spend to £3.8m.		The cumulative capital spend of £3.8m is £4.0m below the planned capital spend of £7.8m. This is due to an underspend against the Kendrick Wing Fire Scheme, Estates and Medical Equipment schemes.	To monitor, report and manage capital planning and spend through the Capital Planning Group to ensure the most effective use of the limited capital resource.
Better Payment Practice Code Red: Cumulative performance below 85% Amber: Cumulative performance between 85% and 95% Green: Cumulative performance 95% or better			
UoR SOF In month the Trust has paid 48% of suppliers within 30 days which increases the year to date performance to 39%.		The cumulative performance of 39% is 56% below the national standard of 95%, this is due to the cash balance and the need to manage cash very closely.	The operating position results in a challenging cash position which makes it difficult to pay all invoices within the recommended target, however invoices are paid as promptly as possible to avoid additional interest charges.

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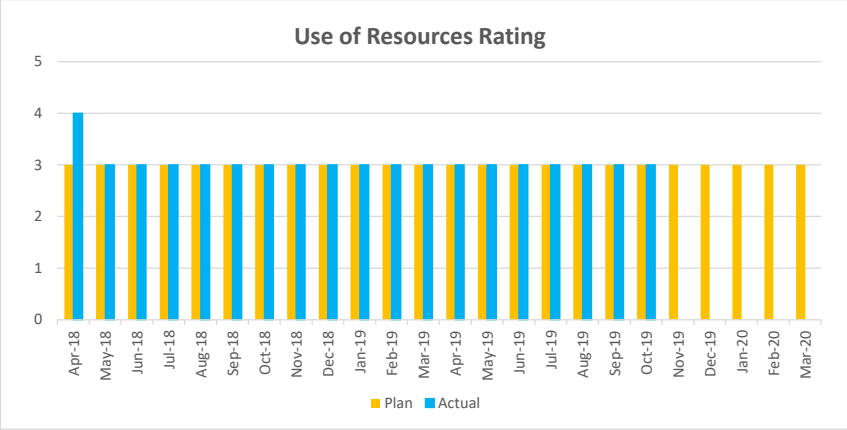
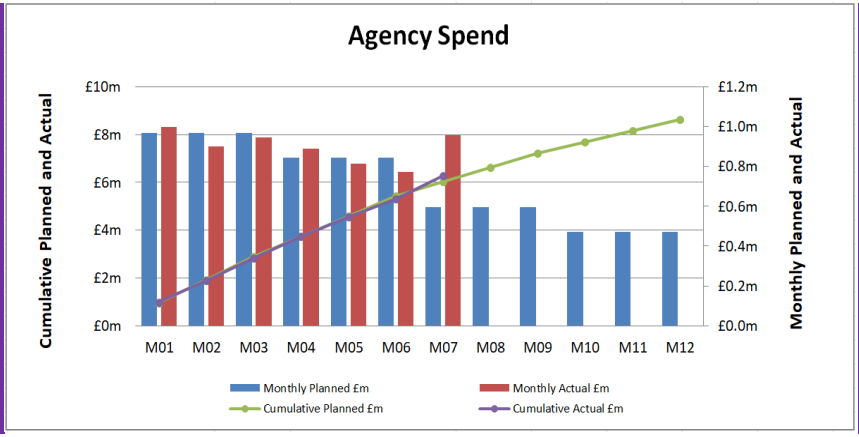
Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
UoR SOF The current Use of Resources Rating is 3 (Capital Servicing Capacity, Liquidity, I&E margin are 4, Agency Ceiling is 2 and Distance from Financial Plan is 1).		The current Use of Resources Rating of 3 which is the planned rating.	To monitor, report and manage financial performance to improve all Use of Resources metrics and achieve the planned rating of 3.
UoR SOF The actual agency spend in the month is £1.0m which increases the year to date spend to £6.3m.		The cumulative spend of £6.3m is £0.3m above the cumulative agency ceiling of £6.0m.	To monitor and report the use and spend of agency and use VAT efficient models to reduce costs. The Trust is part of a Cheshire & Mersey collaborative that is working to establish a standard rate card across all staff groups and specialties to reduce rates and is enhancing processes and controls to ensure appropriate and best use of agency staff.

Use of Resources Rating
Red: Use of Resource Rating 4
Amber: Use of Resource Rating 3
Green: Use of Resource Rating 1 and 2

Agency Spending

Red: More than 105% of ceiling
Amber: Over 100% but below 105% of ceiling
Green: Equal to or less than agency ceiling.

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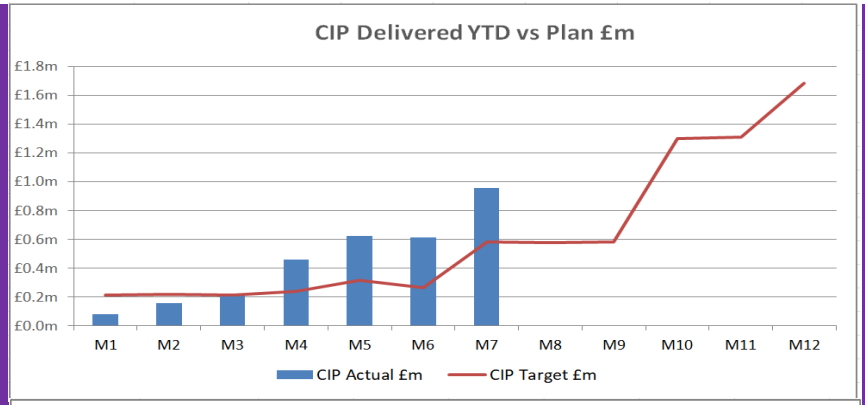
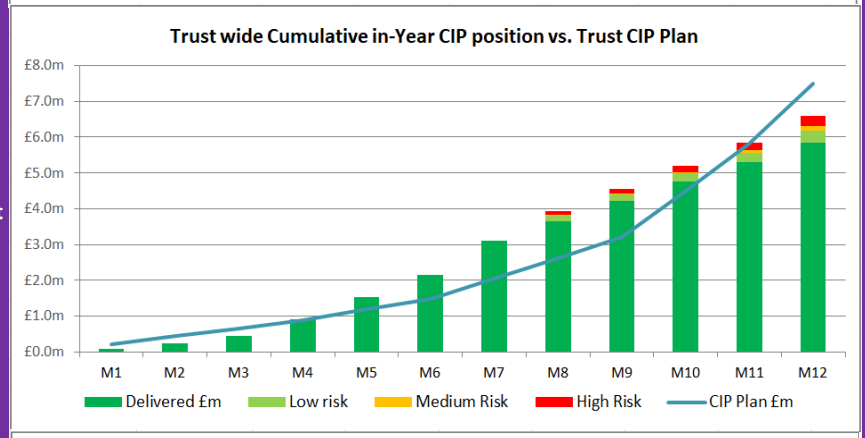
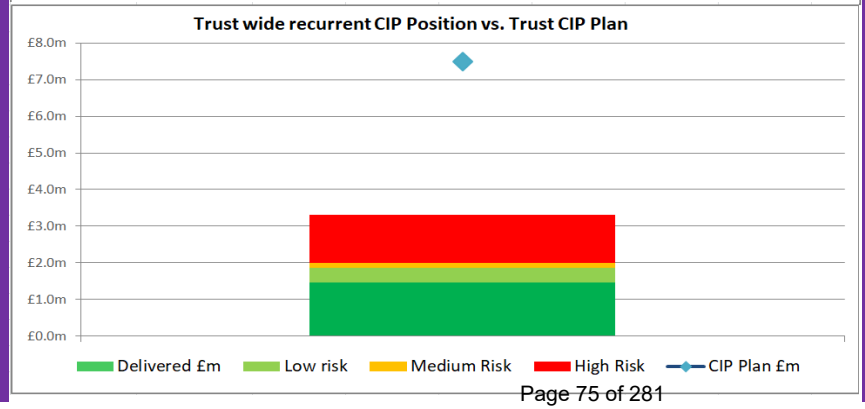
Cost Improvement Programme - In year performance to date Red: 0-70% Plan delivered YTD Amber: 70-90% Plan delivered YTD Green: >90% Plan delivered YTD		The monthly savings are £1.0m which increases the year to date savings to £3.1m.	The cumulative savings are £3.1m which is £1.0m above the £2.1m plan.
Cost Improvement Programme - Plans in Progress - In Year Red: Forecast is less than 50% of annual target Amber: Forecast is between 50% and 90% of the annual target Green: Forecast is more than 90% of the annual target		Best case In-year forecast for CIP is £6.6m (88% of target).	Best case In-Year forecast for CIP is £6.6m which is £0.9m below the £7.5m target.
Cost Improvement Programme - Plans in Progress - Recurrent Red: Forecast is less than 50% of annual target Amber: Forecast is between 50% and 90% of the annual target Green: Forecast is more than 90% of the annual target		Best case Recurrent forecast for CIP is £3.3m (44% of target).	In month recurrent CIP reduced by £1.1m to £3.3m. This mainly relates to the removal of the spinal activity income generation scheme. This increases the 2020/21 cost savings requirement by £1.1m.

To support all CBUs and Corporate Divisions with schemes utilising all tools and benchmarking information available such as Model Hospital, GIRFT, NHSI support. CIP progress is reviewed on a weekly and monthly basis. Where possible, the Trust seeks to accelerate schemes and is reviewing additional areas to support further cost reductions.

Appendix 3 – Trust IPR Indicator Overview

Indicator	Detail
Quality	
Incidents	Number of Serious Incidents and actions breached. Number of open incidents is the total number of incidents that we have awaiting review. As part of the 2018 - 2021 Trust Quality Strategy, the Trust has pledged to Increase Incident Reporting to ensure that we don't miss opportunities to learn from our mistakes and make changes to protect patients from harm.
CAS Alerts	The Central Alerting System (CAS) is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and others, including independent providers of health and social care. Timescales are individual dependent upon the specific CAS alerts.
Duty of Candour	Every healthcare professional must be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress. Duty of Candour is where we contact the patient or their family to advise of the incident; this has to be done within 10 working days. Duty of Candour must be completed within 10 working days.
Adult, Children's and Maternity Safety Thermometer	Measures % of adult patients who received "harm free care" defined by the absence of pressure ulcers, falls, catheter-acquired UTI's and VTE (Safety Thermometer). Children's and Maternity data has been requested. Measures % of child patients who have received an appropriate PEWS (paediatric early warning score), IV observation, pain management, pressure ulcer moisture lesion. Measures % of maternity patients who received "harm free care" in relation to defined by proportion of women that had a maternal infection, 3rd/4th perineal trauma, that had a PPH of more than 1000mls, who were left alone at a time that worried them, term babies born with an Apgar of less than 7 at 5 minutes, mother and baby separation and women that had concerns about safety during labour and birth not taken seriously.
Healthcare Aquired Infections (MRSA, CDIFF and Gram Negative)	Methicillin-resistant Staphylococcus aureus (MRSA) is a bacterium responsible for several difficult-to-treat infections in humans. Those that are sensitive to methicillin are termed methicillin susceptible Staphylococcus aureus (MSSA). Clostridium difficile, also known as C. difficile or C. diff, is a bacterium that can infect the bowel. Escherichia coli (E-Coli) bacteraemia which is one of the largest gram negative bloodstream infections. MRSA - National objective is zero tolerance of avoidable MRSA bacteraemia. If breached a £10,000 penalty in respect of each incidence in the relevant month. MSSA - Has no National objective set by public health. Clostridium Difficule (c-diff) due to lapses in care; agreed threshold is <=27 cases per year. E-Coli, Klebsiella, Pseudomonas aeruginosa - A national objective has been set to reduce gram negative bloodstream infections (GNBSI) by 50% by March 2021.
Total Falls & Harm Levels	Total number of falls per month and their relevant harm levels (Inc Staff Falls).
Pressure Ulcers	Pressure ulcers, also known as pressure sores, bedsores and decubitus ulcers, are localised damage to the skin and/or underlying tissue that usually occur over a bony prominence as a result of pressure, or pressure in combination with shear and/or friction.

Medication Safety	Overview of the current position in relation to medication, to include; medication reconciliation, controlled drugs incidents and medication incidents relating to harm.
Staffing Average Fill Levels	Percentage of planned verses actual for registered and non-registered staff by day and night. Target of >90%. The data produced excludes CCU, ITU and Paediatrics.
Care Hours Per Patient Day (CHPPD)	Staffing Care Hours Per Patient Per Day (CHPPD). The data produced excludes CCU, ITU and Paediatrics.
HSMR Mortality Ratio	Hospital Standardised Mortality Ratio (HSMR 12 month rolling). The HSMR is a ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in-hospital deaths (multiplied by 100) for 56 specific Clinical Classification System (CCS) groups.
SHMI Mortality Ratio	Summary Hospital-level Mortality Indicator (SHMI 12 month rolling). SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.
NICE Compliance	The National Institute for Health and Clinical Excellence (NICE) is part of the NHS and is the independent organisation responsible for providing national guidance on treatments and care for people using the NHS in England and Wales and is recognised as being a world leader in setting standards for high quality healthcare and are the most prolific producer of clinical guidelines in the world.
Complaints	Overall review of the current complaints position, including; Number of complaints received, number of dissatisfied complaints, total number of open complaints, total number of cases over 6 months old, total number of cases in backlog where they have breached timeframes, number of cases referred to the Parliamentary and Health Service Ombudsman and the number of complaints responded to within timeframe.
Friends and Family Test (Inpatient & Day Cases)	Percentage of Inpatients and day case patients recommending the Trust. Patients are asked - How likely are you to recommend our ward to friends and family if they needed similar care or treatment?
Friends and Family (ED and UCC)	Percentage of AED (Accident and Emergency Department) patients recommending the Trust: Patients are asked - How likely are you to recommend our AED to friends and family if they needed similar care or treatment?
CQC Insight Composite Score	The CQC Insight report measures a range of performance metrics and gives an overall score based on the Trust's performance against these indicators. This is the CQC Insight Composite Score.
Continuity of Carer	Better Births, the report of the National Maternity Review, set out a clear recommendation that the NHS should roll out continuity of carer, to ensure safer care based on a relationship of mutual trust and respect between women and their midwives. This relationship between care giver and receiver has been proven to lead to better outcomes and safety for the woman and baby, as well as offering a more positive and personal experience.
Access & Performance	
Diagnostic Waiting Times – 6 weeks	All diagnostic tests need to be carried out within 6 weeks of the request for the test being made. The national target is 99% or over within 6 weeks.

	This metric also forms part of the Trust's Sustainability and Transformation Plan (STP) Improvement trajectory. The proposed tolerance levels applied to the improvement trajectories are also illustrated.
RTT Open Pathways and 52 week waits	Percentage of incomplete pathways waiting within 18 weeks. The national target is 92% This metric also forms part of the Trust's STP Improvement trajectory. The proposed tolerance levels applied to the improvement trajectories are also illustrated.
Four hour A&E Target and STP Trajectory	All patients who attend A&E should wait no more than 4 hours from arrival to admission, transfer or discharge. The national target is 95% This metric also forms part of the Trust's STP improvement trajectory. The proposed tolerance levels applied to the improvement trajectories are also illustrated.
A&E Waiting Times Over 12 Hours (Decision to Admit to Admission)	The number of patients who has experienced a wait in A&E longer than 12 hours.
Cancer 14 Days	All patients need to receive first appointment for cancer within 14 days of urgent referral. The national target is 93%. This target is measured and reported on a quarterly basis.
Breast Symptoms – 14 Days	All patients need to receive first appointment for any breast symptom (except suspected cancer) within 14 days of urgent referral. The national target is 93%. This target is measured and reported on a quarterly basis.
Cancer 31 Days - First Treatment	All patients to receive first treatment for cancer within 31 days of decision to treat. This national target is 96%. This target is measured and reported on a quarterly basis.
Cancer 31 Days - Subsequent Surgery	All patients to receive a second or subsequent treatment for cancer within 31 days of decision to treat/surgery. The national target is 94%. This target is measured and reported on a quarterly basis.
Cancer 31 Days - Subsequent Drug	All patients to receive a second or subsequent treatment for cancer within 31 days of decision to treat – anti cancer drug treatments. The national target is 98%. This target is measured and reported on a quarterly basis.
Cancer 62 Days - Urgent	All patients to receive first treatment for cancer within 62 days of urgent referral. The national target is 85%. This metric also forms part of the Trust's STP Improvement trajectory. The proposed tolerance levels applied to the improvement trajectories are also illustrated.
Cancer 62 Days – Screening	All patients must wait no more than 62 days from referral from an NHS screening service to first definitive treatment for all cancers. The national target is 90%. This target is measured and reported on a quarterly basis.
Ambulance Handovers 30 – 60 minutes	Number of ambulance handovers that took 30 to <60 minutes (based on the data record on the HAS system).
Ambulance Handovers – more than 60 minutes	Number of ambulance handovers that took 60 minutes or more (based on the data record on the HAS system).
Discharge Summaries – Sent within 24 hours	The Trust is required to issue and send electronically a fully contractually complaint Discharge Summary within 24 hrs of the patients discharge. This metric relates to Inpatient Discharges only.
Discharge Summaries – Not sent within 7 days	If the Trust does not send 95% of discharge summaries within 24hrs, the Trust is then required to send the difference between

	the actual performance and the 95% required standard within 7 days of the patients discharge.
Cancelled operations on the day for non-clinical reasons	% of operations cancelled on the day or after admission for non-clinical reasons.
Cancelled operations on the day for non-clinical reasons, not rebooked in within 28 days	All service users who have their operation cancelled on the day or after admission for a non-clinical reason, should be offered a binding date for readmission within 28 days.
Urgent Operations – Cancelled for a 2nd Time	Number of urgent operations which have been cancelled for a 2nd time.
Super Stranded Patients	Stranded Patients are patients with a length of stay of 7 days or more. Super Stranded patients are patients with a length of stay of 21 days or more. The number relates to the number of inpatients on the last day of the month.
Workforce	
Sickness Absence	Comparing the monthly sickness absence % with the Trust Target (4.2%) previous year, and peer average.
Return to Work	A review of the completed monthly return to work interviews.
Recruitment	A measurement of the average number of days it is taking to recruit into posts. It also shows the average number of days between the advert closing and the interview (target 10) to measure if we are taking too long to complete shortlisting and also highlights the number of days for which it takes successful candidates to complete their pre-employment checks.
Vacancy Rates	% of Trust vacancies against whole time equivalent.
Retention	Staff retention rate % over the last 12 months.
Turnover	A review of the turnover percentage over the last 12 months.
Bank & Agency Reliance	Trust reliance on bank/agency staff against the peer average.
Agency Shifts Compliant with the Price Cap	% of agency shifts compliant with the Trust cap against peer average.
Pay Spend – Contracted and Non-Contracted	A review of Contracted and Non-Contacted pay against budget.
Core/Mandatory Training	A summary of the Core/Mandatory Training Compliance, this includes: Conflict Resolution, Equality & Diversity, Fire Safety, Health & Safety, Infection Prevention & Control, Information Governance, Moving & Handling, PREVENT, Resuscitation and Safeguarding.
Performance & Development Review (PDR)	A summary of the PDR compliance rate.
Finance	
Financial Position	Operating surplus or deficit compared to plan.
Cash Balance	Cash balance at month end compared to plan (excluding cash relating to the hosting of the Sustainability and Transformation Partnership).
Capital Programme	Capital expenditure compared to plan (The capital plan has been increased to £10.2m as a result of additional funding from the Department of Health, Health Education England for equipment and building enhancements).
Better Payment Practice Code	Payment of non NHS trade invoices within 30 days of invoice date compared to target.
Use of Resources Rating	Use of Resources Rating compared to plan.
Agency Spending	Agency spend compared to agency ceiling.
Cost Improvement Programme – In Year Performance	Cost savings schemes deliver Year to Date (YTD) compared to plan.

Cost Improvement Programme – Plans in Progress (In Year)	Cost savings schemes in-year compared to plan.
Cost Improvement Programme – Plans in Progress (Recurrent)	Cost savings schemes recurrent compared to plan.

Appendix 4 - Statistical Process Control

What is SPC?

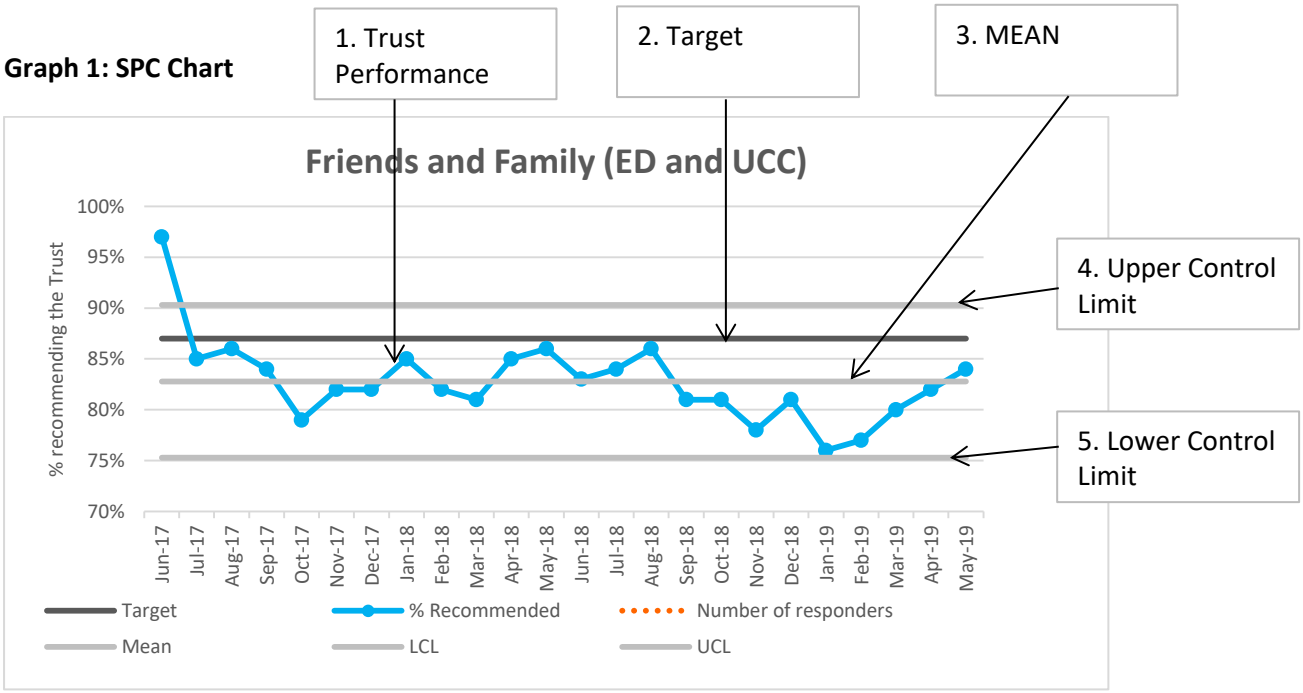
Statistical Process Control (SPC) is method used to measure changes in data/processes over time and is designed to move away from month to month data comparisons. SPC charts help to overcome the limitations of RAG ratings, through using statistics to identify patterns and anomalies, distinguishing changes and both common cause (normal) and special cause (unexpected) variation.

SPC Charts

In addition to the process/metric being measured, SPC charts on the IPR have 3 additional lines.

- Mean – is the average of all the data points on the graph. This is used a basis for determining statistically significant trend or pattern.
- Upper Control Limit – the upper limit that any data point should statistically reach within expected variation. If any one datapoint breaches this line, this is what is known as special cause variation.
- Lower Control Limit – the lower limit than any data point should statistically reach within expected variation. If any one datapoint breaches this line, this is what is known as special cause variation.

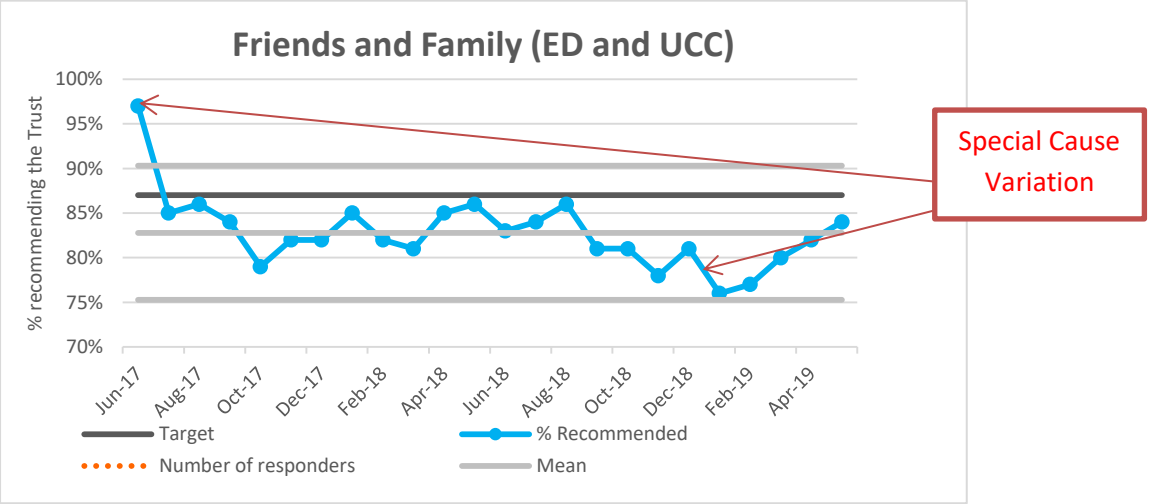
Graph 1: SPC Chart



Interpreting a SPC Chart

There are 3 main rules to interpreting a SPC chart, if one of these rules is broken, there special cause variation present and this means the process is not in control and requires investigation. Please note that breaching the rules does not necessarily mean the process needs to be changed immediately, but it does need to be investigated to understand the reasons for the variation.

1. All data points should be within the upper and lower control limits.
2. No more than 6 consecutive data points are above or below the mean line.
3. There are more than 5 consecutive points either increasing or decreasing.



In the example above, there are two instances of special cause variation; in June 2017 the data point was outside of the upper control limit. Between September 2018 and April 2019, the data points all fall below the mean line.

For high targets (e.g. above 90%) if the upper control limit is below the target, it's unlikely the Trust will achieve the target using the current process.

For low targets (e.g. below 10%) if the lower control total is above the target, it's unlikely the Trust will achieve the target using the current process.

For the purposes of the Trust IPR, the RAG ratings (Red, Amber, Green) will be maintained to understand the Trusts current performance against the outlined targets. SPC should be considered side by side with the RAG rating as it's possible for a process to be within control but not meeting the target.

Appendix 5

Income Statement, Activity Summary and Use of Resources Ratings as at 31st October 2019

Income Statement	Month			Year to date		
	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Operating Income						
NHS Clinical Income						
Elective Spells	2,696	2,899	203	19,479	17,893	-1,586
Elective Excess Bed Days	14	27	13	96	123	27
Non Elective Spells	5,342	5,641	299	37,648	40,776	3,128
Non Elective Bed Days	163	209	46	1,156	1,209	52
Non Elective Excess Bed Days	257	158	-99	1,798	849	-949
Outpatient Attendances	3,138	3,381	244	21,580	22,009	429
Accident & Emergency Attendances	1,405	1,395	-10	9,760	9,799	38
Other Activity	5,468	5,308	-160	38,150	37,276	-874
Sub total	**18,482**	**19,018**	**535**	**129,667**	**129,932**	**265**
Non NHS Clinical Income						
Private Patients	21	13	-8	155	74	-81
Non NHS Overseas Patients	6	4	-2	42	81	39
Other non protected	85	79	-6	599	522	-77
Sub total	**112**	**96**	**-16**	**796**	**676**	**-120**
Other Operating Income						
Training & Education	609	662	53	4,264	4,349	85
Donations and Grants	0	40	40	0	40	40
Provider Sustainability Fund (PSF)	487	487	0	2,191	2,418	227
Financial Recovery Fund (FRF)	1,201	1,201	0	5,406	5,406	0
Marginal Rate Emergency Tariff (MRET)	81	81	0	567	567	0
Miscellaneous Income	1,168	1,649	481	8,102	10,851	2,749
Sub total	**3,546**	**4,120**	**574**	**20,530**	**23,631**	**3,101**
Total Operating Income	**22,140**	**23,234**	**1,093**	**150,993**	**154,239**	**3,246**
Operating Expenses						
Employee Benefit Expenses	-15,841	-16,569	-728	-113,308	-113,954	-646
Drugs	-1,233	-1,404	-171	-8,657	-9,259	-601
Clinical Supplies and Services	-1,627	-1,773	-146	-11,510	-12,678	-1,167
Non Clinical Supplies	-2,151	-2,161	-10	-15,486	-16,166	-680
Depreciation and Amortisation	-594	-584	10	-4,151	-4,027	124
Total Operating Expenses	**-21,446**	**-22,490**	**-1,045**	**-153,113**	**-156,084**	**-2,971**
Operating Surplus / (Deficit)	**695**	**744**	**49**	**-2,120**	**-1,845**	**275**
Non Operating Income and Expenses						
Interest Income	3	6	3	21	56	35
Interest Expenses	-74	-74	0	-518	-522	-4
PDC Dividends	-148	-148	0	-1,032	-1,032	0
Total Non Operating Income and Expenses	**-219**	**-216**	**3**	**-1,529**	**-1,499**	**30**
Surplus / (Deficit)	**476**	**527**	**52**	**-3,649**	**-3,344**	**305**
Adjustments to Financial Performance						
Less Donations & Grants Income	0	-40	-40	0	-40	-40
Add Depreciation on Donated & Granted Assets	14	16	2	94	114	20
Total Adjustments to Financial Performance	**14**	**-24**	**-38**	**94**	**74**	**-20**
Performance against Control Total inc PSF, FRF & MRET	**490**	**503**	**14**	**-3,555**	**-3,270**	**285**
Less PSF, FRF & MRET Funding	-1,769	-1,769	0	-8,164	-8,391	-227
Performance against Control Total exc PSF, FRF & MRET	**-1,279**	**-1,266**	**14**	**-11,719**	**-11,661**	**58**

Activity Summary	Planned	Actual	Variance	Planned	Actual	Variance
Elective Spells	2,921	3,169	248	20,573	19,856	-717
Elective Excess Bed Days	51	100	49	356	465	109
Non Elective Spells	3,001	3,464	463	21,269	23,355	2,086
Non Elective Bed Days	463	593	130	3,284	3,433	149
Non Elective Excess Bed Days	985	600	-385	6,897	3,233	-3,664
Outpatient Attendances	26,624	28,659	2,035	183,074	185,062	1,988
Accident & Emergency Attendances	10,250	9,582	-668	70,703	67,872	-2,831

Use of Resources Ratings	Planned Metric	Actual Metric	Variance Metric	Planned Metric	Actual Metric	Variance Metric
Metrics						
Capital Servicing Capacity (Times)				1.3	0.9	-0.4
Liquidity Ratio (Days)				-46.6	-47.0	-0.4
I&E Margin - Metric (%)				-2.4%	-2.3%	0.1%
I&E Margin - Distance from financial plan (%)				0.0%	0.1%	0.1%
Agency Ceiling (%)				0.0%	4.2%	4.2%
Ratings						
Capital Servicing Capacity (Times)				3	4	1
Liquidity Ratio (Days)				4	4	0
I&E Margin - Metric (%)				4	4	0
I&E Margin - Distance from financial plan (%)				1	1	0
Agency Ceiling (%)				1	2	1
Use of Resources Rating				**3**	**3**	**0**

Appendix 6

Capital programme as at 31st October 2019

Scheme Name	Approved Programme 2019/20 £000	Adjustments M01 M06 2019/20 £000	Adjustments M07 2019/20 £000	Total Revised Budget 2019/20 £000
ESTATES				
Estates - Schemes b/f 18/19				
Emergency Fire Exit Staircases (Kendrick & Appleton)	41	(41)		**0**
Water Safety Compliance	3	(3)		**0**
Halton Endoscopy Essential power supply to rooms 1 & 2	20	(20)		**0**
Air Conditioning / Cooling Systems upgrade. Phase 1 - Survey	12	(12)		**0**
Automatic sliding / entrance doors across all sites	20			**20**
Estates Minor Works	12			**12**
Dishwasher x 5	1	(1)		**0**
CCU Relocation to Ward A3	8			**8**
Substation B Air Circuit Breakers	404	(356)		**48**
Electrical Infrastructure Upgrade	42			**42**
North Lodge Fire Compartmentation	150			**150**
Appleton Wing Fire Doors	100	(100)		**0**
Thelwall House Emergency Escape Lighting	4			**4**
Cheshire House Fire Doors	23	(3)		**20**
Discharge Lounge/Bereavement Office	17			**17**
Essential Power Installation - Halton Pharmacy	6			**6**
N20 Exposure	100			**100**
Catering EHO Works	9	(9)		**0**
CQC (Environmental Improvements)	923	(449)		**474**
CQC Prep Room Doors	24			**24**
CQC (Enviromental Improvements) - A4 Bathroom	24			**24**
CQC (Enviromental Improvements) - A8 Bathroom	24			**24**
Halton Outpatients Refurbishment	69	(69)		**0**
CQC (MLU)	600	268		**868**
Emergency Generator Repairs - Halton	7			**7**
AER machines (4 W 2 H)	700			**700**
Butterfly Suite	19			**19**
ITU UPS Replacement	7			**7**
Door Lock (FAU)	5			**5**
Estates Schemes b/f 18/19 Total	**3,374**	(795)	0	**2,579**
Estates - Mandated Schemes 19/20				
Replacement Lift - Phase 1 Halton	250		(70)	**180**
Staffing Costs for Capital Team on Capital Schemes	177	6		**183**
Halton 30 Minute Fire Compartmentation	150			**150**
Appleton Wing 60 Minute Fire Doors	100	(100)		**0**
Warrington & Halton Gas Meter Replacement	100	(100)		**0**
North Lodge Basement - Fire Compmt Part 2/2	100			**100**
Fixed Installation Wiring & Testing & Repairs	150			**150**
6 Facet Survey	60		(20)	**40**
North Lodge & Catering Emergency Lighting	50			**50**
Water Safety Compliance	50			**50**
Replacement of External Fire Escapes to Kendrick & Appleton	40			**40**
Asbestos Management Survey Reinspection and works	30			**30**
Pharmacy Fire Doors	30	(30)		**0**
Halton Residential Blocks 2 & 3 Fire Doors	25	(25)		**0**
Daresbury Plant Room - Alternative Fire Escape	20			**20**
Estates Dept Fire Doors	20	(20)		**0**
Cheshire House Emergency Lighting	20	(20)		**0**
Thelwall House - Improvements to Fire Alarm system	20	(20)		**0**
Estates Dept Fire Compartmentation of Risk Areas	10			**10**
Estates - Mandated Total	**1,402**	**(309)**	**(90)**	**1,003**
Estates - Trust Funded Schemes 19/20				
Appleton Wing - replace 5 No LV Changeover Switches	40	(40)		**0**
Backlog - High Voltage Annual Requirements & Maintenance	60	(20)		**40**
Backlog - Patient Environment Improvements	100	(65)		**35**
Induction of Labour Ward (CQC)	78	(78)		**0**
Diagnostics Business Case - Electrical Substation	1,365	(468)		**897**
Diagnostics Business Case - Estates	0	468		**468**

Chillers - Day case Theatre & MRI	0	65		65
Contact Centre Relocation (OPD)	0	24		24
Paediatric Outpatients	0	20		20
Ward Bathroom Falls Prevention	0	80		80
Conversion of 6 Accommodation Rooms	0	20		20
Front Entrance	0	80		80
Estates - Trust Funded 19/20 Total	**1,643**	**86**	**0**	**1,729**
Estates Total	**6,419**	**(1,018)**	**(90)**	**5,311**
INFORMATION TECHNOLOGY				
Information Technology b/f from 18/19				
Technology & Devices Refresh and Developments	141			141
Security (Stonesoft Firewall Renewal)	2			2
VDI Roll Out	117			117
Meditech Restoration	5			5
Deontics Care Pathway	8			8
Falsified Medicines Directive	83			83
BI Interactive Screens	11			11
BI Tool Physical Servers	0			0
Information Technology b/f from 18/19 Total	**367**	**0**	**0**	**367**
Information Technology Trust Funded 19/20				
EPMA	319	65		384
EPMA - Eprescribing/Drugs Trolleys	229			229
ICE Upgrade	0	31		31
Devices Refresh Phase 1	0	188		188
Molis Infection Control Module	0	15		15
Cardiology Systems Upgrade			92	92
Information Technology Trust Funded 19/20 Total	**548**	**299**	**92**	**939**
Information Technology Total	**915**	**299**	**92**	**1,306**
MEDICAL EQUIPMENT				
Medical Equipment - Schemes b/f 18/19				
Oral Surgery Dental Chair x 1	1	(1)		0
Bladder Scanner (FAU)	8		(8)	0
Ultrasound Rheumatology	29			29
Stress Test System	31			31
Medical Equipment Schemes b/f 18/19 Total	**69**	**(1)**	**(8)**	**60**
Medical Equipment Trust Funded 19/20				
Replacement Anaesthetic Machines & Monitors	260	324		584
Recovery Monitors	390			390
Foetal CTG Monitor Labour Ward	39			39
Anaesthetic Ultrasound for Vascular	70			70
Patient Transfer Ventilators	55			55
Laparoscopic Video Imagery Systems	160			160
Ultrasound Machines	150			150
Ultrasound Transducer No1	0	7		7
Curvilinear Transducer	0	6		6
Paediatric MRI Scanning	0	13		13
Osmometer	0	11		11
Replacement Patient Monitoring System in ED	300		81	381
NIV Machines	47			47
Ultrasound Transducer - No 2 - Interventional Radiology	0	7		7
Screening Quality Assurance Service - Cold Coagulation	0	11		11
Screening Quality Assurance Service - Monitors	0	30		30
CT Scanner	0	1,000		1,000
Cell Washer	0	0	7	7
Intra-Aortic Balloon Pump	0	0	49	49
Medical Equipment Trust Funded 19/20 Total	**1,471**	**1,409**	**137**	**3,017**
Medical Equipment Total	**1,540**	**1,408**	**129**	**3,077**
Total Trust Funded Capital	**8,874**	**689**	**131**	**9,694**
CONTINGENCY				
Prior Year Adjustments (VAT Rebates)	0			0
General Contingency (increased due to the Replacement Lift - Phase 1 Halton and 6 Facet Survey forecast underspend)	972	(889)	69	152
CQC Contingency	0	200	(200)	0
Contingency Total	**972**	**(689)**	**(131)**	**152**

Externally Funded				
CANTREAT Modifications	84	(72)		12
Outdoor Play Area Phase 1 (CF)	5		36	41
Cancer Trans Prog - MDT Equipment (PDC)	7	(7)		0
EPR Developments WA Digital Maturity (PDC)	81			81
Training Simulator Equipment (HEE)	10			10
Tomosynthesis (Boot Out Breast Cancer)	10			10
Parents Bathroom - Childrens Ward (CF)	0	8		8
Bladder Scanner - FAU (LOF)			9	9
Externally Funded Total	**197**	**(71)**	**45**	**171**
Kendrick Wing Fire				
Kendrick Wing Fire	3,500			3,500
Kendrick Wing Fire Total	**3,500**	**0**	**0**	**3,500**
Grand Total	**13,543**	**(71)**	**45**	**13,517**

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/19/11/108 a**			
SUBJECT:	**Safe Staffing Assurance Report**			
DATE OF MEETING:	27 November 2019			
AUTHOR(S):	Rachael Browning, Associate Chief Nurse, Clinical Effectiveness			
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse			
LINK TO STRATEGIC OBJECTIVES:	All			
EXECUTIVE SUMMARY (KEY ISSUES):	Ward staffing data continues to be systematically reviewed to ensure we safely staff our wards and provide mitigation and action when a ward falls below 90% of planned staffing levels. In the month of August 2019 it was noted that 13 of the 23 wards were below the 90% target during the day. In order to ensure safe staffing levels, mitigation and responsive plans continue to be put in place to ensure that the safe delivery of patient care is discussed at every bed meeting and escalated as appropriate. It is a recommendation of the National Quality Board (NQB 2018) that the Board of Directors receives a monthly Safe Staffing report, which includes the measure of Care Hours Per Patient Day (CHPPD) and 'planned' versus 'actual' staffing levels, highlighting areas where average fill rates fall below 90%, along with mitigation to ensure safe, high quality care is consistently delivered for those areas. The report demonstrates the progress that continues to be made across the organisation in Nursing and Midwifery staffing as the number of wards reporting staffing levels below the 90% reduces.			
PURPOSE: (please select as appropriate)	**Information ***	Approval	**To note ***	Decision
RECOMMENDATION:	Trust Board asked to note the contents of this report as discussed and received at the Strategic People Committee.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Strategic People Committee		
	Agenda Ref.	SPC/19/11/108		
	Date of meeting	20 November 2019		
	Summary of Outcome	Approved		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

NAME OF COMMITTEE

SUBJECT	Safe Staffing Assurance Report	AGENDA REF:	BM/19/11/108 a

1. BACKGROUND/CONTEXT

Safe Staffing Assurance Report

The purpose of this report is to provide transparency with regard to the nursing and midwifery ward staffing levels during August 2019. The Trust has a duty to ensure nursing and midwifery staffing levels are sufficient to maintain safety and provide quality care. It forms part of the expectation set out in the National Quality Board (NQB) guidance published in 2016 and in their recommendations in 2018, that Boards take full responsibility for the quality of care provided to patients, and, as a key determinant of quality, take full responsibility for nursing, midwifery and care staffing capacity and capability. This paper provides assurance that any shortfalls on each shift are reviewed and addressed, with actions to ensure safe staffing levels are provided and reviewed at the daily staffing meeting. It is well documented that nurse staffing levels make a difference to patient outcomes (mortality and adverse events, including levels of harm), patient experience, and quality of care and the efficiency of care delivery.

2. KEY ELEMENTS

All Trusts submit staffing data to NHS England via the Unify Safe Staffing return and provide assurance to the Board of Directors via the Chief Nurse.

The safer staffing data consists of the 'actual' numbers of hours worked by registered nursing and health care support staff on a shift by shift basis, measured against the numbers of 'planned' hours to calculate a monthly fill rate for nights and days by each ward. A monthly fill rate of 90% and over is considered acceptable nationally and when fill rates are below 90% the ward staffing is reviewed at the daily staffing meeting taking into account acuity and activity, where necessary staff are moved from other areas to support.

Care Hours Per patient Day

Warrington and Halton Hospitals NHS Trust currently collects and reports CHPPD data on a monthly basis. CHPPD is the total time spent on direct patient care based on the number of occupied beds at midnight. The August 2019 Trust wide staffing data was analysed and cross-referenced, with ward level data for validation by the Deputy Chief Nurse, Lead Nurses, and the Associate Chief Nurse (Clinical Effectiveness).

Chart 1 illustrates the monthly data and in August 2019 and reduction in CHPPD was seen at 7.1, in comparison to the previous months of 7.5 with the Trust overall year to date position of 7.4. This is in comparison to the peer median of 7.8 and the national median figure of 8.1 hours over the same period and represents an improvement from 2018 / 19 where we ended the year with an overall rate of 7.0.

This will continue to be monitored via the Trust monthly Safer Staffing Report.

Chart 1 – CHPPDD 2019

Finyear	Month	Cumulative count over the month of patients at 23:59 each day	CHPPD - Registered	CHPPD - Care Staff	CHPPD All
2019/20	Apr	14008	4.4	3.2	7.6
	May	14623	4.3	3.3	7.6
	Jun	14410	4.3	3.2	7.5
	Jul	14917	4.2	3.3	7.5
	Aug	15282	3.9	3.2	7.1
2019/20 Total		73240	4.2	3.2	7.4

Key Messages

Although there are areas above the 90% fill rate in month, it is acknowledged that the percentage of registered nurses/midwives on 13 of the 23 wards is below target during the day. August is peak holiday season and is often challenging due to a number of factors including leave management, sickness and a reduction in temporary staffing fill rates. We have undertaken a deep dive into ward staffing over the month of August 2019 and the report will be presented at the next Workforce and Safe Staffing meeting, where any actions for improvement will be monitored. The report summary and recommendations can be found at Appendix 3.

In order to ensure safe staffing levels, mitigation and responsive plans continue to be put in place to ensure that the safe delivery of patient care is discussed at every bed meeting and escalated as appropriate. Shift fill rates continue to improve month on month.

Maternity (ward C23) although showing below the 90% target on the ward, use their responsive staffing plans in the unit to move staff to support if acuity requires additional staffing.

Recruitment and retention remains a priority for the senior nursing team. Further recruitment events are planned for both registered nurses and health care assistants.

The Trust are part of cohort 4 of the NHSI Retention workforce collaborative, which has enabled access to best practice and exemplar practice from other organisations as well as identifying our retention priorities and plan for 2019.

Initial assessment of the data, in conjunction with staff engagement, has indicated a requirement to focus on the following areas

- Work life balance
- Continued professional development
- Recognising and Valuing Experience (RAVE)
- Developing and empowering line managers

The aim of the collaborative is to reduce the turnover of our Nursing and Midwifery workforce by 1.5% over the next 12 months. Good progress has been made under these work streams, it is pleasing to note at month 9 we have seen a reduction of 2.95% in nursing and midwifery turnover.

Additional bed capacity has been utilised to support the operational pressures in the Trust in August 2019. The General Practitioner Assessment Unit (GPAU, 16 beds), on occasion, has been used as an inpatient overnight facility, and Ward A9 was located on 2 wards (K25 and C22) throughout the month, both of these areas required additional nurse staffing. Staffing levels are reviewed daily to determine the additional staffing required ensuring patient safety as part of the daily operational staffing plans.

Patient Harm by Ward

In August 2019 we have reported 3 category 2 pressure ulcers on wards A1, A2 and ITU which are currently being investigated. There have been no patient falls with moderate harm.

Infection Incidents

In August 2019 we have reported 2 cases of MRSA bacteraemia on wards A5 and A8 which are currently being investigated.

	Appendix 1	MONTHLY SAFE STAFFING REPORT – August 2019																
Monthly Safe Staffing Report – August 2019																		
		Day	Day	Day	Day	Day	Day	Night	Night	Night	Night	Night	Night		CHPPD			
CBU	Ward	Planned RN hours	Actual RN hours	Planned HCA hours	Actual HCA hours	% RN fill rate	% HCA fill rate	Planned RN hours	Actual RN hours	Planned HCA hours	Actual HCA hours	% RN fill rate	% HCA fill rate	Cumulative count over the month of patients at 23:59 each day	RN	HCA	RNA	Overall
		= above 100%		= above 90%			= above 80%			= below 80%								
DD	SAU	930	900	697.5	697.5	96.8%	100%	0	0	0	0	-	-	-	-	-	-	-
DD	Ward A5	1782.5	1334	1426	1316.8	74.8%	92.3%	1069.5	851	1069.5	1081	79.6%	101.1%	992	2.2	2.4	0.0	4.6
DD	Ward A6	1782.5	1361.5	1426	1349.5	76.4%	94.6%	1069.5	920	1069.5	1069.5	86%	100%	992	2.3	2.4	0.0	4.8
DD	Ward B4	655	598.5	590.5	579.5	91.4%	98.1%	184	174.5	230	218.5	94.8%	95%	270	2.9	3.0	0.0	5.8
DD	Ward A4	1690.5	1431.8	1426	1391.5	84.7%	97.6%	1069.5	851	1069.5	1068.5	79.6%	100%	992	2.3	2.5	0.0	4.8
MSK	Ward CMTC	1012	1007.5	575	570.5	99.6%	99.2%	701.5	678.5	356.5	356.5	96.7%	100%	203	8.3	4.6	0.7	13.6
MSK	Ward A9	1782	1698	1989.5	1543	95.3%	77.6%	1426	1426	1426	1426	100%	100%	1150	2.7	2.6	0.1	5.4
W&C	Ward B11	2606.5	2524.5	812.5	812.5	96.9%	100%	1390	1400.8	322.4	322.4	100.8%	100%	277	14.2	4.1	0.0	18.8
W&C	NNU	1782.5	1400	356.5	276	78.5%	77.4%	1782.5	1322.5	356.5	264.5	74.2%	74.2%	208	13.1	2.6	0.0	15.7
W&C	Ward C20	862	954	713	639.5	110.7%	89.7%	713	460	0	0	64.5%	-	365	3.9	1.8	0.4	6.0
W&C	Ward C23	1426	1092.5	713	678.5	76.6%	95.2%	759	747.5	713	667	98.5%	93.5%	413	4.5	3.3	0.0	7.7
W&C	Birth Suite	2415	2191.5	345	401.5	90.7%	116.4%	2415	2079.5	345	345	86.1%	100%	246	17.4	3.0	0.0	20.4
UEC	Ward A1	2325	1937.5	2325	2862.5	83.3%	123.1%	1625.5	1441.7	1239.3	1352	88.7%	109.2%	1147	2.9	3.7	0.0	6.6
UEC	Ward A2	1426	1075.5	1552.5	1499.5	75.4%	96.6%	1069.5	1035	1322.5	1368.4	96.8%	103.5%	868	2.4	3.3	0.0	5.7
IM&C	Ward C21	1069.5	894.5	1069.5	1395	83.6%	130.4%	713	713	1069.5	1276.5	100%	119.4%	744	2.2	3.6	0.0	5.8
IM&C	Ward A8	1782.5	1499.5	1426	1615	84.1%	113.3%	1426	1391.5	1069.5	1138	97.6%	106.4%	1054	2.7	2.6	0.0	5.4
IM&C	Ward B12	1069.5	819	2405.5	1899.5	76.6%	79%	713	713	1782.5	1426	100%	80%	651	2.4	5.1	0.0	7.5
IM&C	Ward B14	1426	1271.5	1426	1387.5	89.4%	97.3%	713	713	713	1161.5	100%	162.9%	744	2.7	3.4	0.0	6.1
IM&C	Ward B18	1426	1157.5	1782.5	1492.4	81.2%	83.7%	1069.5	816.5	1495.5	1426	76.3%	95.4%	744	2.7	3.9	0.0	6.6
IM&C	Ward B19	1069.5	945.5	1437.5	1484.5	88.4%	103.3%	713	713	1069.5	1191	100%	111.4%	930	1.8	2.9	0.0	4.7
MC	Ward A7	1782.5	1308	1426	1537	73.4%	107.8%	1426	1144	1069.5	1403	80.2%	131.2%	992	2.5	3.0	0.0	5.4
MC	ACCU	2495	2318	1069.5	1058	92.9%	98.9%	1782.5	1696	1058	1150	95.1%	108.7%	806	5.0	2.7	0.2	7.9
MC	ICU	4991	4335.5	1069.5	1069.5	86.9%	100%	4991	4301	1069.5	931.5	86.2%	87.1%	494	17.5	4.1	0.0	21.5

Appendix 2

July 2019 - Mitigating Actions

The Unify Safe Staffing return guidance states that all wards with inpatient beds need to be included, with the exception of;

- Day care wards
- CDU/other clinical assessment units
- Additional capacity wards (B3 and C21)

Ward B1 at Halton is a CCG Ward and therefore is not part of the Trusts Unify return

	DAY		NIGHT		MITIGATING ACTIONS
	Average fill rate - registered nurses/midwives (%)	Average fill rate – Health Care support staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - Health Care support staff (%)	
SAU	96.8%	100%	-	-	**Vacancy:** - Band 6 1.0 wte **Sickness rate** 3.78 % **Action taken:** - Attendance management policy followed. Band 6 role advertised
Ward A5	74.8%	92.3%	79.6%	101.1%	**Vacancy:** Band 5 6.02 wte band 2 3.0 wte **Sickness rate:** 5.84% **Action taken:** Daily review by the matron to review staffing levels and acuity, staff moved from other areas to support. Attendance management policy followed, monthly meeting with HR and welfare meetings arranged. Ongoing recruitment plans in place
Ward A6	76.4%	94.6%	86%	100%	**Vacancy:** - Band 5 11.99 wte Band 2 4.2 wte **Sickness rate** – 9.25% **Action taken:** Daily review by the matron to review staffing levels and acuity, staff moved from other areas to support. Attendance management policy followed, monthly meeting with HR and welfare meetings arranged. Targeted recruitment plan in place
Ward B4	91.4%	98.1%	94.8%	95%	**Vacancy**: Band 5 3.0wte **Sickness rate** –15.15% **Action taken:** Daily staffing review against acuity and activity. Recruitment plan in place. Band 6 recruited and awaiting start date. Sickness absence reduced in month and being managed in line with Trust policy.
Ward A4	84.7%	97.6%	79.6%	100%	**Vacancy:** - Band 5 3.92 wte **Sickness rate** – 4.73% **Action taken:** Staffing and activity reviewed daily. Recruitment programme in place. Attendance management policy followed, Sickness absence being managed in line with the Trust policy.
Ward CMTC	99.6%	99.2%	96.7%	100%	**Vacancy:** Band 5 2.89wte **Sickness rate –** 8.53% **Action taken**: Sickness absence being managed in line with the Trust policy. Recruitment programme in place.
Ward A9	95.3%	77.6%	100%	100%	**Vacancy:** Band 5 – 2.0 wte band 2 4.0wte **Sickness rate** – 7.51% **Action taken:** Staffing reviewed daily and support provided if necessary. Ward has moved to 2 areas (C22/K25) during

					refurbishment. Increase in 6 beds. Staffing adjusted to cover both areas. Band 5 vacancies will be filled in Sept. Advert to go out for Band 2s. Sickness absence being managed in line with the Trust policy.
Ward B11	96.9%	100%	100.8%	100%	**Vacancy:** Band 5 – 4.0 wte **Sickness Rate:** 1.47% **Action taken:** - recruitment process in place. 2 band 5's due to start in September. Staffing reviewed daily and support provided if necessary.
NNU	78.5%	77.4%	74.2%	74.2%	**Vacancy rate:** 1.8wte band 6 **Sickness Rate:** 2.67% **Action taken:** sickness is managed via the Trust policy. Staffing reviewed daily and support provided if necessary. Recruitment process in place
Ward C20	110.7%	89.7%	64.5%	-	**Vacancy: :** Band 5 1.0 wte **Sickness Rate:** 0.6% **Action taken:** Staffing reviewed daily by the matron and staff moved to support if required and additional shifts request via NHSP. RN vacancies filled due to commence in Oct 2019. Sickness is being managed in line with Trust policy.
Ward C23	76.6%	95.2%	98.5%	93.5%	**Vacancy:** Band 5 1.72 wte **Sickness rate** – 8.67% **Action taken:** Daily review of staffing and staffed moved from other areas depending on acuity and occupancy.
Delivery Suite	90.7%	116.4%	86.1%	100%	**Vacancy:** - Band 2 1.0 wte **Sickness rate** – 6% **Action taken:** Daily review of staffing and acuity, staff moved from other areas to support and additional staff access via NHSP. Sickness is being managed in line with Trust policy.
Ward A1	83.3%	123.1%	88.7%	109.2%	**Vacancy :** - Band 6 1.74wte 9.4wte Band 5 4.51wte band 2 **Sickness Rate:** 4.47% **Action taken:** 7 band 5 nurses commencing in post in October 2019. Daily review of staffing and acuity, staff moved from other areas to support and additional staff access via NHSP.
Ward A2	75.4%	96.6%	96.8%	103.5%	**Vacancy:** Band 5 9.58wte **Sickness Rate:** 4.88% **Action taken:** Daily review of staffing and acuity, staff moved from other areas to support and additional staff access via NHSP. Band 5 recruitment plans in place.
Ward C21	83.6%	130.4%	100%	119.4%	**Vacancy :-** Band 5 0.51 wte **Sickness Rate:** 22.6% **Action taken:** - Daily review of staffing and acuity, staff moved from other areas to support and additional staff access via NHSP.
Ward A8	84.1%	113.3%	97.6%	106.4%	**Vacancy :** - Band 6 2.0 wte band 5 –5.0wte Band 2 2.0wte **Sickness Rate:** 24% **Action taken:** Recruitment plans in place/ 2 band 5 recruited and awaiting start dates Ward support by the continued use of NHSP and agency to ensure safe staffing levels. Pharmacy Technician support morning and lunchtime supports nursing staff.
Ward B12	76.6%	79%	100%	80%	**Vacancy :** - Band 5 1.57wte Band 2 3.17 wte **Sickness Rate:** 8.5% **Action taken**: - Recruitment plan in place. Daily review by the matron to review staffing levels and acuity, staff moved from other areas to support.

Ward B14	89.4%	97.3%	100%	162.9%	**Vacancy :-** 3.36wte Band 5 **Sickness Rate:** 11.3% **Action taken:** - recruitment plan in place Staffing reviewed daily against acuity and activity.
Ward B18	81.2%	83.7%	76.3%	95.4%	**Vacancy :** -Band 5 2.94 wte band 2 0.5wte **Sickness Rate:** 5% **Action taken:** - Recruitment ongoing, staffing reviewed on daily basis by matron and ward manager
Ward B19	88.4%	103.3%	100%	111.4%	**Vacancy :** -Band 5 1.21wte band 2 0.78 **Sickness Rate:** 3.03% **Action taken:** - Ward reviewed daily for acuity and staffing.
Ward A7	73.4%	107.8%	80.2%	131.2%	**Vacancy :** Band 5 4.92wte band 2 0.56wte **Sickness Rate:** 5.94% **Action taken:** - Staffing reviewed daily against acuity and activity. 2 RN's to start in September.
ACCU	92.9%	98.9%	95.1%	108.7%	**Vacancy :** Band 2 1.0wte **Sickness Rate:** 5.6% **Action taken:** Staffing reviewed daily against acuity and activity, staff support accessed from other areas when required. Sickness is being managed in line with Trust policy
ICU	86.9%	100%	86.2%	87.1%	**Vacancy :** – 9.54wte band 5 **Sickness rate** – 2.88% **Action taken:** - Sickness absence managed robustly in line with Trust Attendance Management Policy. Rota shortfall managed with temporary staffing, mainly own staff via NHSP. Recruitment plan in place

Appendix 3 – Analysis of Nurse Staffing Report Conclusion and recommendations – Summer 2019

ANALYSIS OF NURSE STAFFING REPORT CONCLUSION

The report summarises a number of the factors that have contributed to a challenging summer holiday period for staffing at the Trust.

- Annual leave was higher than the recommended parameter of 17% in most CBUs.
- A small amount of extra annual leave was given out at short notice rather than move staff between wards.
- There was an increase in the number of shifts cancelled by NHSP staff at short notice. Whilst this is a common occurrence, the fact that it was higher contributed to an already challenging problem.
- Sickness remained high in the holiday period, with some key CBUs (Integrated Medicine & Community and Digestive Diseases) being particularly high.
- The Trust carries a significant vacancy factor, a problem that is shared across most wards. Comparing the acuity/dependency level of our patients with the number of staff in post shows that there is an estimated shortfall of 86.96 WTE.
- Ward B3 at Halton was open throughout the summer with no budgeted staff – this is part of the vacancy number.
- Ward A9 was being refurbished and the patients moved to 2 wards. This led to extra capacity being open and as a consequence an increased number of staff was required.
- The GP Assessment Unit was frequently used for overnight accommodation of patients. This required staff from the already stretched wards described above.

ANALYSIS OF NURSE STAFFING REPORT RECOMMENDATIONS

The number of Registered Nurse vacancies is the key factor. If that is addressed then accommodating a slight increase in annual leave is easier. The temporary staff requirement would be reduced thereby reducing the number of cancelled shifts. Finally opening areas for short term escalation is more achievable because wards can release staff at a time when temporary staff will be more readily available.

3. ASSURANCE COMMITTEE

The monthly staffing report is received and discussed at the Strategic People Committee

4. RECOMMENDATIONS

Board asked to note the contents of this report as discussed and received at the Strategic People Committee

Kimberley Salmon-Jamieson
Chief Nurse and DIPC
August 2019

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/19/11/108 a**			
SUBJECT:	**Safe Staffing Assurance Report**			
DATE OF MEETING:	27 November 2019			
AUTHOR(S):	Rachael Browning, Associate Chief Nurse, Clinical Effectiveness			
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse			
LINK TO STRATEGIC OBJECTIVES:	All			
EXECUTIVE SUMMARY (KEY ISSUES):	Ward staffing data continues to be systematically reviewed to ensure we safely staff our wards and provide mitigation and action when a ward falls below 90% of planned staffing levels. In the month of September 2019 it was noted that 13 of the 23 wards were below the 90% target during the day. In order to ensure safe staffing levels, mitigation and responsive plans continue to be put in place to ensure that the safe delivery of patient care is discussed at every bed meeting and escalated as appropriate. It is a recommendation of the National Quality Board (NQB 2018) that the Board of Directors receives a monthly Safe Staffing report, which includes the measure of Care Hours Per Patient Day (CHPPD) and 'planned' versus 'actual' staffing levels, highlighting areas where average fill rates fall below 90%, along with mitigation to ensure safe, high quality care is consistently delivered for those areas. The report demonstrates the progress that continues to be made across the organisation in Nursing and Midwifery staffing as the number of wards reporting staffing levels below the 90% reduces.			
PURPOSE: (please select as appropriate)	**Information** *	Approval	**To note** *	Decision
RECOMMENDATION:	Trust Board asked to note the contents of this report as discussed and received at the Strategic People Committee			
PREVIOUSLY CONSIDERED BY:	**Committee**	Strategic People Committee		
	Agenda Ref.	SPC/19/11/108		
	Date of meeting	20 November 2019		
	Summary of Outcome	Approved		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

SUBJECT	Safe Staffing Assurance Report	AGENDA REF:	BM/19/11/108 a

1. BACKGROUND/CONTEXT

Safe Staffing Assurance Report

The purpose of this report is to provide transparency with regard to the nursing and midwifery ward staffing levels during September 2019. The Trust has a duty to ensure nursing and midwifery staffing levels are sufficient to maintain safety and provide quality care. It forms part of the expectation set out in the National Quality Board (NQB) guidance published in 2016 and in their recommendations in 2018, that Boards take full responsibility for the quality of care provided to patients, and, as a key determinant of quality, take full responsibility for nursing, midwifery and care staffing capacity and capability. This paper provides assurance that any shortfalls on each shift are reviewed and addressed, with actions to ensure safe staffing levels are provided and reviewed at the daily staffing meeting. It is well documented that nurse staffing levels make a difference to patient outcomes (mortality and adverse events, including levels of harm), patient experience, and quality of care and the efficiency of care delivery.

2. KEY ELEMENTS

All Trusts submit staffing data to NHS England via the Unify Safe Staffing return and provide assurance to the Board of Directors via the Chief Nurse.

The safer staffing data consists of the 'actual' numbers of hours worked by registered nursing and health care support staff on a shift by shift basis, measured against the numbers of 'planned' hours to calculate a monthly fill rate for nights and days by each ward. A monthly fill rate of 90% and over is considered acceptable nationally and when fill rates are below 90% the ward staffing is reviewed at the daily staffing meeting taking into account acuity and activity, where necessary staff are moved from other areas to support.

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Chart 1 illustrates the monthly data and in September 2019 and reduction in CHPPD was seen at 7.1, in comparison to the previous months of 7.5 with the Trust overall year to date position of 7.4. This is in comparison to the peer median of 7.8 and the national median figure of 8.1 hours over the same period and represents an improvement from 2018 / 19 where we ended the year with an overall rate of 7.0.

This will continue to be monitored via the Trust monthly Safer Staffing Report.

Chart 1 – CHPPDD 2019

Financial year	Month	Cumulative count over the month of patients at 23:59 each day	CHPPD - Registered	CHPPD - Care Staff	CHPPD All
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	August	15282	3.9	3.2	7.1
	September	14927	4.0	3.1	7.1
2019/20 Total		88167	4.2	3.2	7.4

Key Messages

Although there are areas above the 90% fill rate in month, it is acknowledged that the percentage of registered nurses/midwives on 13 of the 23 wards is below target during the day.

In order to ensure safe staffing levels, mitigation and responsive plans continue to be put in place to ensure that the safe delivery of patient care is discussed at every bed meeting and escalated as appropriate. Shift fill rates continue to improve month on month.

Maternity (ward C23) although showing slightly below the 90% target on the ward (89.9%), use their responsive staffing plans in the unit to move staff to support if acuity requires additional staffing.

Recruitment and retention remains a priority for the senior nursing team. Further recruitment events are planned for both registered nurses and health care assistants.

The Trust are part of cohort 4 of the NHSI Retention workforce collaborative, which has enabled access to best practice and exemplar practice from other organisations as well as identifying our retention priorities and plan for 2019.

Initial assessment of the data, in conjunction with staff engagement, has indicated a requirement to focus on the following areas

- Work life balance
- Continued professional development
- Recognising and Valuing Experience (RAVE)
- Developing and empowering line managers

The aim of the collaborative is to reduce the turnover of our Nursing and Midwifery workforce by 1.5% over the next 12 months. Good progress has been made under these work streams, it is pleasing to note in September 2019 we have seen a further reduction in nursing and midwifery turnover to 11.77%, making an overall reduction of 3.22% at month 10 of the NHSI programme.

Additional bed capacity has been utilised to support the operational pressures in the Trust in September 2019. The General Practitioner Assessment Unit (GPAU, 16 beds) on occasion, has been used as an inpatient overnight facility. The senior nursing team monitor the additional beds and associated staffing costs for these areas (based on NHSP rates). The table below provides a summary of the areas with associated weekly, monthly and annual costs;

Area	Weekly cost	Monthly	Annual
Discharge Lounge	£529	£2116	£25,392
GPAU (7nights)	£5720	£22,880	£274,560
Ward B3	£17,301.70	£69,206.80	£830,481.60
Total	**£23,550.70**	**£94,202.80**	**£1,130,433.60**

Staffing levels are reviewed daily to determine the additional staffing required ensuring patient safety as part of the daily operational staffing plans.

In September 2019 we have 240 active volunteers working across the organisation; many of these volunteers support the teams in the clinical areas with administrative and patient support and engagement activities. It is pleasing to note that in month we have converted 2 of our volunteers to substantive posts at WHH.

Patient Harm by Ward

In September 2019 we have reported 6 category 2 pressure ulcers on wards A8, A9, B19, ITU (x2) and B1. We have also reported 1 category 3 pressure ulcer on ward ACCU which is currently being investigated. There has been 1 patient fall with moderate harm on the corridor in Appleton Wing and 2 patient falls with major harm reported on A2 and B12 which are currently being investigated.

Infection Incidents

In September 2019 we haven't reported any cases of MRSA bacteraemia.

Warrington and Halton Hospitals NHS

Appendix 1	MONTHLY SAFE STAFFING REPORT - September 2019

Monthly Safe Staffing Report – September 2019

		Day	Day	Day	Day	Day	Day	Night	Night	Night	Night	Night	Night		CHPPD				
CBU	Ward	Planned RN hours	Actual RN hours	Planned HCA hours	Actual HCA hours	% RN fill rate	% HCA fill rate	Planned RN hours	Actual RN hours	Planned HCA hours	Actual HCA hours	% RN fill rate	% HCA fill rate	Cumulative count over the month of patients at 23:59 each day	RN	HCA	RNA	AHP	Overall
		= above 100%		= above 90%			= above 80%			= below 80%									
DD	SAU	930	900	697.5	697.5	96.8%	100%	-	-	-	-	-	-	-	-	-	-		-
DD	Ward A5	1621.5	1322.5	1380	1276.5	81.6%	92.5%	1035	931.5	1035	1046.5	90%	101.1%	960	2.3	2.4	0	0.2	4.9
DD	Ward A6	1621.5	1178.8	1380	1293.5	72.7%	93.7%	1035	908.5	1035	1035	87.8%	100%	960	2.2	2.4	0	0.2	4.8
DD	Ward B4	701.5	671	616	616	95.7%	100%	241.5	241.5	0	0	100%	-	-	-	-	-	-	-
DD	Ward A4	1621.5	1357	1380	1368.5	83.7%	99.2%	1035	920	1035	1035	88.9%	100%	960	2.4	2.5	0.2	-	5.0
MSK	Ward CMTC	1005.5	983.5	816.5	778.5	98.3%	95.3%	690	678.5	414	414	98.3%	100%	275	6.0	4.3	1.0	-	11.4
MSK	Ward A9	1621.5	1357	1380	1368.5	87.3%	93%	1035	920	1035	1035	99%	99.2%	960	2.4	2.5	0.2	-	5.0
W&C	Ward B11	2858.3	2823.3	870	870	98.8%	100%	1596	1596	312	312	100%	100%	399	11.1	3.0	-	-	14.2
W&C	NNU	1725	1604	345	276	93%	80%	1725	1403	345	289	81.3%	83.8%	289	10.4	2.0	-	-	12.4
W&C	Ward C20	966	880.5	644	506	91.1%	78.6%	678	678.5	-	-	100.1%	-	432	3.6	1.2	0.1	-	5.1
W&C	Ward C23	1426	1282	713	667	89.9%	93.5%	759	759	713	713	100%	100%	526	3.9	2.6	-	-	6.5
W&C	Birth Suite	2415	2283.5	345	306.5	94.6%	88.8%	2415	2079.5	345	345	86.1%	100%	246	17.7	2.6	-	-	20.4
UEC	Ward A1	2250	1737.5	2250	2625	77.2%	116.7%	1575	1560.1	938.7	938.7	99.1%	100%	1110	3.0	3.2	-	-	5.2
UEC	Ward A2	1380	1046.5	1725	1391.5	75.8%	80.7%	1035	1035	1035	1081	100%	104.4%	840	2.5	2.9	-	-	5.4
IM&C	Ward C21	1035	842	1035	1268.5	81.4%	122.6%	690	690	1035	958	100%	92.6%	720	2.1	3.1	-	0.2	5.5
IM&C	Ward A8	1725	1357	1380	1425	78.7%	103.3%	1380	1276.5	1035	1150	92.5%	111.1%	1020	2.6	2.5	-	0.1	5.3
IM&C	Ward B12	1035	892.5	2415	2146.5	86.2%	88.9%	690	690	1725	1690.5	100%	98%	630	2.5	6.1	-	0.2	8.9
IM&C	Ward B14	1380	1257.5	1380	1456.5	91.1%	105.5%	690	690	690	1174.5	100%	170.2%	720	2.7	3.7	-	-	6.4
IM&C	Ward B18	1380	1131	1725	1481	82%	85.9%	1035	851	1380	1311	82.2%	95%	720	2.8	3.9	-	-	6.6
IM&C	Ward B19	1035	1016.5	1380	1399.5	98.2%	101.4%	690	701.5	1035	1023.5	101.7%	98.9%	720	2.4	3.4	-	-	5.8
MC	Ward A7	1725	1384.5	1380	1443	80.3%	104.6%	1380	1242	1035	1230.5	90%	118.9%	990	2.7	2.7	-	-	5.4
MC	ACCU	2495.5	2481.5	1069.5	1069.5	99.4%	100%	1782.5	1782.5	1069.5	1138.5	100%	106.5%	931	4.6	2.4	-	-	7.0
MC	ICU	4830	4209	1035	977.5	87.1%	94.4%	4830	4163	1035	931.5	86.2%	90%	431	18.2	4.1	-	-	22.3

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Appendix 2

July 2019 - Mitigating Actions

The Unify Safe Staffing return guidance states that all wards with inpatient beds need to be included, with the exception of;

- Day care wards
- CDU/other clinical assessment units
- Additional capacity wards (B3 and C21)

Ward B1 at Halton is a CCG Ward and therefore is not part of the Trusts Unify return

	DAY		NIGHT		MITIGATING ACTIONS
	Average fill rate - registered nurses/midwives (%)	Average fill rate – Health Care support staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - Health Care support staff (%)	
SAU	96.8%	100%	-	-	**Vacancy:** - Band 6 1.0 wte **Sickness rate** 10.11% **Action taken:** - Attendance management policy followed. Band 6 role advertised
Ward A5	81.6%	92.5%	90%	101.1%	**Vacancy:** Band 6 2.62 wte Band 5 2.1 wte band 2 4.2 wte **Sickness rate:** 7.9% **Action taken:** Daily review by the matron to review staffing levels and acuity, staff moved from other areas to support. Attendance management policy followed, monthly meeting with HR and welfare meetings arranged. Ongoing recruitment plans in place
Ward A6	72.7%	93.7%	87.8%	100%	**Vacancy:** - Band 5 11.99 wte **Sickness rate** – 9.48% **Action taken:** Daily review by the matron to review staffing levels and acuity, staff moved from other areas to support. Attendance management policy followed, monthly meeting with HR and welfare meetings arranged. Targeted recruitment plan in place
Ward B4	95.7%	100%	100%	-	**Vacancy**: Band2 1.51wte **Sickness rate** –23.9% **Action taken:** Daily staffing review against acuity and activity. Recruitment plan in place.. Sickness absence reduced in month and being managed in line with Trust policy.
Ward A4	83.7%	99.2%	88.9%	100%	**Vacancy:** - Band 5 3.54 wte **Sickness rate** – 5.77% **Action taken:** Staffing and activity reviewed daily. Recruitment programme in place. Attendance management policy followed, Sickness absence being managed in line with the Trust policy.
Ward CMTC	98.3%	95.3%	98.3%	100%	**Vacancy:** Band 5 4.0 wte band 2 1.0 **Sickness rate –** 9.99% **Action taken**: 1.0 band 5 and 1.0 HCA due to commence in October 2019. Sickness absence being managed in line with the Trust policy. Recruitment programme in place.
Ward A9	87.3%	93%	99%	99.2%	**Vacancy: band 6 1.0 wte** Band 5 – 2.0 wte band 2 3.0wte **Sickness rate** – 6.10%

					Action taken: Staffing reviewed daily and support provided if necessary. 2.0 band 5and 2.0 band 2 due to commence in October 2019. Sickness absence being managed in line with the Trust policy.
Ward B11	98.8%	100%	100%	100%	**Vacancy:** Band 5 – 4.0 wte **Sickness Rate:** 1.71% **Action taken:** - recruitment process in place. 2 band 5's due to start in October. Staffing reviewed daily and support provided if necessary.
NNU	93%	80%	81.3%	83.8%	**Vacancy rate:** 1.8wte band 6 **Sickness Rate:** 6.1% **Action taken:** band 6 recruited to awaiting pre-employment checks. Sickness is managed via the Trust policy. Staffing reviewed daily and support provided if necessary.
Ward C20	91.1%	78.6%	100.1%	-	**Vacancy: :** Band 5 1.0 wte **Sickness Rate:** 0.69% **Action taken:** Staffing reviewed daily by the matron and staff moved to support if required and additional shifts request via NHSP. Sickness is being managed in line with Trust policy.
Ward C23	89.9%	93.5%	100%	100%	**Vacancy:** fully established **Sickness rate** – 8.75% **Action taken:** Daily review of staffing and staffed moved from other areas depending on acuity and occupancy. Sickness policy followed and supported by HR
Delivery Suite	94.6%	88.8%	86.1%	100%	**Vacancy:** - Band 2 1.0 wte **Sickness rate** – 4.4% **Action taken:** Daily review of staffing and acuity, staff moved from other areas to support and additional staff access via NHSP. Sickness is being managed in line with Trust policy.
Ward A1	77.2%	116.7%	99.1%	100%	**Vacancy :** - 0.54 wte Band 6, 3.66wte Band 5 and 2.51wte band 2 **Sickness Rate:** 4.06% **Action taken:** 7 band 5 nurses commencing in post in October 2019. Daily review of staffing and acuity, staff moved from other areas to support and additional staff access via NHSP.
Ward A2	75.8%	80.7%	100%	104.4%	**Vacancy:** Band 5 10.58wte **Sickness Rate:** 9.24% **Action taken:** Daily review of staffing and acuity, staff moved from other areas to support and additional staff access via NHSP. Band 5 recruitment plans in place. Sickness is being managed in line with Trust policy.
Ward C21	81.4%	122.6%	100%	92.6%	**Vacancy :-** Band 5 0.54 wte **Sickness Rate:** 21.35% **Action taken:** - Daily review of staffing and acuity, staff moved from other areas to support and additional staff access via NHSP. Sickness is being managed in line with Trust policy.
Ward A8	78.7%	103.3%	92.5%	111.1%	**Vacancy :** - Band 6 2.0 wte band 5 –3.0wte Band 2 2.35wte **Sickness Rate:** 19.5% **Action taken:** Recruitment plans in place/ 2 band 5 and 2 band 6 and 1 band 2 recruited

					and awaiting start dates Ward support by the continued use of NHSP and agency to ensure safe staffing levels. Pharmacy Technician support morning and lunchtime supports nursing staff.
Ward B12	86.2%	88.9%	100%	98%	**Vacancy :** - Band 5 2.57wte Band 2 1.0 wte **Sickness Rate:** 14.9% **Action taken**: - Recruitment plan in place. Daily review by the matron to review staffing levels and acuity, staff moved from other areas to support.
Ward B14	91.1%	105.5%	100%	170.2%	**Vacancy :-** 3.37wte Band 5, 1.68wte band 2 **Sickness Rate:** 11.7% **Action taken:** - recruitment plan in place Staffing reviewed daily against acuity and activity. Sickness is being managed in line with Trust policy.
Ward B18	82%	85.9%	82.2%	95%	**Vacancy :** -Band 5 2.94 wte band 2 0.5wte **Sickness Rate:** 7.34% **Action taken:** - Recruitment ongoing, staffing reviewed on daily basis by matron and ward manager
Ward B19	98.2%	101.4%	101.7%	98.9%	**Vacancy :** -Band 5 1.21wte band 2 0.78 **Sickness Rate:** 1.88% **Action taken:** - Ward reviewed daily for acuity and staffing.
Ward A7	80.3%	104.6%	90%	118.9%	**Vacancy :** Band 5 5.61wte band 2 0.22wte **Sickness Rate:** 4.84% **Action taken:** - Staffing reviewed daily against acuity and activity.
ACCU	99.4%	100%	100%	106.5%	**Vacancy :** fully established **Sickness Rate:** 5.6% **Action taken:** Staffing reviewed daily against acuity and activity, staff support accessed from other areas when required. Sickness is being managed in line with Trust policy
ICU	87.1%	94.4%	86.2%	90%	**Vacancy :** – 7.91wte band 5 2.15wte band 2 **Sickness rate** – 6.7% **Action taken:** - Sickness absence managed robustly in line with Trust Attendance Management Policy. Rota shortfall managed with temporary staffing, mainly own staff via NHSP. Recruitment plan in place
Total Fill Rate (%)	**87.8%**	**97.3%**	**92.5%**	**103%**	

3. ASSURANCE COMMITTEE

The monthly staffing report is received and discussed at the Strategic People Committee

4. RECOMMENDATIONS

Board asked to note the contents of this report as discussed and received at the Strategic People Committee

Kimberley Salmon-Jamieson
Chief Nurse and DIPC
September 2019

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NHS Warrington and Halton Hospitals NHS Foundation Trust

BOARD OF DIRECTORS CHAIR'S KEY ISSUES REPORT

AGENDA REFERENCE:	BM 19/11/108 b	COMMITTEE OR GROUP:	Trust Board	DATE OF MEETING	27 November 2019

Date of Meeting	5 November 2019
Name of Meeting + Chair	Quality Assurance Committee, Chaired by Margaret Bamforth
Was the meeting quorate?	Yes

The Quality Assurance Committee met on 5 November 2019. The following matters were discussed:

- A Patient Story was received;
- Update provided of a deep dive in to Urology was received;
- The Committee received a High Level Briefing relating to Moving to Outstanding Action Plan;
- The Committee reviewed the Quality Dashboard and associated KPIs;
- An update was provided on Maternity Services and on the Maternity Safety Champions work;
- The Committee reviewed and received Joint Maternity + IM&T Data Quality Report;
- The Committee reviewed and received the Managing Clinically Related Challenging Behaviour output report from the T&F Group;
- The Committee reviewed and considered SI Lessons Learned Q2 report;
- The Committee reviewed and received the Bi-Annual Safeguarding Report.
- The Committee reviewed and considered Clinical Audit Q2 Report;
- The Committee reviewed and considered Dementia Strategy Q1 Report;
- The Committee reviewed and considered Infection and Prevention Control Q2 Report;
- The Strategic Risk Register, Board Assurance Framework and Corporate Risk Register were reviewed and considered;
- The Committee reviewed and considered Quality Priorities Q2 Report;
- The Committee reviewed and considered Quality Impact Assessment + CIP Report Q2
- The Committee reviewed and considered a Summary of enabling strategies alignment to committees

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- The Committee received recommendations from NCEPOD – 'Know the Score' review of care provided to patients with pulmonary embolism PHE Screening Programme
- A HLB was received from the Patient Safety and Clinical Effectiveness Sub-Committee, the Urgent & Emergency Care Improvement Committee, the Safeguarding Sub-Committee, the Complaints Quality Assurance Group, the Patient Experience Sub-Committee, the Infection Control Sub-Committee, the End of Life Steering Group & Strategy and the Information Governance & Corporate Records Sub Committee.

Following consideration of the above, the Committee wishes to bring the following matters to the attention of the Board:

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/ mandate to receiving body	Follow up/ Review date
QAC/19 /11/163	Moving to Outstanding	The Committee noted the following in respect of the action plan following the recent CQC inspection: • 62 actions, 54 aligned to 'should do' recommendations following the recent CQC inspection. 24 Actions completed, 28 on track, 37 still to be completed of which 23 are due by the end of November 2019. • M20 framework/programme of work to be agreed at Executives, future Trust Board and QAC for review. • Anticipated core services inspections next year will include ED, End of Life, Paediatrics, Surgery and a Well Led inspection. Work progressing in preparation for these and a further unannounced focussed inspection	The Committee noted the update and received high assurance.	**QAC January 2020**
QAC/19 /11/164	Urology	• Following a Urology GIRFT report and an increase in incidents and complaints during July 2017-May 2019 a service deep dive had been undertaken. • Urology Improvement Committee established, ToR and action plan agreed. • Monitoring committee is Patient Safety + Clinical Effectiveness Sub Committee with issues escalated to QAC as appropriate	The Committee noted the update and agreed that action plan progress wouls be monitored at Patient Safety & Clinical Effectivess Sub-Committee and Quality Assurance Committee; and received moderate assurance	**PSCE November QAC January**

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QAC/19 /11/165	Quality Dashboard and Review and refresh of KPIs	The Committee received the Quality Dashboard which highlighted the following matters which are included in the IPR which will be received by the Trust Board at this meeting. Of particular note were the following matters: • 6 Serious Incidents reported in September 2019, improvement over last 12 months. • Medication Safety – implementation of the 7 day service on track; medicines reconciliation - the overall % has remained the same at 27% within 24hrs against a minimum target of 60%. • F&F A&E + UCC - achieved 78% against a target of 87%. a review of the data completed for Sept 2019 identified a notable decrease in patients recommending the service in ED ambulatory care unit, escalated to CBU triumvirate, deep dive undertaken and findings reported to PSCE and ED Improvement Committee monitoring action plan.	The Committee received moderate assurance and the Board will review the full IPR as part of the meeting today	**Trust Board November 2019 QAC January**
QAC/19 /11/166	Maternity Safety Champion Report	• QAC supported the opening of Hub at Halton and development of a business case for in-reaching into Ingleside Birth Centre to support increase of Continuity of Care pathway. • Future maternity reports to include section on Lorenzo progress	The Committee noted the update and received moderate assurance	**QAC January 2020**
QAC/19 /11/167	Joint Maternity + IM&T Data Quality	• Explanation provided on actions and mitigations following recent issues relating to poor data quality to maximise IT support for maternity services which will support a holistic approach for staff to record and extract maternity data as part of the Trust Digital Framework. Progress to be included in Maternity Safety Champion report.	The Committee received moderate assurance	**QAC January 2020**
QAC/19 /11/169	SI Lessons Learned Audit Q2 Report	• Learning continues to be shared and reinforced through the Safety Huddle, weekly harm meetings and CBU governance meetings with enhanced support from Governance team. • Governance team will support CBUs reiterating how to upload evidence onto Datix reiterating 'smart' actions and what is required as evidence for uploading. Actions are to be quality checked by the Patient Safety Governance	The Committee received moderate assurance. Further updates to be presented March QAC. SI lessons learned further audit to PSCE and QAC in	**PSCE & QAC May 2020**

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		Manager	May	
QAC/19 /11/171	LFE Q2	• Non-Clinical Incidents – H&S Sub Committee had requested a further audit of Sharps and outcomes to be recorded on CBU Dashboard for monitoring.	The Committee received moderate assurance. Update to be provided at PSCE and QAC	**PSCE November QAC January 2020**
QAC/19 /11/174	Learning From Deaths Q1 report	• Of 228 deaths within the Trust, 53 deaths met the criteria for a structured judgement review (SJR) through the Mortality Review Group • 3 were to subject to investigation using root cause analysis (RCA) methodology. • The Trust is not an outlier for HSMR or SHMI. The Trust is not an outlier for R-Codes, focussed review will be undertaken for learning on processes put in place including through Ward Rounds and Grand Round. • Care of patients with LD will be a focus at the Patient Safety Summit and the Trust Quality Priorities for next year to support robust mechanisms to appropriately identify a potent on MH, Acute and Community systems and support care of this cohort of patients when presenting in Acute setting.	The Committee received moderate assurance. Further updates to be presented at next meeting. R Codes review in March	**QAC March 2020**
QAC/19 /11/175	Clinical Audit Q2 report	A number of audits had been undertaken providing Moderate and Significant levels of assurance. Improving Surgeries launched by Quality Academy October 2019 to support trainees in undertaking of clinical audits and quality improvement projects.		**QAC March 2020**
QAC/19 /11/176	Dementia Strategy Q1	• Trust Dementia Strategy extended to 31.12.2019 to align with national directives and C&M partnership work. Refreshed Strategy to incorporate feedback following a number of engagement events. • Significant assurance provided relating to Dementia and Delirium assessments achieving above 90% for Part 1 and 2 and 100% for Part 3. Further updates in Q2 report	The Committee received significant assurance.	**QAC January 2020**
QAC/19 /11/181	High Level Briefing - Patient Safety + Clinical	The Committee particularly noted the following matters: • DNACPR baseline audit for period October 2019-March 2020 to be undertaken aligned to GIRFT, reported to future PSCE and QAC when completed.	The Committee received moderate assurance.	**QAC and PSCE**

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	Effectiveness Sub Committee			
QAC/19 /11/190	High Level Briefing U+E Care Committee	The Committee particularly noted the following matters: • 35 actions on action plan to address Regulatory Breaches, 14 aligned to 'Must' do completed, 4 'Should' completed, 17 in progress. • MADE event commenced 23.10.2019, improvement reported supporting flow in ED and management of Super Stranded patients.	The Committee received moderate assurance. Further updates to be presented at next meeting	**QAC January 2020**

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Strategic People Committee Chair's Report

Agenda Ref	BM 19 11 108	COMMITTEE OR GROUP:	Strategic People Committee	DATE OF MEETING	18 September 2019	CHAIR:	Anita Wainwright, Non-Executive Director

Attendance

Anita Wainwright	Non-Executive Director (Chair)
Ian Jones	Non-Executive Director
Michelle Cloney	Director of HR and OD
Deborah Smith	Deputy Director of HR and OD
Dan Moore	Deputy Chief Operating Officer
Kimberley Salmon-Jamison	Chief Nurse
Alex Crowe	Medical Director

In attendance

Jennie Myler	Executive Assistant
Christine Samosa	Cheshire and Merseyside Strategic Workforce Lead

AGENDA ITEM	LEAD OFFICER	Issue / Exception Report	Recommendation / Assurance/ Action/Decision
SPC/19/09/77	Cheshire and Merseyside Strategic Workforce Lead	Cheshire and Merseyside Workforce Programme.	Christine Samosa, Cheshire and Merseyside Strategic Workforce Lead, attended the Committee to present an update on the Cheshire and Merseyside workforce programme. zz. C&M Warrington Presentation for SPC
SPC/19/09/84	Deputy Medical Director	GMC Trainee Survey Results 2019	**Assurance** Following the 2018 GMC Trainee Survey the overall risk Score was recorded as Category 2 - with 2 concerns graded at Category 3. The 2019 survey

			results showed a marked improvement and the Trust overall risk score was reduced to Category 1. A meeting will take place in October 2019 with HENW to review the Trust's Enhanced Monitoring status.
SPC/19/09/86	Deputy Director of HR and OD	Workforce Race Equality Standard Workforce Disability Equality Standard	Decision The Committee approved the Workforce Race Equality Standard and the Workforce Disability Equality Standard documentation for publication. WDES Action Plan.docx WRES Reporting Template.pdf WRES Action Plan.docx WDES Reporting Template.docx

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Strategic People Committee Chair's Report

CHAIR:

Agenda Ref	BM/19//11/108	COMMITTEE OR GROUP:	Strategic People Committee	DATE OF MEETING	20 November 2019		Anita Wainwright, Non-Executive Director

AGENDA ITEM	LEAD OFFICER	Issue / Exception Report	Recommendation / Assurance/ Action/Decision
SPC/19/11/98	Director of HR and OD	Cheshire and Mersey Agency Rate Cards	**Escalation** The Director of HR and OD reported that there had been an agreement across Cheshire and Mersey to implement the Agency Rate Cards for both Medical and Nursing staff from 1.12.2019 however that had since been challenged by some Chief Executive Officers. Due to the fact that there was not 100% 'sign up' from Chief Executive Officers it is now unlikely that the implementation date will be met. The implementation of the Rate Cards is a key element of the Trust's financial recovery plan.
SPC/19/11/99	Deputy Director of HR and OD	Local Induction – Temporary Medical Staff	**Action** The Deputy Director of HR and OD reported that local induction compliance was low for bank and agency medical staff. Actions undertaken in the HR and OD Team include a review of policy, streamlining paperwork and refining reporting. Actions agreed to be undertaken at a CBU level include oversite at CBU Governance Meetings, clarification of expectation at Medical Cabinet and identification of a lead administrator in each CBU.
SPC/19/11/103	Deputy Director of	Clinical Excellence Awards Policy	**Decision**

	HR and OD		The Committee were updated on progress in regards to the local Clinical Excellence Awards (CEA) round for 2018. The Chair of SPC had taken Chair's action to approve the CEA Policy ahead of the Committee Meeting and the round has been opened in November. The intention is to close in December 2019 and ensure any awards are paid within the financial year.
SPC/19/11/108	Associate Director of Nursing	Burdett Trust for Nursing Awards	The Nursing and HR Teams were won the 'Best Career Planning and Development Offer' award and were highly commended in the 'Best Use of Data Diagnostic to Inform Retention Initiatives' award.

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CHAIR'S KEY ISSUES REPORT

AGENDA REFERENCE:	BM/19/11/108	COMMITTEE OR GROUP:	Trust Board	DATE OF MEETING	27 November 2019

Date of Meeting	23 October 2019
Name of Meeting + Chair	Finance & Sustainability Committee - Terry Atherton
Was the meeting quorate?	Yes

REF	AGENDA ITEM	ISSUE	Recommendation / Assurance/ mandate to receiving body	Follow up/ Review date
FSC/19/10/133	Pay Assurance Dashboard Monthly Report	• Total pay in September £15.9M against a budget of £16.0M • The staffing of unfunded areas such as GPAU and Discharge Lounge is impacting on temporary staffing costs for nursing and midwifery staff group. • Additional plans are required in relation to pay spend, The proposals were reviewed in PPSRG prior to submission to the Executive Team and include items from the 'Pay' section of the NHSI/E Grip and Control Checklist.	The Committee reviewed, discussed and noted the report.	FSC Nov 2019
FSC/19/10/134	Risk Register	One risk has been re-escalated - Failure to provide continuity of services caused by the scheduled March 2019 EU Exit resulting in difficulties in procurement of medicines, medical devices and clinical and non-clinical consumables.	The Committee reviewed, discussed and noted the report.	FSC Nov 2019

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FSC/19/10/135	Corporate Performance	• Based on the performance in month 6 the Trust has a Service Performance Score of 1. • There was a discussion relating to ambulance handovers and the connectivity to activity and length of stay/super stranded.	The Committee noted the report.	FSC Nov 2019
FSC/19/10/165	Monthly Finance report	• The Trust has recorded a deficit of £3.9m which is £0.2m better than plan • There remains underperformance on activity and income plans however there has been an improvement in month. • There are unmitigated residual cost pressures of £1.0m, unidentified CIP of £0.5m and high risk CIP of £0.8m • The latest forecast outturn including mitigation shows risk to delivery of plan by c£2.5m • For the period ending 30 September 2019 actual agency expenditure is £5.3m which is £0.1m below plan. The ceiling will reduce in month 7. A clear plan identifying how these costs will reduce is required. • The system financial risk that has been identified by Warrington and Halton CCGs at £15m (£10m for CCGs and £5m for Trusts). System recovery meetings have been held with partners and NHSI/E to reduce the level of risk. The mitigated risk reduced to £11.6m at month 5. •	The Committee reviewed, discussed and noted the report and the financial risks.	FSC Nov 2019
FSC/19/10/137	Combined Financial Position	• There are pressures relating to CIPs, QIPP and acute activity. At present the forecast out turn has not been adjusted for the mitigated combined risk.	The Committee reviewed, discussed and noted the report and the financial risks.	FSC Jan 2020
FSC/19/10/139	Medical Staffing Review	• A presentation was received highlighting the progress and future plans for Integrated Medicine and Community CBU in respect of clinical vacancies and use of locums.	The Committee thanked the CBU for the presentation and excellent progress made.	

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NHS Warrington and Halton Hospitals NHS Foundation Trust

FSC/19/10/139	5 Year Plan	• Submitted 1st draft 13 September 2019 with a deficit of £22.8m for 2020/21 • Latest draft is deficit of £21.8m for 2020/21 • Final Submission due 1st November 2019 • Further system meetings are planned to seek to reduce the deficit for next year and across the scope of the Long Term Plan.	The Committee noted the progress made and highlighted that the plan will be presented to Trust Board on 30 October 2019.	
FSC/19/10/140	Key issues for escalation	• The FSC wished to highlight the agency ceiling, cost pressures and high risk/unidentified CIP which pose risk to delivery of the financial position.		

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NHS Warrington and Halton Hospitals NHS Foundation Trust

CHAIR'S KEY ISSUES REPORT

AGENDA REFERENCE:	BM/19/11/108	COMMITTEE OR GROUP:	Trust Board	DATE OF MEETING	27 November 2019

Date of Meeting	20 November 2019
Name of Meeting + Chair	Finance & Sustainability Committee - Terry Atherton
Was the meeting quorate?	Yes

REF	AGENDA ITEM	ISSUE	Recommendation / Assurance/ mandate to receiving body	Follow up/ Review date
FSC/19/11/147	Pay Assurance Dashboard Monthly Report	• Total pay in October £16.8m against a budget of £15.7m • Agency cap was breached in October with spend circa £1m. This is worrying as one of the Trust mitigations is to reduce agency. • One doctor had significant back pay which impacted on month 7 figures – process to be reviewed • The Trust is booking more staff cover than the established gaps some of this will relate to escalation areas. Temporary spend in month was £2.5m 13% of pay • 40 new registered nurses started in October • The launch of standardised rate card across Cheshire and Mersey has been delayed which is disappointing and should be escalated to NHSE/I	The Committee reviewed, discussed and noted the report.	FSC Dec 2019

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FSC/19/11/148	Risk Register	• No changes to risks in month 7, current advice is to keep BREXIT risks as they currently are.	The Committee reviewed, discussed and noted the report.	FSC Dec 2019
FSC/19/11/149	Corporate Performance	• October A&E performance is 80.04% hitting trajectory – 7th consecutive month of increase in activity • Diagnostics, RTT and Cancer targets met for October • Ambulance handover over 60 minutes and 30-60 has been higher than average but showing some improvement	The Committee noted the report.	FSC Dec 2019
FSC/19/11/150	Monthly Finance report	• The Trust has recorded a deficit of £3.3m which is on plan and a surplus of £0.5m delivered in month • Improvement of activity levels in October needs to be maintained • Maternity activity recording is a concern and a working group has been set up • Other issues discussed included B3, K25 and MLU • Benchmarking results shared highlighting on average higher pay for staff however with lower productivity. This has been shared with Medical Cabinet and recording on Lorenzo is being looked at	The Committee reviewed, discussed and noted the report and the financial risks.	FSC Dec 2019
FSC/19/11/151	Cost Pressure	• Noted reduction in recurrent CIP due to removal of the spinal scheme • CIP delivery is above plan and expected to be until January 2020, main concern is the percentage of non-recurrent schemes which will impact on 2020/21 • Cost Pressures remain similar to last month and those which are not managed will impact on 2020/21	The Committee noted the report.	FSC Dec 2019
FSC/19/11/152	SLR	• An update of the Service Line Reporting was received, noted		FSC June

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NHS Warrington and Halton Hospitals NHS Foundation Trust

		progress and next steps.		2020
FSC/19/11/154	C&M Pathology	• The Committee noted the OBC which did not contain any financial analysis. It was noted the finance is important but the specification of the service will be the main driver for any new service	The Committee discussed and supported. The Committee highlighted that future detail would need to go to various Committees	TBC
FSC/19/11/155	Key issues for escalation	• Note the impact of agency expenditure being above the ceiling on both the Trust finances and reputation. • Note the financial challenges facing the Trust including winter pressures, non-recurrent CIP and unfunded cost pressures • Mid Cheshire benchmarking should be developed further to support increased productivity • Pathology Outline Business Case has limited information but over the coming months all Committees should be sighted on the progress – Quality, Finance and Workforce implication • Winter Pressures – operational and financial risks should be noted, particular risk with K25, capacity and financial.		

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NHS Warrington and Halton Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/19/11/109**			
SUBJECT:	**Learning from Experience Report Q2 2019/2020**			
DATE OF MEETING:	27 November 2019			
AUTHOR(S):	Layla Alani, Deputy Director Governance			
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse			
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future. SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.			X
LINK TO BAF RISK: **(*Please DELETE as appropriate)***	All			
EXECUTIVE SUMMARY *(KEY ISSUES):*	This is the quarterly integrated "Learning from Experience" (LFE) report. It focuses on the learning from incidents, complaints, claims and inquests over Q2, 1st July – 30 September 2019			
PURPOSE: *(please select as appropriate)*	Information	Approval	To note X	Decision
RECOMMENDATION:	The Board is asked to; • Note and approve the contents of the report • Receive assurance that the Learning from Experience process continues within the organisation. The presentation of the data is included within the slide deck provided.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.	QAC/19/11/171		
	Date of meeting	5 November 2019		
	Summary of Outcome	Assurance Provided		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None			

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

SUBJECT	Learning from Experience Report Q2 2019/2020	AGENDA REF:	BM/19/11/109

1. BACKGROUND/CONTEXT

This report relates to the period 1st July – 30 September 2019. It contains a quantitative and qualitative analysis (using information obtained from the Datix risk system) and includes incidents, complaints, claims and inquests. The report includes a summary of key issues identified in Q2 and makes specific recommendations in respect to the findings.

The purpose of the report is to:

- Identify themes arising from the incidents, complaints and claims that have been reported during the period,
- Make recommendations to the CBUs highlighting areas of focus for improvement; and
- Provide a summary of incidents, complaints and claims reported during the review period, highlighting any trends apparent from review of the data.

2. KEY ELEMENTS

2.1 Assurance to the Board of Directors

2.1.1 Incidents

- There was a slight decrease in incident reporting within the Trust in Q2 (2530 in Q2 vs 2594 in Q1) .
- There has been a marginal increase in the number of slips, trips and falls (218 in Q2 Vs 212 in Q1). This is mainly attributed to wards A4 and A8.
- Falls incidents in Q2 have been linked to 6 incidents of harm, compared to 4 incidents in Q1. Focused work continues with both the falls collaborative and CQUIN.
- Incidents relating to security, communications and pressure ulcers decreased in Q2.
- During Q2 the Trust reported 1 Never Event following the administration of an interscalene block to the wrong side of a patient. The patient was scheduled for left shoulder surgery. Duty of candour was completed and the case was reported to the CCG and CQC. The investigation is now complete.
- A trend in incidents involving mail being sent to incorrect recipients was identified at the Information Governance and Corporate Records Sub-Committee in October 2019. Data subjects whose confidentiality had been compromised were informed as per the requirements of the Data Protection Act 2018. Possible solutions are being explored to reduce future risk.

2.1.2 Complaints and PALs

- Q2 reported improved performance across CBU's in the timeliness of responding to complaints. There was also improvement in the number of complaints closed within specified timeframes (152 in Q2 Vs 118 in Q1).
- The Trust currently has no complaints over 6 months old.
- There has been a decrease in the timeliness of responding to concerns during Q2. This is being monitored through TOB and through the complaints team. The Trust currently has 5 open PHSO cases.
- Themes identified in complaints mirror those found across PALs and incident reporting; delay in treatment, prolonged periods of waiting for appointments and cancellation of appointments. Themes within the complaints continue to reference poor communication and staff attitude. Training on 'First Impressions and Customer Care' continues to be rolled out across the Trust.
- Actions from complaints are monitored via the speciality governance dashboards and the Clinical Governance Department, reporting to the Complaints Quality Assurance Group.

2.1.3 Mortality

- Medical Care, Integrated Medicine and Community and Urgent and Emergency Care report the highest number of mortalities, though this is not disproportionate when considering the type and number of patients cared for in these areas.
- As part of the mortality review process the majority of Structure Judgement Reviews (SJR) conducted in Q2, concluded the overall standard of care as 'Good or adequate'. 0 SJRs were reported as 'poor'.
- Comparing the data with Q1, the absence of DNACPR, DoLs and under 55 remain the most common trigger for conducting SJRs; their frequency has increased by 1-2 since Q1.
- The Summary Hospital Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratios (HSMR) are within expected range and stabilising.
- The Trust has approved the End of Life Strategy and two Palliative Care Consultants have now taken up post.

2.1.4. Clinical Audit

- There are a number of audits ongoing across the Trust. For Q2 this briefing makes reference to Sentinal Stroke National Audit Programme (SSNAP). WHH have already addressed a number of issues by the collaboration with Whiston and the movement of the hyper acute stroke service. The latest SSNAP scores have been published (Sept 2019) for the first quarter (April 19 – June 2019) since the collaboration and have shown an improvement in performance.

3.0 Items Escalated in Q2

3.1 Clinical Incidents

- The number of open incidents marginally increased from 337 in Q1 to 345 in Q2. Urgent and Emergency Care, Women's and Children's, Digestive Diseases and Integrated Medicines and

Community have a relatively high number of incidents open. This is not suprising given the correlation in frequency of incidents and the nature of such areas.

- A total of 2329 incidents were reported across the 8 CBUs in Q2 indicating a slight decrease when compared to Q1 which reported 2353. The top 5 categories reported in Q2 were clinical care, medication, communication, pressure ulcers and falls (Q1 categories were clinical care, communication, pressure ulcers and security). Incidents relating to medication showed a significant increase of 261 in Q1 Vs 331 in Q2.
- In relation to the top 5 categories there are several ongoing programmes of work within the Trust that aim to improve patient safety; the seven day pharmacy service (which includes a pharmacist situated within ED) and the implementation of ePMA. Pressure Ulcers have a Quality Improvement collaborative ongoing with good progress being made in areas of innovation. Updates are reported through the Trust Tissue Viability Steering Group.
- Q2 reported 22 moderate, 10 major and 2 catastrophic incidents across the Trust. The 2 catastrophic events were a delay in treatment in ED and a complication of an endoscopic procedure. These investigations concluded that the outcomes were unavoidable.

3.1.2 Non-Clinical Incidents

- Q2 reported 328 non clinical incidents which is a reduction when compared to Q1, 381. The top 2 categories were Security Incidents and Health & Safety Incidents. Needlestick injury was one of the top sub-categories for Health & Safety Incidents and a Trustwide Sharps Audit relating to 'sharps safety' was undertaken in August 2019. All CBUs have an action plan in place to evidence improvement.

3.1.3 Claims

- Clinical claims settled with damages totalled: £699,715.04 including costs
- Payments for non-clinical claims settled with damages totalled: £20,720.64 including costs.

4 RECOMMENDATIONS

Matters noted in this paper were discussed at the Quality Assurance Committee on 5 November 2019. A review of the learning framework with the teams and key leads is to be progressed.
The Board are asked to discuss and note this highlight report and accompanying slides.

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/19/11/110**
SUBJECT:	**Infection Prevention and Control**
DATE OF MEETING:	27 November 2019
AUTHOR(S):	Lesley McKay Associate Chief Nurse for Infection Prevention and Control/Associate DIPC
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse/DIPC
LINK TO STRATEGIC OBJECTIVES:	SO1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience
	SO2: We will .. Be the best place to work with a diverse, engaged workforce that is fit for the future
	SO3: We will .. Work in partnership to design and provide high quality, financially sustainable services
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	Nil link to current risks on the Board Assurance Framework
EXECUTIVE SUMMARY ***(KEY ISSUES):***	This report provides a summary of infection prevention and control activity for Quarter 2 (Q2) of the 2019/20 financial year and highlights the Trust's progress against infection prevention and control key performance indicators. The Trust reported:- • 11 Clostridium difficile cases in Q2. 3 cases have been reviewed by the CCG and agreed to have no lapses in care. The Trust is on trajectory • 2 MRSA bacteraemia cases in Q2: 1 avoidable; 1 unavoidable • 10 MSSA bacteraemia cases in Q2. There is no national reduction target • 13 E. coli bacteraemia cases in Q2. This is a slight reduction from Q1. However the Trust is above the planned trajectory Due to the rise in E. coli bacteraemia cases, a 5% reduction target has been set as a priority in the Quality Strategy for 2019/20. Action plans, which focus on learning from GNBSI incidents, are in place to manage and monitor these infections. The Trust commissioned a mobile ward (K25) to support operational activity and ward upgrade work. Water testing identified growth of Pseudomonas and the Estates Team has carried out appropriate action including chemical and thermal disinfection and replacement of pipework. Additional high level disinfection was implemented, however the issue persisted. Following a meeting with the mobile ward company point of use filters have been refitted on all water outlets in the facility. The Infection Prevention and Control Team have carried out a number of promotional activities to support reductions in healthcare associated infections. Overall compliance for attendance at mandatory infection control training is 89%. Urgent and Emergency Care, Integrated Medicine and Community and Digestive Diseases CBUs are below the 85% compliance threshold and have plans in place to improve compliance.

	The audit programme is highlighting concerns relating to the environment. In the main this relates to furniture requiring replacement. In addition, ward kitchens, handling of linen and decontamination are areas for improvement. Actions are in place to address audit findings. The Quarterly Antibiotic Point Prevalence audit result was 94% compliance with the Trust Formulary. Dates have been set and stakeholders invited to participate in the Infection Prevention and Control Strategy review.			
PURPOSE: (please select as appropriate)	Information √	Approval	To note √	Decision
RECOMMENDATION:	The Board is asked to note the contents of the report, exceptions highlighted and progress made.			
PREVIOUSLY CONSIDERED BY:	**Committee**		Quality Assurance Committee	
	Agenda Ref.		QAC/19/11/172	
	Date of meeting		5th November 2019	
	Summary of Outcome		Analysis of themes from ward environmental audits to direct improvements.	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

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NHS Warrington and Halton Hospitals NHS Foundation Trust

SUBJECT	Infection Prevention and Control Q2 report 2019/20	Agenda Ref:	BM/19/11/110

1. BACKGROUND/CONTEXT

This report provides an overview of infection prevention and control activity for Quarter 2 (Q2) of the 2019/20 financial year (FY). The report highlights the Trust's progress against Healthcare Associated Infection (HCAI) reduction targets, learning from incidents and an update on activity for audit, education, surveillance and policy reviews.

NHSI use Clostridium difficile infection rates as one of a number of metrics to assess Trust performance. Both avoidable and unavoidable cases are taken into account for regulatory purposes. The Trust is assessed for breaches of the Clostridium difficile objective using a cumulative year to date (YTD) trajectory.

The zero tolerance threshold for avoidable cases of Meticillin resistant Staphylococcus aureus (MRSA) bacteraemia remains in place.

There is a national ambition to halve gram-negative bloodstream infections (GNBSIs). The Antimicrobial resistance 5 year plan provided a revised timescale to meet this objective and advises a systematic approach is required to deliver a 25% reduction by 2021-2022 with the full 50% by 2023-2024.

2. KEY ELEMENTS

HCAI data

RAG rating of Trust performance for HCAIs by month is as shown in Table 1.

Table 1: HCAI data by month

Indicator	Target	Position	A	M	J	J	A	S	Total
C. difficile	≤44	On trajectory	3	1	4	4	6	1	19
MRSA bacteraemia	Zero tolerance	Above trajectory	0	0	0	0	2	0	2
MSSA bacteraemia	No target	No target	0	0	1	2	3	5	11
E. coli bacteraemia	5% reduction ≤46	Above trajectory	4	6	5	3	2	8	28
Klebsiella spp. bacteraemia	5% reduction ≤13	Above trajectory	1	1	1	3	1	1	8
P. aeruginosa bacteraemia	5% reduction ≤4	On trajectory	0	0	1	0	0	2	3

Breakdown by ward is included at appendix 1.

Clostridium difficile

- 11 cases reported in Q2 (9 hospital onset/ healthcare associated: 2 community onset/ healthcare associated). The trust is on trajectory against the annual threshold
- All hospital apportioned cases undergo post infection review. Action plans for care improvements are aligned to findings from the reviews
- 4 cases from Q2 were considered avoidable following internal review, 3 cases were submitted to the CCG and agreed unavoidable
- 4 cases are awaiting review at the next CCG panel meeting

The Chief Nurse/DIPC chairs a meeting weekly, where healthcare associated infection investigation reports are reviewed. Themes identified from the C. difficile case reviews include: stool documentation, timely sampling and isolation. Learning from these meetings is shared with clinical teams via CBU Governance

meetings. In addition, work is in progress with the Communications Team to develop an awareness raising video that will be delivered at mandatory training sessions. This will complement the existing single point lesson (appendix 2) on C. difficile.

Bacteraemia Cases

Gram positive bacteraemia

Meticillin resistant Staphylococcus aureus (MRSA) bacteraemia

- 2 hospital onset cases in August

Case 1 occurred on ward A8. The patient had a long term history of MRSA colonisation and presented with bilateral leg cellulitis. A comprehensive incident investigation was completed and the case was considered unavoidable. There were some learning points identified that were not related to the development of the bacteraemia. These included ensuring all the required admission screening samples for MRSA are taken, completing documentation for cannula site monitoring and blood culture sampling.

Case 2 occurred on ward A5. The patient did not have any prior history of MRSA and presented with urology problems. A comprehensive incident investigation was completed and the case was considered avoidable. Learning from the review included: documentation of urinary catheter care and blood culture sampling, timely microbiological sampling on suspicion of sepsis/elevated NEWS2.

Meticillin sensitive Staphylococcus aureus MSSA bacteraemia

- 11 hospital onset cases in Q2. Post infection reviews are in progress
- No national reduction target/threshold

Gram negative bacteraemia (GNBSI)

E coli bacteraemia

- 13 hospital onset cases

Klebsiella Spp.

- 5 hospital onset cases

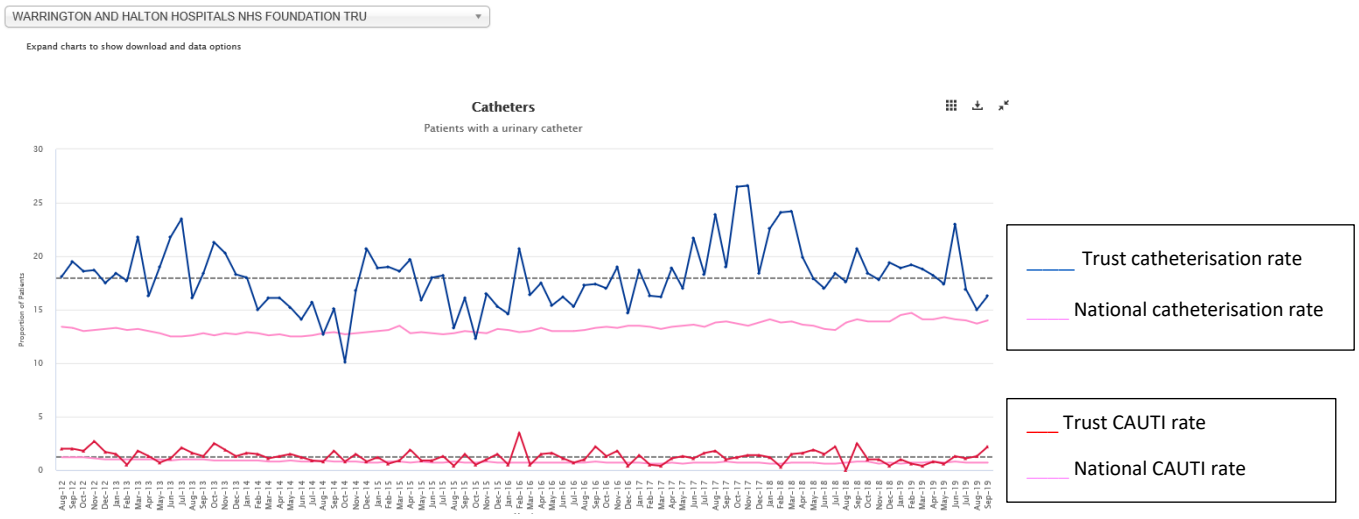
Pseudomonas aeruginosa

- 2 hospital onset case

There was a slight decrease in E. coli cases in Q2. All E.coli bacteraemia cases undergo post infection review. Action plans for care improvements are aligned to findings from the reviews and include urinary catheter care, timely blood culture sampling and education on the UTI pathway. These work streams are in progress.

Activity to reduce use of urinary catheters has seen a decrease in use over the last quarter according to the latest Safety Thermometer data (Figure 1). Over the time period the national average ranged from 13.7% to 14%. The Trust use ranged from 15% to 16.9%. Whilst the trust remains above the national average, figures have dropped below the upper control limit. Further awareness raising events for urinary catheter removal are planned for October 2019.

Figure 1 Urinary Catheter Safety Thermometer data



Catheter associated urinary tract infections (CAUTI) have increased slightly and further work is required to identify learning from these incidents.

Comparative data on HCAI cases and rates from August 2018 to July 2019 across the Northwest is included in appendix 3. Appropriate comparison with other similar Trusts (local delivery system partners), shows similar case numbers and for C. difficile and MRSA and a significantly lower number of cases for E.coli, Klebsiella spp. and Pseudomonas aeruginosa bacteraemia cases than one of our Local Delivery System partners.

Outbreaks - Norovirus

There were nil outbreaks of norovirus in Q2.

Table 2: Norovirus incidents by month

	A	M	J	J	A	S
Outbreaks	6	4	0	0	0	0

Incidents

K25 Water Safety

A mobile ward was commissioned by the Trust to support ward upgrades. Since the installation of the facility there have been water safety issues with high colony counts and Pseudomonas detected. The Estates Team has carried out a vast amount of work including: replacing pipework, thermal and chemical disinfection and installation of point of use filters. Agreement was reached to commence chemical dosing. This was carried out at high levels whilst the unit was vacant. Repeat water testing shows this has not eradicated the Pseudomonas. Point of use filters have been refitted on all water outlets in the facility and the unit returned to patient use. There is an escalated water testing programme in place to provide assurance on water safety.

Scabies

A case of scabies was identified in a patient admitted from a care home. Scabies was diagnosed pre-admission however the patient had only received one of two skin treatments. Subsequently, five members of staff reported rash illness. Scabies was not confirmed in any of these staff. As a precaution a decision was

taken to give prophylactic treatment to all ward based staff. The ward remains under surveillance for development of rash illness in patients and or staff.

Surveillance

A capital funding bid has been finalised and submitted to the Diagnostics and Outpatients CBU Manager to purchase software to make improvements in surveillance. There are a number of control measures currently in place to provide surveillance data including: local databases for alert organisms (those microorganisms with a potential to cause outbreaks of infection) and HCAI cases and functionality to undertake a retrospective review of microbiology results. A surveillance Nurse has been appointed and is scheduled to commence in post in November.

Infection Prevention and Control Training

Overall compliance with mandatory infection control training is above the 85% threshold and has remained around 90% for the last 11 months.

Table 3 Infection Control Training compliance

Infection Control Training	A	M	J	J	A	S
Overall % of staff trained	91%	91%	89%	90%	90%	89%

Infection Prevention and Control Audits

A total of 10 audits were completed (table 4). There is a schedule in place for completing audits. In addition, audits are carried out in response to evolving concerns e.g. increase in infections identified. Audit reports are returned to Ward Mangers who are responsible for developing action plans to address areas requiring improvement.

Action plans are monitored at the Infection Control Operational Group Meetings. Repeat audits are carried out where low compliance with standards are identified.

Table 4 Infection Control Audits

Ward	A2	A5	A7	A8	A5	C20	B14	ICU	A6	SAU
Environment	81%	71%	71%	66%	71%	83%	85%	70%	62%	66%
Ward Kitchens	83%	93%	84%	83%	74%	72%	76%	76%	74%	N/A
Handling/Disposal of Linen	89%	89%	84%	89%	89%	100%	94%	67%	84%	100%
Departmental Waste	100%	95%	100%	89%	94%	100%	100%	84%	94%	100%
Safe Handling Disposal of Sharps	100%	96%	96%	76%	92%	100%	100%	79%	83%	100%
Patient Equipment (General)	93%	78%	95%	88%	89%	100%	98%	79%	84%	77%
Patient Equipment (Specialist)	100%	N/A	100%	N/A	N/A	100%	100%	100%	100%	100%
Personal Protective Equipment	100%	91%	60%	92%	91%	100%	100%	93%	100%	100%
Short Term Catheter Management	100%	100%	94%	82%	83%	100%	100%	94%	94%	100%
Enteral Feeding	100%	N/A	82%	N/A	100%	100%	82%	100%	100%	100%
Care of Peripheral Intravenous Lines	91%	100%	100%	91%	100%	90%	100%	100%	90%	100%
Non-Tunnelled Central Venous Catheters	N/A	N/A	N/A	N/A	N/A	N/A	N/A	100%	N/A	N/A
Isolation Precautions	100%	100%	100%	87%	87%	100%	100%	92%	87%	N/A
Hand Hygiene	97%	97%	97%	74%	81%	100%	89%	95%	97%	97%
Overall Compliance	95%	92%	90%	83%	88%	96%	94%	88%	89%	95%

Areas for care improvement include: the environment, ward kitchens, handling and disposal of linen, safe handling of sharps and decontamination of patient equipment. Action to improve includes:-

- Discussion on the environmental concerns at the IPC operational group. Lower scores relate to a number of issues including damage to furniture (tables and lockers), exposed foam on foot stools, dusty ventilation extract vents and IT equipment. Action is being taken by the Estates Department to implement improvements with vent cleaning and wards have been asked to replace damaged furniture. ICU had a reduction in domestic staffing which has been raised with the Domestic and Portering Manager to address. Lead Nurses have been asked to review damaged furniture and prioritise replacements. Areas with lower scores will be re-audited within 3 months
- Ward kitchens have been added to the capital programme. Two kitchens per annum will be upgraded over the forthcoming years. The Task Team are supporting improvements to provide assurance essential standards are met
- A single point lesson has been developed to support improvements in compliance with handling linen and additional guidance provided on linen storage
- Health and Safety are leading on an action plan to improve sharps management. The concerns identified at audit have been discussed at the Infection Control Operational Group and Housekeepers are carrying out daily checks on bin assembly, labelling and use of temporary closure mechanism
- Decontamination of equipment is included in the medical devices group and additional auditing is being implemented

Environmental Hygiene

Cleanliness monitoring is carried out by the Facilities team. These audits review domestic cleaning, nursing cleaning and the general estate.

- Overall cleanliness score for Warrington
    - Very high risk areas - 97%
    - High risk areas – 95%

- Overall cleanliness score for Halton
    - Very high risk areas - 98%
    - High risk areas – 96%

Infection Control Policies

The following documents were revised and approved by the Infection Control Sub-Committee in July.

- Meningitis policy
- Decontamination policy
- Mattress inspection and cleaning sop

Antimicrobial Stewardship

- Quarterly point prevalence audit (August) showed overall compliance with the Trust's Antibiotic Formulary is 94% and is improved from the previous quarter (90%)
- 16 wards were 100% compliant with the formulary
- 5 wards had less than 90% compliance (ACCU, A4, A6, A8 and C20). The audit results are reported directly to Consultants' in charge of patients' for action

Awareness raising events

The Infection Prevention and Control Team have been proactive during Q2 and carried out a number of activities including:-

- Showcasing the Trust's use of PCR testing to investigate suspected outbreaks of Viral Gastroenteritis at the Academy of Medical Sciences in London
- Desk top messages on the UTI Pathway
- Launch of the skip the dip campaign to support achieving the UTI CQUIN
- Delivering Hot Topic sessions at Trust Wide Safety Brief including: UTI Pathway, Urinary catheter care; importance of hydration and blood culture sampling
- ANTT competency assessor training in partnership with the Clinical Education Team

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

- Work continues to meet the recommendations of the external review of Infection Prevention and Control reported in 2018
- Aseptic Non-Touch Technique (ANTT) assessor training commence in Q2 and a programme of annual competency assessments for staff undertaking procedures requiring ANTT is being put in place
- Dates have been set to invite stakeholders to participate in the Infection Prevention and Control Strategy review. This will be aligned to the Trust's Mission, Values and aims and objectives
- Review of Infection Prevention and Control Service survey results is in progress to inform the strategy review
- Approval is sought for the capital funding bid for laboratory surveillance software

4. IMPACT ON QPS

Q: A reduction in HCAIs will demonstrate a positive impact on patient outcomes.

P: Improved attendance at training assists staff in fulfilling mandatory training requirements.

S: Reduction in HCAIs supports sustainability by avoidance of contractual financial penalties.

5. MEASUREMENTS/EVALUATIONS

- Mandatory reporting of healthcare associated infection (HCAI) to Public Health England
- The Infection Prevention and Control Team meet fortnightly to monitor cases of HCAI. Action is implemented in response to increased incidences of HCAIs and infection control related incidents
- The Infection Control Sub-Committee meets bi-monthly (6 times per annum) and discusses HCAI surveillance data and learning from HCAI incidents
- Meetings take place weekly with the DIPC to review HCAI incident investigation reports and actions are agreed to support care improvements

6. TRAJECTORIES/OBJECTIVES AGREED

- The Clostridium difficile threshold for 2019/20 is ≤44 cases

The apportionment algorithm has changed (reduction in one day from admission i.e. samples taken from 3rd day of admission onwards will be apportioned to the Trust – previously this was from 4th day). Any cases arising within 28 days of a patient discharged will be classified as community onset/ healthcare associated and will also be apportioned to the Trust.

- The zero tolerance to avoidable MRSA bacteraemia cases remains in place
- GNBSI 5% reduction target has been set as a priority within the Quality Strategy

Work streams will continue to:-

- Progress GNBSI reduction
- Reduce the incidence of Clostridium difficile infection
- Promote Antimicrobial Stewardship and challenge inappropriate prescribing
- Partnership working with Urgent and Emergency Care CBU to support timely blood culture sampling
- Monitor invasive device management/bacteraemia reduction
- Continue ANTT competency assessor training
- Implement an infection control surveillance systems
- Support staff training in Infection Prevention and Control where CBU compliance is lower than 85%
- Promote excellent standards in uniform/workwear and the Bare Below the Elbows campaign
- Support assessment of decontamination standards
- Complete actions from the external review
- Set up a surgical site infection surveillance programme
- Review policies as per the work schedule

7. MONITORING/REPORTING ROUTES

High level briefing papers from the Infection Control Sub-Committee are submitted to:-

- Quality and Assurance Committee
- Health and Safety Sub-Committee
- Patient Safety and Clinical Effectiveness Committee

DIPC reports are submitted quarterly to the Quality and Assurance Committee and Trust Board.

Verbal updates are provided to Trust Board monthly as part of the IPR (in full) report.

A Director of Infection Prevention and Control Report is submitted to Trust Board annually.

Exception reports will be submitted to the Quality and Assurance Committee when increased incidences of infection are identified.

8. TIMELINES

2019/20 Financial Year

9. ASSURANCE COMMITTEE

- Infection Control Sub-Committee

10. RECOMMENDATIONS

The Board is asked to: note the content of the report; the exceptions reported - including being over trajectory for E. coli bacteraemia cases, the reduction plan in place as discussed at Quality Assurance Committee and the progress made.

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

APPENDIX 1 HEALTHCARE ASSOCIATED INFECTION DATA April – September 2019

Clostridium difficile Cases

Hospital onset/Healthcare associated = HOHA

Community onset/Healthcare assocaiated = COHA

Community onset/Healthcare associated cases are linked to the ward the patient was most recently discharged from

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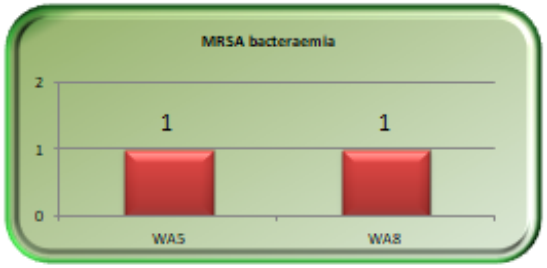
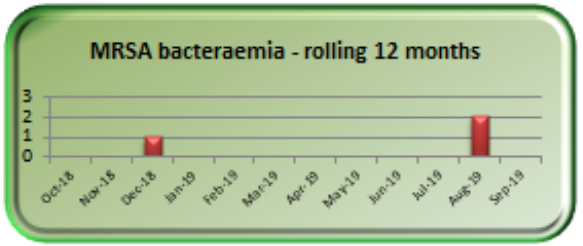
Gram Positive Bacteraemia Cases

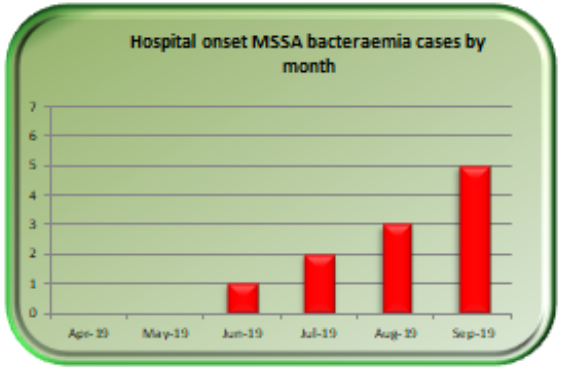
CDT | Bacteraemias | IPCT Activity | Antibiotics | MDROs

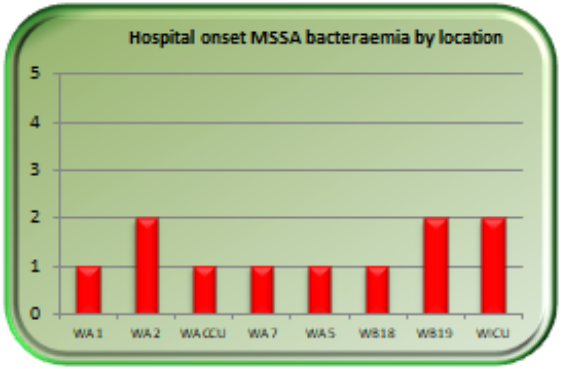
Hospital onset MRSA bacteraemia data Zero tolerance

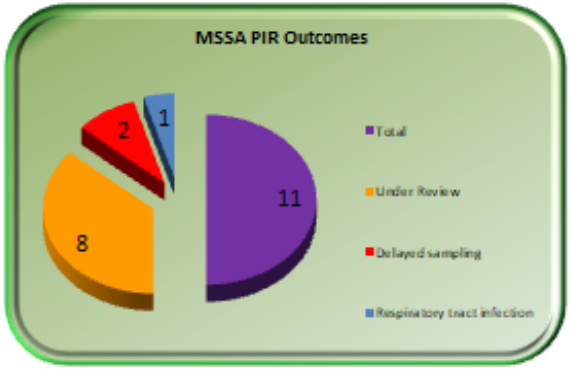




MSSA bacteraemia data (no thresholds set)







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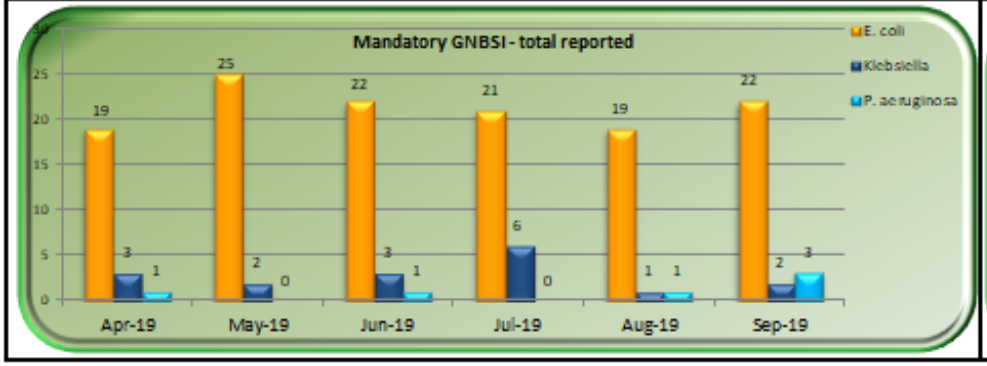
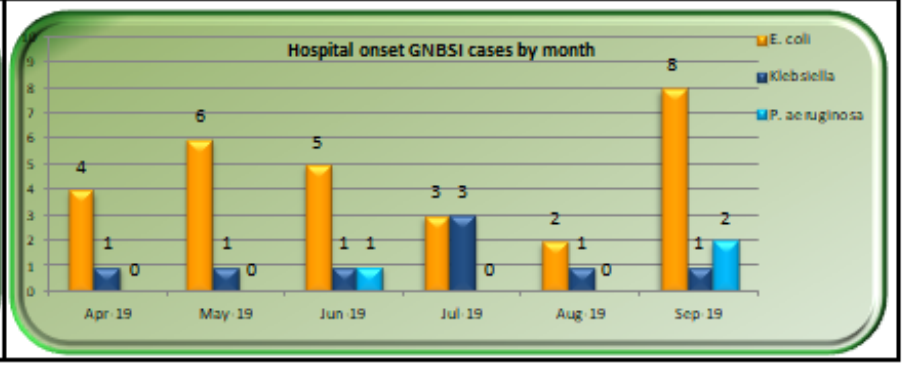
Gram Negative Bacteraemia Cases

CDT | Bacteraemias | IPCT Activity | Antibiotics | MDROs

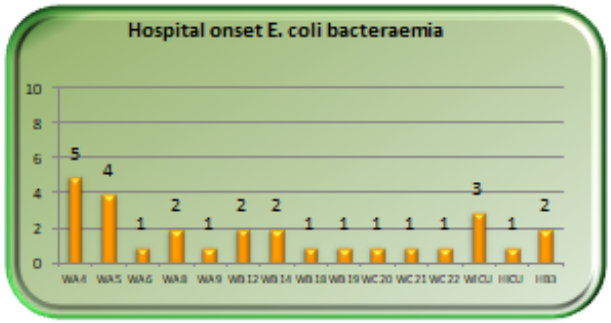
Mandatory GNBSI bacteraemia (total reported)



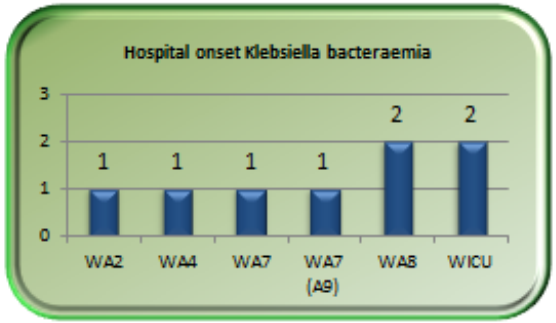
Hospital onset GNBSI cases (all)



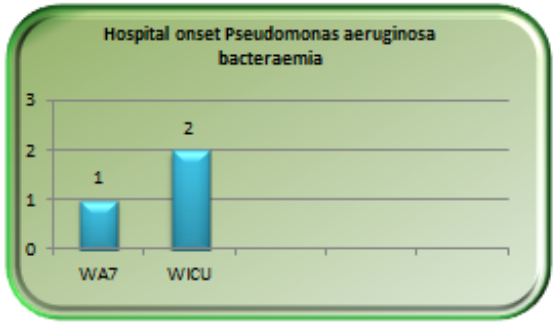
Hospital onset E. coli bacteraemia



Hospital onset Klebsiella bacteraemia



Hospital onset Pseudomonas aeruginosa bacteraemia



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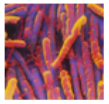
APPENDIX 2 Single Point Lesson C. difficile

High Quality, Safe Healthcare

Warrington and Halton Hospitals NHS Foundation Trust



Clostridium difficile

Single Point Lesson

SUSPECT - Diarrhoea (Bristol Stool Chart type 5 -7 not attributable to other cause)
ISOLATE - Single room (complete a DATIX if unable to isolate)
GLOVES AND APRONS - For contact with the environment/exposure risk to body fluids
HAND WASHING - Soap and water (alcohol gel is ineffective for C. difficile)
TESTING - Obtain stool specimen

ACTIONS

Stool chart – use to monitor severity and risk of dehydration/electrolyte imbalance

Antibiotic review – recent history/is current treatment required/right drug (route/dose)?

Medications review – laxatives, antidiarrhoeal, proton pump inhibitors (stop if possible)

Environmental hygiene – clean with chlorine based disinfectants

Clostridium difficile PCR	No toxins but patient is at higher risk of developing infection (Contact ICT before sending specimens for retesting)
Clostridium difficile toxin	Clostridium difficile infection

INFECTION CONTROL ASSESSMENT FOR TRANSFER TO THE COHORT FACILITY

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APPENDIX 3 COMPARISION OF HEALTHCARE ASSOCIATED INFECTION DATA ACROSS THE NORTHWEST

Clostridium difficile July – September 2019

Organisation Name	July to September 2019 Counts	Rates	Significance
AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	28	39.0	
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	0	0.0	
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	31	54.0	High (0.025)
BOLTON NHS FOUNDATION TRUST	25	48.8	High (0.025)
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	12	27.6	
EAST CHESHIRE NHS TRUST	0	0.0	
EAST LANCASHIRE HOSPITALS NHS TRUST	22	27.6	
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	35	51.5	High (0.025)
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	2	17.7	
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	0	0.0	
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	43	24.5	
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	7	15.9	
NORTH CUMBRIA UNIVERSITY HOSPITALS NHS TRUST	9	19.0	
PENNINE ACUTE HOSPITALS NHS TRUST	29	29.3	
ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST	21	32.6	
SALFORD ROYAL NHS FOUNDATION TRUST	10	14.9	Low (0.025)
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	6	17.2	
ST HELENS AND KNOWSLEY HOSPITAL SERVICES NHS TRUST	14	22.4	
STOCKPORT NHS FOUNDATION TRUST	14	26.7	
TAMESIDE HOSPITAL NHS FOUNDATION TRUST	11	32.1	
THE CHRISTIE NHS FOUNDATION TRUST	6	44.1	
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	4	62.1	
THE WALTON CENTRE NHS FOUNDATION TRUST	2	16.3	
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	14	27.2	
WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST	11	24.9	
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	15	23.1	
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	11	28.4	
North West	382	28.4	

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MRSA – Annual rolling rate

Organisation Name	October 2018 to September 2019 Counts	Rates	Significance
AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	3	1.1	
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	0	0.0	
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	1	0.4	
BOLTON NHS FOUNDATION TRUST	1	0.5	
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	3	1.6	
EAST CHESHIRE NHS TRUST	1	0.9	
EAST LANCASHIRE HOSPITALS NHS TRUST	1	0.3	
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	1	0.3	
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	0	0.0	
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	1	3.5	
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	9	1.3	
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	3	1.7	
NORTH CUMBRIA UNIVERSITY HOSPITALS NHS TRUST	1	0.6	
PENNINE ACUTE HOSPITALS NHS TRUST	3	0.8	
ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST	2	0.8	
SALFORD ROYAL NHS FOUNDATION TRUST	2	0.8	
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	1	0.7	
ST HELENS AND KNOWSLEY HOSPITAL SERVICES NHS TRUST	1	0.4	
STOCKPORT NHS FOUNDATION TRUST	0	0.0	
TAMESIDE HOSPITAL NHS FOUNDATION TRUST	4	2.7	
THE CHRISTIE NHS FOUNDATION TRUST	1	1.8	
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	0	0.0	
THE WALTON CENTRE NHS FOUNDATION TRUST	0	0.0	
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	0	0.0	
WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST	3	1.6	
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	3	1.1	
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	1	0.7	
North West	46	0.9	

MSSA – Annual rolling rate

Organisation Name	October 2018 to September 2019 Counts	Rates	Significance
AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	35	12.8	
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	12	18.6	
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	20	8.7	
BOLTON NHS FOUNDATION TRUST	16	8.0	
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	12	6.4	
EAST CHESHIRE NHS TRUST	11	10.1	
EAST LANCASHIRE HOSPITALS NHS TRUST	31	10.0	
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	25	8.7	
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	17	38.4	High (0.001)
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	3	10.6	
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	88	12.8	
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	12	6.7	
NORTH CUMBRIA UNIVERSITY HOSPITALS NHS TRUST	19	10.5	
PENNINE ACUTE HOSPITALS NHS TRUST	20	5.2	Low (0.001)
ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST	28	11.1	
SALFORD ROYAL NHS FOUNDATION TRUST	22	8.3	
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	14	10.4	
ST HELENS AND KNOWSLEY HOSPITAL SERVICES NHS TRUST	32	13.1	
STOCKPORT NHS FOUNDATION TRUST	13	6.0	Low (0.025)
TAMESIDE HOSPITAL NHS FOUNDATION TRUST	16	11.0	
THE CHRISTIE NHS FOUNDATION TRUST	10	18.0	
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	3	11.6	
THE WALTON CENTRE NHS FOUNDATION TRUST	9	17.5	
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	34	16.5	High (0.025)
WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST	17	9.2	
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	19	7.3	
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	17	11.2	
North West	555	10.4	

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E. coli bacteraemia - Annual rolling rate

Organisation Name	October 2018 to September 2019 Counts	Rates	Significance
AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	66	24.2	
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	8	12.4	
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	48	21.0	
BOLTON NHS FOUNDATION TRUST	42	20.9	
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	30	15.9	
EAST CHESHIRE NHS TRUST	16	14.7	
EAST LANCASHIRE HOSPITALS NHS TRUST	77	24.9	
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	60	20.9	
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	7	15.8	
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	11	38.9	
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	136	19.8	
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	41	23.0	
NORTH CUMBRIA UNIVERSITY HOSPITALS NHS TRUST	39	21.5	
PENNINE ACUTE HOSPITALS NHS TRUST	65	17.0	Low (0.025)
ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST	71	28.1	
SALFORD ROYAL NHS FOUNDATION TRUST	53	20.1	
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	27	20.1	
ST HELENS AND KNOWSLEY HOSPITAL SERVICES NHS TRUST	64	26.2	
STOCKPORT NHS FOUNDATION TRUST	52	23.9	
TAMESIDE HOSPITAL NHS FOUNDATION TRUST	28	19.2	
THE CHRISTIE NHS FOUNDATION TRUST	29	52.2	High (0.001)
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	7	27.1	
THE WALTON CENTRE NHS FOUNDATION TRUST	12	23.4	
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	39	18.9	
WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST	48	25.8	
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	52	19.9	
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	32	21.1	
North West	1160	21.6	

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Klebsiella bacteraemia - Annual rolling rate

Organisation Name	October 2018 to September 2019 Counts	Rates	Significance
AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	25	9.2	
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	10	15.5	
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	23	10.1	
BOLTON NHS FOUNDATION TRUST	13	6.5	
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	12	6.4	
EAST CHESHIRE NHS TRUST	9	8.3	
EAST LANCASHIRE HOSPITALS NHS TRUST	19	6.2	
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	8	2.8	Low (0.001)
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	5	11.3	
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	2	7.1	
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	94	13.7	High (0.001)
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	11	6.2	
NORTH CUMBRIA UNIVERSITY HOSPITALS NHS TRUST	11	6.1	
PENNINE ACUTE HOSPITALS NHS TRUST	29	7.6	
ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST	20	7.9	
SALFORD ROYAL NHS FOUNDATION TRUST	24	9.1	
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	9	6.7	
ST HELENS AND KNOWSLEY HOSPITAL SERVICES NHS TRUST	22	9.0	
STOCKPORT NHS FOUNDATION TRUST	19	8.7	
TAMESIDE HOSPITAL NHS FOUNDATION TRUST	12	8.2	
THE CHRISTIE NHS FOUNDATION TRUST	9	16.2	
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	4	15.5	
THE WALTON CENTRE NHS FOUNDATION TRUST	3	5.8	
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	15	7.3	
WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST	16	8.6	
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	16	6.1	
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	9	5.9	
North West	449	8.4	

Pseudomonas aeruginosa - Annual rolling rate

Organisation Name	October 2018 to September 2019 Counts	Rates	Significance
AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	10	3.7	
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	1	1.6	
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	4	1.7	
BOLTON NHS FOUNDATION TRUST	2	1.0	
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	2	1.1	
EAST CHESHIRE NHS TRUST	2	1.8	
EAST LANCASHIRE HOSPITALS NHS TRUST	7	2.3	
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	14	4.9	
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	2	4.5	
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	2	7.1	
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	31	4.5	High (0.025)
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	3	1.7	
NORTH CUMBRIA UNIVERSITY HOSPITALS NHS TRUST	5	2.8	
PENNINE ACUTE HOSPITALS NHS TRUST	4	1.0	Low (0.025)
ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST	5	2.0	
SALFORD ROYAL NHS FOUNDATION TRUST	4	1.5	
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	7	5.2	
ST HELENS AND KNOWSLEY HOSPITAL SERVICES NHS TRUST	10	4.1	
STOCKPORT NHS FOUNDATION TRUST	3	1.4	
TAMESIDE HOSPITAL NHS FOUNDATION TRUST	4	2.7	
THE CHRISTIE NHS FOUNDATION TRUST	6	10.8	
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	5	19.4	
THE WALTON CENTRE NHS FOUNDATION TRUST	1	1.9	
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	5	2.4	
WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST	4	2.2	
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	8	3.1	
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	3	2.0	
North West	154	2.9	

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NHS Warrington and Halton Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/19/11/111**
SUBJECT:	**CQC Action Plan update**
DATE OF MEETING:	November 2019
ACTION REQUIRED	**Review, discuss and approve**
AUTHOR(S):	Margaret Armstrong, Compliance and Improvement Manager
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse
LINK TO STRATEGIC OBJECTIVES:	All
EXECUTIVE SUMMARY (KEY ISSUES):	The following are key issues to highlight within the report: • There are 61 actions across 35 recommendations in the CQC action plan • The Urgent and Emergency Care Improvement Plan progressing and 26 actions have been completed to date, leaving 4 remaining which are expected to be completed by end of December 2019. • Moving to Outstanding Steering Group has met and agreed a revised governance structure to deliver the next steps of Moving to Outstanding • A Moving to Outstanding framework is in development which will self-assess core services against the Key Lines of Enquiry (KLoE) outstanding characteristics • The quarterly CQC Provider Engagement Meeting was held with Executives on 31st October 2019. Future dates are to be confirmed. • CQC have requested to attend Trust Board and Quality Assurance Committee – dates for their attendance are to be confirmed. • The Trust action plan following receipt of the CQC report from the 2019 inspection is shown in Appendix 1
RECOMMENDATION:	Assurance can be offered to the Board that an action plan has been developed in response to the CQC action plan and is on track. In addition it is recommended that the Board review the Moving to Outstanding framework which is in

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	development at the Board Away Day in February 2020.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Committee
	Date of meeting	November 2019
	Summary of Outcome	Noted the development of the action plan which was approved by Executive and core service leads.
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

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Warrington and Halton Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

SUBJECT	CQC Update Report	AGENDA REF:	BM/19/11/111

1. BACKGROUND/CONTEXT

The Trust received the CQC Report in June 2019, following the inspection in April/May 2019.

An action plan has been developed, in response to this report, which is outlined in Appendix 1. This action plan has been approved by Executive and core service leads, and will be monitored going forward by the Moving to Outstanding Steering Group, which is chaired by the Chief Nurse.

In addition to the CQC action plan, there is a Moving to Outstanding Framework in development, which will self-assess the Trust against the Key Lines of Enquiry (KLoE) outstanding characteristics, and develop actions to progress the Trust to outstanding. This will be presented for consideration by the Executive team at the December 2019 meeting.

The quarterly CQC Provider Engagement meeting was held at the trust with the Chief Nurse, Chief Operating Officer, Medical Director and team on 31st October 2019.

CQC have requested to attend Trust Board and Quality Assurance Committee at future meetings and dates for their attendance are to be agreed.

2. KEY ELEMENTS

2.1 CQC action plan

The following are key points relating to the CQC action plan.

- There are 62 actions across 35 recommendations made by CQC
- There are no ‘Must Do’ actions or regulatory breaches – there are 55 actions relating to ‘Should Do’ recommendations
- Current compliance of the CQC action plan is as follows.

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Action Status by Type

	Report completed - Compliant	Report completed - further evidence requested	On Track	Amended date agreed	Report in progress	Action closed-merged with another	Report received for review	Grand Total
HOWEVER	4		4					8
SHOULD	20	2	24	1	5	1	2	55
Grand Total	**24**	**2**	**28**	**1**	**5**	**1**	**2**	**63**

This can be further shown broken down by core service.

Row Labels	HOWEVER	SHOULD	(blank)	Grand Total
Surgery	**2**	**15**		**17**
Amended date agreed		1		1
Report in progress		3		3
On Track	2	8		10
Report completed - further evidence requested		2		2
Action closed-merged with another		1		1
Trustwide		**12**		**12**
Report in progress		1		1
On Track		5		5
Report completed - Compliant		6		6
Critical Care	**4**	**5**		**9**
On Track	2	3		5
Report completed - Compliant	2	2		4
Maternity	**1**	**2**		**3**
Report completed - Compliant	1	2		3
Medical Care	**1**	**20**		**21**
Report in progress		1		1
On Track		8		8
Report completed - Compliant	1	10		11
Report received for review		1		1
Outpatients		**1**		**1**
Report received for review		1		1
(blank)				
(blank)				
Grand Total	**8**	**55**		**63**

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Progress is underway to deliver the full action plan – 19 actions are due for delivery by end November 2019.

2.2 Urgent & Emergency care Improvement action plan

Compliance with the Urgent and Emergency Care action plan, following the 2019 focused inspection by the CQC, is as follows:

	On Track	Amended date agreed	Action closed-merged with another	Complete	further evidence requested	Completed - further action added	Grand Total
MUST	1			12		1	14
SHOULD			2	2			4
Trust action		2	2	12	1		17
Grand Total	**1**	**2**	**4**	**26**	**1**	**1**	**35**

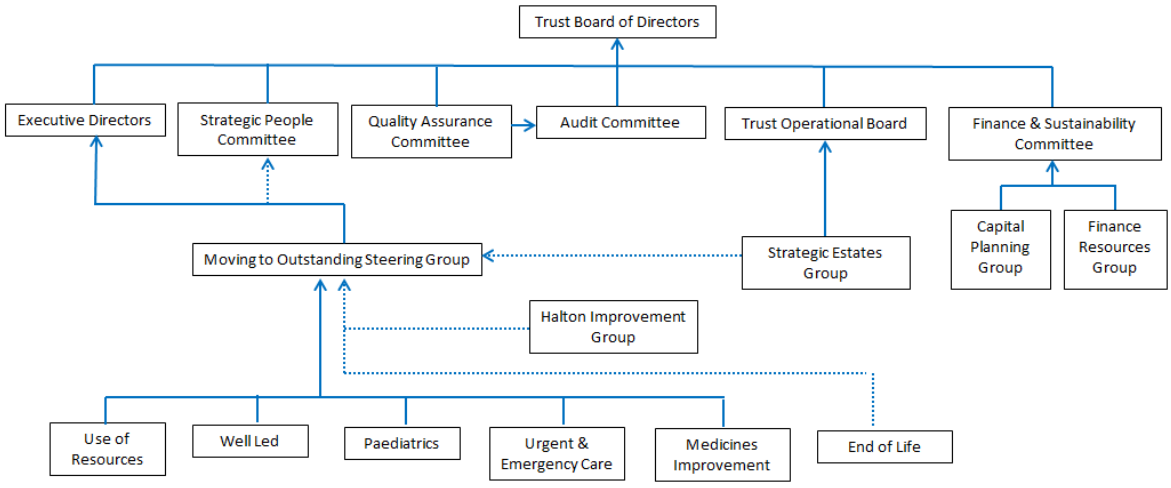
4 regulatory breaches were identified during the focused inspection:

- Regulation 12(2)(a)(b) - Patients whose clinical condition is at risk of deteriorating are rapidly identified and reviewed at suitable intervals
- Regulation 12(2)(b) - Crowding in the emergency department is reduced so that patients do not have to wait on trolleys in corridors
- Regulation 17(2)(a) Information about the performance of the service is accurate and properly analysed and reviewed by the leadership team
- Regulation 18(1) - There are sufficient numbers of suitably qualified, skilled and experienced doctors and nurses to meet the needs of patients in the Emergency Department

The action plan will continue to be monitored and overseen by the Chief Operating Officer, and the remaining 4 actions outstanding are expected to be completed by end of December 2019.

2.3 Governance and oversight structure of CQC action plan

The Trust Moving to Outstanding Steering Group has agreed the below governance structure



Work streams for Paediatrics and Medicines Improvement have been established and Terms of Reference have been drafted.

Existing Executive led groups for Use of Resources, Well Led, Urgent and emergency Care and End of Life will monitor the CQC action plan.

3 RECOMMENDATIONS

Trust Board are asked to support:

- CQC action plan progress and update
- Urgent and Emergency Care action plan progress
- Revised governance structure for CQC Moving to Outstanding

Kimberley Salmon-Jamieson

Chief Nurse

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

Appendix 1 – CQC Action plan

Ref	Core service	Domain	Areas for Review	Action	Type	Exec Lead	Lead Person	Target date for completion	Action Completion Status
CC01a	**Critical Care**	**Effective**	The trust should consider increasing the number of isolation rooms with negative and positive ventilation, in accordance with Department of Health guidelines. The unit only had two isolation rooms with negative and positive ventilation. This was below the recommended number in national guidance.	Ensure capital bid is developed and timeframe agreed Provide an option paper to enable decision on what can be done 19/20 or 20/21 to share with CQC with risk appraisal	SHOULD	Chris Evans	Mark Carmichael	21/11/19	**On Track**
CC01b	**Critical Care**	**Effective**	The trust should consider increasing the number of isolation rooms with negative and positive ventilation, in accordance with Department of Health guidelines. The unit only had two isolation rooms with negative and positive ventilation. This was below the recommended number in national guidance.	check with network and regulators what the specification is for regulation	SHOULD	Chris Evans	Mark Carmichael	31/08/19	**Report completed - Compliant**
CC02a	**Critical Care**	**Safe**	The trust should review the process for fridge checks so they are completed daily, in line with the trust's medicines management policy.	implement a daily fridge check process to give assurance that the process is fully embedded in to practice	SHOULD	Alex Crowe	Sarah Brennan	31/08/19	**Report completed - Compliant**

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			Fridge checks were not always completed daily, in line with the medicines management policy. This had been an issue raised at the previous inspection.						
CC02b	**Critical Care**	**Safe**	The trust should review the process for fridge checks so they are completed daily, in line with the trust's medicines management policy. Fridge checks were not always completed daily, in line with the medicines management policy. This had been an issue raised at the previous inspection.	audit of effectiveness of daily fridge checks in 6 months - Sarah Brennan	SHOULD	Alex Crowe	Sarah Brennan	29/02/20	**On Track**
CC03	**Critical Care**	**Responsive**	The trust should continue to review the number and occurrence of patients nursed in a recovery area while they await a critical care bed.	Audit in December 19 and present to January Patient Safety & Effectiveness Sub Committee	SHOULD	Chris Evans	Jerome McCann	31/12/19	**On Track**
CC04	**Critical Care**	**Responsive**	At the time of the inspection there was not a dedicated critical care pharmacist for the unit, although this was being addressed in the weeks following the inspection.	Ensure a dedicated pharmacist is allocated to the critical care unit	HOWEVER	Chris Evans	Natalie Crosby		**Report completed - Compliant**
CC05a	**Critical Care**	**Safe**	Not all prescriptions had review of stop dates documented; the indication for the antibiotic was not always recorded. A medicines reconciliation had	standardise where information will be documented	HOWEVER	Alex Crowe	Jerome McCann	31/08/19	**Report completed - Compliant**

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			been completed for most of the records reviewed.						
CC05aa	**Critical Care**	**Safe**	Not all prescriptions had review of stop dates documented; the indication for the antibiotic was not always recorded. A medicines reconciliation had been completed for most of the records reviewed.	Standardise where information will be documented Audit of standardised document to be undertaken by Pharmacist end October and provided to M2O November meeting.	HOWEVER	Alex Crowe	Jerome McCann	21/11/19	**On Track**
CC05b	**Critical Care**	**Safe**	Not all prescriptions had review of stop dates documented; the indication for the antibiotic was not always recorded. A medicines reconciliation had been completed for most of the records reviewed.	audit in 3 months for effectiveness - Jerome	HOWEVER	Alex Crowe	Jerome McCann	30/11/19	**On Track**
M01	**Maternity**	**Safe**	The trust should ensure that all midwives complete adult safeguarding training level three.Midwifery staff compliance for adult safeguarding level three was below the trust target.Following implementation of updated guidance, compliance for midwives for safeguarding adults level three was 58% at time of inspection, although the service always had someone who	provide an assurance report to confirm that all band 7 staff are trained to adult safeguarding level 3give assurance for training compliance going forward	SHOULD	Kimberley Salmon-Jamieson	Tracey Cooper	30/09/19	**Report completed - Compliant**

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			was level three trained on each shift.						
M02	**Maternity**	**Safe**	The trust should review the availability of nets in case of a pool evacuation. There were two birthing pools, however, only one net in the event of an emergency.	Give assurance that additional nets (1 net for each of the 2 pools) are available.	SHOULD	Kimberley Salmon-Jamieson	Tracey Cooper	31/08/19	**Report completed - Compliant**
M03	**Maternity**	**Responsive**	There was no information available in formats other than standard English. There was no information available in languages other than English or alternative formats such as easy read.	Present the Accessible Information Standards Programme Plan to M2O September 2019 meeting	HOWEVER	Pat McLaren	Gina Coldrick	30/09/19	**Report completed - Compliant**
MC01a	**Medical Care**	**Safe**	The trust should continue to monitor staffing levels and follow escalation plans to ensure levels of nursing and medical staff are sufficient to provide safe care and treatment. In medical care there were not always enough staff to meet planned staffing levels, although there were processes to review staff shortages and take action to keep people safe. The service did not always have enough staff with the right qualifications, skills, training and	Reconfiguration of medicine ward management relating to medical staffing	SHOULD	Alex Crowe/ Kimberley Salmon-Jamieson	Fraser Gordon	31/10/19	**On Track**

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			experience to meet planned staffing levels, although it had processes to review staff shortages and take action to keep people safe.						
MC01b	**Medical Care**	**Safe**	The trust should continue to monitor staffing levels and follow escalation plans to ensure levels of nursing and medical staff are sufficient to provide safe care and treatment. In medical care there were not always enough staff to meet planned staffing levels, although there were processes to review staff shortages and take action to keep people safe. The service did not always have enough staff with the right qualifications, skills, training and experience to meet planned staffing levels, although it had processes to review staff shortages and take action to keep people safe.	Reconfiguration of management of outlying patients	SHOULD	Alex Crowe/ Kimberley Salmon-Jamieson	Fraser Gordon	31/12/19	**On Track**

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MC01c	**Medical Care**	**Safe**	The trust should continue to monitor staffing levels and follow escalation plans to ensure levels of nursing and medical staff are sufficient to provide safe care and treatment. In medical care there were not always enough staff to meet planned staffing levels, although there were processes to review staff shortages and take action to keep people safe. The service did not always have enough staff with the right qualifications, skills, training and experience to meet planned staffing levels, although it had processes to review staff shortages and take action to keep people safe.	Implementation of electronic rostering	SHOULD	Alex Crowe/ Kimberley Salmon-Jamieson	May Moonan	31/03/20	**On Track**
MC01d	**Medical Care**	**Safe**	The trust should continue to monitor staffing levels and follow escalation plans to ensure levels of nursing and medical staff are sufficient to provide safe care and treatment. In medical care there were not always enough staff to meet planned staffing levels, although there were processes to review staff shortages and take action to keep	Review escalation processes for medical staff and develop a Standard Operating procedure	SHOULD	Alex Crowe/Kimberley Salmon-Jamieson	Mark Forrest	31/10/19	**On Track**

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			people safe.The service did not always have enough staff with the right qualifications, skills, training and experience to meet planned staffing levels, although it had processes to review staff shortages and take action to keep people safe.						
MC01e	**Medical Care**	**Safe**	The trust should continue to monitor staffing levels and follow escalation plans to ensure levels of nursing and medical staff are sufficient to provide safe care and treatment. In medical care there were not always enough staff to meet planned staffing levels, although there were processes to review staff shortages and take action to keep people safe. The service did not always have enough staff with the right qualifications, skills, training and experience to meet planned staffing levels, although it had processes to review staff shortages and take action to keep people safe.	Review medical and nurse staffing and develop plans as appropriate	SHOULD	Alex Crowe/ Kimberley Salmon-Jamieson	Judith Burgess/ Sarah Coppell Mark Carmichael / Kate Brizell	30/09/19	**Report completed - Compliant**

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MC01e(2)	**Medical Care**	**Safe**	The trust should continue to monitor staffing levels and follow escalation plans to ensure levels of nursing and medical staff are sufficient to provide safe care and treatment. In medical care there were not always enough staff to meet planned staffing levels, although there were processes to review staff shortages and take action to keep people safe. The service did not always have enough staff with the right qualifications, skills, training and experience to meet planned staffing levels, although it had processes to review staff shortages and take action to keep people safe.	Review medical and nurse staffing and develop plans as appropriate	SHOULD	Alex Crowe/ Kimberley Salmon-Jamieson	Judith Burgess/ Sarah Coppell Mark Carmichael / Kate Brizell	30/09/19	**Report completed - Compliant**
MC01f	**Medical Care**	**Safe**	The trust should continue to monitor staffing levels and follow escalation plans to ensure levels of nursing and medical staff are sufficient to provide safe care and treatment. In medical care there were not always enough staff to meet planned staffing levels, although there were processes to review staff shortages and take action to keep	A7 tracheostomy competencies – ensure that all staff have achieved and there is a process of review in place Report in progress	SHOULD	Alex Crowe/ Kimberley Salmon-Jamieson	Sarah Coppell	30/09/19	**No report provided**

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			people safe. The service did not always have enough staff with the right qualifications, skills, training and experience to meet planned staffing levels, although it had processes to review staff shortages and take action to keep people safe.						
MC01g	**Medical Care**	**Safe**	The trust should continue to monitor staffing levels and follow escalation plans to ensure levels of nursing and medical staff are sufficient to provide safe care and treatment. In medical care there were not always enough staff to meet planned staffing levels, although there were processes to review staff shortages and take action to keep people safe.The service did not always have enough staff with the right qualifications, skills, training and experience to meet planned staffing levels, although it had processes to review staff shortages and take action to keep people safe.	Explore other wards re capacity to manage patients with tracheostomies in the Trust	SHOULD	Alex Crowe/Kimberley Salmon-Jamieson	Mark Carmichael / Kate Brizell	31/10/19	**On Track**

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MC01h	**Medical Care**	**Safe**	The trust should continue to monitor staffing levels and follow escalation plans to ensure levels of nursing and medical staff are sufficient to provide safe care and treatment. In medical care there were not always enough staff to meet planned staffing levels, although there were processes to review staff shortages and take action to keep people safe. The service did not always have enough staff with the right qualifications, skills, training and experience to meet planned staffing levels, although it had processes to review staff shortages and take action to keep people safe.	Develop and implement a speciality specific Competency training framework in medicine for nursing staff	SHOULD	Alex Crowe/ Kimberley Salmon-Jamieson	Judith Burgess/ Sarah Coppell	31/03/20	**On Track**
MC02a	**Medical Care**	**Safe**	The trust should continue to monitor audit performance to identify further potential improvements.	Ensure monthly reporting to Patient Safety & Effectiveness Sub Committee outlines remedial actions where performance needs to be improved and tracks the performance improvement.	SHOULD	Alex Crowe	Louisa Connolly	30/09/19	**Report received for review**
MC02b	**Medical Care**	**Safe**	The trust should continue to monitor audit performance to identify further potential	Ensure monitoring of clinical audit actions are tracked through specialty and CBU	SHOULD	Alex Crowe	Fraser Gordon/ Mark	30/09/19	**Report completed -**

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			improvements.	Governance processes.			Forrest		**Compliant**
MC02c	**Medical Care**	**Safe**	The hospital was below the England averages for audits for stroke and lung cancer. The trust had plans to improve performance. Audit results for patients following a stroke and for patients with lung cancer had been below England average. Improvement plans were identified and arrangements for transfer of hyper-acute stroke services to a neighbouring trust were imminent.	Provide assurance paper to Patient Safety & Effectiveness Sub Committee regarding remedial actions required in relation to stroke and lung cancer national audits	HOWEVER	Chris Evans	Jill Wright/ Mithun Murthy	31/10/19	**Report completed - Compliant**
MC03	**Medical Care**	**Safe**	The trust should continue to sustain improvement and practice in application of capacity assessment and application of Deprivation of Liberty Safeguards where required.	Ensure staff attend Safeguarding/DoLS Masterclasses being put in place	SHOULD	Kimberley Salmon-Jamieson	Judith Burgess/ Sarah Coppell	31/12/19	**On Track**
MC04a	**Medical Care**	**Responsive**	The trust should continue work to reduce delays in patient discharges where possible.In medical care, there were delays in discharge for patients.Delays in discharge were a frequent issue for patients, particularly in elderly care and dementia ward.	Co-location of Health and Social Care Discharge Team - opening day 12/7/19	SHOULD	Chris Evans	Caroline Williams	12/07/19	**Report completed - Compliant**

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MC04b	**Medical Care**	**Responsive**	The trust should continue work to reduce delays in patient discharges where possible. In medical care, there were delays in discharge for patients. Delays in discharge were a frequent issue for patients, particularly in elderly care and dementia ward.	Agree a trajectory for improvement in long length of stay with NHSE	SHOULD	Chris Evans	Caroline Williams	01/05/19	**Report completed - Compliant**
MC04c	**Medical Care**	**Responsive**	The trust should continue work to reduce delays in patient discharges where possible. In medical care, there were delays in discharge for patients. Delays in discharge were a frequent issue for patients, particularly in elderly care and dementia ward.	Development of discharge patient tracking list to further understand reasons for delays in discharge	SHOULD	Chris Evans	Caroline Williams	05/07/19	**Report completed - Compliant**
MC04d	**Medical Care**	**Responsive**	The trust should continue work to reduce delays in patient discharges where possible. In medical care, there were delays in discharge for patients. Delays in discharge were a frequent issue for patients, particularly in elderly care and dementia ward.	Work with system partners to review and agree actions from Venn Consultants system capacity and demand exercise undertaken in 2018	SHOULD	Chris Evans	Caroline Williams	01/08/19	**Report completed - Compliant**

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MC04e	**Medical Care**	**Responsive**	The trust should continue work to reduce delays in patient discharges where possible.In medical care, there were delays in discharge for patients.Delays in discharge were a frequent issue for patients, particularly in elderly care and dementia ward.	Develop a plan to reconfigure Care of the Elderly workforce	SHOULD	Chris Evans	Caroline Williams	29/07/19	**Report completed - Compliant**
MC04f	**Medical Care**	**Responsive**	The trust should continue work to reduce delays in patient discharges where possible. In medical care, there were delays in discharge for patients. Delays in discharge were a frequent issue for patients, particularly in elderly care and dementia ward.	Continuation of ECIST long length of stay/safer collaborative - 3 out of 4 events completed, 4th event due September 2019	SHOULD	Chris Evans	May Moonan	30/09/19	**Report completed - Compliant**
MC04g	**Medical Care**	**Responsive**	The trust should continue work to reduce delays in patient discharges where possible.In medical care, there were delays in discharge for patients.Delays in discharge were a frequent issue for patients, particularly in elderly care and dementia ward.	Ward Round accreditation participation for medicine - Development of a ward round accreditation scheme to support reduction in delays in discharges • Paper presented to Executive Directors for approval - 15th August 2019 – complete • Wards participating in the Pilot are B19, B14, A6, AMU,	SHOULD	Simon Constable	Alex Crowe	31/12/19	**Report completed - Compliant**

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				A7, B10/11 (Medicine, Specialist Medicine, Surgery, Paediatrics and Rehabilitation) - agreed • Pilot dry run of Ward Round Accreditation Process to be undertaken 17th/18th September 2019 on Ward B19 to test agreed standards from the Rapid Improvement Event • Baseline questionnaire to be sent to every member of staff in WHH in respect of ward rounds to assess culture change in the organisation – date to be agreed following pilot of Ward B19 • Remaining wards participating in the pilot to undertake dry run – by end October 2019• Schedule of roll out to all other wards – by end May 2019					
MC04i	**Medical Care**	**Responsive**	The trust should continue work to reduce delays in patient discharges where possible. In medical care, there were delays in discharge for patients. Delays in discharge were a	Development of the Trust Frailty pathway	SHOULD	Chris Evans	Fraser Gordon	31/03/20	**On Track**

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			frequent issue for patients, particularly in elderly care and dementia ward.						
OP01	**Outpatients**	**Safe**	The trust should review the training available for staff on updating patients' risk assessment records. Although staff assessed risks to patients, staff had not received specific training to be able to update the patient's risk record.	provide assurance to confirm that staff are trained to be able to update the patient's risk record and give assurance for training compliance going forward	SHOULD	Kimberley Salmon-Jamieson	Deb Hatton	30/09/19	**Report received for review**
S01	**Surgery**	**Safe**	The trust should consider needs such as safeguarding and deprivation of liberty are highlighted. Although records were clear, there was no system to quickly highlight issues such as whether there were any safeguarding concerns, or patients were subject to a deprivation of liberty.	Ensure the trust patient alerts policy is reviewed including alerts on Safeguarding and DoLS.	SHOULD	Kimberley Salmon-Jamieson	John Goodenough	31/01/20	**Amended date agreed**
S02a	**Surgery**	**Effective**	The trust should make sure that all care plans in paper records are filled in consistently. Care records were not always filled in consistently in the paper records, for example the cognitive impairment and dementia section in the fractured hip pathway.	Weekly spot checks to be undertaken to ensure consistency of completed records and monthly audit of spot checks to give assurance that care plans in paper records are being completed correctly and	SHOULD	Kimberley Salmon-Jamieson	Cheryl Finney	31/10/19	**Report completed - further evidence requested**

			This was important as relevant information may be missed.	consistently.					
S02b	**Surgery**	**Effective**	The trust should make sure that all care plans in paper records are filled in consistently. Care records were not always filled in consistently in the paper records, for example the cognitive impairment and dementia section in the fractured hip pathway. This was important as relevant information may be missed.	Audit to be conducted to give baseline and set further trajectories - will be added to the ward quality improvement metrics. Report in progress	SHOULD	Kimberley Salmon-Jamieson	Cheryl Finney	30/09/19	**No report provided**
S02c	**Surgery**	**Effective**	The trust should make sure that all care plans in paper records are filled in consistently. Care records were not always filled in consistently in the paper records, for example the cognitive impairment and dementia section in the fractured hip pathway. This was important as relevant information may be missed.	Ensure that an audit of hip fracture pathway is undertaken and present to the Patient Safety & Effectiveness Sub Committee	SHOULD	Alex Crowe	Rajiv Sanger	31/03/20	**On Track**
S03	**Surgery**	**Safe**	The trust should review the monitoring of expiry dates of sepsis bags. We found that blood cultures stored in sepsis bags had expired, which was important for testing the presence of sepsis in a	Ensure the process for monitoring of sepsis bag expiry is reviewed Report in progress	SHOULD	Kimberley Salmon-Jamieson	Alison Kennah	30/09/19	**No report provided**

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			patient.						
S04a	**Surgery**	**Responsive**	The trust should ensure that mental capacity assessments and best interest decisions are recorded consistently in records. In surgery, we saw an example of mental capacity assessment not in line with current guidance and trust policy.	Ensure staff attend Safeguarding/DoLS Masterclasses being put in place	SHOULD	Kimberley Salmon-Jamieson	Cathy Johnson	31/12/19	**On Track**
S04b	**Surgery**	**Responsive**	The trust should ensure that mental capacity assessments and best interest decisions are recorded consistently in records. In surgery, we saw an example of mental capacity assessment not in line with current guidance and trust policy.	Ensure an audit of mental capacity/best interest is undertaken	SHOULD	Kimberley Salmon-Jamieson	Cathy Johnson	31/03/20	**On Track**
S05	**Surgery**	**Effective**	The trust should continue to look at ways to reduce the risk of readmission for elective admissions. From September 2018 to August 2019, all patients at Warrington Hospital had a higher than expected risk of readmission for elective admissions when compared to the England Average. Surgical leads have put measures in place to address this	clarity of governance arrangements and monitoring/scrutiny - clarify where readmissions are being recorded and monitored within the trust and put a process in place to understand the reasons for readmissions develop a SOP around performance monitoring	SHOULD	Chris Evans	Val Doyle	31/10/19	**On Track**

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			and have seen improvements in readmission rates.	and process of local specialty deep dive, and report to KPI meeting and escalation if we are an outlier for any specialty for readmissions					
S06	**Surgery**	**Effective**	The trust should continue to look at ways to improve outcomes on the national hip fracture database. The service performed lower than other trusts in the national hip fracture database 2018. Surgical leads had recognised this and put an action plan in to place to address.	Ensure that the hip fracture action plan is received at Patient Safety & Effectiveness Sub Committee on a quarterly basis Report in progress	SHOULD	Alex Crowe	Paul Scott	30/09/19	**No report provided**
S07a	**Surgery**	**Safe**	The trust should ensure that controlled drugs are stored securely at all times in theatres.In surgery, we observed on instance of a controlled drug being left unattended in the operating theatres and found some consumables that were past their use by dates.	Controlled DrugsImmediate actions were taken at the time of the inspection.Pharmacy to conduct bi-monthly spot check audits and report to Theatre Manager - assurance to be given to Moving to Outstanding regarding this process	SHOULD	Alex Crowe	Mark Rigby	31/12/19	**On Track**

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S07b	**Surgery**	**Safe**	The trust should ensure that controlled drugs are stored securely at all times in theatres. In surgery, we observed on instance of a controlled drug being left unattended in the operating theatres and found some consumables that were past their use by dates.	Consumables Weekly check list to be developed on each of the 3 trolleys to check expiry dates for replacement, managed by the Housekeeper, which ward manager oversees.	SHOULD	Kimberley Salmon-Jamieson	Cheryl Finney	30/09/19	**Report completed - further evidence requested**
S08	**Surgery**	**Safe**	The trust should review the levels of safeguarding training with reference to the intercollegiate documents on safeguarding.	Ensure a revised Training Needs Analysis is developed for Safeguarding training aligned to the intercollegiate document and that ESR is updated with these training requirements	SHOULD	Kimberley Salmon-Jamieson	John Goodenough	31/12/19	**On Track**
S09	**Surgery**	**Safe**	The trust should review the process for monitoring consumables so they remain in date and fit for use.	see action S07b - Day Case Ward- MERGE	SHOULD	Kimberley Salmon-Jamieson	Cheryl Finney		**Action closed- merged with another**
S10	**Surgery**	**Safe**	The trust should review the process for monitoring maintenance of patient trolleys. Some patient trolleys in Cheshire and Merseyside Treatment Centre also had not had annual maintenance.	Ensure an audit is undertaken of the asset register and that all trolleys are included	SHOULD	Chris Evans	Cheryl Finney	31/03/20	**On Track**

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S11	**Surgery**	**Safe**	The trust should continue the work around safer surgery and the pre-operative briefing and documentation. In surgery, some processes around the pre-operative briefing were not thorough, but work was in progress to improve this.	Revised process put in place from 1st June 2019. Ensure this process is audited across all theatres (observational audit) and reported to Patient Safety & Effectiveness Sub Committee	SHOULD	Alex Crowe	Mark Rigby	31/12/19	**On Track**
S12	**Surgery**	**Safe**	The hospital was below the England averages for audits for hip fractures. The trust had plans to improve performance.	Provide assurance paper to Patient Safety & Effectiveness Sub Committee regarding remedial actions required in relation to hip fracture national audits	HOWEVER	Alex Crowe	Paul Scott	31/10/19	**On Track**
S13	**Surgery**	**Safe**	Whilst staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005 and knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care; we saw an example of the application of such processes not in line with current guidance and trust policy.	Increased support via Masterclasses for staff in surgery	HOWEVER	Kimberley Salmon-Jamieson	Wendy Turner	31/12/19	**On Track**

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TW01	**Trustwide**	**Well Led**	The trust should review the fit and proper persons process so all the required information is retained for all directors.	Head of Corporate Affairs to give written assurance that there is a central electronic system held by the Trust for capturing all required information relating to fit and proper persons. The Head of Corporate Affairs will retain copies of all of this information within the Foundation Trust Office and updated as necessary.	SHOULD	Simon Constable	John Culshaw	12/09/19	**Report completed - Compliant**
TW02	**Trustwide**	**Well Led**	The trust should consider how it records the delivery plans for the enabling strategies.	Ensure a timetable is developed for key enabling strategy review in the Trust	SHOULD	Simon Constable	Lucy Gardner	30/09/19	**Report completed - Compliant**
TW03a	**Trustwide**	**Well Led**	The trust should review the progress of the implementation of strategies for patients living with dementia and with a learning disability and consider the implementation of a strategy for patients with mental health needs. The trust did not currently have strategies to support patients living with dementia, learning disabilities or mental health illness. Some of the enabling strategies lacked clear delivery plans.	Ensure there is a strategy and implementation plan for patients living with dementia	SHOULD	Kimberley Salmon-Jamieson	John Goodenough	30/11/19	**On Track**

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TW03b	**Trustwide**	**Well Led**	The trust should review the progress of the implementation of strategies for patients living with dementia and with a learning disability and consider the implementation of a strategy for patients with mental health needs. The trust did not currently have strategies to support patients living with dementia, learning disabilities or mental health illness. Some of the enabling strategies lacked clear delivery plans.	Ensure there is a strategy and implementation plan for patients living with Learning Disabilities	SHOULD	Kimberley Salmon-Jamieson	John Goodenough	30/11/19	**On Track**
TW03c	**Trustwide**	**Well Led**	The trust should review the progress of the implementation of strategies for patients living with dementia and with a learning disability and consider the implementation of a strategy for patients with mental health needs. The trust did not currently have strategies to support patients living with dementia, learning disabilities or mental health illness. Some of the enabling strategies lacked clear delivery plans.	Ensure there is a strategy and implementation plan for patients living with Mental Health needs	SHOULD	Kimberley Salmon-Jamieson	John Goodenough	30/11/19	**On Track**

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TW04	**Trustwide**	**Use of Resources**	The trust should continue to review the plans to achieve financial sustainability and the action required to deliver financial plan for 2019-20. The trust had not yet fully addressed the plans to break even in 2019-20 which were predicated by the delivery of a cost improvement programme of £7.5million and the resolution of £5million of cost pressures.	Work collaboratively on the 2019/20 Recovery Plan with Bridgewater, Warrington CCG and Halton CCG, and present a High Level Recovery Plan to NHSI in August (6.8.19)	SHOULD	Andrea McGee	Jane Hurst	31/08/19	**Report completed - Compliant**
TW05	**Trustwide**	**Use of Resources**	The trust should review the information reported in the finance report to consider including remedial action on the financial position, risk-based forecasting and the level of recurrent cost improvement plans.	Provide robust forecast reporting, including risk and mitigation on financial position and in year and recurrent cost improvement programme to Finance & Sustainability Committee, including monthly CBU cost improvement and forecast updates at Financial Resources Group.	SHOULD	Andrea McGee	Jane Hurst	31/08/19	**Report completed - Compliant**
TW06	**Trustwide**	**Safe**	The trust should review the processes for identifying, reporting and investigation of missed doses for critical medicines across the trust. The service prescribed, gave, and stored medicines well. Although not all medicines prescribed had	Ensure a review of missed doses and critical meds is undertaken and reported to Patient Safety & Effectiveness Sub Committee Review of Process – D	SHOULD	Alex Crowe	Diane Matthew	31/10/19	**On Track**

			a signature or appropriate code to indicate if the medicines had been administered and some medicines were not available.	Matthew Review of Datix missed doses – D Matthew Audit of missed doses and missed doses of critical meds – A Kennah					
TW07	**Trustwide**	**Safe**	The trust should consider further development and investment in systems to improve medicines reconciliation rates across the trust. While medicines optimisation within the trust was well-led medicines reconciliation rates for the whole trust were currently at 33% of medicines reconciled within 24 hours; this is well below National Institute for Health and Care Excellence guidelines of 90% within 24 hours. The hospital was not following best practice for medicines reconciliation and in medical care and critical care medicines were not always properly recorded or available.	Ensure a plan is developed of how to meet the Trust trajectory to be 80% compliant with Medicines reconciliation within 24 hours by end March 2020 and present to Moving to Outstanding Steering Group Report in progress	SHOULD	Alex Crowe	Diane Matthew	30/09/19	**No report provided**

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TW08	**Trustwide**	**Safe**	We saw examples where the trust did not properly record the best interest decisions or capacity assessments for patients who lacked capacity. The trust should review the root cause analysis form for serious incidents to consider how information about safeguarding, capacity, patient involvement is included. In Surgery, we saw two cases where mental capacity assessments and best interests decisions were not fully recorded in patient records.	Review the route cause analysis report templates to ensure safeguarding information is recorded appropriately	SHOULD	Kimberley Salmon-Jamieson	Layla Alani	30/09/19	**Report completed - Compliant**
TW09	**Trustwide**	**Safe**	The trust should review the process for senior clinician input into structured judgement reviews.	Undertake quarterly review of a random selection of SJRs across the board to assess the outcome reached by the reviewer (senior clinician), and give assurance to the Quality Assurance Committee that all issues are being identified following higher risk deaths. Commence October onwards with a review of the 2nd quarter reviews undertaken.	SHOULD	Alex Crowe	Phil Cantrell	31/10/19	**Report completed - Compliant**

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TW10	**Trustwide**	**Safe**	Review of compliance with the current standards and level of risk for the organisation The professional guidance on the safe and secure handling of medicines is produced by the Royal Pharmaceutical Society and is NICE accredited. The updated guidance was issued in December 2018. The guidance advises that all medicines cupboards comply with British Standard 2881	Replacement of Medicines Storage cupboards that do not meet the British Standard requirements - Phase One	SHOULD	Alex Crowe	Diane Matthew	31/03/20	**On Track**

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NHS Warrington and Halton Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/19/11/112**
SUBJECT:	**Mortality Review (Learning from Deaths) Q2**
DATE OF MEETING:	27th November 2019
AUTHOR(S):	Hayley McCaffrey, Head of Clinical Effectiveness & Quality Dr Phil Cantrell, Trust Mortality Lead
EXECUTIVE DIRECTOR SPONSOR:	Alex Crowe, Acting Executive Medical Director
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience.
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): ***(Please DELETE as appropriate)***	To be determined
EXECUTIVE SUMMARY ***(KEY ISSUES):***	This briefing paper overviews Trust mortality data, including; • total number of deaths of patients; • number of reviews of deaths; • number of investigations of deaths; • lessons learned, actions taken, improvements made During Quarter 2, 2019/20; • 238 deaths that occurred within the Trust. • 53 have met the criteria to be subject to a structured judgement review (SJR) through the Mortality Review Group • 3 were to subject to investigation using root cause analysis (RCA) methodology. We are not an outlier for HSMR or SHMI. However, the Mortality Review Group analyses data in relation to Mortality and it is indicated that we have an excess number of deaths in the following diagnosis groups; • Chronic Obstructive Pulmonary Disease & Bronchiectasis • R Codes MRG have requested that Focused Reviews be undertaken to obtain any learning. It is important for the committee to note that we are no longer an outlier for R codes but will complete the Focused Review that is underway for learning. Attached as appendices is the latest HED report for information.

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PURPOSE: ***(please select as appropriate)***	Information	Approval	**To note**	Decision
RECOMMENDATION:	The Board is asked to note the contents of the briefing paper.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.	QAC/19/11/174		
	Date of meeting	5th November 2019		
	Summary of Outcome	Paper read and noted.		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

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Warrington and Halton Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

SUBJECT	Mortality Review (Learning from Deaths) Q2	AGENDA REF:	BM/19/11/112

1. BACKGROUND/CONTEXT

The National Quality Board report published in March 2017 - National Guidance on Learning from Deaths; A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care stated that,
"Following events in Mid Staffordshire, a review of 14 hospitals with the highest mortality noted that the focus on aggregate mortality rates was distracting Trust boards "from the very practical steps that can be taken to reduce genuinely avoidable deaths in our hospitals".

This report followed the findings of the CQC report published in December 2016 - Learning, Candour and Accountability: A review of the way NHS trusts review and investigate the deaths of patients in England. This found that none of the Trusts the CQC contacted were able to demonstrate best practice across every aspect of identifying, reviewing and investigating deaths and ensuring that learning is implemented. The purpose of this publication was *'to help initiate a standardised approach, which will evolve as we learn'*.

All Trusts were tasked with reviewing their processes and to implement systems to review, understand and learn from deaths that occurred and the National Guidance set the requirements of this:

- governance and capability;
- improved data collection and reporting;
- death certification, case record review and investigation;
- engaging and supporting bereaved Families and carers

This report follows on from the October 2017 report to the Board which outlined the proposed process for the Trust to ensure there are systems in place to review deaths which occur and the content of this report provides an overview of this process.

2. KEY ELEMENTS

We use the HED (Healthcare Evaluation Data) system to asses our overall mortality data. This allows us to assess our position against other Trusts nationally. We evaluate areas for concern or trends which points us towards focused reviews in these particular areas.

Using both the HED and Datix Risk Management system to obtain data, this report will include;

- total number of deaths of patients;
- number of reviews of deaths;
- number of investigations of deaths;
- themes identified from reviews and investigations;

- lessons learned, actions taken, improvements made

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

It is important for the Board to note that we are no longer an outlier for R codes but will complete the Focused Review that is underway for learning.

Assurance Statement: We would like to provide the Board with the following assurance for learning from deaths; **Moderate -** There is an adequate system of internal control, however, in some areas weaknesses in design and/or inconsistent application of controls puts the achievement of some aspects of the system objectives at risk.

4. IMPACT ON QPS?

The learning from deaths helps us to make changes that will ensure high quality, safe care and an excellent patient experience.

5. MEASUREMENTS/EVALUATIONS

5.1 Total number of deaths and investigation levels

During 1st April 2019 to 30th September 2019, 412 of WHH patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 174 in the first quarter;
- 238 in the second quarter

By 30th September 2019, 88 care record reviews (SJR) and 6 investigations (Serious Incidents) have been carried out in relation to 412 of the deaths included above. They occurred in each quarter of that reporting period as follows:

- 35 SJRs and 3 Serious Incidents (1 case was subject to both an SJR and Serious Incident Investigation);
- 53 SJRs and 3 Serious Incidents

*Details of the SJRs and RCAs can be seen later within this report.

5.2 Investigations of deaths

Structured Judgement Reviews of deaths - Structured Judgement Reviews are presented to the MRG, an assessment of problems in care is made and any actions or lessons to be learned are sent to the appropriate fora. Particular groups of patients are reviewed at the MRG:

- All deaths of patients subject to care interventions with elective procedures. These will be identified using the electronic patient record which provides a daily update as to patients that have died.
- Patients undergoing an emergency laparotomy.

- SHMI/HSMR outliers identified using the HED system.
- Deaths where learning will inform our existing or planned improvement work, for example if work is planned on improving sepsis care, relevant deaths should be reviewed, as determined by the Trust;
- Death of a patient with mental health needs (this covers Inpatients who are detained under the Mental Health Act) identified via the Trust Patient Safety Manager. If the death may have been due to, or partly due, to problems in care including suspected self-inflicted death it will be investigated as a serious incident.
- Trauma deaths will be reviewed and presented at MRG on a quarterly basis.
- Patients who have died aged between 18 and 55 years.
- Patients who have died with no DNACPR in place.
- Once a quarter, a further sample of other deaths will be selected that do not fit the above identified categories, to ensure we take an overview of where learning and improvement is needed most overall.
- All Coroners' reports received post-inquest will be triangulated with the SJR to enhance the learning.
- Any concern that a member of staff may have in relation to a patient death will be reviewed through the mortality process.
- At the request of the Medical Director or Chief Nurse.

During Quarter 2, 53 Structured Judgement Reviews were completed by member of the MRG between July 1st and September 30th 2019. The table below details their overall care rating;

Jul/ Aug / Sept 19	Overall Assessment Care Rating Following SJR					Total
	1: Very Poor	2: Poor	3: Adequate	4: Good	5:Excellent	
	0	0	10	35	8	53

Cases rated as *1: Very Poor* or *2: Poor* are reviewed by MRG and then referred to Governance for further discussion in case they require further investigation and external reporting via StEIS.
Cases rated as *3: Adequate* are referred to MRG for further discussion and cases rated as *4: Good* and *5: Excellent* are disseminated for learning through the Mortality & Morbidity Meetings.

Focused Reviews - The Mortality Review Group analyses data in relation to Mortality and where is it indicated that there is a high SHMI/HSMR (i.e. greater than expected number of deaths) in a diagnosis group, we request that a Focused Review be undertaken. The table below details the current Focused Reviews that are underway at present;

Diagnosis Group	Trigger	Observed deaths/ expected deaths	Date due for completion	Learning Identified
R Codes	SHMI	33/18.75	September 2019	Full report to be presented to Mortality Review Group in October 19.
Chronic Obstructive Pulmonary Disease & Bronchiectasis	SHMI	41/31.29	September 2019	Full report to be presented to Mortality Review Group in

				October 19.

We are now no longer showing as an outlier for R Codes but will continue the Focused Review to see if any further learning can be identified. A report was provided to the Quality Assurance Committee in January 2019 highlighting the issues regarding R Codes and documentation.

The issue regarding documentation had been raised from findings from the Mortality Review Group that there was a general lack of decision making on a diagnosis across the Trust which led to the below mentioned R codes being used.

R codes are conditions and signs or symptoms included in categories R00 to R94 and they consist of:

(a) cases for which no more specific diagnosis can be made even after all the facts bearing on the case have been investigated;

(b) signs or symptoms existing at the time of initial encounter that proved to be transient and whose causes could not be determined;

(c) provisional diagnosis in a patient who failed to return for further investigation or care;

(d) cases referred elsewhere for investigation or treatment before the diagnosis was made;

(e) cases in which a more precise diagnosis was not available for any other reason;

(f) certain symptoms, for which supplementary information is provided, that represent important problems in medical care in their own right.

Since the previous report submitted the following work has been undertaken within the Trust to positively impact on R codes and documentation;

- **QUALITY ACADEMY** - Clinical Coding worked on a project with two Junior Doctors (SAMP) to investigate the 'R' Code (signs & symptoms) coding issue. As a result of the findings from the project a Grand Round in relation to R Codes and documentation was presented. Also created was a training package for the Junior Doctors which is presented by a member of the MRG group and Clinical Coding. Work is still ongoing to develop an e-learning teaching package to further support staff.

- **PRIORITISED CODING** – Bereavement notes will be prioritised for coding which will support the mortality review process. Clinical Coding and a member of the MRG group review all deaths with a primary 'R' code in 1st and 2nd episode and refer back to the responsible consultant for review.

- **WARD ROUND ACCREDITATION** - Alex Crowe, Medical Director and May Moonan, Associate Medical Director, are currently overseeing a project to commence a Ward Round Accreditation Scheme. Medical ward rounds are complex clinical activities, critical to providing high quality, safe care for patients in a timely, relevant manner. They provide an opportunity for the multidisciplinary team to come together to review a patient's condition and develop a co-ordinated plan of care, while facilitating full engagement of the patient and/or carers in making shared decisions about care. Adopting these principles will improve patient safety, patient experience, shared learning, collaborative working and efficient use of resources. Success requires a concerted cultural change, with clinical staff, managers and hospital executives all fully engaged and focused on improving the quality of ward rounds. The review of documentation will form part of the accreditation process on each Ward Round.

- **FINISHED CONSULTANT EPISODES** - A Task and Finish group to look at Finished Consultant Episodes is established, led by the Trust Mortality Lead. A SOP has been developed to enable ward clerks to edit the system instead of multiple episodes being created each time a patient is moved. Although this will take some time to action it is believed that this will have a positive impact on HSMR/SHMI going forwards.

- **WORKING DIAGNOSIS AND CDC FORMS** - MRG members are working with the Lorenzo team to develop CDC forms from a mortality perspective. To reduce R codes the team are looking at removing the possibility for clinicians to input words such as 'likely' or 'possibly' into their working diagnosis.

- **PATIENT SAFETY SUMMIT** – The Mortality Review Group aim to host a Mortality element with the Safety Summit in November 2019/20 where all learning from Mortality is shared again and educational sessions will be held with staff to promote areas such as Coding and documentation.

- **MORTALITY EVENT –** In February 2020 the Mortality Review Group will be hosting a multi-agency shared learning event. A Save the Date card with further details will be issued shortly.

5.3 Cases subject to Root Cause Analysis investigation - The following data outlines those deaths that have been deemed by the Trust to be having problems in care which may contribute to death, which are subject to Root Cause Analysis investigation. Some cases may be referred from Mortality Review Group to ensure a Root Cause Analysis investigation is undertaken. The majority of cases are identified through incident and complaint processes.

To note all Root Cause Analysis investigations are shared with patients/families, commissioners and where applicable HM Coroners and regulators/external agencies such as NHS Resolutions.

The following table provides an update on outstanding cases from 2018/19 and also from Quarter 1 and Quarter 2 2019/20 that were deemed to be due to having problems in care which may contribute to death or are still outstanding;

STEIS Reference	INC Description	Deemed as having problems in care
2018/19 - Q3		
2018/19771	The patient was found collapsed with breathing difficulties. The patient was transferred from the Halton ward to the Warrington Emergency Department (ED). The patient was reviewed on arrival to ED by the consultant. Initial tests showed respiratory failure and appropriate treatment were commenced despite a poor prognosis for the patient. The patient was kept comfortable and sadly passed away in the department. Whilst an inpatient on the ward at Halton, it is thought that the patient had potentially been taking illegal substances on several occasions. On transfer to Warrington, it was noted that the patient had illegal substances on his possession. *This case was not subject to an SJR as a 72 hour review was already underway.	*Inquest heard on 15th August 2019. Patient died from acute exacerbation of COPD which was contributed to by long term heroin use. *No problems in care.
2018/19 - Q4 - There were no cases of harm due to having problems in care to date. However, 1 is awaiting Inquest.		
2018/26921	The patient had a past medical history of Alzheimer's disease, COPD, myeloma, hypothyroidism and a 6 month history of weight loss and was admitted through WHH ED under GP referral for overnight delirium suffering from hallucinations on 12/09/18 the patient was transferred to Halton with a plan for discharge. On the morning of 04/11/18, the staff nurse in charge of the patient's care identified that the patient appeared drowsier. Medication had been taken, however the patient struggled to eat and began coughing when attempting to eat. On the afternoon of 04/11/18, an NHS Professionals (NHSP) Health Care Assistant (HCA) arrived on the ward to begin a shift and received handover and induction. The HCA was asked to assist the patient with eating. The patient was observed being assisted with feeding by the HCA, but when staff went into the bay (approximately 1-2 minutes later), the patient was found to have died and food was seen inside and around their mouth. The patient was DNACPR. *This case was not subject to an SJR as a 72 hour review was already underway.	*Subject to inquest – date set for 11th December 2019.
2018/23091	The patient was found collapsed at home by his wife having fallen down the stairs after developing chest pain. An ambulance was called and the patient had a cardiac arrest in the ambulance. Resuscitation commenced and the NWAS team diverted to WHH Emergency Department (ED). On arrival at ED the Consultant made the decision that the patient needed to be transferred immediately to Liverpool Heart and Chest Hospital (LHCH) for Percutaneous transluminal coronary angioplasty (PPCI.) The patient was the taken to LHCH, but sadly died. *This case was not subject to an SJR as it did not meet the criteria for a review.	Inquest heard on 8th July 19 – Natural Causes. *Problems in care.
2019/20 – Q1 – Of the 3 cases in Q1 there was one case of harm due to having problems in care. However, 1 is awaiting Inquest.		
2019/8122	The patient was admitted to Warrington Hospital on 31/03/2019 after a fall at home, shortness of breath and increased confusion. The patient was admitted to AMU. On 02/04/2019 the patient had an unwitnessed fall and was found on the floor at the end of the bed. Following a brief loss of consciousness the patient displayed acute confusion, pain to right shoulder, laceration to right arm and hematoma to right temporal region. The x-ray confirmed the patient also sustained a fractured clavicle. The CT scan showed a large right hemispheral, falcine and left tentorial subdural haematoma which had progressed since the	*Subject to inquest – no date set as yet.

	previous imaging. In the right frontoparietal region there was an impression of extension of haemorrhage. The CT results however were not documented in the patient's records until 04/04/2019. The patient's condition deteriorated and the patient sadly passed away on 08/04/2019. *This case was not subject to an SJR as a 72 hour review was already underway.	
2019/11932	Patient care reviewed in MRG. A brief summary of the issues found; The patient died of Sepsis and Pneumonia following a fall Relatively little medical input for 3 days Went for 3 days without repeated bloods Problems with pain management Considered for discharge but she had an overwhelming infection No IV access for 3-4 days *This case was subject to an SJR and MRG requested that this be reviewed by Governance. This was subsequently deemed to be a Serious Incident.	*Problems in care.
2019/13089	In July 2015, an ultrasound scan was completed and reported seeing a probable haemangioma in the right lobe of the liver. The patient attended both her own GP and out of hours GP numerous times, before attending the Spire for a privately funded scan on 28th January 2016. This revealed multiple liver metastases and Histology later confirmed neuroendocrine carcinoma. The review, following this incident being raised following a claim, concluded that it could not be assured that the original probable haemangioma was not actually metastases, as there was one later noted in exactly the same location on the later scan. The patient sadly died on 16th May 2016. *This case is historical and before we undertook SJRs.	*No problems in care.
2019/20 – Q2 - Of the 3 cases in Q2 1 investigation is ongoing and 2 are awaiting Inquest.		
2019/15506	On 03/07/19, the patient was admitted for an endoscopic retrograde cholangiopancreatography (ERCP). A pancreatic stent was inserted during the procedure following failed attempts to cannulate the common bile duct (CBD). The patient was observed following the procedure for 4 hours. The patient's observations were reported to be stable following the procedure and had tolerated diet and fluids. At 17:15, on the same day following the procedure, the patient telephoned the hospital and spoke to an endoscopy nurse, complaining of vomiting, feeling unwell and some discomfort. The patient was readmitted with a diagnosis of post-procedure pancreatitis and initially referred to the medics. On 04/07/19 at 00:13, the patient was accepted by the surgical registrar. The patient's condition deteriorated - the patient was admitted to HDU at 14:00 and a CT scan was performed. On 05/07/19 at 10:00, there was a discussion with the patient's family and the patient's current condition was discussed. The patient was in multiple organ failure (MOF) for his kidneys, liver, lungs and heart - the patient was not responding to current treatment. A planned withdrawal of treatment was agreed. At 11:35, the patient sadly passed away. The patient's death has been referred to HM Coroner.	*Subject to inquest – no date set as yet.

	*The case was not subject to an SJR as it did not meet the criteria for review.	
2019/15878	The patient attended Warrington Hospital Emergency Department (ED) by ambulance at their GPs request. The patient arrived in ED 18.41 and remained in the hub as there was no space in the 'majors' or 'resus' areas. On review of the incident, the patient should have been accommodated in one of these areas. Full triage occurred at 19.11, and observations on ambulance documentation and triage documentation are reported to be the exact same. Observations were later taken at 20:15 (NEWS score=3), 21:30 (NEWS score=6) and at 23:30 (NEWS score=3) - Although on review of the incident, NEWS at 23:30 was calculated as scoring 5. The following observations were at 02:45. Bloods were taken at 21:05; HB had dropped further to 45 (blood pressure was trending downward since admission, saturations dropped and respiration rate had increased). Although the medical registrar reviewed the patient's blood results, documentation of this could not be found on review and planned antibiotics and fluids do not appear to have been administered. The patient went into cardiac arrest at around 02:45 and was reviewed by ITU - But was not for ITU admission due to commodities and the recent cardiac arrest. The patient had a further cardiac arrest in the department at around 04:50 and sadly passed away. *This case was not subject to an SJR as a 72 hour review was already underway.	*Ongoing investigation
2019/16094	Patient was sat at the side of the bed with the Occupational Therapist. Patient went to reach down to put slippers on, lost her balance and started to fall forward. Occupational Therapist attempted to facilitate balance, but the patient continued to fall forward. Patient assisted to the floor. *This case was not subject to an SJR as a 72 hour review was already underway.	*Subject to inquest – no date set as yet.

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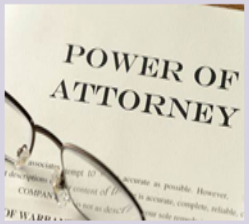
5.4 Learning from deaths

We found....	We are doing....	
40y/o male with autism/Asperger's and moderate learning disability. Patients' mother had approached GP re DNACPR prior to admission. GP refused as it was felt that the patient would not be able to understand to consent as he lacked capacity, despite mother having power of attorney.		DNACPR is a clinical decision. It was clearly appropriate in this case and the patients Mother had Power of attorney. The DNACPR could and should have been done by the GP. This learning has been fed back to all GPs via the Primary Care GP Newsletter which is coordinated by the CCG.
SHMI/HSMR have stabilised.		A Task and Finish group to look at Finished Consultant Episodes is established, led by the Trust Mortality Lead. A SOP has been developed to enable ward clerks to edit the system instead of multiple episodes being created each time a patient is moved. Although this will take some time to action it is believed that this will have a positive impact on HSMR/SHMI going forwards.
Perinatal deaths were presented to MRG, 5 cases were summarised.		Learning disseminated; Mothers should be reviewed for physical fitness if there is sleep deprivation and prolonged or difficult labour. Physical fitness of carers should be assessed (both parents exhausted). Advice on safe sleeping environments for baby and other aspects of preventing cot death should be reinforced.
Working Diagnosis: Repeated use of R Codes in documentation.		MRG members are working with the Lorenzo team to develop CDC forms from a mortality perspective. To reduce R codes the team are looking at removing the possibility for clinicians to input words such as 'likely' or 'possibly' into their working diagnosis.

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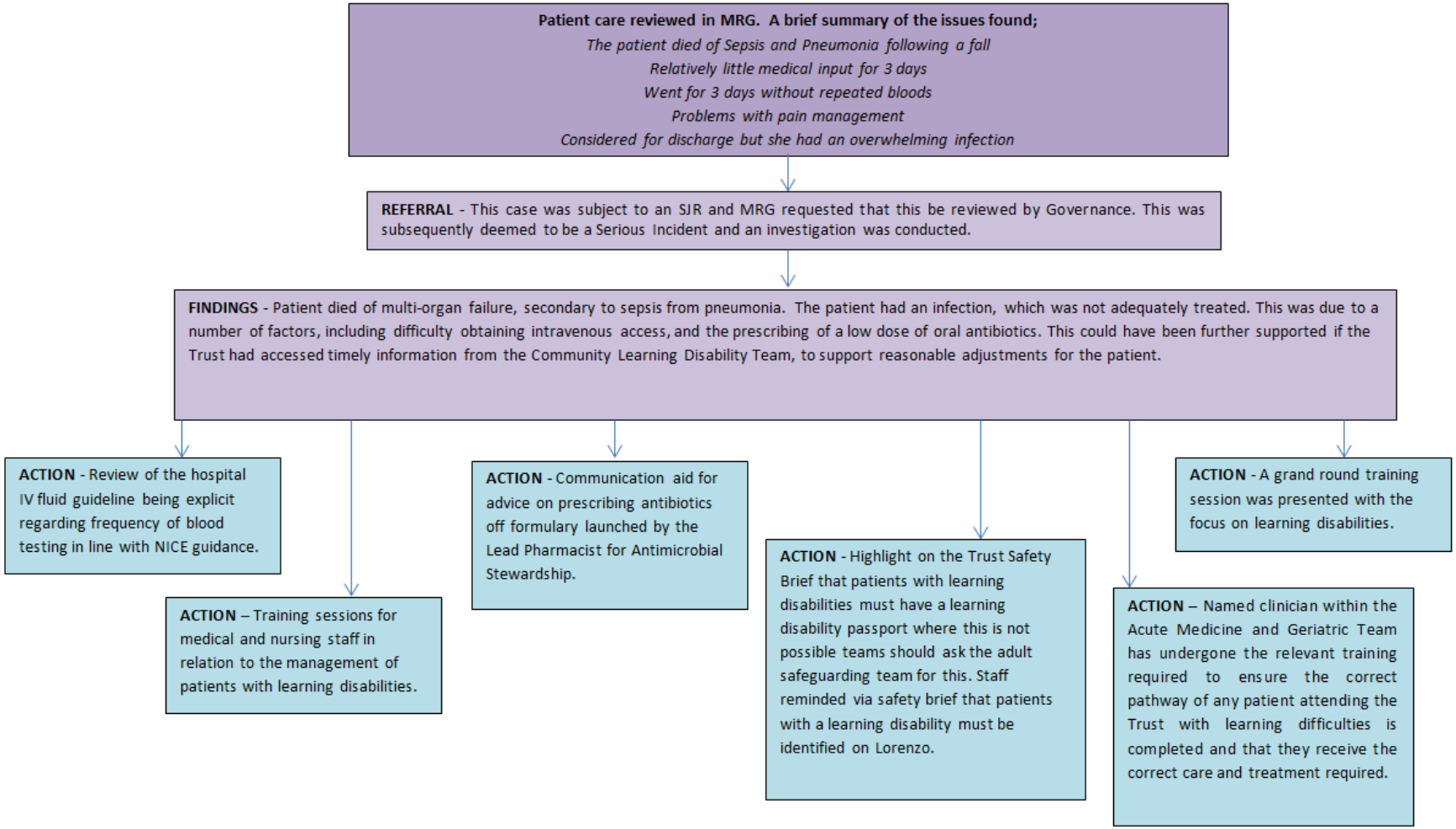
5.5 Case Study: Learning Disability Case subject to both an SJR and Serious Incident Investigation



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6. TRAJECTORIES/OBJECTIVES AGREED

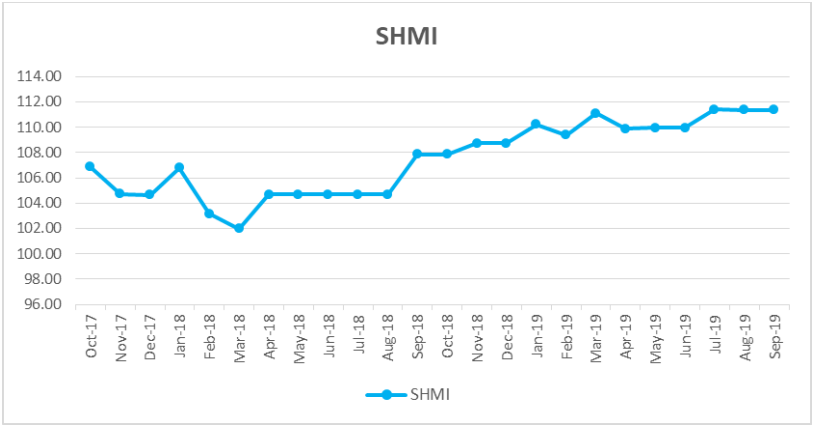
SHMI / HSMR Summary

In 2010 the Department of Health endorsed the national review of HSMR commissioned by the NHS Medical Director who committed to implementing SHMI as the single hospital level of mortality indicator to be used across the NHS. Therefore, although we still look at HSMR, it is the SHMI which is being used and evaluated nationally as the mortality indicator.

SHMI (Summary Hospital Mortality Indicator)

All observed deaths in hospital and within 30 days of discharge. Adjustments are made only for age, admission method, comorbidities. Still births, specialist community, mental health and independent sector hospitals, day cases, regular day and night attenders are excluded.

The table below shows the Trust position since October 2017 and demonstrates our current position as 111.38. Our peers' average is 103.46 and we are 15th out of the 20 hospitals in our peer group.

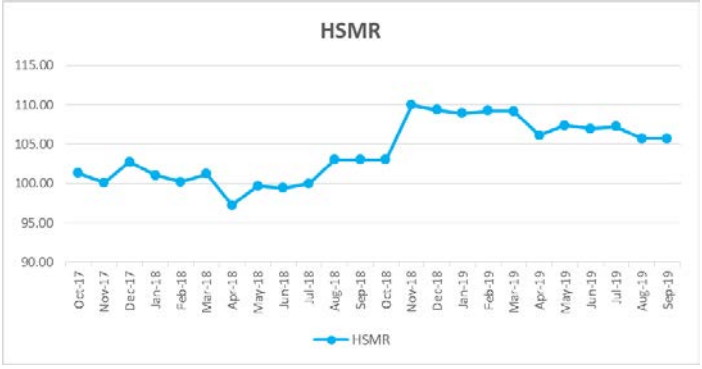


The work being undertaken in relation to the Focussed Reviews should provide us with learning that we can implement to positively impact on SHMI going forwards.

HSMR (Hospital Standardised Mortality Ratio)

All spells culminating in death at the end of a patient pathway defined by the primary diagnosis for the spell. It uses 56 diagnosis groups which account for about 80% of in-hospital deaths; therefore it does not included 'all' deaths.

The table below shows the Trust position since October 2017 and demonstrates our current position as 105.72. Our peers' average is 100.16 and we are 14th out of the 20 hospitals in our peer group.



We are not showing as an outlier in any of the diagnosis groups that are monitored by HSMR.

Our HSMR has been showing signs of improvement and we are in a better position against our peers since the previous reporting period.

We ask the committee to note that the above results are based on data up to May 2019. NHS Digital failed to provide data in relation to out of hospital deaths. They have acknowledged this issue and are working to provide a file to HED who provide our mortality reports. As a result the SHMI module has not been updated and therefore is not the most up to date position; this will be available in November.

7. MONITORING/REPORTING ROUTES

Learning from Deaths is monitored by the Mortality Review Group which reports monthly to the Patient Safety and Clinical Effectiveness Committee, Quarterly to the Quality Assurance Committee and annually in both the Quality Account and to the Clinical Commissioning Group via the Clinical Quality Focus Group.

8. TIMELINES

The Mortality Review Group meets monthly to review deaths that have been subject to a Structured Judgement Review.

9. ASSURANCE COMMITTEE

Both Patient Safety and Clinical Effectiveness Committee and the Quality Assurance Committee.

10. RECOMMENDATIONS

During Quarter 2, 2019/20;

- 238 deaths that occurred within the Trust.
- 53 have met the criteria to be subject to a structured judgement review (SJR) through the Mortality Review Group
- 3 were to subject to investigation using root cause analysis (RCA) methodology.

Our HSMR has been showing signs of improvement and we are in a better position against our peers since the previous reporting period.

We ask the committee to note that the results are based on data up to May 2019. NHS Digital failed to provide data in relation to out of hospital deaths. They have acknowledged this issue and are working to provide a file to HED who provide our mortality reports. As a result the SHMI module has not been updated and therefore is not the most up to date position; this will be available in November.

We are not an outlier for HSMR or SHMI. However, the Mortality Review Group analyses data in relation to Mortality and it is indicated that there is an unusual pattern to Mortality in the following diagnosis groups;

- Chronic Obstructive Pulmonary Disease & Bronchiectasis

MRG have requested that Focused Reviews be undertaken to obtain any learning. It is important for the committee to note that we are no longer an outlier for R codes but will complete the Focused Review that is underway for learning.

Learning is now being disseminated to the CBUs and Specialties through the form of a high level briefing paper. This form provides them with the deaths for their area and also Trustwide learning from MRG to disseminate to staff. This process is still under development and we aim to provide some examples of what good looks like so that we receive meaningful responses back from the leads.

Appendix 1 – HED report

Warrington Aug 2019.pdf

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/19/11/113**	
SUBJECT:	**Progress on Lord Carter Report Recommendations & Use of Resource Assessment (UoRA)**	
DATE OF MEETING:	27th November 2019	
AUTHOR(S):	Marie Garnett, Head of Contracts & Performance	
EXECUTIVE DIRECTOR SPONSOR:	Andrea McGee, Director of Finance + Commercial Development	
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future. SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.	x x x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): ***(Please DELETE as appropriate)***	#115 Failure to provide adequate staffing levels in some specialities and wards. #134 (a) Failure to sustain financial viability. #134 (b) Failure to deliver the financial position and a surplus #135 Failure to provide adequate and timely IMT system. #125 Failure to maintain an old estate. #145 (a) Failure to deliver our strategic vision. #145 (b) Failure to fund two new hospitals. #241 Failure to retain medical trainee doctors.	
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The Trust continues to develop and improve its Use of Resources both internally and in collaboration with system wide partners. The Trust has received the National Benchmarking Report for Corporate Services. The report highlights a number of areas where costs (based on a scale of cost/£100m income) are higher than the national median. Corporate leads are reviewing their costs to identify any warranted variation, data issues and most importantly areas for improvement which will be incorporated into the UoR work plan.	

PURPOSE: ***(please select as appropriate)***	Information	Approval	To note	Decision
			x	

RECOMMENDATION:	The Board of Directors is requested to note the contents of the report.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.
	Agenda Ref.	
	Date of meeting	

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

	Summary of Outcome	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.	

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

SUBJECT	Progress on Lord Carter Report Recommendations & Use of Resource Assessment (UoRA)	AGENDA REF:	BM/19/11/113

1. BACKGROUND/CONTEXT

The UoRA is designed to improve understanding of how effectively and efficiently the Trust uses its resources. The UoRA is based on 5 key lines of enquiry (KLOEs) these are; clinical services, people, clinical support services, corporate services and finance. The UoRA workstream has prepared a narrative for each KLOE and has developed a dashboard. This forms the basis from which to review and improve each KLOE indicator.

Where appropriate, Lord Carter Recommendations have been aligned with the UoRA indicators for the purposes of this report. UoRA indicators are denoted by the UoR stamp:

UoR data is from the Model Hospital and has been benchmarked against peer and national median groups. The RAG rating is based on the Trust's position against the national median on the model hospital. The peer median group is based on NHSI's peer finder tool.

2. KEY ELEMENTS

This paper presents the update for Quarter 2. Performance against each UoRA KLOE is set out in **Appendix 1**, the full detail for each KLOE indicator and progress against the Lord Carter recommendations can be found in **Appendix 2**. The majority of the Lord Carter recommendations are either complete or are on track.

Collaboration at Scale

The Trust continues to work with other organisations across the Cheshire & Mersey Network on Carter at Scale Collaboration opportunities across a number of corporate functions including; Procurement, Finance, Payroll, HR, Legal and IM&T. Work is taking place at pace around the standardised agency rate card across the network with an expected go live date of 1st December 2019.

National Benchmarking for Corporate Services

The Trust has received the national benchmarking report which highlighted a number of areas where corporate service costs were above the national median based on cost per £100m of income.

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Warrington and Halton Hospitals NHS Foundation Trust

When comparing absolute costs, the Trust is lower than the national and peer medians, with the exception of procurement. This is shown in **Table 1**. However the Trust ranks in the best quartile for non-pay costs which is influenced by procurement.

Table 1: 2018/19 WHH Absolute Costs

	2018/19		
	WHH	NM	PM
Finance	£2m	£2.1m	£2m
Governance & Risk	£2.4m	£2.7m	£2.7m
HR	£2.6m	£3.4m	£3m
IM&T	£6.3m	£7.6m	£8.2m
Legal	£380k	£408k	£450k
Payroll	£236k	£322k	£260k
Procurement	£660k	£643k	£783k

NM = National Median
PM = Peer Median

Table 2: WHH Corporate Costs per £100m income in comparison with the Peer and National Median

	2018/19				
	WHH	NM	PM	Adjustment	
Finance	838.9k	704.5k	673.2k	£684k*	Adjusted to remove SBS 100% costs.
Governance & Risk	998.6k	862.7k	924.3k	£881k**	Removal of risk posts centralised from CBU and Communications non pay.
HR	1,087.6k	1,087.5k	980.4k		
IM&T	2,600.0k	2,521.1k	3,130.0k		
Legal	156.0k	122.9k	125.6k		
Payroll	97.0k	98.9k	103.4k		
Procurement	271.6k	208.4k	286.3k		

*data quality issues with outsourced financial service. Adjusted moves the Trust below the national median.
**warranted variation in the centralisation of risk posts previously held in operational services.

When comparing corporate costs per £100m turnover, the majority of indicators are red, highlighting the impact of organisational size. Corporate services are reviewing their costs to understand any areas of warranted variation, any data issues and most importantly areas for improvement which will be brought into the UoR work plan.

3. RECOMMENDATIONS

The Board of Directors is requested to note the contents of the report.

Andrea McGee
Director of Finance and Commercial Development
20th November 2019

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

Appendix 1 – Benchmarking Performance against the National Median

KLOE Indicator	Quarter 1 18/19	Quarter 2 18/19	Quarter 3 18/19	Quarter 4 18/19	Quarter 1 19/20	Quarter 2 19/20
KLOE 1 - Clinical						
Pre Procedure Elective Bed Days	Q4 2017/18	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q2 2019/20
Pre Procedure Non Elective Bed Days	Q4 2017/18	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q2 2019/20
Emergency Readmission (30 Days)	Q4 2017/18	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q2 2019/20
Did Not Attend (DNA) Rate	Q4 2017/18	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q2 2019/20
KLOE 2 - People						
Staff Retention Rate	March 2018	June 2018	September 2018	December 2018	December 2018	December 2018
Sickness Absence Rate	February 2018	May 2018	August 2018	November 2018	November 2018	June 2019
Pay Costs per Weighted Activity Unit	2016/17	2016/17	2017/18	2017/18	2017/18	2017/18
Medical Costs per WAU	2016/17	2016/17	2017/18	2017/18	2017/18	2017/18
Nurses Cost Per WAU	2016/17	2016/17	2017/18	2017/18	2017/18	2017/18
AHP Cost per WAU (community adjusted)	2016/17	2016/17	2017/18	2017/18	2017/18	2017/18
KLOE 3 – Clinical Support Services						
Top 10 Medicines - Percentage Delivery of Savings	March 2018	March 2018	March 2018	March 2018	March 2018	September 2019
Pathology - Overall Costs Per Test	Q2 – 2017/18	Q4 2017/18	Q4 2017/18	Q2 2018/19	Q2 2018/19	Q4 2018/19
KLOE 4 – Corporate Services						
Non Pay Costs per WAU	2016/17	2016/17	2017/18	2017/18	2017/18	2017/18
Finance Costs per £100m Turnover	2016/17	2016/17	2017/18	2017/18	2017/18	2018/19
Human Resource Costs per £100m Turnover	2016/17	2016/17	2017/18	2017/18	2017/18	2018/19
Procurement Process Efficiency and Price Performance Score Clinics	Q4 2016/17	Q4 2016/17	Q4 2017/18	Q3 2018/19	Q3 2018/19	Q4 2018/19
Estates Costs Per Square Meter	2016/17	2017/18	2017/18	2017/18	2017/18	2018/19
KLOE 5 - Finance						
Capital Services Capacity*						
Liquidity (Days)*						
Income & Expenditure Margin*						
Agency Spend - Cap Value*						
Distance from Financial Plan*						

*the model hospital does not benchmark these indicators against the national median and therefore there is no RAG rating available.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Use of Resource Graph Key
Trust Position
National Median
Peer Median

Key
Complete/Green on Model Hospital (against National median)
On track for completion
Progress off track - plans in place to get back on track/Amber on the Model Hospital
Progress significantly off track/Red on Model Hospital
Not started/Awaiting further information/New actions parameters to be established

Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 2 2019/20

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
	Recommendation 1 - NHS Improvement (NHSI) should develop a national people strategy and implementation plan by October 2016 that sets a timetable for simplifying system structures, raising people management capacity, building greater engagement and creates an engaged and inclusive environment for all colleagues by significantly improving leadership capability from "ward to board", so that transformational change can be planned more effectively, managed and sustained in all Trusts. **Lead Director:** Director of Human Resources & Organisational Development			
Development and Approval of People Strategy and Dashboard	• The refreshed People Strategy was signed off by the Trust board in Q2 2018/19. Quarterly reports are presented to the Strategic People Committee.	• Ongoing monitoring and management of the dashboard.	Trust Board, TOB, Strategic People Committee	Complete
Restructure of HR Directorate	• The HR department restructure is complete and key posts in the Senior Management Team have been recruited to.		Trust Board, Strategic People Committee	Complete
HR Polices reviewed to ensure they are clear, simple and transparent	• The Human Resources & Organisational Development (HR&OD) Directorate has a policies and procedures group with management and staff side representation. All HR policies are taken through this group and then progressed to JNCC. • Policies reviewed and ratified to date include; the Disciplinary, Relationships at Work, Special Leave, Secondments, Annual Leave, Equality in Employment, Temporary Staffing and Professional Clinical Registration. • A review and refresh of the essential managers training was undertaken during Q1 2019/20. The new training has been rolled out including topics on Difficult Conversations and Equality & Diversity. • The Trust has introduced a new policy for the recovery of employee overpayments and outstanding debt.	• The Trust is undertaking a programme to review, and where required, simplify HR policies. This is monitored by the Strategic People Committee. • In Q3, the Trust's attendance management policy will be reviewed with staff side representatives.	Strategic People Committee	Ongoing Monitoring

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Use of Resource Graph Key

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Peer Median

Key

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UoR Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 2 2019/20

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
"Fit to Care" Heath & Wellbeing Programme	• The Trust has a wide range of wellbeing approaches aimed at supporting staff back into work which has included; a Weight management clinic, Healthy Topics, Drop in sessions for healthy hearts and Wellbeing clinics. • The Trust launched its mental health first aid courses which aims to help managers spot the signs of mental health and signpost colleagues to support. • The rollout of the refreshed fit to care programme was completed during Q1 2019/20. The Trust is building on the previous approach of educational/informative campaigns, to adopt an impact based approach e.g. Know Your Heart Age event in April 2019, where staff were offered a range of screening tests and access to a Consultant Cardiologist where appropriate. The new programme has now been introduced and will reviewed annually.	• Wellbeing initiatives will continue to be offered and monitored for effectiveness.	Strategic People Committee	Complete
Development of Workforce Streaming Programme across the North West	• The Trust has worked with colleagues across the North West to agree unified ways of working and to reduce bureaucracy. • Key actions included: o Implementation of factual references. o Streamlining of notice periods for new starters. o Agreed the honorary contract process and streamlining of mandatory training across the region. o Values based recruitment. • Region wide TUPE guidelines have been implemented. • The streamlining programme is now complete with benefits realisation signed off by Operational Peoples Committee in May 2019 and a summary provided to Strategic People Committee.		Operational People Committee	Complete
Staff Opinion Survey	• Themes from the staff survey were used to develop the refreshed People Strategy. • The Trust achieved a very positive response rate of 50.6% in 2018, a 4.6% improvement on the previous year. The Trust achieved average or above average score for 9/10 of the key themes as well as statistically significant improvements in safety culture and staff engagement. The CBU level results have been shared for local implementation and the Trust level results will be mapped to the delivery of key strategies such as the People Strategy and EDI Strategy. • A detailed analysis was undertaken around EDI by protected characteristics and was reviewed by the EDI sub-committee in Q2.	• The 2019 SoS opened in late September 2019, as at the end of October the Trust response rate was 35%, the national median was 27%. The SoS closes at end November. The Trust has a campaign in place throughout the survey period which includes regular reporting across the workforce, a communications plan, incentives and a emphasis on ownership by local managers.	Trust Board, TOB, Strategic People Committee	Rolling Programme

Warrington and Halton Hospitals NHS
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UoR Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 2 2019/20

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Reduction in the high rates of bullying and harassment with a sustained campaign led personally by each trust Chief Executive	• The Freedom to Speak Up Guardian has a network of champions to support staff to raise concerns. • The Trust performed in the upper quartile in the 2017 & 2018 staff surveys in relation to bullying and harassment in comparison with other Acute Trusts. • The Trust has reviewed the SoS results against other employee relations metrics around bullying and harassment and has analysed the areas where we are doing well to look how learning can be shared across other areas. This was focused specifically around; managers training, standards, policy implementation and reward. It was identified that the approach in leadership style within these areas was similar. This learning has been incorporated into the essential managers training. • Work was undertaken with the Trust's communications team to ensure staff know who to raise concerns with and how they would go about this. • An Equality, Diversity and Inclusion Strategy has been developed and implemented.	• The Trust has the culture and infrastructure to address bullying and harassment and this is supported by the latest staff survey results. October 2019 was our Freedom to Speak up month which involved a series of events and workshops to promote this function.	Strategic People Committee	Complete
Ensure Staff have regular performance reviews	• The number of staff with a valid PDR is 76.00% (September 2019) against a target of 85%. • The PDR process has been reviewed, with a particular focus on engaging staff and condensing timescales to avoid winter pressures. • The Trust has implemented the pay progression policy. As per the national policy, this is currently for new starters to the Trust only. • Part of the People Strategy focuses on improving the quality of appraisals, the Trust set up a task and finish group in July 2019 to initiate this review which included new documents/system, guidance and training. The appraisal system is integral to our talent management and succession planning framework.	• HR Business Partners will continue to work with the CBU managers to further improve PDR compliance. • A new appraisal tool has been drafted with engagement from staff across the workforce, the focus is on little paperwork, big conversation. This will be piloted in November 2019 using a Plan Do Study Act (PDSA) test of change cycle.	Trust Board, TOB, Strategic People Committee	Ongoing Monitoring
Improving Sickness Absence	• Sickness absence was 5.27% in September 2019. • An audit was completed on compliance with the Trust's Attendance Management Policy and a number of recommendations were implemented. • Promotion and improvement of flu vaccination uptake takes place annually. • Mental Health "Train the Trainer" training is complete. • A new clinical supervision framework was rolled out which will help to address some of the stress/anxiety related absences. • An ongoing programme of Mental Health first aid training has been rolled out across the Trust.	• The HR&OD team have used the NHSE/I endorsed Health & Wellbeing Partnership framework to undertake a high level gap analysis in order to identify immediate actions to improve attendance. A number of initiatives are being piloted using a PDSA approach as advocated in the framework. A full impact evaluation will be undertaken in January 2019, which will feed into a Trust-wide employee engagement and wellbeing strategic plan including a detailed wellbeing diagnostic and health needs assessment of the workforce. • In addition, the Trust is investing in a employee assistance programme which will enable the Occupational Health team to implement a four tier mental health provision, including the introduction of Schwartz rounds in Q3/4.	Trust Board, TOB, Strategic People Committee	Ongoing Monitoring

Warrington and Halton Hospitals NHS
NHS Foundation Trust

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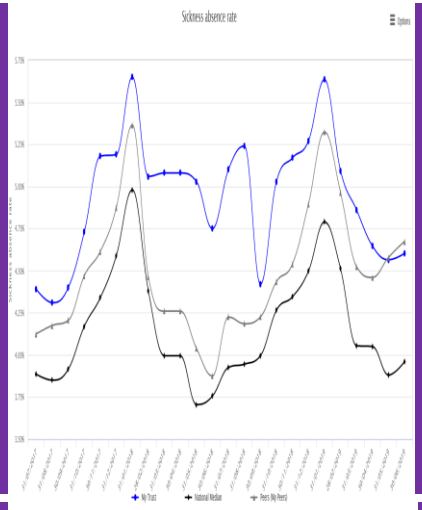
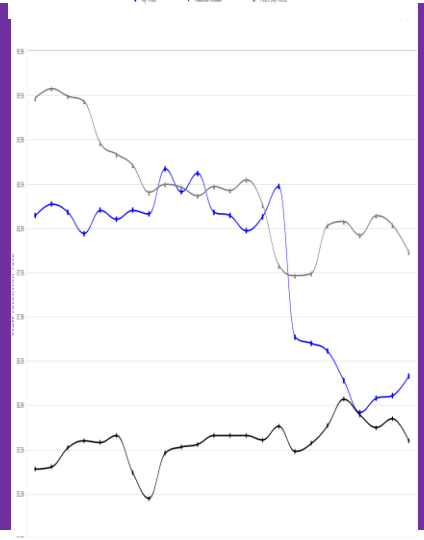
UoR Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 2 2019/20

KLOE 2 - People

	Progress/Performance			Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Sickness Absence Rate	Percentage of staff FTE sick days.	**National Median = 3.96%** **Peer Median = 4.67%** 1. Sunderland 1.52% 2. Bournemouth 3.77% 3. Gateshead 4.13% 4. Chester 4.40% 5. Mid-Cheshire 4.58% 6. WHH 4.60% **Current Quartile:** **Best Quartile Target:** **Source: HSCIC - NHS Digital iView Stability Index Monitoring - Trust Board, TOB, SPC**	**June 2019** 7. STHK 4.77% 8. N Lincolnshire 4.80% 9 N Tees 4.82% 10. Southport 5.12% 11. Wirral 5.72% **4 (Worst)** **3.88%**		The Trust is above the national median but below the peer median for sickness absence in the latest reporting period. Significant strategic and operational work has been undertaken to improve the position and from March 2019 the sickness absence rates have dipped below the 2018/19 rate.	• The HR&OD team have used the NHSE/I endorsed Health & Wellbeing Partnership framework to undertake a high level gap analysis in order to identify immediate actions to improve attendance. A number of initiatives are being piloted using a PDSA approach as advocated in the framework. A full impact evaluation will be undertaken in January 2020, which will feed into a Trust-wide employee engagement and wellbeing strategic plan including a detailed wellbeing diagnostic and health needs assessment of the workforce.	
Staff Retention Rate	The percentage of staff that remained stable over 12 months period.	**National Median = 85.6%** **Peer Median = 87.7%** 1. N Lincolnshire 89.0% 2. Wirral 89.0% 3. Sunderland 88.6% 4. STHK 88.4% 5. Gateshead 87.8% 7. Southport 87.7% **Current Quartile:** **Best Quartile Target:** **Source: HSCIC - NHS Digital iView Stability Index Monitoring - SPC**	**December 2018** 8. Mid Cheshire 87.4% 9. Bournemouth 86.5% 10. North Tees 86.5% 11. WHH 86.3% 12. Chester 85.6% **3 (2nd Best)** **87.50%**		Retention is currently at the highest rate since October 2017 at 88.42% and Turnover is at the lowest rate since October 2017 at 10.96%, demonstrating the success of the programme of work implemented in line with the NHSI nursing retention programme.	• Improvement in our workforce's ability to achieve a better work life balance through promoting what we offer and reviewing our processes/policies. • Support our staff to explore and pursue career progression within the Trust. • The promotion of the Recognising and Valuing Experience (RAVE) role/initiative. • Develop an R&R Champion role, so they are able to support our managers in both Recruitment and Retention practices. • Improving our retire and return options/promotion through the Pre-Retirement courses.	

Warrington and Halton Hospitals NHS
NHS Foundation Trust

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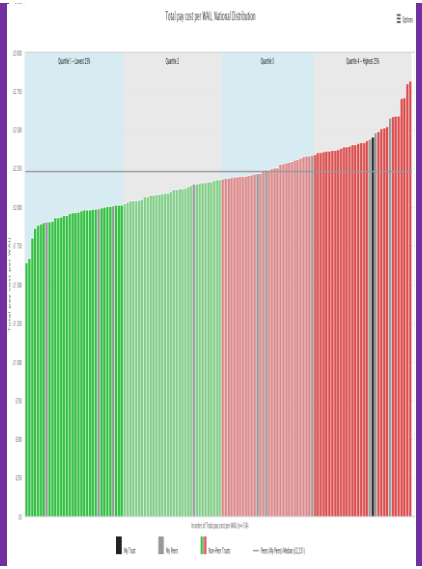
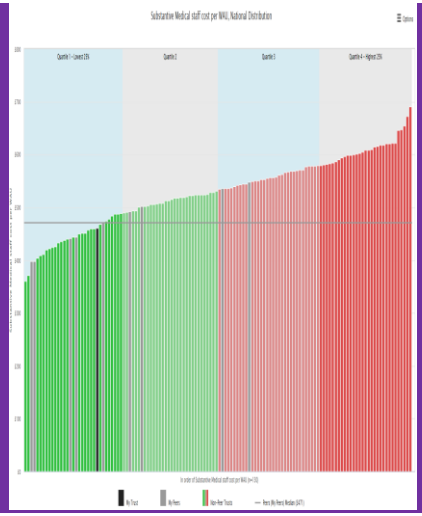
UoR Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 2 2019/20

	Progress/Performance			Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Pay Costs per Weighted Activity Unit	UoR Cost per WAU is the headline productivity metric used within the Model Hospital. It shows the amount spent by a Trust to produce one Weighted Activity Unit (WAU) of clinical output. This metric shows the amount the trust spends on pay per WAU across all areas of NHS clinical activity.	**National Median = £2180** Peer Median = £2312 1. Sunderland £1904 2. STHK £1995 3. Bournemouth £2010 4. Gateshead £2151 5. Wirral £2219 6. North Tees £2242 7. Chester £2336 8. Mid Cheshire £2442 9. WHH £2455 10. N Lincolnshire £2482 11. Southport £2577 **Current Quartile:** 4 (Worse) **Best Quartile Target:** £2,014 **Source: Trust consolidated annual accounts and reference cost data.** **Monitoring - Trust Board, SPC (From March 2019), FSC, TOB.**	**2017/18**		Pay Costs per WAU exceeds the Peer and National Medians. The below shows the WAU Staff Costs per staff group and the percentage difference compared to our peers: **Staff Group / Trust / Peer %** Medical £465 -4.5% Nursing £764 -6.2% AHP £188 19.1% Scientists £192 9.4% Corp Supp £413 -3.1% Agency £169 32.0% Non-Sub £183 8.2% When removing AHP costs associated with external SLA, this impacts positively on the overall position.	Additional controls and challenge around pay spend have been identified, to support a reduction in premium pay: • Monthly deep dives into Nursing Agency, supported by NSH Professionals; • Enhanced ECF process for non-clinical vacancies; • Expanded ECF process for some temporary staffing pay spend; • Implementation of Cheshire and Mersey Rate Cards; • Implementation of consistent additional hours rates for Medical Staff; • Introduction of Patchwork Medical Bank system; • Review of all long term locums, led by the Chief Operating Officer ; • Review and action of pay elements within NHSI/E Grip and Control Checklist.
Substantive Medical Costs per WAU	UoR Cost per WAU is the headline productivity metric used within the Model Hospital. It shows the amount spent by a trust to produce one Weighted Activity Unit (WAU) of clinical output. This metric shows the amount the trust spend on pay for medical staff per WAU across all areas of NHS clinical activity.	**National Median = £533** Peer Median = £471 1. Gateshead £398 2. Mid Cheshire £399 3. Sunderland £442 4. North Tees £444 5. WHH £461 6. Wirral £471 7. Bournemouth £493 8. Chester £502 9. Southport £536 10. N Lincolnshire £548 **Current Quartile:** 1 (Best) **Best Quartile Target:** £488 **Source: ESR, Trust consolidated annual accounts and reference cost.** **Monitoring - SPC**	**2017/18**		The Trust is below the national and peer median (positive), however the large number of vacancies within this workforce will have contributed to this. As we seek to recruit to these vacant posts, we could see costs per WAU increase, however this may lead to the reduction in other areas such as agency.	The key actions relate to the Medical Establishment Review include: > Analyse the established medical model and the proposed effective establishment, within the context of RCP Safe Medical Staffing Guide. > Identify the gaps within the Medical Workforce based on the analysis, developing innovative solutions to fill the gaps. > Working with WWL to recruit Drs Internationally.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

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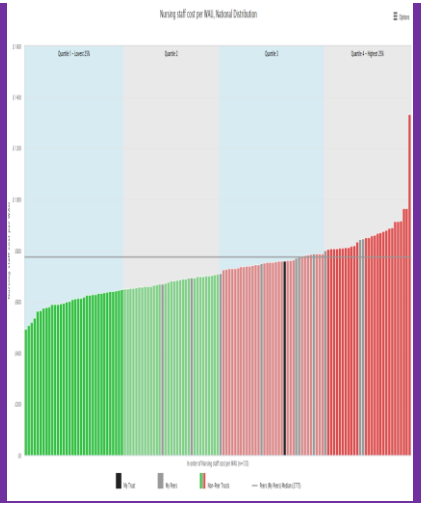
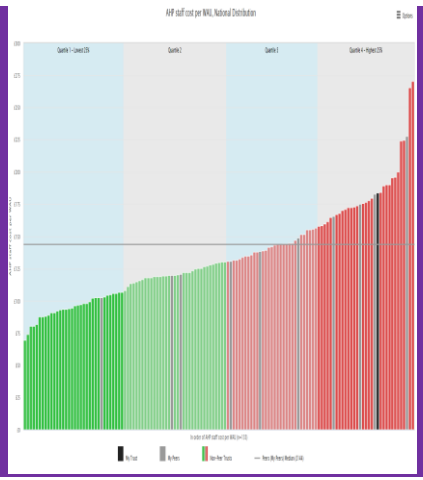
UoR Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 2 2019/20

	Progress/Performance			Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Substantive Nursing Cost Per WAU	UoR Total pay costs for nursing staff, adjusted for the % of Trust expenditure reported in reference costs, the MFF, and the % of pay costs that are capitalised, divided by Cost Weighted Output in WAUs.	**National Median = £710** Peer Median = £783 1. Bournemouth £671 2. Sunderland £694 3. STHK £711 4. Gateshead £750 5. WHH £761 6. Wirral £772 **Current Quartile:** **Best Quartile Target:** Source: ESR, Trust consolidated annual accounts and reference cost. Monitoring - SPC	**2017/18** 7. Chester £778 8. N Lincolnshire £789 9. North Tees £801 10. Southport £845 11. Mid Cheshire £848 **3 (2nd Worse)** **£649**		The Trust is below the peer median for Nursing Costs per WAU which is positive, however again the large number of vacancies will have contributed to this. The Trust seeks to reduce reliance on temporary staffing by offering alternative retention and recruitment solutions with the expansion of the nursing workforce, advanced practice and specialist interest roles.	The key actions are: > Working alongside the WHH Recruitment and Retention group, develop retention strategy and NHSI. > Continue the successful Staff Nurse recruitment open days. The Trust has been in contact with NHSI to look at conflicting data points, which has been escalated to national level within NHSI. The Trust has also been in contact with other Trusts who have the same data issue. The Trust has queried this indicator with NHSI as the data on the model hospital indicators does not triangulate with Trust data.	
Substantive AHP Cost per WAU	UoR Total pay costs for Allied Health Professionals, adjusted for the % of trust expenditure reported in Reference Costs, the MFF, and the % of pay costs that are capitalised, divided by Cost Weighted Output in WAUs.	**National Median = £130** Peer Median = £141 1. STHK £103 2. Wirral £120 3. Bournemouth £121 4. Chester £131 5. Sunderland £138 6. Gateshead £149 **Current Quartile:** **Best Quartile Target:** Source: ESR, Trust consolidated annual accounts and reference cost. Monitoring - SPC	**2017/18** 7. N Lincolnshire £166 8. Southport £175 9. Mid Cheshire £183 10. WHH £184 11. North Tees £228 **4 (Worse)** **£107**		Across the therapy element of AHP, pay costs for community/other work has been included in the cost per WAU calculation on Model Hospital. This indicator includes costs for staffing who are outsourced via SLA to other Trusts. This activity is not included in the WAU, if these costs were removed, the revised estimated costs per WAU would be £123 which brings the Trust below the national median. • For example, we have Therapists working as 'first point of contact' in GP surgeries. Rather than seeing a GP first, patients with musculoskeletal issues are triaged by a Therapist and either discharged, treated or referred to secondary care.		

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Use of Resource Graph Key

Trust Position
National Median
Peer Median

Key

- Complete/Green on Model Hospital (against National median)
- On track for completion
- Progress off track - plans in place to get back on track/Amber on the Model Hospital
- Progress significantly off track/Red on Model Hospital
- Not started/Awaiting further information/New actions parameters to be established

UoR Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 2 2019/20

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
	Recommendation 2 - NHS Improvement should develop and implement measures for analysing staff deployment during 2016, including metrics such as Care Hours Per Patient Day (CHPPD) and consultant job planning analysis, so that the right teams are in the right place at the right time collaborating to deliver high quality, efficient patient care. **Lead Director(s):** Medical Director & Chief Nurse			
Care hours per patient day	• The Trust continues to systematically collect and submit Care Hours per Patient Day (CHPPD) data since the national changes in April 2016. • The data is included in the monthly safe staffing and assurance report presented by the Chief Nurse at the Trust Board. • Data is submitted monthly to NHSI via the Trust Information team.	• Care Hours are reviewed each month as part of the Integrated Performance Report (IPR). In 2018/19 this went from 6.2 to 7.6 CHPPD. As at October 2019, the Trust was at 7.4 hours.	Trust Board, TOB	Ongoing Monitoring
Electronic roster and safe care module – six week rosters submitted to NHSI, process for improvement, cultural change and communications	• Implementation of Electronic Roster & Safe Care – all core wards are now live on the system with over 50 wards or departments. • The corporate nursing team has taken over management of the e-roster team. • The E-Rostering team is co-located with the operational management team in a centralised location. • Capacity and demand meetings are held after the bed meetings and the staffing template updated in real time. • The interface between e-roster and NHS(P) is now in place and temporary staff must now be booked via e-roster. • Safe Care acuity is now embedded and the information is used for 6 monthly safe staffing review. • The Trust has shared its achievements with Safe Care and Health Roster products with 4 Trusts in the region and continues to be seen as an exemplar by Allocate for Nurse Rostering & SafeCare.	• Continue to support the Matron daily safe staffing meetings, allows for early identification of hotspots/issues. • Future rollouts for Outpatient Nursing, Administration Staff, Medical Staff and Corporate Functions - the Trust has submitted bids for funding for future rollouts.	Trust Board	Ongoing development and daily monitoring with Senior Nurse Oversight

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Use of Resource Graph Key
Trust Position
National Median
Peer Median

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UoR Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 2 2019/20

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Consultant job planning - improving analysis of consultant job plans and better collaboration within and between specialist teams	• The Trust uses Allocate Software for e-Job planning. • The Trust is in the process of launching the Job Planning round for 2020/21 with the current status of Consultant job plans being as follows: **Job plan year / Number of Job plans progressing** 2018/19: 13 2019/20: 86 2020/21: 65 Grand Total: 164 • The project involving Programmed Activity (PA) corporate budgets for Medical Leadership, Education & Training, Quality & Governance and Appraisal & Revalidation has been completed. The Trust has provided a SOP to detail the revised process for the financial management of PAs. • The renewed Job planning policy for Consultants was agreed with Staff Side via JLNC and was implemented on 19th June 2018. • A proposal for reducing sign off levels from 3 to 2 was accepted. • The language used within the e-Job planning software has been improved to allow more effective reporting and easier inputting.	• Job planning progress will continue to be monitored. • Updates are provided regarding progress to the Trust Joint Local Negotiating Committee. • Mediation meetings continue to be scheduled for outstanding job plans. • Consistency panels will be convened as and when required. • A strategic meeting was held in July 2019 which aimed to consider 1) advanced planning for future job planning rounds, 2) the NHSI Levels of attainment standards and 3) the current situation and agree any action. • Regular multi disciplinary team meetings continue to take place to discuss current progress on Job Planning and related financial aspects. Representatives from CBUs are now invited to meetings to review progress in their respective areas.	Operational People Committee	Ongoing development and daily monitoring

Warrington and Halton Hospitals NHS
NHS Foundation Trust

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UoR Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 2 2019/20

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Recommendation 3 - Trusts should, through a Hospital Pharmacy Transformation Programme (HPTP), develop plans by April 2017 to ensure hospital pharmacies achieve their benchmarks such as increasing pharmacist prescribers, e-prescribing and administration, accurate cost, coding of medicines and consolidating stockholding by April 2020, in agreement with NHS Improvement and NHS England so that their pharmacists and clinical pharmacy technicians spend more time on patient facing medicines optimisation activities.				
Lead Director(s): Medical Director & Chief Nurse				
Hospital Pharmacy Transformation Programme - developing HPTP plans at a local	• Developed and approved HPTP Plan, nominated Directors, Board sign off and submission of final plan to NHS Improvement. • The HPTP was completed in May 2017.	• Model hospital metrics are monitored at the Trust's Medicines Governance Committee.	Trust Board	Complete
Moving prescribing and administration from traditional drug cards to Electronic Prescribing and Medicines Administration systems (EPMA)	• The electronic prescribing and medicines administration (ePMA) business case and PID signed off by Trust Board and NHS Digital – the outline business case was approved by the Trust board in October 2017, NHS Digital approved the business case in principle in November 2017. • The ePMA rollout plan was signed off by the Digital Operational Group and the IM&T Committee. • The ePMA pilot commenced on CDU on 5th March 2018. Positive feedback from staff/system users was received. 2nd ePMA pilot at Halton UCC – the pilot was a success and operation of the system has continued post pilot. • ePMA was successfully implemented on the surgical pathway on Ward B4 in December 2018 and within Ward and Theatre orthopaedic pathways at the CMTC in March 2019. • Planning for rollout across Warrington was completed with the lessons learned from Halton pilots incorporated. A desktop exercise was undertaken to determine implementation and early live support requirements. A number of issues were identified and resolved.	• Rollout of ePMA on the Warrington site commenced in November 2019 for all wards/services with the exception of Maternity, Paediatrics and ITU will be completed by end of November. The final phase will involve rollout in Maternity, Paediatrics and ITU in Q4 2019/20. • A business case is being developed to deliver parts 3 (dose range checking) and 4 (to develop interface with JAC Pharmacy to support closed loop prescribing).	Trust Board/IM&T Committee	Project expected completion – March 2020
Ensuing that coding of medicines are accurately recorded	• The Trust continues to work on improving data quality with workshops held to identify gaps, issues and areas for improvement with plans to address. • PHE SACT data has been reviewed, based on this, the Trust is achieving current data quality targets.	• The Trust continues to monitor the contents of the Schedule 6 schema reports to address any data quality issues. Data quality and content is now at 95% for September 2019. • The Trust continues to rollout Blueteq and is further on with implementation than other Trusts in the region.	Medicines Governance Committee	Ongoing Work Programme

Warrington and Halton Hospitals NHS
NHS Foundation Trust

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UoR Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 2 2019/20

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
80% of Trusts' pharmacist resource utilised for direct medicines optimisation activities, medicines governance and safety remits	• The Trust is achieving the recommendation for pharmacists. • All Pharmacy technicians have now been upskilled to carry out medicines reconciliation with new starters being trained as they commence in post. • The ward medicines management technician role has been reviewed with the Associate Directors of Nursing. • Midwifes are screening for regular medication so that pharmacy resources can be focused on those specific patients, this has resulted in an increase in medicines reconciliation within the Women's & Children's CBU.	• The ongoing training program continues to upskill pharmacy technicians on medicines optimisation and administration. • Ongoing recruitment, training and skill mixing. The Trust is implementing Sunday on ward services from November 2019 which will be followed by Saturday service in December 2019. In addition the hours of operation for the dispensary is going to increase from 09:00-17:30 (previously 10:00-13:00), Sunday 09:00-17:30 (previously 11:00-13:00).	Quality & Assurance Committee	Ongoing Monitoring
Reduce stockholding days from 20 to 15, deliveries to less than 5 per day and ensure 90% orders and invoices are sent and processed electronically	• The Trust's current stockholding days are 18, which is below the national and peer median. • Average number of deliveries to the Trust per day is 14 which is below the national median. • 97% orders are carried out electronically.	• Reducing stockholding days or number of deliveries to the Trust per day any further would carry an unacceptable level of risk. The Trust continues to monitor performance against our peers.	Medicines Governance	Ongoing Monitoring

KLOE 3 - Clinical Support Services

Top 10 Medicines - Percentage Delivery of Savings

UoR

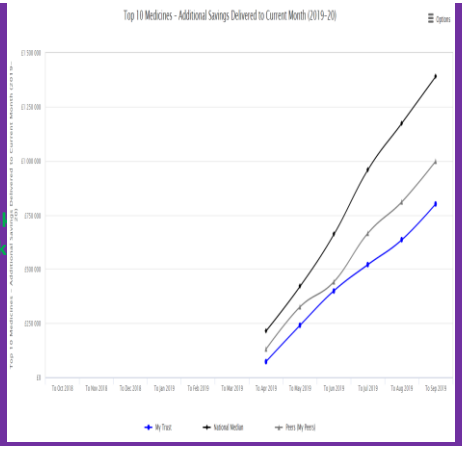
Benchmark = £603k | **September 2019**
Peer Median = £1m

1. N Lincolnshire £1.7m
2. Bournemouth £1.4m
3. Gateshead £1.1m
4. Wirral £1.0m
5. North Tees £1.0m
6. Chester £992k
7. STHK £950k
8. WHH £802k
9. Mid Cheshire £695k
10. Sunderland £670k
11. Southport £556k

Current Quartile: N/A
Best Quartile Target: N/A

Source: Rx-Info Define© (processed by Model Hospital)

Monitoring - Medicines Governance Committee



As of September 2019, the Trust has achieved £802k which is positive and above the national benchmark.

The Trust will continue to engage with target for Top 10 Savings and will work with system partners to identify opportunities for further savings.

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UoR Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 2 2019/20

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
	Recommendation 4 - Trusts should ensure their pathology and imaging departments achieve their benchmarks as agreed with NHS Improvement by April 2017, so that there is a consistent approach to the quality and cost of diagnostic services across the NHS. If benchmarks for pathology are unlikely to be achieved, trusts should have agreed plans for consolidation with, or outsourcing to, other providers by January 2017.			
	Lead Director(s): Chief Operating Officer & Director of Strategy			
Establishment of a shared pathology across the local economy	• NHSI has proposed 29 Pathology Networks across the country, with Cheshire & Merseyside being "North 4". An STP wide Pathology Board has been created with a Clinical Director and Pathology Manager from each of the Trusts in the region. • STP Cheshire & Mersey Pathology Board – the CEO of Aintree Hospital NHS Trust has been named Executive lead for the relaunched group. • A Transition Management Team has been established (Wirral, Chester, Aintree, Liverpool and Southport & Ormskirk). A project manager has been appointed by the STP. • Branch work stream meetings were established to look at equipment with a view to joint procurement opportunities and contract alignments. • Several drafts of the strategic outline case have been developed. The final case was approved by the Executive Oversight Group on 20th December 2018. • The project appointed a Clinical Director and Director of Operations during Q1 2019/20.	• The outline business case has been developed which includes 5 options, which are being reviewed by the Executive Oversight Group with representation from each Trust. The Workforce and IT workstreams have commenced. A business case has been developed to implement NPEX which will enable referrals from WHH to other Trusts within the network.	Strategic Development and Delivery Committee	Project – expected completion 2021
Development of pathology service specification	• The original plan called for a new specification to be developed, however this has now been superseded by the STP wide pathology board.	N/A	N/A	N/A
Introduce the Pathology Quality Assurance Dashboard (PQAD) by July	• A Pathology Quality Assurance Dashboard (PQAD) has been developed. • PQAD implemented from November 2016.	• Monthly data indicators continue to be submitted. • PQAD data is reviewed monthly at the KPI sub-committee. • The Trust continues to review quarterly and bi-annual indicators, however we understand that the indicators are under review and a new dashboard is under development.	KPI Sub-Committee	Rolling Programme

Warrington and Halton Hospitals NHS
NHS Foundation Trust

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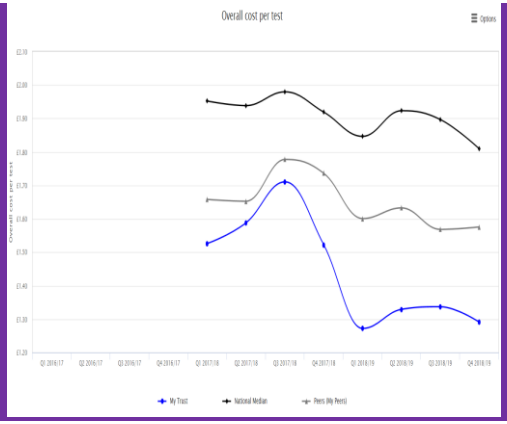
UoR Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 2 2019/20

	Progress/Performance			Actions to Improve Position/Actions for Next Quarter	Assurance	Status
KLOE 3 - Clinical Support Services						
Pathology - Cost Per Test	UoR The cost per test is the average cost of undertaking one pathology test across all disciplines, taking into account all pay and non-pay cost items.	**National Median = £1.81** Peer Median = £1.58 1. WHH £1.29 2. Chester £1.57 3. Gateshead £1.58 4. Bournemouth £2.93 **Current Quartile:** **Best Quartile Target:** Source: NHSI Q Pathology Data Collection 18/19 Monitoring - Pathology Business Meeting	**Q4 2018/19** **1 (Best)** **£1.47**		The Trust benchmarks well against the peer and national median and also against Trusts within our STP footprint. Overall the Trust's pathology service is efficient with the use of streamlined processes, technology and procurement opportunities.	The Trust is working with STP partners as part of the Lord Carter recommendations to look at how further efficiencies can be made across the footprint. > The Trust is continuing to engage with the network consolidation, and a number of activities are going to operationalise the new model by 2021.	

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Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 2 2019/20

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
	Recommendation 5 - All trusts should report their procurement information monthly to NHS Improvement to create an NHS Purchasing Price Index commencing April 2016, collaborate with other trusts and NHS Supply Chain with immediate effect, and commit to the Department of Health's NHS Procurement Transformation Programme (PTP), so that there is an increase in transparency and a reduction of at least 10% in non-pay costs is delivered across the NHS by April 2018. **Lead Director(s):** Director of Finance & Commercial Development			
Provide data to NHSi for the NHS purchasing price index benchmarking tool (PPIB)	• The procurement team continues to provide data to NHSI for the NHS Purchasing Price Index benchmarking tool on a monthly basis. • The Trust continues to review combined PPIB data with St Helen's & Knowsley and Southport and Ormskirk NHS Trusts for a collaborative approach to be taken in reviewing and securing lower prices. • The Trust has agreed to run PPIB data on behalf of the Group Purchasing Organisation (GPO) run by HealthTrust Europe which will inform their work plans for driving down costs. • A report of the Top 25 variances has been produced which compares the Trust nationally and against peers. • The Trust has reviewed data for Trusts of a comparable size to look at areas around the Top 100 products for commonality of spend with view to renegotiating on our prices with suppliers, this brought a small saving. • In August 2019, PPIB was replaced with the NHS Spend Comparison Service (SCS).	• The Trust is reviewing the available suite of reports within SCS to understand how these can be most efficiently implemented. • The Trust is working with the SCS team on issues regarding the format Manufacturers Product Code (MPC) which will improve benchmarking.	Finance & Sustainability Committee	Rolling Programme
Developing PTP plans at a local level with each trust board nominating a director to work with their procurement lead to implement changes	• The Procurement Transformation Plan has been drafted and submitted to NHSI. To support this, a procurement dashboard has been established to measure Trust performance against the Carter metrics. The PTP was refreshed using the new NHSI format. • The Director of Finance & Commercial development is the responsible board member and will work with the Associate Director of Procurement to implemented changes around the PTP plan. • A review has been completed for all direct spend (i.e. that not with NHS SC) to determine which products can be transferred to NHS SC to further support the operating model. • All savings identified by Supply Chain Coordination Ltd (SCCL) will be incorporated in the Trust's 2019/20 CIP Plans. Based on 2018/19, 375 lines were transferred into the operating model representing a saving of £0.08m.	• The Trust continues to measure progress against the PTP. • The Trust continues to work with the network, SCCL account manager and the category towers to understand how savings can be achieved.	Finance & Sustainability Committee	Project Implementation

Warrington and Halton Hospitals NHS
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UoR Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 2 2019/20

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Adoption plan for Scan4Safety	• The Trust's adoption plan for Scan4Safety (formally the Global Standard: GS1) and pan European Public Procurement Online (PEPPOL) standards was drafted, the procurement lead for the project is the Deputy Head of Procurement. • Scan4Safety was presented to a number of forums throughout the Trust. • A draft PID was developed. The Trust has made progress in a number of areas: • Been allocated our 10,000 GLN's by GS1 as a way to assign a GLN to all of the locations within the Trust. • Agreed in principle that the issue relating to GSRN will be dealt with by replacing all staff ID Badges with a badge which as well as a photograph, will contain a barcode linked to the member of staffs payroll number. • The inventory management systems offered by the main providers in this area have been evaluated. This area along with the associated hardware and software represents the biggest cost to the Trust, so care is required to ensure that the solution selected meets the requirements into the future.	• It was announced by NHS Digital earlier this year that Trust's lead executive for Scan 4 Safety should be the Chief Information Officer. A meeting will be arranged between the Chief Information Officer, the Director of Finance and Commercial Development and the Deputy Head of Procurement to agree an Executive handover and to ensure that Scan 4 Safety is incorporated in the Trust's Digital Strategy. Cheshire & Merseyside Healthcare Partnership will meet with representatives from GS1 UK* on 19th December 2019 to discuss the possibility of implementing the Scan 4 Safety initiative across a wider footprint. Estimated costs have been obtained for a trust inventory management system and visits to demonstrator sites are being set up. Following this a briefing paper will be provided to the Exec Team to consider next steps.	Trust Board, Trust Operational Board	Project Implementation
NHS Standards of Procurement - to achieve level 1 by October 2016, develop improvement plan to meet target by March 2017	• The Trust has achieved NHS Standards of Procurement Level 1 accreditation. • The Trust has successfully achieved Level 2 for the Procurement Skills Development Network (FSD) which was signed off in August 2019.	• The Trust will undertake a gap analysis during Q4 to understand what is required to achieve Level 3.	Finance & Sustainability Committee	Project Implementation
Benchmarking – Model Hospital Procurement	• The Trust is currently ranked 71/133 Trusts – placing the Trust in the 2nd upper quartile (2nd best). • A review has taken place for each of the model hospital procurement metrics which looks at how far the Trust is from reaching with upper quartile. • The procurement team has produced a strategy to look at the feasibility of the Trust reaching the upper quartile for each metric and actions needed to get there. • The procurement team has developed a tracker to review progress against the key metrics. • The main metrics are included on the Trust Procurement Dashboard.	• The Trust continues to work through actions to improve its position against the Model Hospital metrics as part of a rolling programme.	Finance & Sustainability Committee	Ongoing

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UoR Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 2 2019/20

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Key Procurement Metrics	• Target of 80% addressable spend transaction volume on catalogue - Trust currently is at 93% (Q2 2019/20). • Target of 90% addressable spend transaction volume with a purchase order - Trust currently at 97% (Q2 2019/20). • 90% addressable spend by value under contract - Trust currently at 79% (Q2 2019/20). • The procurement team produce monthly reports on all orders raised to ensure the contract register is upto date. The contract register is reviewed monthly by the Senior Contract Managers with oversight from procurement management meetings.	• Addressable Spend Transaction Volume Even though the target has been achieved, this continues to be monitored on a monthly basis. For suppliers where spend that is not transacted via a PO , these are placed on a 100% PO rule i.e. if they do not have an order number their invoice will be rejected.	Finance & Sustainability Committee	Ongoing Monitoring

KLOE 4 - Corporate Services

Procurement Process Efficiency and Price Performance Score Clinics

UoR

This measure provides an overall view of how efficient and how effective an NHS Provider is in it's procurement process and price performance, respectively, when compared to other NHS providers.

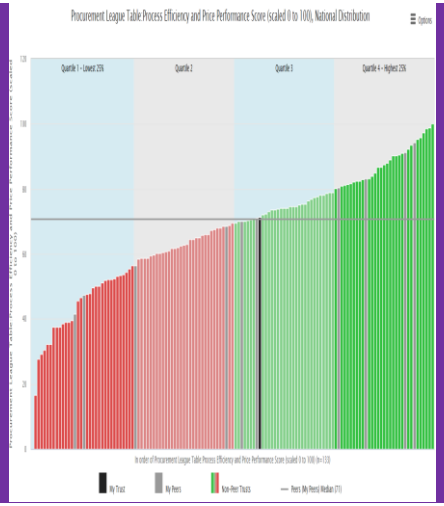
National Median = 69 — **Q4 2018/19**
Peer Median = 71

1. STHK 94
2. Bournemouth 91
3. Southport 83
4. WHH 71
5. N Lincolnshire 71
6. Wirral 70
7. Mid Cheshire 69
8. North Tees 57
9. Gateshead 47
10. Sunderland 42

Current Quartile: **3 (2nd Best)**
Best Quartile Target: **80**

Source: Purchase Price Index and Benchmark (PPIB) tool

Monitoring: Senior Procurement Meeting



The Trust is above the National Median and peer median. The latest procurement league table has the Trust at a weighted score of 71 (Peer Median 71 National Median 69) which puts the Trust in the 3rd quartile (2nd Best).

The Procurement Team has a strategy in place for improving performance which is reviewed on a monthly basis.

The Trust has undertaken a review of all procurement metrics and track this on a monthly basis. The key actions are as follows:
> Undertake a monthly review of a rolling top 25 by spend to identify and implement any areas of opportunity producing a monthly summary report.
> Undertake an analysis of all non-pay spend to understand what is not applicable to PPIB and why.

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Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 2 2019/20

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Recommendation 6 - All trusts estates and facilities departments should operate at or above the benchmarks for the operational management of their estates and facilities functions by April 2017 (as set by NHS Improvement by April 2016); with all trusts (where appropriate) having a plan to operate with a maximum of 35% of nonclinical floor space and 2.5% of unoccupied or under-used space by April 2017 and delivering this benchmark by April 2020, so that estates and facilities resources are used in a cost effective manner. **Lead Director:** Chief Operating Officer				
Strategic estates strategy inc cost reduction based on benchmarks and in the longer term plan for investment/reconfiguration	• The Trust has an estates strategy in place to meet the overall Trust strategy. The strategy is phased 1, 2, and 3. Phase 1 is to explore immediate options for delivering savings by rationalising part of the estate. Phase 2 is to explore the potential for external and/or better utilised 'on site' accommodation for current service provision and phase 3 is to explore opportunities for wider STP collaborative initiatives. • Phase 1 is being delivered and monitored through Strategic Development and Delivery Committee. The strategy has been refreshed to reflect local clinical strategy and the STP estates strategy. • The Associate Director of Estates and Facilities has been nominated as co-chair for the One Halton estates enabler sub-group. • The estates and facilities strategy was approved during Q2.	• The Trust continues to explore internal and partnership collaboration opportunities for relocation of back office and clinical support functions with Bridgewater Community Healthcare NHS Foundation Trust using a joint executive estates working group to move forward this agenda. Analysis has been undertaken around current estates, heads, locations and space. Next steps will be jointly agreed and a programme of work will be developed over a series of phases. • The Cheshire and Mersey Partnership is reviewing facilities management contracts across the patch and has identified four initial areas for collaboration opportunities, these include; Energy, Linen, Post and Decontamination.	Estates and Facilities sub-Committee, TOB, Strategic Development and Delivery Committee	Ongoing management and monitoring of the plan
Investing in energy saving schemes such as LED lighting, combined heat and power units, and smart energy management systems	• The Trust has procured an energy infrastructure upgrade (CHP) which will save carbon, energy, money and future investment, upgrading their facilities using private sector capital repaid through guaranteed savings. • Estates have accessed funding from Carbon Energy Fund (CEF) replacing 4000 halogen bulbs with more cost effective LED. • The Trust has realised saving of £140k from the CHP contract which has been used for the departments CIP target.	• The Trust is progressing an internal replacement programme for emergency lighting as and when the lighting needs to be replaced.	Estates and Facilities Sub-Committee	Complete

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UoR Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 2 2019/20

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Estates and facilities costs embedded into trusts' patient costing and service line reporting systems.	• Estates and Facilities costs are incorporated into the PLICS system. Quarterly service line reports are provided to CBUs by the financial planning team. The costing teams use the estates system, MICAD, to export floor area and can allocate energy/facilities costs based on m2.		Estates and Facilities Sub-Committee	Complete
Model Hospital & Effectiveness of Estates	• The Trust continues to review the effectiveness of its estate and monitors cost efficiency metrics to ensure it provides value for money and take actions for any deviation from the benchmark values. • Results of the Trust PLACE assessment have been developed into an action plan which is monitored by the estates and facilities operational board and the Quality Assurance Committee.	• The model hospital data shows the Trust favourable when benchmarking against peer and national medians. The Trust's ERIC return was completed at the end of Q1 with new benchmarking data is received in October 2019.	Estates and Facilities Sub-Committee/TOB/ Quality Assurance Committee	Ongoing Monitoring
All Trusts (where appropriate) have a plan to operate with a maximum of 35% of non-clinical floor space and 2.5% of unoccupied or under-used space by April 2017 and delivering this benchmark by April 2020, so that estates and facilities resources are used in a cost effective manner	• Model hospital data reports the Trust utilises 38.6% of its estate for non-clinical use and has 0.0% of empty space. Whilst every effort to minimise the use of trust accommodation for non-clinical purposes has been made, it is difficult given the complexities of the numerous corporate functions and the estate footprint. • The current estate strategy aims to address the under-utilised space to under 2.5% by rationalising the estate. Better use of under-utilised estate will result in a reduction in the size of the estate and the amount of estate used by non-clinical functions.	• The estates and facilities function is fully involved in the Halton Healthy New Towns and New Hospital for Warrington initiatives. Changes to the estate are centred around patient care. Opportunities to work with Bridgewater should provide better flexibility in terms of estate.	Strategic Development and Delivery Committee	Ongoing Monitoring

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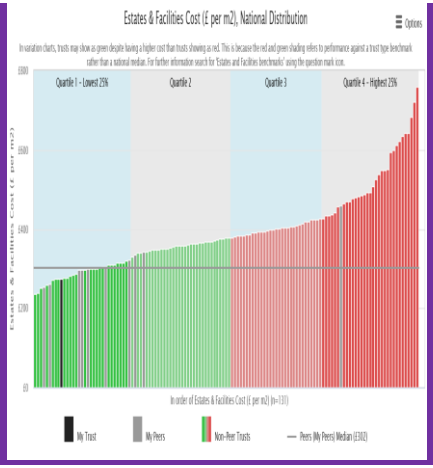
Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 2 2019/20

	Progress/Performance			Actions to Improve Position/Actions for Next Quarter	Assurance	Status
KLOE 4 - Corporate Services						
Estates & Facilities Costs (£ per m2)	The total estates and facilities running costs is the total cost of running the estate in an NHS trust including, staff and overhead costs. In-house and out-sourced costs, including PFI costs, will be included.	**National Median = £377** **Peer Median = £302** 1. Sunderland £253 2. N Lincolnshire £263 3. WHH £275 4. Southport £296 5. Wirral £297 6. Mid Cheshire £299 7. North Tees £305 8. Chester £322 9. Gateshead £335 10. Bournemouth £342 11. STHK £461 **Current Quartile:** 1 (Best) **Best Quartile Target:** £322 **Source: ERIC 2018-19 Total Estates and Facilities Running Costs Monitoring - Estates and Facilities Operational Group**	**2018/19**		The Trust benchmarks well against national and peer median for hard facilities costs even with the challenges of maintaining an aging estate. We have invested year on year to reduce backlog maintenance, however without a significant increase in investment, the amount of backlog to bring the estate up to appropriate standards will always rise. This in turn has and will continue to have an adverse effect on overall estates and facilities costs.	Estates and facilities costs are continually monitored. Where efficiencies can be made, proposals/business cases produced for consideration by the Trusts Executive Team.	

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Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 2 2019/20

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
	Recommendation 7 - All trusts corporate and administration functions should rationalise to ensure their costs do not exceed 7% of their income by April 2018 and 6% of their income by 2020 (or have plans in place for shared service consolidation with, or outsourcing to, other providers by January 2017), so that resources are used in a cost effective manner.			
	Lead Director(s): Director of HR & OD, Director of Finance & Commercial Development and Chief Information Officer			
Rationalisation of corporate and administration functions	• The Trust's corporate and administration functions current costs are 7.3% of income based on actual income as of Q2 2019/20. This includes Finance, HR, IM&T, Communications, Research, Transformational and Executive costs. • The Trust will collaborate with other organisations where appropriate to provide services in a more streamlined way maximizing opportunities to procure and work at scale, reduce waste and support the delivery of clinical services, facilitating change where required. • The NHSI operational productivity team visited the Trust in August 2018 to look at the whole of the model hospital and identify opportunities. • As a follow up to the NHSI productivity session, a specific corporate service session took place in October 2018 which will focus on IM&T, Finance and HR. • Corporate Services are utilising NHSI Corporate Service Productivity Programme to review opportunities around Chart of Accounts, Journal Policy, Budget Holder Support, Accounts Payable Automation, Sharing Ledger Costs, Policies and Procedures and Financial Reporting. The Trust is working with Mid-Cheshire Hospitals NHS Trust to review structures as part of a wider benchmarking exercise. • A benchmarking exercise has been undertaken with Mid Cheshire Hospitals NHS Foundation Trust. Results were presented to the executive team and medical cabinet. • Improving the consistency of Benchmarking returns was discussed at the Collaboration @ Scale workshop. NHSi is to support work to assess returns and advise on amendments. • The IM&T SLT have reviewed the IM&T Model Hospital metrics and apportioned the costs so that they accurately reflect the work areas for pay and non-pay. Looking at the pure IT areas the department is within national levels however further work is underway to see where tangible improvements can be made.	• The Trust has received the National Benchmarking Report for Corporate Services. The report highlights a number of areas where costs (based on a scale of cost/£100m income) are higher than the national median. Corporate leads are reviewing their costs to identify any warranted variation, data issues and areas for improvement which will be incorporated into the work plan. As part of the system wider recovery plan the Trust will be looking to make c£2m of corporate savings over the next two years.	Strategic Development and Delivery Committee	Rolling Programme
Corporate CIP Targets	• All corporate divisions have been assigned costs savings targets in 2019/20. The targets and the progress to date in identifying schemes to meet the targets are summarised. The cost savings being delivered either reduce costs or increase income, thereby improving their respective percentage cost figures.	• Corporate CIP performance for 2019/20 as at M6 is £0.367m in-year CIP delivered against a M6 target of £0.236m. The 2019/20 full year target is £1.203m. • Collaboration at Scale activity is now seen as key to future gains and aims to identify future procurement opportunities.	Finance & Sustainability Committee	Rolling Programme

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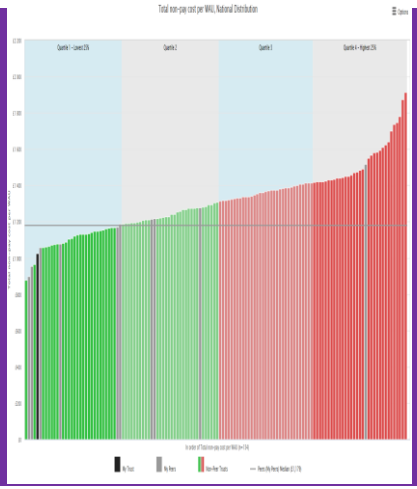
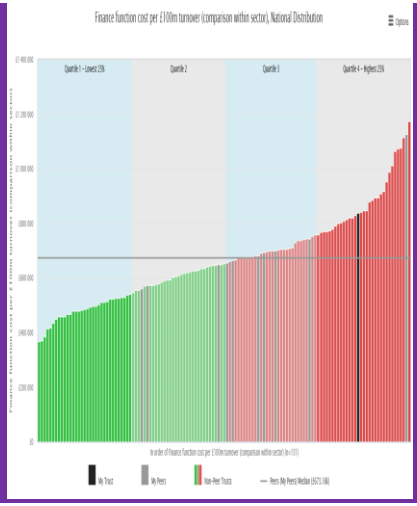
Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 2 2019/20

KLOE 4 - Corporate Services

	Progress/Performance			Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Non Pay Costs per WAU	UoR Cost per WAU is the headline productivity metric used within the Model Hospital. It shows the amount spent by a trust to produce one Weighted Activity Unit (WAU) of clinical output. This metric show the amount the trust spends on non-pay per WAU across all areas of NHS clinical activity.	**National Median = £1307** Peer Median = £1200 1. Chester £898 2. Mid Cheshire £954 3. WHH £1027 4. Gateshead £1058 5. Wirral £1078 6. Southport £1172 **Current Quartile:** **Best Quartile Target:** **Source: HSCIC - NHS Digital iView Stability Index**	**2017/18** 7. N Lincolnshire £1187 8. Bournemouth £1213 9. STHK £1218 10. North Tees £1280 11. Sunderland £1518 **1 (Best)** **£1172**		The Trust is performing in the upper quartile (best) nationally. The Trust continues to review opportunities to reduce non-pay costs whilst maintaining quality.	All departments across the Trust are continuously looking at ways to reduce costs as part of day to day business as well as via CIP.
Finance Costs per £100m Turnover	UoR Total finance cost divided by trust turnover multiplied by a £100m	**National Median = £653k** Peer Median = £673k 1. Bournemouth £560k 2. Sunderland £572k 3. STHK £649k 4. Chester £656k 5. Wirral £665k 6. Mid Cheshire £682k **Current Quartile:** **Best Quartile Target:** **Source: Trust consolidated annual accounts and NHSI improvement 18/19 data collection template.**	**2018/19** 7. North Tees £694k 8. N Lincolnshire £701k 9. Gateshead £745k 10. WHH £839k 11. Southport £1.1m **4 (Worst)** **£541k**		The Trust is above the national and peer median when compared to costs per £100m income, however based on absolute costs, the Finance function is lower than the national and peer median. There remains an issue with the way the SBS costs are treated and this has skewed the position, if these costs were removed, it would bring the Trust to below the national median.	The Trust is reviewing collaboration opportunities and will carry out a review into the 2018/19 Benchmarking data to understand areas where improvements can be made. As part of a system wide recovery plan, the Trust has plans to reduce corporate costs by £2m over the next 2 years.

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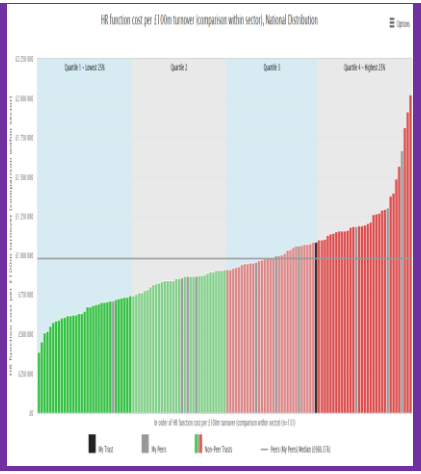
Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 2 2019/20

	Progress/Performance		Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Human Resource Costs per £100m Turnover	UoR HR is made up of a number of sub compartments taken into consideration when considering total HR costs per £100m turnover.	**National Median = £911k** 2018/19 Peer Median = £980k 1. Sunderland £713k 2. Wirral £860k 3. Gateshead £870k 4. Bournemouth £872k 5. STHK £958k 6. Chester £1.00m 7. North Tees £1.01m 8. WHH £1.1m 9. Mid Cheshire £1.2m 10. N Lincolnshire £1.3m 11. Southport £1.7m **Current Quartile:** 3 (2nd Worse) **Best Quartile Target:** £745k **Source: Trust consolidated annual accounts and NHSI improvement 16/17 data collection template.**		The Trust is above the national median by £100 when compared to costs per £100m income based on the national benchmarking data.	The Trust is reviewing collaboration opportunities and will carry out a review into the 2018/19 Benchmarking data to understand areas where improvements can be made. As part of a system wide recovery plan, the Trust has plans to reduce corporate costs by £2m over the next 2 years.	

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Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 2 2019/20

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
	Recommendation 8 - NHS Improvement and NHS England should establish joint clinical governance by April 2016 to set standards of best practice for all specialties, which will analyse and produce assessments of clinical variation, so that unwarranted variation is reduced, quality outcomes improve, the performance of specialist medical teams is assessed according to how well they meet the needs of patients and efficiency and productivity increase along the entire care pathway. **Lead Director(s):** Chief Operating Officer and Director of Strategy			
Variation in Theatres and Outpatients	• A new theatre scheduling process was launched and is designed to provide improved visibility and forward planning around utilising theatre and anaesthetic capacity. • Theatre listing meetings immediately follow '6-4-2' scheduling meetings and examine the patients on each individual list for the following week. • Theatre '6-4-2' scheduling meetings are now fully established. Theatre sessions are now 'locked down' at two weeks. • A list planning process was launched with the aim of formally introducing expected list timings into the discussion to ensure all scheduled lists are planned to run at or close to maximum operating time available. • Demand and Capacity work is complete and the model is now fully functional. Clinic templates for all specialties are being validated to ensure the accuracy of all outcomes. • The KPI Sub-Committee continue to monitor Theatre utilisation, Late starts and Cancellations. • A Theatre Transformation Board chaired by the CBU Manager for Digestive Diseases has been established. • The Transformation Team have developed a capacity and demand summary which CBU managers will monitor. • A programme of work around improving Theatre Utilisation and Late Starts has commenced. Full analysis and benchmarking with peers has been undertaken regarding late starts and improvements have been made. • The Theatre productivity group has been established with a sub-group focusing specifically on cancellations with a view to address the number of cancelled sessions.	• Options and plans around the co-location of Breast Screening and Orthopaedics are being finalised. • The Trust is in the process of implementing new dashboards allowing live reporting of theatre productivity. • An Outpatient Transformation scheme is a workstream in the Collaborative and Sustainability Meeting which will include T&O, Gastro and Ophthalmology. This will include the implementation of Straight to Test, Telephone and Virtual clinics.	Trust Operational Board	Ongoing

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Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 2 2019/20

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Emergency Care Improvement Programme	• An improvement programme for patient flow agreed a number of key work streams across mid Mersey following a system review, these work streams feed into the Mid-Mersey A&E delivery board. • The Trust has its own internal flow board which focuses on 9 key work streams to support improvements in flow. • Red 2 Green patient data is collected on all wards through daily board rounds and a process to share the data around patient delays with partner organisations is in place with partner organisations expected to respond with actions in place to reduce the delays. • Frailty work stream – the frailty assessment unit is operational. • The Emergency Care Improvement Programme visited the Trust. There was an NWAS challenge for all conveyances and a walk through of the urgent/emergency care system. Positive informal feedback was received. • As a result on the system wide capacity and demand review carried out by the Venn Group, the Trust has agreed with partners to approve capacity and flow in the short term. • ED Ambulatory Care opened January 2019. This has resulted in increased assessment throughput and a reduction in direct admissions from ED. • The Trust will continue to focus on Super Stranded Patients with system partners, the trajectory for 2019/20 is > 95 patients. • Ambulance Handovers over 30 and 60 minutes continues to reduce month on month. • The Trusts dedicated discharge lounge opened in March 2019. • The Integrated Care team is now co-located from June 2019. • A new ward round accreditation process is being developed. • CAU (Combined Assessment Unit) test of change took place in September 2019 bringing together GPAU and SAU, significant positive impact was demonstrated.	• The Trust will continue to work with One Halton and Warrington Together to ensure proposals are developed consistently with an integrated approach. • The Trust is working with NHSI around SAFER/LLOS Collaboration to run until November 2019. • An Urgent & Emergency improvement committee is now in place with an action plan to support improvement and address breaches. There are 35 actions of which 16 are complete. • The CAU (Combined Assessment Unit) business case was approved and plans are in place to go live, following a period of consultation, in December 2019. • A system wide winter plan has been developed and will be implemented throughout the winter period. • The Trust is taking part in a collaboration with North West Ambulance Service (NWAS) in November 2019 to improve the handover of patients.	A&E Delivery Board Flow Board	Ongoing

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Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 2 2019/20

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Specialty level reviews across local delivery system	• The Trust is participating in a series of specialty level reviews across the Local Delivery System (LDS). • Implementation of plans to reduce variation within pathways across the LDS. • Specialty reviews have now been held in urology, trauma & orthopaedics and ophthalmology. • A programme of workshops across priority specialties has been agreed, led by the LDS Director of Service Redesign. • A new clinical strategy was developed and launched. • Work to re-invigorate the DTOC process to include daily validation with weekly reviews and a weekly corporate flow meeting has been completed. • The Trust is working with Cheshire and Mersey Cancer Alliance to develop optimal pathways beginning with Colorectal, the Trust is supported by Aqua. A one stop shop has been launched. Colorectal Straight to Test has been implemented. • A new clinical model around the Stroke Pathway has been agreed, implementation took place in April 2019. • An Integrated Discharge Manager has been recruited who will manage both Health & Social Care Teams. • All 33 clinical services now have 3-5 year clinical strategies agreed and prioritised. The Clinical strategies seek to address variation and target improvement.	• GIRFT reviews continue to take place within a number of specialities across the Cheshire & Mersey footprint, with each speciality developing an action plan. • The Trust has signed up with NHSI to carry out a length of stay evaluation programme, this is included in the SAFER collaboration to run until November 2019. • The Trust is working in collaboration with St Helens & Knowsley NHS Trust in the development of a Rapid Diagnostic Centre - virtual model. • The Trust is working in collaboration with Bridgewater Community Healthcare NHS Foundation Trust to look at the integration of clinical pathways.	QPS, Strategic Development and Delivery Committee	Ongoing

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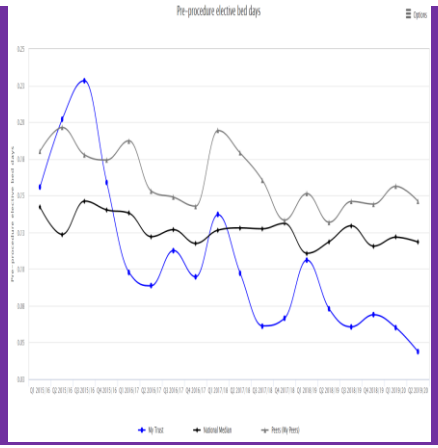
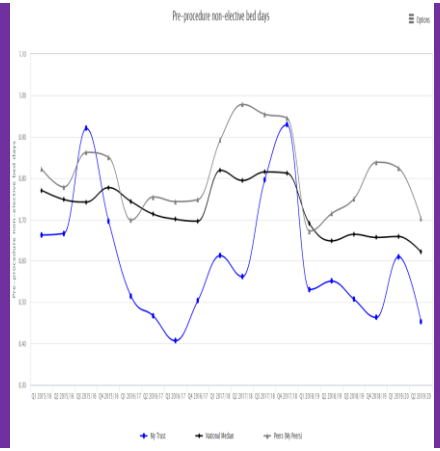
Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 2 2019/20

KLOE 1 - Clinical

	Progress/Performance			Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Pre Procedure Elective Bed Days	UoR The number of bed days between the elective admission date and the date that the procedure taken place.	**National Median = 0.12** **Peer Median = 0.15** 1. North Tees 0.01 2. Mid Cheshire 0.02 3. Bournemouth 0.03 4. WHH 0.04 5. STHK 0.13 6. Chester 0.16 7. Wirral 0.21 8. N Lincolnshire 0.24 9. Gateshead 0.39 **Current Quartile:** 1 (Best) **Best Quartile Target:** 0.07 days **Monitoring : KPI Sub-Committee** **Source: Hospital Episode Statistics**	**Q2 2019/20**		The Trust continually reviews opportunities to provide same day admission. The surgical transformation programme is supporting the reduction in theatre cancellations and improving productivity and efficiency.	Theatre productivity and efficiency remains a focus for the surgical theatre transformation in 2019/20. Performance against this metric is further monitored via the Theatre Performance Dashboard.	
Pre Procedure Non Elective Bed Days	UoR The number of bed days between an emergency admission date and the date the procedure taken place.	**National Median = 0.62** **Peer Median = 0.70** 1. Bournemouth 0.26 2. WHH 0.45 3. Wirral 0.47 4. North Tees 0.54 5. Chester 0.77 6. Gateshead 0.87 7. N Lincolnshire 1.01 8. STHK 1.26 **Current Quartile:** 1 (Best) **Best Quartile Target:** 0.49 days **Monitoring: KPI Sub-Committee** **Source: Hospital Episode Statistics**	**Q2 2019/20**		The Trust continually reviews opportunities to improve efficiency around emergency and non elective procedures. The surgical transformation programme is supporting the reduction in theatre cancellations and improving productivity and efficiency.	Theatre productivity and efficiency remains a focus for the surgical theatre transformation in 2019/20. Performance against this metric is further monitored via the Theatre Performance Dashboard.	

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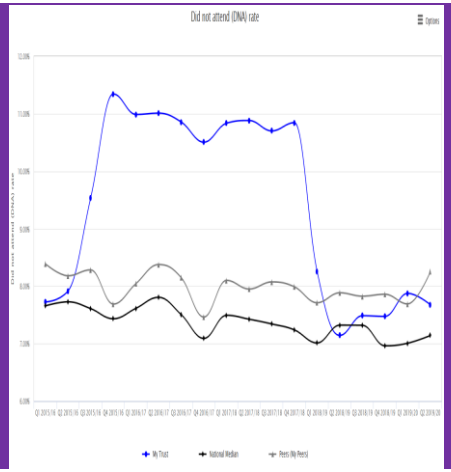
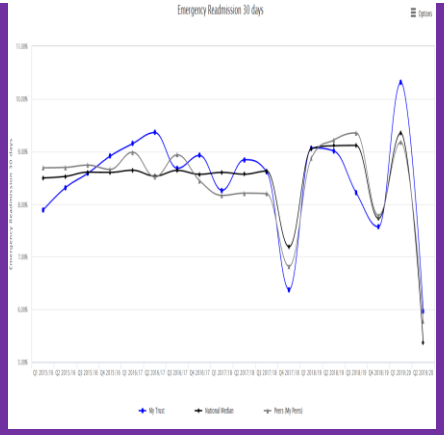
	Progress/Performance		Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Did Not Attend (DNA) Rate	UoR Rate of patients not attending their outpatient appointment.	**National Median = 7.14%** Peer Median = 8.25% **Q2 2019/20** 1. Chester 5.75% 2. Mid-Cheshire 6.02% 3. Southport 6.98% 4. N Lincolnshire 7.25% 5. WHH 7.68% 6. Bournemouth 8.25% 7. Gateshead 8.25% 8. North Tees 8.30% 9. STHK 9.18% 10. Wirral 9.30% **Current Quartile: 3 (2nd Worst)** **Best Quartile Target: 6.05%** **Monitoring: KPI Sub-Committee** **Source: Hospital Episode Statistics**		The Trust reintroduced a text reminder service which has resulted in a significant improvement in the DNA rate. The Trust is slightly above the national median, however we perform better than our peers.	The Trust has continued to implement improvements in the interface with patients. Further improvements in the interface are being implemented via the Outpatient Steering group, which is intended to improve the position further.
Emergency Readmission (30 Days)	UoR This indicator measures the percentage of admissions of people who returned to hospital as an emergency within 30 days of the last time they left hospital after a stay. Admissions for cancer and obstetrics are excluded as they may be part of the patient's care plan.	**National Median = 5.36%** Peer Median = 5.78% **Q2 2019/20** 1. N Lincolnshire 3.57% 2. Chester 4.49% 3. Wirral 5.06% 4. Gateshead 5.72% 5. Bournemouth 5.83% 6. STHK 5.91% 7. WHH 5.97% 8. Mid Cheshire 6.07% 9. North Tees 6.99 **Current Quartile: 3 (2nd Worse)** **Best Quartile Target: 4.75%** **Monitoring: KPI Sub-Committee** **Source: Hospital Episode Statistics**		Every effort is made when discharging patients to ensure that the discharge is appropriate. Readmissions are reviewed by the clinical directors to review any inappropriate discharges and ensure lessons are learned.	The Trust will continue to review the improvement through the Trust clinical governance processes to ascertain if there is a need to review discharge procedures.

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- Not started/Awaiting further information/New actions parameters to be established

UoR Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 2 2019/20

Recommendation 9 - All trusts should have the key digital information systems in place, fully integrated and utilised by October 2018, and NHS Improvement should ensure this happens through the use of 'meaningful use' standards and incentives.

Lead Director: Chief Information Officer

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Electronic Patient Record & Structured Clinical Notes	• The Trust implemented Lorenzo EPR in December 2015. • The Trust continues to optimise Lorenzo functionality to ensure that it meets with developing business and clinical needs. This project is monitored by the Digital Board. • The Trust continues to upgrade Lorenzo in line with the development roadmap. • The Trust has been selected as a Digital Exemplar for work relating to the use of the Electronic Patient Record. This project is making excellent progress. The team is pulling together conceptual designs to support future state for the selected pathways ' Head Trauma and Diabetes'. • Electronic Maternity Nursing Observations (MEWS) went live during Q4 2018/19. • The Trust was successful in their bid to HLSI (Health System Led Investment Programme) to support implementation of Inpatient nursing observations.	• Lorenzo Digital Exemplar – Diabetes future state is making good progress. ' Day in Life' workshops are complete to run through principles of a digitised case note. Further workshops are planned for December 2019. Head Trauma future state has been moved to the to end of Q4 to allow for ePMA go live. • Warrington Care Record - Project Initiation Document for Phase 1 Integration to Share2Care has been drafted. Programme Manager interviews scheduled for 11th November 2019. • Work continues with the GP viewer which will give Trust clinicians access to Warrington GP records via Lorenzo. Go live is scheduled for Q3 2019/20. • The first of type for NHS Digital GP Connect project has commenced, to enable patient medications from GP systems to be integrated to Lorenzo. Testing progressing well, functionality will be transferred into the live environment with Lorenzo 2.18 (date in for Nov/Dec 2019 remains to be confirmed by supplier). • The HLSI (Health System Led Investment Programme) Funding Agreement has been submitted to NHSE for approval. Funding to deliver clinical decision support is expected in Q4 2019/20.	IM&T Sub-Committee/ Trust Board	Project Implementation – expected completion – Plan up to 2020 on track.
Electronic Document Management System	• A review of requirements now Lorenzo has been live for 3 years has been undertaken to ensure any investment required is for the right solution.	• The Trust Digital Strategy will be refreshed during Q2/3 to ensure a fit with the EPR and paperless strategy. • A revised EDMS/Paperless 2020 business case will be developed followed by a procurement process in order to achieve a paperless Trust by 2020. • Estimated costs are included in capital bids for 2020/21.	IM&T Sub-Committee	Project Implementation – Initiation

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Use of Resource Graph Key
Trust Position
National Median
Peer Median

Key
Complete/Green on Model Hospital (against National median)
On track for completion
Progress off track - plans in place to get back on track/Amber on the Model Hospital
Progress significantly off track/Red on Model Hospital
Not started/Awaiting further information/New actions parameters to be established

UoR Use of Resource Assessment Indicator

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Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 2 2019/20

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
ePMA	• Electronic prescribing and medicines administration (ePMA) business case and PID signed off by Trust Board and NHS Digital – the outline business case was approved by the Trust board in October 2017, NHS Digital approved the business case in principle in November 2017. • The ePMA rollout plan was signed off by the Digital Operational Group and the IM&T Committee. • The ePMA pilot commenced on CDU on 5th March 2018. Positive feedback from staff/system users was received. 2nd ePMA pilot at Halton UCC – the pilot was a success and operation of the system has continued post pilot. • ePMA was successfully implemented on the surgical pathway on Ward B4 in December 2018 and within Ward and Theatre orthopaedic pathways at the CMTC in March 2019.	• ePMA go live has commenced. A 4 Week phased rollout was agreed - 4th November to 30th November 2019. • A business case is being developed to deliver parts 3 (dose range checking) and 4 (to develop interface with JAC Pharmacy to support closed loop prescribing).	IM&T Sub-Committee	Project Implementation

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Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 2 2019/20

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
	Recommendation 10 - DH, NHS England and NHS Improvement, working with local government representatives, to provide a strategy for trusts to ensure that patient care is focussed equally upon their recovery and how they can leave acute hospitals beds, or transfer to a suitable step down facility as soon as their clinical needs allow so they are cared for in the appropriate setting for themselves, their families and their carers. **Lead Director:** Not Applicable			
	Recommendation 11 - Trust boards to work with NHS Improvement and NHS England to identify where there are quality and efficiency opportunities for better collaboration and coordination of their clinical services across their local health economies, so that they can better meet the clinical needs of the local community. **Lead Director:** Not Applicable			
Collaborative working across the healthcare economy	• The Trust continues to work in collaboration with external providers and commissioners within the STP and LDS to seek to address clinical and financial constraints through service, productivity and rationalisation opportunities.			
	Recommendation 12 - NHS Improvement should develop the Model Hospital and the underlying metrics, to identify what good looks like, so that there is one source of data, benchmarks and good practice. **Lead Director:** Not Applicable			
Development of a Model Hospital	• NHS Improvement has now published the model hospital data and the Trust is focussing on the use of the information to drive forward clinical and corporate practices so that outputs and financial performances can be improved.	• A report that extracts all key metrics from the Model Hospital portal that enables our individual services to review and analyse has been produced. • The key metrics include Clinical Service Lines (Emergency, General Surgery, Urology and Paediatrics) Operational (Theatres, Procurement, Pathology, Estates) and People (Nursing, AHP, Medical, Workforce Analysis). https://model.nhs.uk	Ongoing Monitoring	

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UoR Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 2 2019/20

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
	Recommendation 13 - NHS Improvement should, in partnership with NHS England by July 2016, develop an integrated performance framework to ensure there is one set of metrics and approach to reporting, so that the focus of the NHS is on improvement and the reporting burden is reduced to allow trusts to focus on quality and efficiency. .			
	Lead Director: Not Applicable			
Implementation of Single Oversight Framework	• NHS Improvement published the document Single Oversight Framework (SOF) effective from 1st October 2016, updated in October 2017. • New SOF reviewed and indicators have been incorporated into IPR and other performance monitoring tools.		Trust Board	Ongoing Monitoring
Segmentation	• The Trust received written confirmation on 7th December 2017 that it has been moved from Segment 3 to Segment 2.		Trust Board	Ongoing Monitoring
	Recommendation 14 - All acute trusts should make preparations to implement the recommendations of this report by the dates indicated, so that productivity and efficiency improvement plans for each year until 2020/21 can be expeditiously achieved.			
	Lead Director: Not Applicable			
	See individual recommendations.			
	Recommendation 15 - National bodies should engage with trusts to develop their timetable of efficiency and productivity improvements up until 2020/21, and overlay a benefits realisation system to track the delivery of savings, so that there is a shared understanding of what needs to be achieved.			
	Lead Director: Not Applicable			

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NHS Foundation Trust

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UoR Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 2 2019/20

KLOE 5 - Finance

	Progress/Performance		Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Capital Services Capacity	UoR **WHH Model = 0.25 (August 2019)** **WHH Current = 0.43 (September 2019)** The degree to which the provider's generated income covers its financial obligations **Source: Provider returns** **Monitoring: FSC/Trust Board**		A score of 0.43 shows that the Trust is currently unable to cover its total operating expenses with the current working capital.	The Trust has worked with Warrington CCG, Halton CCG and Bridgewater Community Healthcare NHS Foundation Trust to develop 12 principles to support the delivery of the LTP. A work programme has been identified to support the future sustainability of services. This programme will be supported by a joint PMO overseen by the CEO oversight group.	
Liquidity (Days)	UoR **WHH Model = -48.45 days (Aug 2019)** **WHH Current = -47.48 days (September 201** Days of operating costs held in cash or cash-equivalent forms, including wholly committed lines of credit available for drawdown. **Monitoring: FSC/Trust Board** **Source: Provider returns**		The Trust is in receipt of £8.2m YTD (full year plan of £17.9m) FRF/PSF for accepting a break even control total. Cash is monitored closely to support the operational requirements of the Trust.	The Trust is working to improve liquidity in a number of ways including the strengthening of treasury management, reduction in aged debt, management of capital programme and access to working capital loans.	

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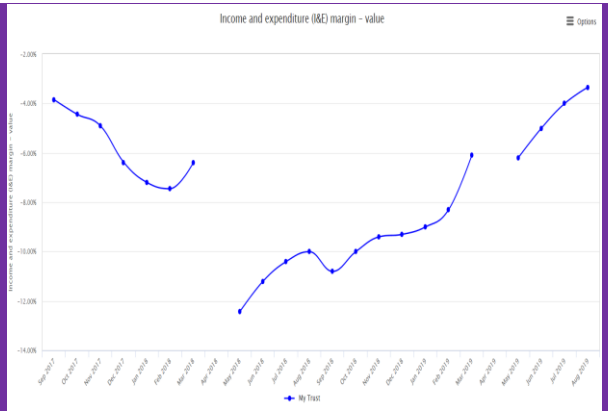
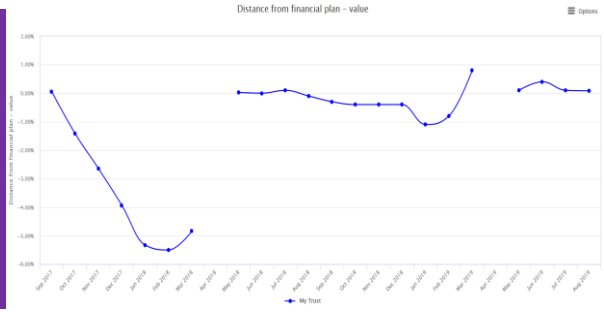
UoR Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 2 2019/20

	Progress/Performance		Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Income & Expenditure Margin	UoR The income and expenditure surplus or deficit, divided by total revenue. **Monitoring: FSC/Trust Board** **Source: Provider returns**	**WHH Model = -3.34% (August 2019)** **WHH Current = -3.10% (September 2019)**	 The Trust I&E margin is a negative value due to the Trust's deficit position. The Trust is working towards a break even position within its 5 year plan.	The Trust has worked with Warrington CCG, Halton CCG and Bridgewater Community Healthcare NHS Foundation Trust to develop 12 principles to support the delivery of the LTP. A work programme has been identified to support the future sustainability of services. This programme will be supported by a joint PMO overseen by the CEO oversight group.	
Distance from Financial Plan	UoR Year-to-date actual I&E margin in comparison to year-to-date plan I&E margin. I&E margin calculated on a control total basis. Measure is in percentage points. **Monitoring: FSC/Trust Board** **Source: Provider returns**	**WHH Model = 0.08% (August 2019)** **WHH Current = -0.08% (September 2019)**	 There is a risk to the delivery of the plan.	A number of mitigations have been identified . These plans are being overseen by the CEO oversight group.	

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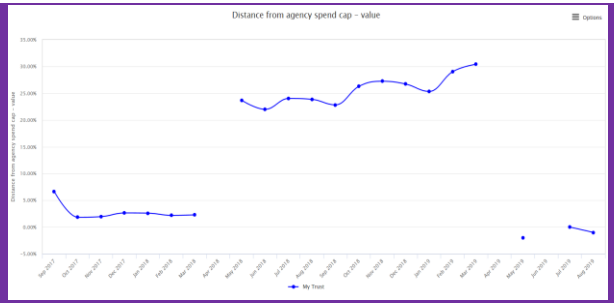
Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 2 2019/20

	Progress/Performance		Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Agency Spend - Cap Value	UoR The extent to which the trust is meeting the target for the amount spend on agency workers for the financial year.	**WHH Model = - 1.00% (August 2019)** **WHH Model = - 2.00% (September 2019)** **Monitoring: FSC/Trust Board** **Source: Provider returns**		The Trust is marginally below the agency ceiling, however the ceiling reduces in the 2nd part of the year and will be a challenge with the continued reliance on agency staffing.	A number of additional agency controls have been introduced as part of the mitigation plans to support the delivery of the control total.	

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/19/11/114**
SUBJECT:	**WHH Annual Board Report for Medical Appraisals and GMC Revalidation** *NHS England - A Framework of Quality Assurance for Responsible Officers and Revalidation – Annual Board Report*
DATE OF MEETING:	November 2019
AUTHOR(S):	Lesley Sala, Business Manager, Medical Education
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Chief Executive
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future. SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	#145 (a) Failure to deliver our strategic vision.
EXECUTIVE SUMMARY ***(KEY ISSUES):***	This Report provides assurances to the Board that our Medical Appraisal System and Processes for monitoring the completion of Annual Appraisals to support GMC Revalidation for the Medical Workforce are robust. In order to meet the GMC Requirements for Revalidation, every Doctor MUST participate in an Annual Appraisal; ensure FIVE Consecutive Appraisals are completed within their Revalidation Cycle and have acquired a 360® Patient/Colleague Feedback Report. This process then informs the GMC directly via GMC Connect which contains the names of every doctor who holds a Registration Number and is licensed to practise in the UK. They identify the Employer – (also referred to as the Designated Body) - for whom they have a prescribed connection to an RO - Responsible Officer – Professor. Simon Constable and for whom either a Recommendation/Non-Engagement/Deferral for Revalidation is able to be made. All NHS Designated Bodies (Employers) throughout the UK must engage in this system and failure to do so can remove the doctor from the GMC Register and remove their license to practise. The GMC have also made clear the minimum requirements for each Appraisal and relevant Supporting Information. In line with GMC Guidance, the Supporting Information is collated via CRMS – a web-based portal that enables safe and secure data and documentation to be held and when the Appraisal moves to Final Sign-Off, this is further triangulated via Revalidation Panel

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NHS Warrington and Halton Hospitals NHS Foundation Trust

	Meetings which are convened and chaired by the RO and relevant colleagues.			
PURPOSE: ***(please select as appropriate)***	Information ✓	Approval	To note ✓	Decision N/A
RECOMMENDATION:	We ask the Board to accept the report (noting it will be shared, with the higher level Responsible Officer). The Board should also be requested to approve the 'Statement of Compliance' confirming that the organisation, as a Designated Body, is in compliance with the regulations. This is also submitted annually to the higher level Responsible Officer.			
PREVIOUSLY CONSIDERED BY:	**Committee**	0T		
	Agenda Ref.			
	Date of meeting	November 2019		
	Summary of Outcomes	In summary, our process and systems enable, track and monitor the completion rates via a robust Notification System with a comprehensive Policy to identify the practice and procedure and accountability which has enabled a very successful 7th Year Set of Results:- ✓ YEAR 1 – 1st MAY 2012 (GO LIVE DATE) – end of April 13 – **99.4%** ✓ YEAR 2 - April 2013 – end of March 2014 - **93%** ✓ YEAR 3 - April 2014 – end of March 2015 - **96%** ✓ YEAR 4 – April 2015 – end of March 2016 - **94%** ✓ YEAR 5 - April 2016 - end of March 2017 - **94%** -*end of 1st GMC Revalidation Cycle* ✓ YEAR 6 – April 2017 – end of March 2018 - **90%** -*beg. of the 2nd GMC Revalidation Cycle** ✓ YEAR 7 = April 2018 – end of March 2019 - **93%**		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

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NHS Warrington and Halton Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

SUBJECT	**WHH Annual Board Report for Medical Appraisals and GMC Revalidation** *NHS England - A Framework of Quality Assurance for Responsible Officers and Revalidation – Annual Board Report*	AGENDA REF:	BM/19/11/114

1. BACKGROUND/CONTEXT

GMC Revalidation and a "strengthened" Medical Appraisal was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system.

As such, WHH has a statutory duty to support our Responsible Officer in discharging their duties under the Responsible Officer Regulations and it is expected that WHH will oversee compliance by:

- monitoring the frequency and quality of medical appraisals in their organisations
- checking there are effective systems in place for monitoring the conduct and performance of their doctors
- confirming that feedback from patients and colleagues is sought periodically so that their views can inform the appraisal and revalidation process for their doctors; and
- Ensuring that appropriate pre-employment background checks (including pre-engagement for locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

The GMC have strong and effective legal powers designed to maintain the standards the public have a right to expect of doctors. Where any doctor fails to meet those standards, the GMC acts to protect patients from harm, if necessary, by removing the doctor from the Register and removing their right to practise.

The introduction of GMC Revalidation across the UK in early December 2012 provided a new way of regulating licensed doctors that seeks to provide extra confidence to patients that their doctors are up to date and fit to practise. Only licensed doctors have to revalidate, usually every five years, by having Annual Appraisals based on the GMC's Core Guidance for doctors, Good Medical Practice.

The GMC have agreed supplementary guidance with the four health departments of the UK to help doctors understand how they can meet the GMC requirements in the first cycle of Revalidation, which will last from early December 2012 to the end of March 2018. This is in line with the GMC Guidance that was published for all licensed doctors.

The Guidance, which is for Doctors and Responsible Officers, will ensure Doctors are recommended for Revalidation in a consistent way.

In order for a Recommendation to be made, a Doctor must, as a minimum:

- be participating in an Annual Appraisal process
- to ensure FIVE consecutive appraisals have been completed in preparation for their Revalidation cycle

- 360® Colleague Feedback
- 360® Patient Feedback

The GMC have also made clear that the minimum requirements for each Medical Appraisal and relevant supporting information are as follows:

- Evidence of Continuing Professional Development
- Review of Significant Events, Complaints and Compliments which relate to the 12 month period prior to the appraisal that precedes any Revalidation Recommendation.
- Evidence of regular participation in Quality Improvement activities that demonstrate the doctor reviews and evaluates the quality of their work which must be considered at each appraisal. The activity should be relevant to the doctor's current scope of practice.
- Evidence of feedback from patients and colleagues (once if the five year cycle) must have been undertaken.
- Focused on the doctor, their practice and the quality of care delivered to patients
- Gathered in a way that promotes objectivity and maintains confidentiality

2. KEY ELEMENTS

Governance Arrangements

Doctors who are becoming due for revalidation are identified from the list of those for whom this Trust is the Designated Body via GMC Connect. Supporting evidence is collated for each Doctor and presented at the next Revalidation Decision Making Panel. This consists of the Responsible Officer, Deputy RO, Governance Lead, Revalidation Lead and Non-Executive Director. Doctors are considered for revalidation in time for any shortfalls to be addressed if possible. Three months prior to the submission date each Doctor becomes 'under notice' with the GMC and the trust is then able to submit their recommendation. The 3 options which can be made to the GMC are for a Positive Recommendation for Revalidation, to request a Deferral of up to 12 months or to report the Doctor for Non-Engagement in the Appraisal Process.

The Revalidation Lead prepares evidence for each doctor to support whether they meet the GMC's criteria for a positive recommendation to be made or whether there are deficiencies. The information is presented to the Revalidation Decision Making Panel and includes whether an appraisal has been undertaken in each calendar year during the 5 year revalidation cycle. If the Doctor is new to the Trust, they are expected to provide either their ARCP/CCT dates or evidence that previous appraisals have taken place elsewhere. Copies of any Claims, Complaints or Serious Incidents are also considered by the panel and a copy of a valid 360 Feedback Report from both patients and colleagues is also provided for their consideration. If any work is undertaken outside the trust then a current Independent Sector Checklist from each additional employer is also shared with the panel. A revalidation response is sought from both the Doctor's Appraiser and their Clinical Director to supplement. Following consideration the decision is made. The Revalidation Lead then submits the decision electronically to the GMC and e-mails each doctor accordingly including details of why a positive recommendation couldn't be made and how this can be resolved if appropriate.

A report is produced on a monthly basis to identify those doctors who have either commenced employment with this trust or who have left our employment. The Revalidation Lead will then decline those doctors from the list of proscribed connections via GMC Connect. For those doctors

who have joined the trust, the Revalidation Lead will add them to our list if they are employed on a full-time basis. For doctors who are employed on either a part-time basis or zero hours contract, they are individually contacted to ascertain whether or not this trust should be their Designated Body or whether they undertake more work elsewhere. They are then either connected to this trust or advised that we cannot be their designated body and they should make a connection to the employer where they undertake the majority of their work.

It is possible for a doctor to attach themselves directly to our list via their own section of the GMC. When this occurs we receive an automatic e-mail from the GMC into our 'Revalidation' Inbox which was set up specifically for this purpose. The Revalidation Lead checks the in-box regularly and decides whether the connection is appropriate and either retains the doctor on our list of proscribed connections or declines them as appropriate.

Doctors are given adequate notification that their appraisal is becoming due in accordance with the trust schedule. Doctors are expected to undertake an appraisal each year in the month of their birth. If there is an acceptable reason this may be changed, for example upon return from maternity or sick leave or if a doctor is new to the trust and only recently been appraised elsewhere. The Trust aims to ensure every doctor has undergone an appraisal in every calendar year to ensure they satisfy the GMC's requirements for revalidation purposes.

Appraisals are undertaken via an electronic system, the contents of which are mapped to the NHS England Medical Appraisal Guide (MAG) and are updated as and when required. Each appraisal requires sign-off by both the Appraiser and Appraisee following which the Deputy RO/Trust Medical Appraisal Lead quality assures the content of the appraisal to ensure it meets the level expected. If the appraisal has fully covered all domains to the required standard then Final Sign-Off is given. However, if the appraisal has not been fully documented or events not reflected upon then it is returned with comments for further attention and re-submission.

Doctors who do not undertake their appraisals on time are subject to the trust Non-Engagement Policy unless there are mitigating circumstances which have been agreed by the Medical Director/Responsible Officer. If a doctor exhausts the non-engagement process without having complied then a REV6 Form is completed to report the doctor to the GMC for their Non-Engagement in the Appraisal Process following which the GMC contact the doctor accordingly.

Medical Appraisal - Appraisal and Revalidation Performance Data

WHH have implemented a comprehensive tracking process as we are required to track evidence for Financial Year - for reporting purposes to NHS Revalidation North and also the Calendar Year to track the "Annual Appraisals for the Revalidation Cycle" to include Notification Periods via our databases:

- Tracking of End of Month Completion Rates – for both the Financial Year and Calendar Year
- Delivery of End of Month 'Medical Appraisal Exception Reports' to the Clinical Directors for every Specialty, including the "Stages" of Notification/reasons for why the Appraisal has not achieved final Sign-off.
- Creation and Delivery of "In-Month" Compliance Rates – By Specialty
- Notification emails and Letters as required

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3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

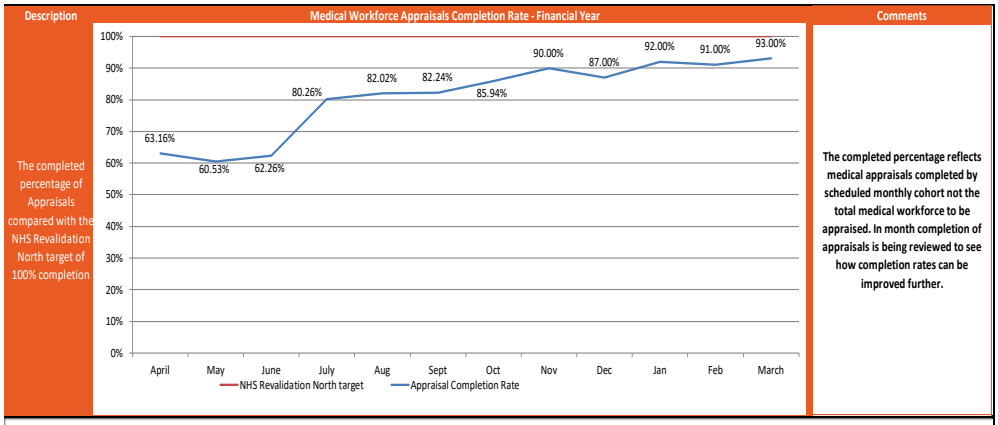
NONE

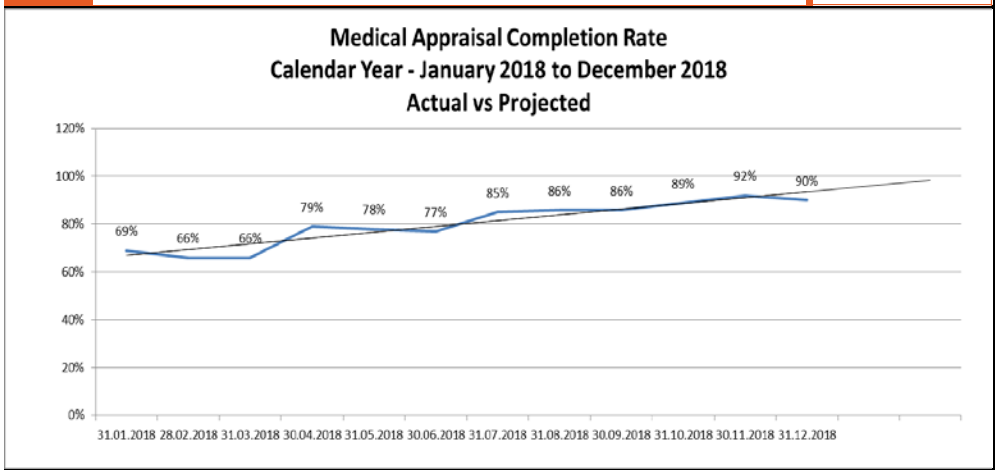
4. IMPACT ON QPS?

The Medical Workforce is an invaluable asset to the Organisation and as such, all doctors with a licence to practise utilise their Medical Appraisals as a demonstration of evidence to the GMC that they remain safe to deliver patient care. The submission of this Annual Report to NHS England provides assurance that the Medical Workforce is fully engaged in the Medical Appraisal process which directly supports GMC Revalidation.

5. MEASUREMENTS/EVALUATIONS

Here are our auditable Data sets for Medical Appraisal Completion Rates as below:-





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Below are the WHH timelines for completion, tracking and and notification periods for medical appraisals:

1. The Appraisal Meeting must take place during the birth month of the Appraisee – but can be between 9 and 15 months of the birth month.
2. The Appraisal Meeting, PDP, Summary and Feedback Evaluation are required to be completed by the end of the following month of the birth month.
3. If completion has not happened by the 1st of the next month (month 3) – **Letter 1** of the "non-engagement" Letters will be sent to the Appraisee.

4. If completion has then not happened by the middle of the third month, **Letter 2** of the "non-engagement" Letters will be sent to the Appraisee

5. If completion has not then happened by the end of the third month, **Letter 3** of the non-engagement Letters will be sent to the Appraisee, informing them that the doctor will be reported to the GMC for non-engagement

Below are the detailed activity levels of appraisal outputs by individual departments such as:

Row Labels	Count of Employee	Count of PDR	PDR Compliance
370 Warrington and Halton Hospitals NHS Foundation Trust	**215**	**178**	82.79%
370 Diagnostics RWW356	26	24	92.31%
370 Digestive Diseases RWW350	51	46	90.20%
370 Integrated Medicine and Community RWW358	3	3	100.00%
370 Medical Care RWW357	33	28	84.85%
370 Musculoskeletal Care RWW351	20	17	85.00%
370 Specialist Surgery RWW353	34	21	61.76%
370 Trust Execs RWW365	2	2	100.00%
370 Urgent & Emergency Care RWW355	22	15	68.18%
370 Womens & Childrens Health RWW352	24	22	91.67%

WHH hold details of any exceptions – by individual doctor for all missed and/or incomplete medical appraisals and below is an example of the reasons for all incomplete and delayed appraisals

Position Title	Assignment Categ	PDR
Consultant	Permanent	18/03/2019
Consultant	Permanent	20/02/2019
Trust Grade	Fixed Term Temp	To be offered an appraisal in next few months, now 6 months of contract has been completed
Consultant	Permanent	Due in November 2019, appraised by Deanery 30.1.18
Consultant	Permanent	Due in June 2019 - will cover 2 year period June 2017-June 2019 due to maternity leave in June 2018 (GMC permit missing an appraisal for this reason)
Consultant	Locum	Appraised by Deanery 20.8.18, Trust appraisal booked for 25.4.19
LAS ST3+	Fixed Term Temp	Due in April 2019
Trust Doctor	Fixed Term Temp	17/01/2019
Consultant	Permanent	09/10/2018, due again June 2019
Clinical Assistant	Permanent	Appraised by full time employer
Consultant	Permanent	Appraised by Deanery 8.2.18, to be appraised by the Trust in July 2019
Consultant	Permanent	Appraised by Deanery 17.2.18, to be appraised by the Trust in June 2018
International Training Fellow	Fixed Term Temp	Due to be appraised in June 2019
LAS ST1/2	Fixed Term Temp	To be offered an appraisal in next few months, now 6 months of contract has been completed
Consultant	Permanent	17/12/2018
Locum Consultant	Locum	To be offered an appraisal in next few months, now 6 months of contract has been completed
Consultant	Permanent	01/08/2018, due again July 2019
Consultant	Permanent	02/08/2018, due again August 2019
Consultant	Permanent	Due April 2019
Specialty Doctor	Permanent	12/12/2018
Specialty Doctor	Permanent	Appraised by full time employer
Specialty Doctor	Permanent	Due June 2019
Hospital Practitioner	Permanent	20/11/2018
Specialty Doctor	Permanent	18/05/2018 due April 2019
Specialty Doctor	Permanent	Appraised by full time employer
Staff Grade Practitioner	Permanent	Appraised by full time employer
Consultant	Permanent	06/02/2019
Specialty Doctor	Permanent	28/11/2017 - was due again November 2018 but on career break July 18 to July 19
LAS ST1/2	Fixed Term Temp	Due to be appraised in May 2019
LAS ST1/2	Fixed Term Temp	To be offered an appraisal in next few months, now 6 months of contract has been completed
Specialty Doctor	Fixed Term Temp	Due to be appraised in May 2019
Consultant	Fixed Term Temp	Booked for 2.4.19 (overdue)
International Training Fellow	Fixed Term Temp	Due to be appraised in June 2019
Trust Grade	Fixed Term Temp	23/01/2019
Consultant	Permanent	Due in April 2019
Locum ST3+ Doctor	Fixed Term Temp	29/01/2019
LAS ST3+	Fixed Term Temp	Due in February 2019 - now overdue

6. TRAJECTORIES/OBJECTIVES AGREED

CRMS Medical Appraisal portfolios:

- Review of appraisal folders to provide assurance that the appraisal inputs: the pre-appraisal declarations and supporting information provided is appropriate and available - by the Deputy RO/Medical Appraisal Lead prior to sign-off. For example, if information that is required to be seen is not held in the portfolio, this will be returned with instructions the Appraisee/Appraiser as required.

- Review of appraisal folders to provide assurance that the appraisal outputs: personal development plan, summary and sign offs are complete and to an appropriate standard - by the Deputy RO/Medical Appraisal Lead prior to sign-off.
- Review of appraisal outputs to provide assurances that any key items identified pre-appraisal as needing discussion during the appraisal is included in the appraisal outputs - by the Deputy RO/Medical Appraisal Lead prior to sign-off.

For the individual Medical Appraiser:

- An annual record of the appraiser's reflection on his or her appropriate continuing professional development.
- An annual record of the appraiser's participation in appraisal calibration events such as reflection on appraisal network meetings.
    - WHH Medical Appraisal Forum Attendance Registers are used to demonstrate engagement of the Appraisers.
    - 360° Patient and Colleague Feedback Reports are provided from the web-based system **360© Clinical** and these Reports are uploaded onto the Medical Appraisal portfolio. These Reports offer a "national confidence interval" in the assessment of a Doctor.

7. MONITORING/REPORTING ROUTES

NHS England Medical Appraisal and GMC Revalidation Annual Report

- NHS England Medical Appraisal and Revalidation Annual Report –due for submission to NHS England annually in Sept
- NHS England Annual "Statement of Compliance" - due for submission to NHS England annually in Sept
- NHS England AOA – "Annual Organisation Audit" - due for submission to NHs England annually in June

There are also the NHS Revalidation North electronic Quarterly Appraisal Activity Reports:

- 1st July 2019 to 30th September 2019 – Q2 submitted as it was due by the 11th Nov 2019
- 1st October 2019 to 31st December 2019 - Q3 due mid-Feb 2020
- 1st January 2020 – 31st March 2020 - Q4 – due mid-May 2020
- 1st April 2020 – 31st June 2020 - Q1- due mid-August 2020

8. TIMELINES

Below are the WHH timelines for completion, tracking and and notification periods for medical appraisals:

1. The Appraisal Meeting must take place during the birth month of the Appraisee – but can be between 9 and 15 months of the birth month.

2. The Appraisal Meeting, PDP, Summary and Feedback Evaluation are required to be completed by the end of the following month of the birth month.

3. If completion has not happened by the 1st of the next month (month 3) – **Letter 1** of the "non-engagement" Letters will be sent to the Appraisee.

4. If completion has then not happened by the middle of the third month, **Letter 2** of the "non-engagement" Letters will be sent to the Appraisee

5. If completion has not then happened by the end of the third month, **Letter 3** of the non-engagement Letters will be sent to the Appraisee, informing them that the doctor will be reported to the GMC for non-engagement

9. ASSURANCE COMMITTEE

This Board Report has also been submitted to the Strategic People Committee

10. RECOMMENDATIONS

1. Ensure all Locum/Temporary/Short-Term Doctors are provided with EXIT Reports are in line with the Strengthened Medical Appraisal Policy and that this Action is recorded or all locum and short-term contracts. This will also ensure their practice is reported for every contractual movement whilst employed within the health service/health care setting.

2. Ensure Remediation "maintaining high professional standards" MHPS - Processes are factored and robustly coordinated to ensure a doctor can be appropriately supported (e.g. further training and resources (financial and otherwise) provided and recognised accordingly.

3. Continuation of current practice for Reporting and Monitoring Systems for WHH, noting the exceptional results achieved year on year.

4. Annual Review of the following Policies and SOP's:
   - WHH The Strengthened Medical Appraisal Policy to support GMC Revalidation 2019
   - WHH GMC Revalidation Policy 2019
   - WHH SOP – Medical Workforce NEW Starter Process 2019
   - WHH SOP – Medical Workforce 360© Clinical Feedback Reports Process 2019
   - WHH SOP – Medical Practice Information Transfer 2019
   - WHH SOP – Revalidation Process 2019

The Board are required to note the results of medical appraisals and GMC Revalidation to support the Medical Workforce at WHH and to review the data provided for assurance.

There are no risks or issues have been identified to be escalated to the Board.

We ask the Board to accept the report (noting it will be shared, with the higher level Responsible Officer). The Board are to be advised that the **'Statement of Compliance'** has been submitted In September 2019 to NHS England confirming that the organisation, as a **Designated Body**, is in compliance with the regulations. This is also submitted annually to the higher level Responsible Officer.

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NHS Warrington and Halton Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/19/11/115**
SUBJECT:	**The Quarterly Report for the Guardian of Safe Working Hours for Junior Doctors in Training** **Quarter 1 Reporting Period:- 1st April 2019 – 31st June 2019**
DATE OF MEETING:	27 November 2019
AUTHOR(S):	Mr Mark Tighe, Guardian of Safe Working Hours.
EXECUTIVE DIRECTOR SPONSOR:	Alex Crowe, Acting Executive Medical Director
LINK TO STRATEGIC OBJECTIVES:	SO1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience
	SO2: We will .. Be the best place to work with a diverse, engaged workforce that is fit for the future
	SO3: We will .. Work in partnership to design and provide high quality, financially sustainable services
EXECUTIVE SUMMARY (KEY ISSUES):	The 2016 Contract stipulates that there is a requirement for WHH to provide assurances with regards to Junior Doctors being able to undertake both safe working hours and fulfil their training and teaching requirements. It has now been in place since August 2016. The 2016 Junior Doctor Contract is now well established at WHH. All of our Foundation Doctors have converted over, as well as the majority of the CT and ST grades. I continue to attend the Regional Guardian of Safe Working Forum, and I can confirm that overall we are in line with our surrounding trusts. It is important to highlight that there has again been no escalation of any ERs to Level 2 Review, nor have I been required to impose any fine on the Trust since the last Report. All our rotas remain compliant, and in general, the Junior Doctors are happy with their allocations. Our Junior Doctors Forum continues to be well attended and enjoys robust discussion. The collaboration of the Medical Director, HR and the Guardian of Safe Working into a single meeting for the Junior Doctors Forum continues to work well, to identify and correct persistent ongoing concerns from the Junior Doctors.

The BMA are also invited to the meeting as our aim is to work in partnership on this important matter. The Junior Doctors also seem happy to engage with their Consultants, Educational Supervisors (ESs) and Guardian of Safe Working, if any new issues develop.

In the event that there was a significant on-going failure to provide assurances with regards to Junior Doctors being able to undertake both safe working hours and fulfil their training and teaching requirements, this would bring a number of challenges. This could include non-compliance with contractual obligations and financial fines.

It may also be reflected in the **GMC National Trainee Survey Results** (as below) and if there were **Areas of Concern** then these are highlighted to our Trust via HEENW who would require an action plan to resolve the concerns.

- ✓ **Noted *many significant improvements* within MEDICINE**
  - **HANDOVER *improving by a significant 50 pts* from 2018**
  - **Improving scores for CMT most is *most noticeable* = RISK score from 2 to 1**
  - **Overall Medical Specialties – *Improvements are apparent* = RISK from 2 to 1**
  - **Monitoring and Reporting Systems (ALL Specialties) = RISK score from 2 to 1**
  - **Burnout Question – *(Gastro – but remains inconclusive)* = RISK Score of 1**
  - **Anaesthetic Trainees - *Managing patients in EM* = RISK Score of 1**
  - **2018 HEE Results 5 = CAT 2/2 CAT 1/1 CAT 3/Patient Safety**
  - **2019 HEE Results = 5 = CAT 1**

If a Trust cannot provide HEENW with the required assurances it risks sanctions, e.g. being placed under enhanced monitoring, or possibly having trainees removed. This is based on the **HEE Quality Framework** as follows:

Risk Category	Description
Category 0	NO Concerns - ALL HEE Standards are met
Category 1	**Minor Concerns** – in one or more areas the HEE Standards are not being met, but we are assured by the Action Plans in place to address the concern,
Category 2	**Significant Concerns** – there are a significant number of areas in which the HEE Standards have not been met, and plans are not demonstrating improvements.
Category 3	**Major Concerns** – the placements concerned are well below the standards expected by HEE; the agreed improvements have not been delivered and there is a significant risk to the quality of education and training
Category 4	**Training Suspended** – when all other avenues have been explored, HEE may decide to suspend placements. This decision may only be made after careful consideration, and at the very highest level of the Organisation.

As noted in previous reports, the majority of Exception Reports (ERs) continue to relate to Junior Doctors working late past their rotas.
We do still see some problems with the sign-off meetings between the Educational Supervisors and the Junior Doctors, with a number of Exception Reports not been completed in a timely manner. This can lead to delays in our Junior Doctors being able to put in claims for time-off in

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	lieu (TOIL) and/or compensatory payment. This has been escalated to Alex Crowe, and it would be preferable for me and Dr Crowe to have the capability on Allocate to take over the management of outstanding ERs. Although there is still a preference for Junior Doctors to request compensatory payment rather than TOIL, this has started to level off, and it is now encouraging to see more Junior Doctors opting for TOIL. Junior Doctors are continuously reminded at the Junior Doctors Forum and at Induction, that it is highly preferential that they take TOIL where this is possible. This will help prevent them exceeding their recommended maximum hours. It is recommended that the Trust reviews its plans to secure and implement an E-rostering system for all Junior Doctors at WHH. I am aware that this is being reviewed in late 2019, but would highlight that it would be beneficial to implement this as soon as possible as this will assist with Junior Doctors receiving timely and robust rotas.			
PURPOSE: (please select as appropriate)	**Information**	Approval	To note ✓	Decision
RECOMMENDATION:	The Board are requested to note the report and progress made with implementing the Junior Doctor Contract and the level of assurance given that the Junior Doctors are working safely for their own health and wellbeing and the safety of patients. Any concerns that the Board have should be reported back to the Guardian of Safe Working for his attention, consideration and actions accordingly.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Strategic People Committee		
	Agenda Ref.	**SPC/19/11/106**		
	Date of meeting	20 November 2019		
	Summary of Outcome	Noted		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None			

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NHS Warrington and Halton Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

SUBJECT	Guardian of Safe Working Hours for Junior Doctors in Training. **Quarter 1 Reporting Period**:- 1st April 2019 – 31st June 2019	AGENDA REF:	BM/19/11/115

1. BACKGROUND/CONTEXT

The 2016 Junior Doctor Contract is now well established at WHH. All our rotas remain compliant, and in general, the Junior Doctors are happy with their allocations. Our Junior Doctors Forum continues to be well attended and enjoys healthy discussion. The collaboration of the Medical Director, HR and the Guardian of Safe Working into a single meeting for the Junior Doctors' Forum continues to work well, to identify and correct persistent ongoing concerns from the Junior Doctors. The BMA are also invited to the meeting as our aim is to work in partnership on this important matter. In addition, the Junior Doctors seem happy in the main to engage with their Consultants, Educational Supervisors (ESs) and Guardian of Safe Working, if any new issues develop.

I continue to attend the Regional Guardian Forum, and overall I can confirm that we are in line with our peers. Once again, I am pleased to be able to confirm that there has again been no escalation of an ER to a Level 2 Review, or fine to the Trust since the last Report.

In the first Quarter of this financial year (2019) we have total of 18 Exception Reports recorded. This is significantly down on previous quarters. I hope this represents general satisfaction from the juniors, rather than under-reporting, but will need close monitoring going forward.

Rather than being seen as a concern for the trust, ERs help to identify any problem areas within the Trust for our junior doctors.

I will continue to reiterate the message to Junior Doctors, ESs and CBU's that TOIL is the preferred option for ERs.

The vast majority of ERs still relate to our F1 Doctors working past their allocated time, usually on an ad hoc basis. Interestingly, these have occurred primarily in Urology, Surgery and Trauma and Orthopaedics during this quarter. This is highly atypical when compared with other periods, where medicine has the most ERs, due to the high volume and acuity of the workload. This is partly due to the quieter nature of the medical posts in the summer months, but also due to the sterling work done to enable safe staffing levels on the medical wards, to give our juniors the support they need.

Importantly, I can confirm that all 72 Foundation Programme Doctors employed during this period were well on track to progress through their current year of training.

Concerns remain that there has been some slippage in the review meetings between ES and Junior Doctor, once an ER has been submitted. I have had a number of useful discussions with both ESs and Junior Doctors in attempts to allow fair resolution of ERs. I have also sent numerous emails to them to remind them of the importance of getting all ERs signed off as quickly as possible. This message is also re-enforced to Junior Doctors at the Junior Doctors Forum and their Trust Induction, whereby they are again reminded that should they experience any difficulties in the ES signing off an ER, this can be escalated to the Guardian of Safe Working. The Deputy Medical Director and Director of Medical Education supports the message being given at the Junior Doctors Forum, advising that everyone must fulfil their roles and responsibilities in a timely manner.

Junior Doctors on the 2002 Contract

It is important to remember that some Junior Doctors (employed by the Lead Employer) will remain on the 2002 contract for a number of years. Such Doctors are therefore not on the 2016 Contract and will require their rotas to be monitored in line with their terms and conditions, so that assurance can be given for all doctors in training and not just those on the new contract. I can confirm that the next monitoring exercise has been completed on these Doctors in July 2019 to ensure that the Trust fulfils its contractual obligations for those on the 2002 contract.

We remain cognisant of a recent Case Law (Hallett vs Derby) which effects Trust's using ALLOCATE for monitoring exercises; a further update will be provided in due course.
These Doctors **(n= 41)** therefore do not form part of this report which is focused on Junior Doctors on the 2016 Contract.

2. KEY ELEMENTS

2.1 Introduction

The role of The Guardian of Safe Working Hours under the Terms and Conditions of Service is to:

- ✓ Provide Trust Boards with assurance that Junior Doctors are safe and able to work, identifying risk and advise the Trust Boards on the required response.

This report primarily covers the period from 1st April 2019 – 31st June 2019 (Q1) and follows the format as recommended by NHS Employers.

Indicator	Number
Number of WHH Doctors / Dentists in training - (FY1/FY2)	72
Number of WHH Doctors / Dentists in training on 2016 TCS	72
Number of WHH Doctors / Dentists in training on the 2002 TCS (inclusive of all Grades of Trainees)	41
Reference period of report	**01/04/2019 – 31/06/2019**
Total number of exception reports received	**18**
Number relating to immediate patient safety issues	2

Number relating to working hours/pattern	16
Number relating to educational opportunities	1
Number relating to service support available to the doctor	1
Total hours of TOIL granted	5
Total incidences of overtime payments issued	5
Total number of work schedule reviews	2
Total number of reports unresolved/pending	6
Total value of fines levied	£0.00
Amount of time available in job plan for guardian to do the role	1PA/p.w
Admin support provided to the guardian	Surgery/Med Ed Admin
Amount of job-planned time for educational supervisors	0.125PA per trainee

The 72 Junior Doctors in training employed by the Trust are made up of 36 FY1 Trainees and 36 FY2 Junior Doctors. In addition, the Lead Employer (St Helens and Knowsley Teaching Hospitals NHS Trust) employ Specialty Junior Doctors at ST1+ and CT1+ who rotate to different Trusts as part of their training. Currently, following the August rotation, WHH has welcomed 138 Junior Doctors (Core/Specialty Grades from the Lead Employer and the most recent rotations now include the vast majority of Junior Doctors now on the new contract. The Lead Employer is responsible for their own monitoring and Quarterly/Annual Reports for the Junior Doctors that they employ.

2.2 Quarterly Report

2.2.1 ERs (with regards to working hours)

Specialty	No. of Exceptions Raised Q1
General Surgery – FY1	**4**
Acute Medicine – FY1/2	**1**
Acute Medicine - ST	**3**
Urology FY1	**7**
T+O FY1/2	**3**
TOTAL	**18**

1. Six ERs (33%) remain open and need resolving. I have communicated the need to close these ERs to both the Junior Doctor and ESs. It should be noted that this continues to be a common theme at our recent Regional Guardian Meeting, and has proved a difficult problem to correct among many Trusts. I will make this a priority to highlight for discussion at the Trust Induction of the new F1s in August 2019. One possible solution is to allow the Guardian or Medical Director access to edit all reports on Allocate, to allow sign-off of delayed reports. I

will discuss this further at the next Regional Guardian meeting and provide an update in the next report and report back to the Trust Board.

For example – here is the LIVE position on ALLOCATE as at the 13th September 2019

TOTAL number of Exception reports for review	**97**
Within the last 30 Days	**12**
Within the last 7 Days	**3**
Immediate Safety Concern within the last 30 Days	**2***
Overdue	**94**
Actions Required	**68**

*relates to another trust involving our juniors (Hollins Park)

ERs (response time) in 1st Quarter				
	Addressed within 48 hours	Addressed within 7 days	Addressed in longer than 7 days	Still open
FY1	0	0	5	7
FY2	0	0	2	4

Guidelines for ERs state that reports should be completed by the Junior Doctor as soon as possible, but no later than 14 days of the exception. If the Junior Doctor is seeking payment as compensation, the report should be submitted within 7 days. Upon receipt of a report, the ES should respond within 7 days. We have allowed some flexibility in the time allowed after submission of an ER, to claim for payment or TOIL. However, we have put a provisional limit for compensation at 3 months, and whenever possible, to only allow TOIL within their current placement.

The above table shows that only no reports in Q1 have been addressed by the ES within 7 days, but 7 reports (39%) were addressed longer than 7 days, and 11 reports (61%) still remain open to this date.

This latter figure is of some concern as the ES should have met to resolve the incidents. Although the numbers of ERs are much lower, there has been some improvement since Q4.

The ERs which have been resolved were largely resolved at the 'Initial Stage', but 3 ERs were escalated to 'Level 1 Review Stage'.

ERs (type of issue) Q1				
	Hours	Education	Service Support	Working Pattern
FY1	10	1	1	0
FY2	6	0	0	0

Clearly the majority of issues relate to the extra hours that the Junior Doctors are required to work, in addition to their contracted hours.

ERs Q1			
	Overtime Payment	Compensation: Time Off in lieu	Work schedule review
FY1	5	2	2
FY2	1	2	0

2.2.2 Work Schedule Reviews and Immediate Safety Concerns

There were two work schedule reviews. One related to staffing levels and support in urology. Dr Crowe met with the F1s on this rotation, in an attempt to rectify this. Meetings were arranged also with the urology consultants, to inform them of the problems here, and to assist in correcting the issues.

The other related to lack of opportunity to attend teaching due to on call commitments. This has been sorted to allow senior cover when the teaching is on, but obviously there will be exceptions if emergency workload is particularly high on the day.

There were no immediate safety concerns during Q4.

2.2.3 Locum Bookings

Bank and Agency

The normal arrangements for covering gaps on the rotas are for the Junior Doctors to be approached first to see what cover they can provide. Where gaps still remain, the shifts which need covering are submitted via the CBUs to the Medical bank for filling shifts.

The table below show the shifts – By Department/Agency Shifts and Hours worked which were presented to the Medical bank.

Locum bookings (bank and agency) by department:

Department	*Number of Agency Shifts*	*Total Agency Hours Worked*
A&E Department	315	2556.25
Acute Medical Staff	8	93.75
Care of the Elderly & Stroke	443	3423.41
CRC ICU Medical Staff	9	108
General Surgery Medical Staff	4	47
Orthopaedic Medical Staff	14	102
Respiratory	34	259.25
Urology	60	525.5
Ward A2 ACUTE MEDICINE	81	584.25
Ward A9 TRAUMA & ORTHOPAEDICS	1	9
Winter Ward 2018/18	84	638.5
Women's Medical Staff	52	607.57
Grand Total	**1105**	**8954.48**

2.2.4 Locum Work Carried Out by Junior Doctors

The table below shows **ALL Medical Grades** who have undertaken internal locum work by performing 'extra duties' which in effect supplement the cover arrangements mentioned in the previous section for agency staff. A claim form is completed and authorised and then processed by Payroll.

All Medical Grades with the exception of Consultants
Date Range: 01/04/2019 to 30/06/2019

Booking Reason	*Number of Agency Shifts*	*Total Agency Hours Worked*
Additional Service Requirement	146	1110.82
Annual Leave	1	9
No on call (Health/Pregnancy)	3	34.25
On Call	2	23
Restricted duties	3	36.5
Sickness	48	558.07
Trust Vacancy	821	6564.84
Vacancy (Recruitment difficulties)	59	448
Winter Pressure	22	170
Grand Total	**1105**	**8954.48**

2.2.5 Vacancies

The table below shows the vacancies at Foundation Programme level from Jan – March 2019:

Specialty	Grade	Jan 18	Feb 18	Mar 18	Total gaps (average)	Number of shifts uncovered
General Medicine	**FY1**	**0**	**0**	**0**	**0**	**0**
General Surgery	**FY1**	**0**	**0**	**0**	**0**	**0**
Trauma & Ortho	**FY1**	**0**	**0**	**0**	**0**	**0**
Paediatrics	**FY1**	**0**	**0**	**0**	**0**	**0**
General Psychiatry	**FY1**	**0**	**0**	**0**	**0**	**0**
Total	**FY1**	**0**	**0**	**0**	**0**	**0**

N.B.

1. It does need to be recognised that there were other medical vacancies at different grades which would have had some impact on the resources available on wards and departments which could have contributed to difficulties in some Junior Doctors leaving wards on time.
2. Another caveat relates to the national reduction in supply of CT1/2 and ST3+ Junior Doctors, which will undoubtedly lead to insufficient Junior Doctors to enable compliant rotas in the future. As well as rota management, this will have a deleterious effect on training and educational opportunities for those left on the rota.

During the period there have been no fines imposed by the Guardian and therefore the balance for disbursement is **nil.**

2.2.6 Qualitative Information

1. **Junior Doctors Forum (JDF)**: The JDF continues to be well attended, and there is good engagement and debate during the meeting. The joint meeting with the Deputy Medical Director/Director of Medical Education, Guardian and HR appears to be appreciated by the Junior Doctors. Hopefully, we can continue to develop this meeting further in the future.

2. **Education Supervisors (ESs)**: Whilst there continues to be good input from most ESs, there are still long delays in the timing of the review meeting. It is of concern that a number of ERs remain outstanding at the current time, and at the Regional meeting, we are all looking at strategies to attempt to sort this problem. I will provide an update in the next report.

3. **Exception reports (ERs)**: There has been a marked reduction in the number of ERs submitted between April 1st and June 30th 2019. This probably reflects the lower acuity and volume of the emergency patients during the summer months, and the greater experience and improved time management of the juniors, as they progress through their Foundation year. However, credit must be given to the managers and clinical leads (notably in medicine), who have worked hard to improve staffing levels and fill rota gaps in the last 12 months. There have been no immediate safety concerns in Q$, which is reassuring.

4. **Compensation for extra duties worked**: There was an equal divide between compensatory payment and TOIL in Q4, which is an improvement. It is currently extremely difficult to assess whether a junior doctor has exceeded the maximum weekly hours, if they take compensatory payments. However, it should become easier to monitor with the planned new e-rostering system.

5. **Allocate Training**: There has been drop-in sessions available for ESs to develop their skills in completion of ER reviews. We will endeavour to repeat these sessions again shortly.

2.2.7 Issues Arising

Our volume of ERs has reduced over this 3 month period. It is vital the Junior Doctors engage with the process, to ensure they are working safely within their allocated rotas. The vast majority of ERs at WHH still relate to working excess hours at the end of their shift. It is very difficult to monitor individual Junior Doctors' hours to ensure they do not breach safe working, as it would be calculated as an average over a full rota.

There were no immediate safety concerns in this 3 month period.

I will continue to encourage TOIL rather than compensatory payments, for extra hours worked, to try and ensure our juniors are not exceeding their recommended hours in a rota cycle.

However, we do rely heavily on in-house locum cover for outstanding shifts, exaggerated by recent changes to IR35 legislation and agency usage. Whilst coverage of shifts in the surgical specialties is usually manageable, this is more difficult in medicine where the Junior Doctors are less inclined to cover extra work. In-house cover again has repercussions on the maximum hours that the Junior Doctors are permitted to work.

We need to ensure continued engagement of our Educational Supervisors with the Junior Doctors, and continue to address the problem of persistent delays in participation of review meetings.

Normally the highest number of ERs has been raised within general medicine followed by general surgery. However, there has been a particular spike in urology and orthopaedics this year. Initially, this related to disquiet from one of the orthopaedic ST3s, who had significant issues with the non-resident on call requirements. This took a lot of time to resolve, with the BMA and HR involved. It entailed an ER being submitted for every on call shift this doctor completed. The second spike related to the workload of the urology F1 doctors, which was addressed earlier in this report

A number of ERs remain open, and whilst the vast majority of these require attention from ESs, there is a proportion which just need accepting by the Junior Doctors on Allocate, where there has been appropriate intervention from the ESs.

The table below shows a summary of ERs by type of issue raised.

ERs (type of issue)				
	Hours	**Education**	**Service Support**	**Working Pattern**
All rotas	**223**	**26**	**10**	**1**

Again, not surprisingly, the vast majority of ERs refer to hours, usually where Junior Doctors have felt they had no alternative but to stay beyond their shift to maintain safe patient care. Only a small number refer to education issues which would suggest that on the whole the majority of Junior Doctors feel that they are able to access their training and education

2.3.1 Action Taken to Resolve Issues

1. Educational Supervisors and the Guardian of Safe Working have received required training on Allocate. Further training sessions will be scheduled from August 2019. I would like access to amend and update ERs on Allocate (currently I do not have access to this).
2. There has been success in increasing staffing and support to Junior Doctors in high intensity areas. This has definitely been assisted by the appointment of Nurse Specialists and Physician Associates on the wards, as well as F3 Doctors, and the Trust is looking to expand the International Medical Graduate Scheme.
3. The Trust is scheduled to further increase the number of Physician Associates and F3 doctors going forward.
4. Some CBU's have started to implement e-rostering systems that help provide timely and robust rotas for Junior Doctors. It is highly recommended that the Trust rapidly seeks to ensure that it has appropriate electronic rota systems across the organisation and that each CBU has staff that are trained in using the systems and designing of rotas. A meeting is scheduled shortly to address this requirement.
5. We will continue to encourage TOIL as a solution to excess hours rather than compensatory payments, to avoid possible breach in hours and increased costs.

6. Liaison with HR to calculate average hours for Junior Doctors across a rota cycle. The planned in-house locum bank should help to spread the extra hours across the Junior Doctors to ensure they remain compliant.
7. Work schedule reviews continue to be implemented to allow regular attendance at educationally beneficial sessions (formal teaching, theatre, clinics).

2.4 Summary

Our Trust has continued to maintain good engagement of the new Junior Doctors Contract across all of the specialties. All our rotas remain compliant, the Junior Doctors are generally satisfied and engaged, and our HR department, rota managers, and ESs have usually been supportive and responsive to any concerns amongst the Junior Doctors.

I continue to attend the Regional Guardian of Safe Working Forum and overall we are in line with our peers. Once again I am pleased to be able to confirm that there has again been no escalation of an ER to a Level 2 Review or fine to the Trust since the last Report.

The number of ERs has significantly dropped during Q1, for the reasons outlined earlier. The main context of ERs remains overtime work, usually doctors staying late to complete tasks. There have been no ISCs during this quarter, and only one ER was submitted for loss of educational opportunities, which is also reassuring.

There remain a number of outstanding ERs, and this clearly needs addressing. However, all completed reports have been signed off without resort to Level 2 or Guardian Reviews. This was one of the main concerns from the BMA prior to implementation of the contract, and it is pleasing to see this continuing in our Trust. We need to ensure we provide continued training for ESs, both in the expectations of their responses to ERs, and instruction for use of the Allocate system.

There are still areas where there are limited numbers of Junior Doctors covering busy wards. This will undoubtedly lead to extra burden on the incumbent Junior Doctors, in terms of workload, compliance to working hours, and opportunity to access educational sessions. It is pleasing to see that the Trust has sought to mitigate this risk through employing Nurse Associates, Physician Associates, International Medical Graduates and F3 Doctors.

In order to ensure compliance with Junior Doctors hours, ESs should continue to encourage to offer TOIL rather than compensatory payment wherever feasible. Work schedule reviews are mandatory where there is persistent infringement of hours or educational opportunities for our doctors.

As Guardian of Safe Working Hours for the Junior Doctors in WHH, I am satisfied with the delivery and implementation of the new contract in our Trust to date. However, we do need to be watchful that work schedules and working hours are maintained in future rotations, being mindful of the likely challenges facing the Trust with service delivery, and reduction in training posts offered to the Trust by HEENW.

specific recommendation would be for the Trust to secure and implements an e-rostering system for all Junior Doctors at WHH as soon as possible, to assist with providing timely and robust rotas. In addition, there may need to be extra recognition of the workload of some of the ESs, whose Junior Doctors are in the more challenging posts, with PA allocation adjusted accordingly.

As Guardian of Safe Working, I would be grateful for feedback from the Trust Board regarding any concerns or recommendations regarding the implementation of the new Junior Doctors Contract in our Trust.

3 ACTIONS REQUIRED/RESPONSIBLE OFFICER

The Trust Board is asked to note and review this report and moving forwards continue to monitor and review the future reports that will be submitted on a quarterly and annual basis in line with our Trust obligations.

4 IMPACT ON QPS?

Providing assurances with regards to Junior Doctors being able to undertake both safe working hours and fulfil their training and teaching requirements helps with:

A. **Retaining HEENW Junior Doctors**
B. **Potential for increased HEENW Junior Doctors**
C. **Removal of risk of financial penalties**
D. **Recruitment and Retention for the wider Medical Workforce**
E. **Reduced expenditure on agency/locums**
F. **Improved moral**
G. **Reduced absence**
H. **Enhanced Trust reputation**

5 MEASUREMENTS/EVALUATIONS

The Trust monitors that Junior Doctors able to undertake both safe working hours and fulfil their training and teaching requirements through:

A) Guardian of Safe Working
B) Exception Reporting System
C) Educational Supervisors
D) Junior Doctors Forum
E) Joint Local Negotiating Committee
F) Medical HR
G) GMC Survey Results
H) HEENW Monitoring Visits

I) Regional Guardian of Safe Working Forum

6 TRAJECTORIES/OBJECTIVES AGREED

The Guardian of Safe Working has a recurrent slot on the Junior Doctors Forum that is chaired by the Deputy Medical Director / Director of Medical Education. This is the agreed forum to ensure our junior doctors are able to keep working safely and fulfil their training and teaching requirements in line with their TCC.

In addition, I attend the Regional Guardian of Safe Working Forum to ensure that we are in line with our peers. Trust Board are provided with quarterly and an annual report from the Guardian of Safe Working which is in line with our Trust obligations.

7 MONITORING/REPORTING ROUTES

It is recommended that the Junior Doctors Forum continues to monitor that Junior Doctors are able to undertake both safe working hours and fulfil their training and teaching requirements. Updates are also provided to the Joint Local Negotiating Committee allowing further discussion. Trust Board are then provided with quarterly and an annual report from the Guardian of Safe Working which is in line with our Trust obligations.

8 TIMELINES

Trust Board are provided with quarterly and an annual report from the Guardian of Safe Working which is in line with our Trust obligations.

9 ASSURANCE COMMITTEE

Trust Board is asked to note and review this report that has been written by the Guardian of Safe Working based on the ERs received and discussions with Junior Doctors at the Junior Doctors Forum.

10 RECOMMENDATIONS

Trust Board are requested to note the Report and progress made with implementing the Junior Doctor Contract and the level of assurance given that the Junior Doctors are working safely for their own health and wellbeing and the safety of patients.

A specific recommendation would be for the Trust to secure and implements an e-rostering system for all Junior Doctors at WHH as soon as possible to assist with providing timely and robust rotas for Junior Doctors.

Any concerns that the Board have should be reported back to the Guardian of Safe Working for his attention, consideration and actions accordingly.

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

Mr Mark Tighe - Guardian of Safe Working Hours

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/19/11/115**
SUBJECT:	**Guardian of Safe Working for Junior Doctors** **Q2 Report - 1st July 2019 – 31st Sept 2019**
DATE OF MEETING:	27th November 2019
AUTHOR(S):	Mark Tighe, Guardian of Safe Working
EXECUTIVE DIRECTOR SPONSOR:	Alex Crowe, Acting Executive Medical Director
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future. SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	#115 Failure to provide adequate staffing levels in some specialities and wards. #145 (a) Failure to deliver our strategic vision. #241 Failure to retain medical trainee doctors.
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The 2016 Junior Doctor Contract is now well established at WHH for all of our Foundation Doctors, and the majority of the CT and ST grades. Monitoring of the safe implementation of the contract is now under the auspices of the Postgraduate Department, overseen by Lesley Sala. Issues regarding safe working hours, rota problems or patient safety issues are noted by Junior Doctors in the form of Exception Reporting, which are escalated to their responsible Educational Supervisors, and then to myself as Guardian of Safe Working Hours for the trust I continue to attend the Regional Guardian of Safe Working Forum, to ensure we are working in line with other trusts in the region. Since the last report, our rotas remain compliant, and the vast majority of our Junior Doctors are happy with their allocations. Our Junior Doctors Forum is supported by the Medical Director, HR and the Guardian of Safe Working into a single meeting on a 3 monthly basis in order to identify and correct persistent ongoing concerns from the Junior Doctors. We have received 38 Exception Reports (ERs) in Q2, which is down on previous Quarters, probably reflecting the influx of newly qualified doctors to the trust. The vast majority (84%) relate to doctors working in excess of their allocated hours, and reflects a busy acute workload

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

	generally. It is reassuring only 4 reports related to missed educational opportunities, and the 2 safety concerns in this 3 month period come from a Psychiatric rotation at Hollins Park (which was sorted expeditiously). The big issue we have had with Exception Reporting is the failure of the Junior Doctors and their Educational Supervisors (ES) to get their reports signed off in a timely manner. This can lead to delays in our Junior Doctors being able to put in claims for time-off in lieu (TOIL) and/or compensatory payment. I am delighted that Lesley Sala has taken the task on personally to expedite quick and robust sign-off meetings, and we hope to see some progression here in Q3. We will still aim to encourage TOIL rather than compensatory payment, in an attempt to ensure our Juniors are not exceeding their maximum weekly hours for safe working (we will be able to mandate this once e-rostering is available for our rotas)			
PURPOSE: ***(please select as appropriate)***	Information ✓	Approval	To note ✓	Decision
RECOMMENDATION:				
PREVIOUSLY CONSIDERED BY:	**Committee**	Strategic People Committee		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome	N/A		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

SUBJECT	Guardian of Safe Working for Junior Doctors Q2 Report - 1st July 2019 – 31st Sept 2019	AGENDA REF:	BM/19/11/115

1. BACKGROUND/CONTEXT

The 2016 Junior Doctor Contract is now well established at WHH. Rotas for our doctors are fully compliant, and work schedule reviews are undertaken if there are persistent problems with certain rotas. Most juniors are on board to engage with their Consultants, Educational Supervisors (ESs) and Guardian of Safe Working, if any new issues develop. We have a Junior Doctors Forum every 3 months, which is attended by Alex Crowe, HR and the Guardian of Safe Working.

I continue to attend the Regional Guardian Forum, and am satisfied that we are in line with other trusts. Once again, I am pleased to be able to confirm that there has again been no escalation of an ER's to a Level 2 Review, although there have been 8 Level 1 Requests in this Quarter. The Trust has not incurred any fines since the last Report.

In the 2nd Quarter of this financial year (2019) we have total of 38 Exception Reports recorded. This will require close monitoring going forward, as well as improvements in the overall engagement process for sign-off and completion.

Rather than being seen as a concern for the trust, ERs help to identify any problem areas within the Trust for our junior doctors.

I will continue to reiterate the message to Junior Doctors and their Educational Supervisors that time-off in lieu (TOIL) is the preferred option for compensation following ERs.

The vast majority (84%) of ERs still relate to our F1 Doctors working past their allocated time, usually on an ad hoc basis. Interestingly, these have occurred primarily in General Surgery, Urology, and Trauma and Orthopaedics during this quarter. This is highly atypical when compared with other periods, where medicine has the most ERs, due to the high volume and acuity of the workload. This is partly due to the quieter nature of the medical posts in the summer months, but also due to extensive work done to enable safe staffing levels on the medical wards, to give our juniors the support they need.

Importantly, I can confirm that all 72 Foundation Programme Doctors employed during this period were well on track to progress through their current year of training.

Concerns remain that there is significant delay in the review meetings between ES and Junior Doctor, once an ER has been submitted. Lesley Sala is tackling this issue currently, aiming to clear all ERs within 4 weeks of submission. This is also being reiterated at the Junior Doctors Forum and the Trust Induction for our junior doctors.

Any difficulties with the sign-off process will be escalated to the Education Department or the Guardian of Safe Working for action.

Junior Doctors on the 2002 Contract

It is important to remember that some Junior Doctors (employed by the Lead Employer) will remain on the 2002 contract for a number of years. Such doctors are therefore not on the 2016 Contract and will require their rotas to be monitored in line with their terms and conditions, so that assurance can be given for all doctors in training and not just those on the new contract. It is hoped in the future that these doctors will be incorporated onto the 2016 contract

We remain cognisant of a recent Case Law (Hallett vs Derby) which effects Trust's using ALLOCATE for monitoring exercises; a further update will be provided in due course.
These Doctors (n= 41) therefore do not form part of this report which is focused on Junior Doctors on the 2016 Contract.

2. KEY ELEMENTS

In reviewing the data the current trends have been identified as follows:

- ER Sign off remains a concern regarding the Q2 position
- Six ERs which did not record a "breach type" from the trainee reporting through Allocate.
- There were a total of 36 ERs reported by FY1 doctors and only 2 submissions from FY2s
- In terms of specialty reporting, 9 ERs were from Medicine; 23 from General Surgery, 2 from Urology and 4 from T&O.
- 32ERs related to late working hours, 4 from missed educational opportunities, and 2 safety issues pertaining to an on call rota (psychiatric rotation at Hollins Park).
- Our report submitted to Lead Employer identified that there was one CT1/2 exception report in O&G, 2 CT1/2s in Respiratory, and I CT1/2 in Gastroenterology i.e. a total of 5 ER's in Q2. The required data submission date was also achieved for Q2.

Quarterly Report on Safe Working Hours Data	
Reporting Time Period:	July 2019 - September 2019
Trust Name:	Warrington and Halton Hospitals NHS Foundation Trust
Guardian of Safe Working Hours Name:	Mark Tighe
SOSW Email Address:	mark.tighe@whh.nhs
No.of doctors/dentists in training (total)	285
No.of doctors/dentists in training on the 2016 contract TCS (total)	221
No. of lead employer trainees on the 2016 contract at your Trust	149
Amount of time available in job plan for Guardian to do the role	
Admin support provided to the Guardian (if any)	
Amount of job-planned time for educational supervisors	0.25 PAs per trainee

	Exception reports								Work Schedule Reviews								Fines by department	
Specialities	No.at CT1/2 Level		No.at ST3+ Level		No. given TOIL or payment			No. that are on-going	No.at CT1/2 Level		No.at ST3+ Level		No. given TOIL or payment			No. that are on-going	No.of fines levied	Values of fines levied
	Raised	Closed	Raised	Closed	TOIL	Payment	Other - Please Specify		Raised	Closed	Raised	Closed	TOIL	Payment	Other- Please Specify			
General Surgery (Inc HPB/OG/CR)																		
Urology																		
Gynaecology & obstretrics								1										
Orthopaedics																		
Vascular																		
ENT/ Head & Neck																		
Plastics (Inc. Burns)																		
Neuro																		
Cardiothoracic																		
Maxillofacial																		
Transplant																		
Anaesthetics																		
ITU																		
Paediatrics																		
Aemergency medicine (A&E)																		
General medicine (AMU)																		
Cardiology																		
Respiratory			2					2										
Gastroenterology								1										
Nephrology																		
Endocrinology (Inc. Diabetes)																		
Neurology																		
Stroke Medicine																		
Elderly care																		
Ophthalmology																		
Dermatology																		
Oncology																		
Haematology																		
Chemical / Histopathology																		
Microbiology																		
Radiology																		
Other (e.g. Psychiatry)																		

*If you have any additional comments, issues arising or concerns then please fully detail in the section below

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

The number of major issues noted in Q2 is thankfully down on previous quarters. This is reflected in a reduction in the number of ERs submitted, but more importantly the absence of any safety

concerns from our juniors in Warrington or Halton. I am satisfied that our junior doctors are happy with their compliant rotas, accepting the fact that it is the nature of their job that they will have to stay beyond their hours at times, if they have unwell patients or higher volume of work. Our main issue with the exception reporting at WHH is the delay in getting sign-off for the reports. Some supervisors are slow to respond to receipt of ERs, but the junior doctor can also be at fault for not signing the report off, once the exception meeting has taken place. Lesley Sala is tackling this problem currently, as we would like all our ERs signed off within 4 weeks of receipt.

We are looking into the problems for the juniors getting time off for mandatory training. On discussions with the Regional Guardian and other HR departments, we should be facilitating time off at work for juniors to complete the trust requirement for training. If this is not allowed, then the juniors will be encouraged to exception report in the future.

There have been no work schedule reviews in Q2, which reflects the introduction of new doctors into established rotas in the F1 and F2 posts

The 2 immediate safety concerns related to a psychiatric rota at Hollins Park – this was resolved by the Guardian there expeditiously, and no further concerns have been raised.

Finally, I am a little surprised there have been no ERs from AED in Q2. I have had discussions with some of the F2s, who are a little unhappy with their rotas, in particular, the number of weekends they are allocated to work. I think this needs exploring in the next Quarter, and possibly liaising with the rota coordinator there.

4. IMPACT ON QPS?

5. MEASUREMENTS/EVALUATIONS

High level data essential for National Data Collection:

Key Indicators	Figures/Dates
Number of WHH doctors in training:	72
Number of WHH doctors in training on 2016 TCS	72
Number of Doctors in Training on the 2002 TCS (inclusive of all Trainees & Lead Employer Trainees)	41
Reference period of report	1st July 2019 – 31st Sept 2019
Total number of exception reports received	38
Number relating to immediate patient safety issues	2 – Psychiatry (Hollins Park)
Number relating to working hours/pattern	32
Number relating to educational opportunities	4
Number of Exception Reports that remain Pending	38 (100%)
Number relating to service support available to the doctor	2 (listed twice but same incident)
Total hours of TOIL granted	**38 with no Outcome**
Total incidences of overtime payments issued	**38 with no Outcome**
Total number of work schedule reviews	**1 – proposed by the GSW**
Total number of reports resulting in no action	**38 are not closed**
Total value of fines levied	**£0.00**

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Amount of time available in job plan for guardian to do the role:	**1.5PAs / 6 hours per week**
Admin support provided to the guardian (if any):	**0**
Amount of job-planned time for educational supervisors:	**0.25PA's per trainee**

Exception Reports

Exception reports relating to working hours by individual Rota/ Grade				
Specialty Total = 13	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
A&E	**0**	**0**	**0**	**0**
F1	**3**	**6**	**0**	**5**
F2	**0**	**0**	**0**	**0**
CT1-2/ST1-2	**0**	**0**	**0**	**0**
ST3-8	**1**	**1**	**0**	**1**
Acute Medicine	**0**	**0**	**0**	**0**
F1	**1**	**1**	**0**	**0**
F2	**0**	**0**	**0**	**0**
CT1-2/ST1-2	**0**	**0**	**0**	**0**
ST3-8	**0**	**0**	**0**	**0**
Cardiology	**0**	**0**	**0**	**0**
F1	**0**	**0**	**0**	**0**
F2	**0**	**0**	**0**	**0**
CT1-2/ST1-2	**0**	**0**	**0**	**0**
ST3-8	**0**	**0**	**0**	**0**
Total	**5**	**8**	**0**	**6**
Exception reports relating to missed training opportunities by department/division				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
General Surgery	**1**	**1**	**0**	**1**
Total	**1**	**1**	**0**	**1**
Exception reports (response time)				
	Addressed within 48 hours	**Addressed within 7 days**	**Addressed in longer than 7 days**	**Still open**
Working hours	0	0	0	**31**
F1	0	0	0	36
F2	0	0	0	2
CT1-2 / ST1-2	0	0	0	0
ST3-8	0	0	0	0

Missed training	0	0	0	**4**
F1	0	0	0	4
F2	0	0	0	0
CT1-2 / ST1-2	0	0	0	0
ST3-8	0	0	0	0
Safety	0	0	0	**1**
F1	0	0	0	0
F2	0	0	0	1
CT1-2 / ST1-2	0	0	0	0
ST3-8	0	0	0	0
Total	**0**	**0**	**0**	**38**

Fines

There have been no reported fines with reference to Exception Reporting in relation to the Q2 Reporting period.

Fines by department			
Department	Breach reason		Value of fines levied (£)
Total	**None**		**£0**
Fines (cumulative)			
Balance at end of last quarter	Fines this quarter	Disbursements this quarter	Balance at end of this quarter
£0	**£0**	**£0**	**£0**

6. TRAJECTORIES/OBJECTIVES AGREED

Under the change of structure from Medical Staffing/HR to Medical Education, the Service will begin to run month-end Exception Reports - beginning the **31.10.19,** to identify Exception Reports that have not been signed-off to improve our the turnaround times, in accordance with the NHS Employers time lines as follows:

1. Exception Reports should be completed ASAP, but no later than 14 days of the Exception being submitted through Allocate.

2. Where the trainee is seeking payment as compensation, the report should be submitted within 7 days.

3. For EVERY Exception Report submitted, ether for payment or TOIL; it is the Educational Supervisor who is required to respond to the Exception Report within 7 days.

4. The Trainees need to indicate "acceptance" or "escalate" to the next stage (Level 1 Review). It is only following confirmation of acceptance, that the Exception Report can be closed.

The GSW will be provided with timely data reports to support his role in the coming year, with particular reference to improvement in response times for ERs.

7. MONITORING/REPORTING ROUTES

Copies of the Guardian of Safe Working Hours' Reports, both the Quarterly and Annual Reports should also be provided to the LNC – Local Negotiating Committee. The Annual Report is also required to be included in the Trust's Annual Quality Account) and signed off by the Chief Executive, the contents of both reports may be included or referenced in Annual Reports provided by the Employer to HEE, Care Quality Commission (CQC) and/or the General Medical Council (GMC)

It is also normal practice for the Trust's Executive Committee (Strategic People Committee) to have sight of the Reports before they are submitted to eth Board as the Executive Committee may be able to describe to corporate responses to the issued raised by the Guardian of Safe Working and to provide relevant advice.

It might also be good practice to share a copy of the report with the Junior Doctors Forum of the employing/host Organisation. Guardians of Safe Working may also wish to share the data across regional networks to allow for aggregated regional and/or national analysis.

8. TIMELINES

SPC – Strategic People Committee
Guardian of Safe Working - Quarterly Reports, Safe Working Hours Jnr Doctors in Training:-

- (Q1 – end of June 2019) –*submitted for Sept*
- (Q2 – end of Sept 2019) – *submitted for November* 2019
- (Q3 - end of Dec 2019) – will be submitted for Jan 2020
- (Q4 – end of March 2020) – will be submitted for May 2020

Trust Annual Board Report
Guardian of Safe Working Annual Report, Safe Working Hours Jnr Doctors in Training:-

- *submitted for May 2020*

9. ASSURANCE COMMITTEE

N/A

10. RECOMMENDATIONS

In summary, this has been a relatively steady quarter in terms of exception reporting. The 38 reports is a little down on previous quarters, and likely reflects the change of junior staff in August, with the introduction of newly qualified doctors into our F1 posts. Most of the ERs were in general surgery, which is unexpected, but these generally reflect staying late to complete jobs, or when asked to assist in theatre. There have been no safety concerns in Q2 in WHH, nor any work schedule reviews to sort non-compliant rotas. Only 4 ERs relate to missed educational opportunities, and this is reassuring considering the workload of our juniors, and the good amount of teaching offered to our junior doctors.

I am pleased that the Education Department has taken ownership of the monitoring process, and Lesley Sala in particular is very motivated to sort the perennial problem of closing off ERs quickly and efficiently. This will ensure that our juniors can receive the compensation they deserve, and for us to be able to highlight and act on ongoing concerns with rotas and working hours. At the end of the day, our remit is that our junior doctors are able to work safely and effectively, for their benefit and our patients in the trust.

There are no new significant areas of concern arising from the data in Q2. However, we will need to be aware of potential problems going forward, especially in areas of under-reporting, as documented in AED in the last quarter.

To conclude, I am currently satisfied with the overall safety of working hours in our organisation. I would ask the board to note the report, and consider the assurances made accordingly. I remain happy to attend the Board meeting if any queries or concerns are raised.

Mr Mark Tighe – Guardian of Safe Working
November 2019

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/19/11/116**
SUBJECT:	**Trust Engagement Dashboard – half year report 2019**
DATE OF MEETING:	27 November 2019
ACTION REQUIRED	**For Assurance**
AUTHOR(S):	Pat McLaren, Director Community Engagement
EXECUTIVE SPONSOR	Pat McLaren, Director of Community Engagement + Fundraising
LINK TO STRATEGIC OBJECTIVES:	All
EXECUTIVE SUMMARY	The Trust has launched its first patient and public participation and involvement strategy for 2019-21, a measure of the success of the deployment of this strategy is the attached Engagement Dashboard. **The Dashboard addresses:** - Level of success in managing the Trust's reputation in the media and across digital and social platforms - Our engagement with patients, staff and public via our social media - The Trust's website and levels engagement with this key platform - Patient enquiries via our website - Patient feedback on the independent platforms - Engagement with the Trust through the Freedom of Information process. **Key items to note:** • **Media** – has steadied again after high volume of negative media reports in the summer • **Twitter** followers continue to grow steadily and are now at 10.85K • **Facebook** likes have more than doubled in the first six months and now exceed 10K • **Website visitors** are steady at around 26K per month (following large surge in June due to media issue) • **Website accessibility** – mobile devices are by far the most common platform used • **Website enquiries** – we dealt with 1,056 enquiries through the website • **FOI** We have received, processed and returned 272 Freedom of Information requests. • **Patient Feedback:** We continue to be highly rated on independent feedback platforms, achieving a 4.5* rating on NHS Choices for Warrington Hospital for the first time. **To note** that NHS Choices has since ceased

<table>
<tr><td></td><td>the publication of ratings for individual sites and are now only reporting on Trusts.

Acute providers Cheshire and Merseyside - NHS CHOICES ratings at 18.10.19

<table><tr><th>Trust</th><th>No of Reviews</th><th>Stars</th><th>Ratings index</th></tr><tr><td>Warrington and Halton Hospitals</td><td>21</td><td>4.5</td><td>40.5</td></tr><tr><td>Southport and Ormskirk</td><td>20</td><td>4</td><td>32</td></tr><tr><td>Aintree Hospital</td><td>16</td><td>5</td><td>30</td></tr><tr><td>Royal Liverpool and Broadgreen</td><td>17</td><td>3.5</td><td>24.5</td></tr><tr><td>St Helen's & Knowsley</td><td>15</td><td>4</td><td>20</td></tr><tr><td>Countess of Chester</td><td>14</td><td>3</td><td>12</td></tr><tr><td>Wirral University Hospital</td><td>13</td><td>3.5</td><td>10.5</td></tr><tr><td>Mid Cheshire</td><td>5</td><td>5</td><td>10</td></tr><tr><td>East Cheshire</td><td>4</td><td>3.5</td><td>3.5</td></tr></table>
The Trust rates in the top 3 in the region compared with peers but is highest ranked when weighted with total reviews.</td></tr>
<tr><td>PURPOSE: (please select as appropriate</td><td>Information
X</td><td>Approval</td><td>To note
X</td><td>Decision</td></tr>
<tr><td>RECOMMENDATIONS</td><td colspan="4">That the Trust Board receives the dashboard for assurance.</td></tr>
<tr><td>PREVIOUSLY CONSIDERED BY</td><td>Committee</td><td colspan="3">Council of Governors</td></tr>
<tr><td></td><td>Agenda Ref.</td><td colspan="3">COG/19/11/65</td></tr>
<tr><td></td><td>Date of meeting</td><td colspan="3">14/11/2019</td></tr>
<tr><td></td><td>Summary of Outcome</td><td colspan="3">Present to Trust Board</td></tr>
<tr><td>NEXT STEPS:
State whether this report needs to be referred to at another meeting or requires additional monitoring</td><td colspan="4">None</td></tr>
<tr><td>FREEDOM OF INFORMATION STATUS (FOIA):</td><td colspan="4">Release Document in Full</td></tr>
<tr><td>FOIA EXEMPTIONS APPLIED: (if relevant)</td><td colspan="4">None</td></tr>
</table>

Warrington and Halton Hospitals NHS Foundation Trust

Involving Patients, Carers, Visitors, Staff, Public and Media

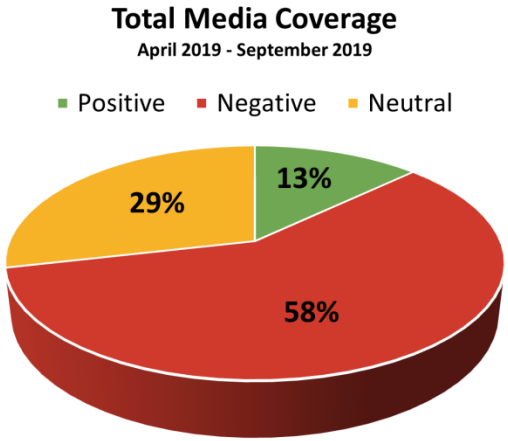
Trust Engagement Dashboard

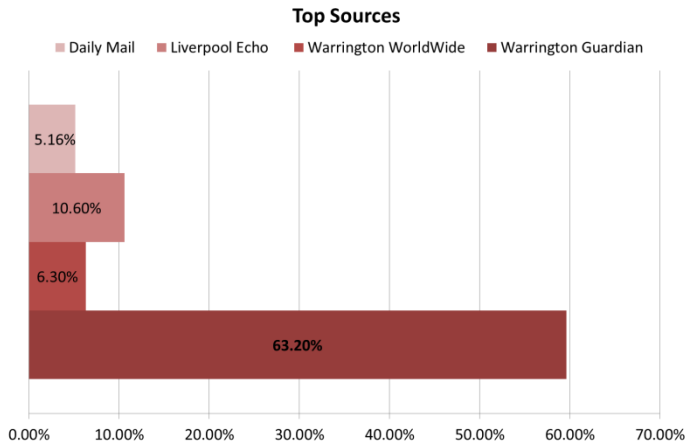
April 2019 – September 2019

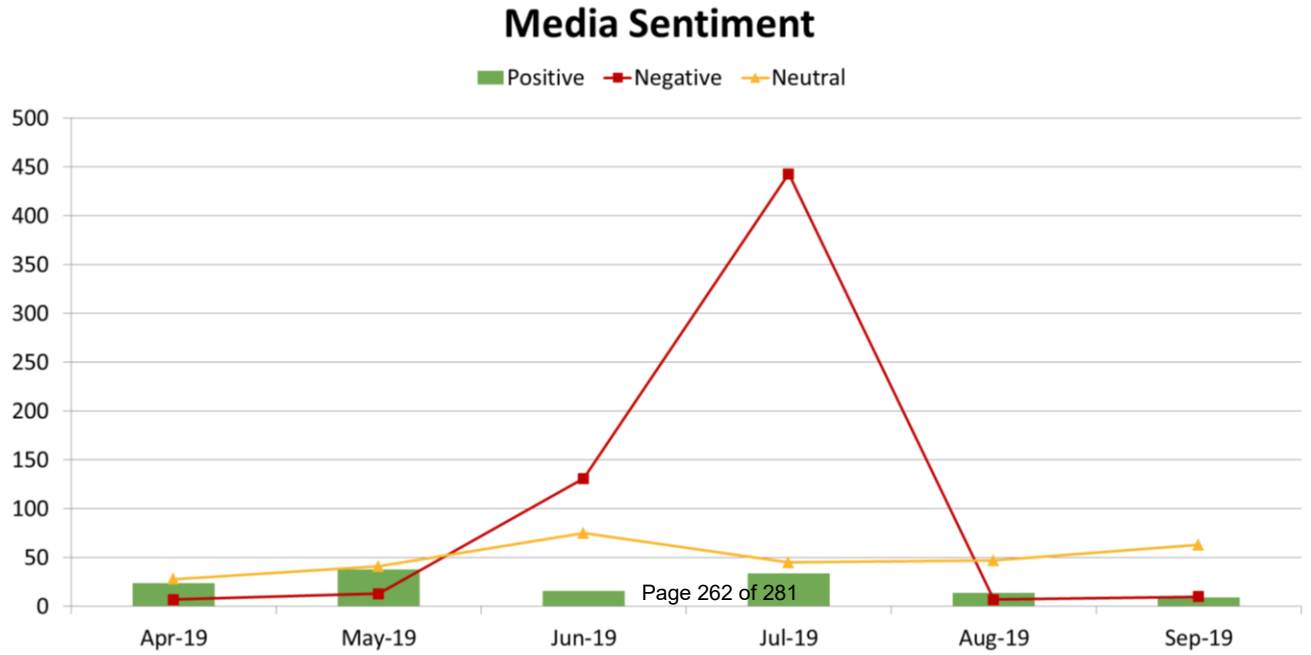
Media Sentiment:

April 2019 – September 2019

Warrington and Halton Hospitals NHS Foundation Trust







Social Media:

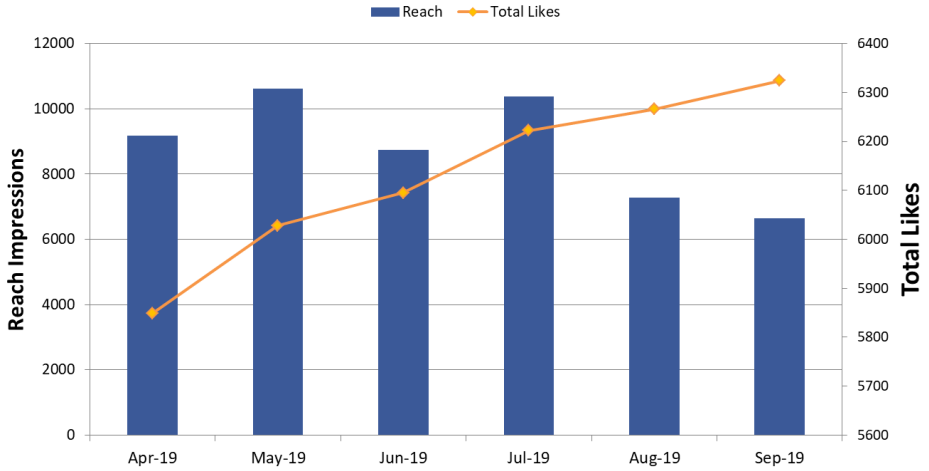
April 2019 – September 2019

NHS Warrington and Halton Hospitals NHS Foundation Trust

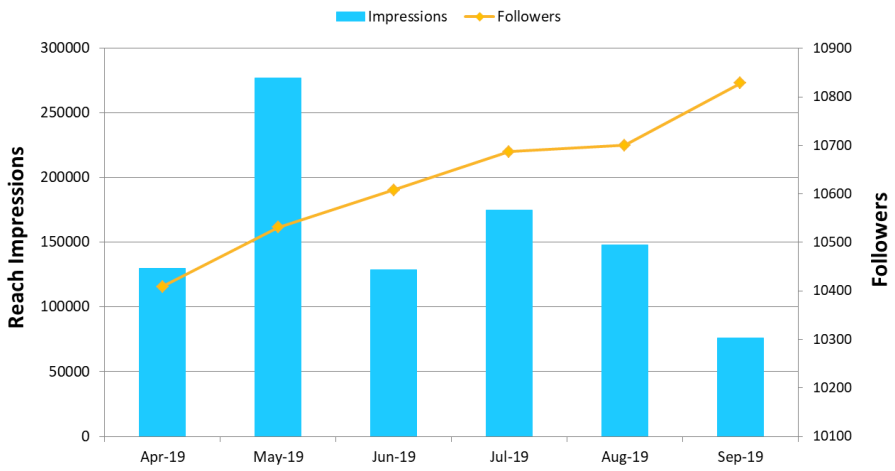
facebook

twitter

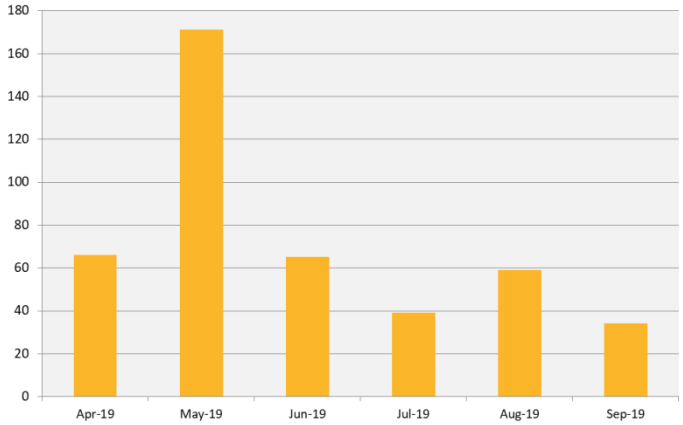
FACEBOOK ENGAGEMENT



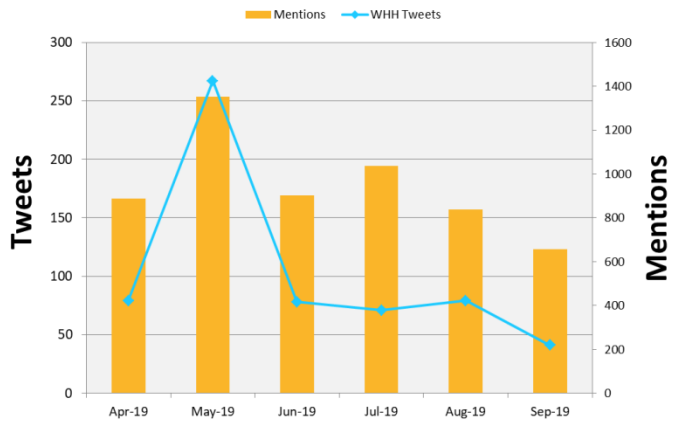
TWITTER ENGAGEMENT



WHH Posts



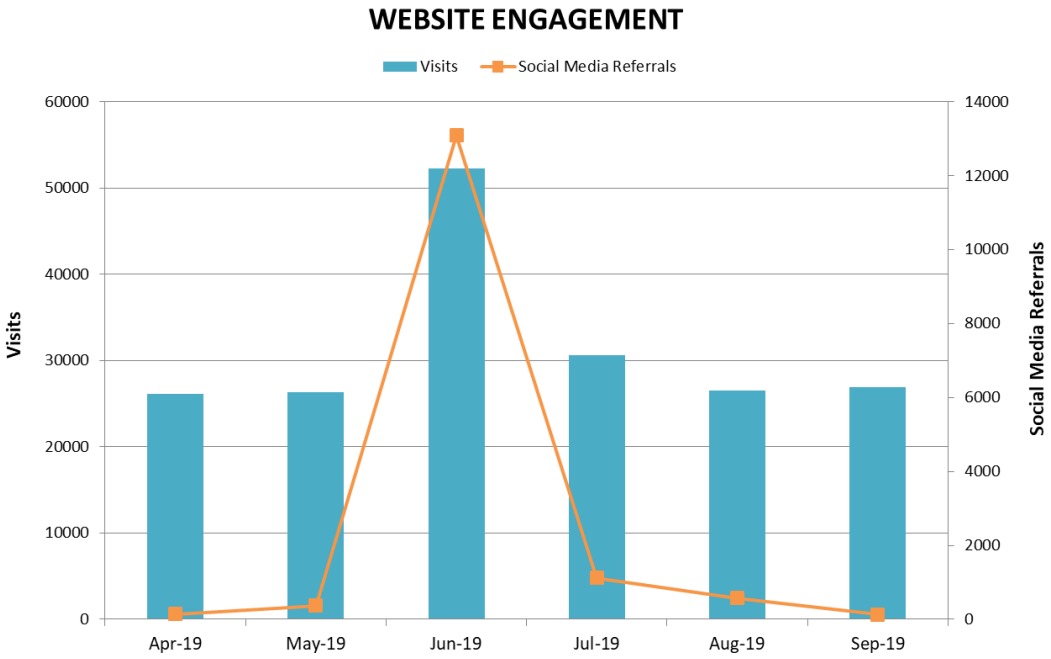
WHH Tweets

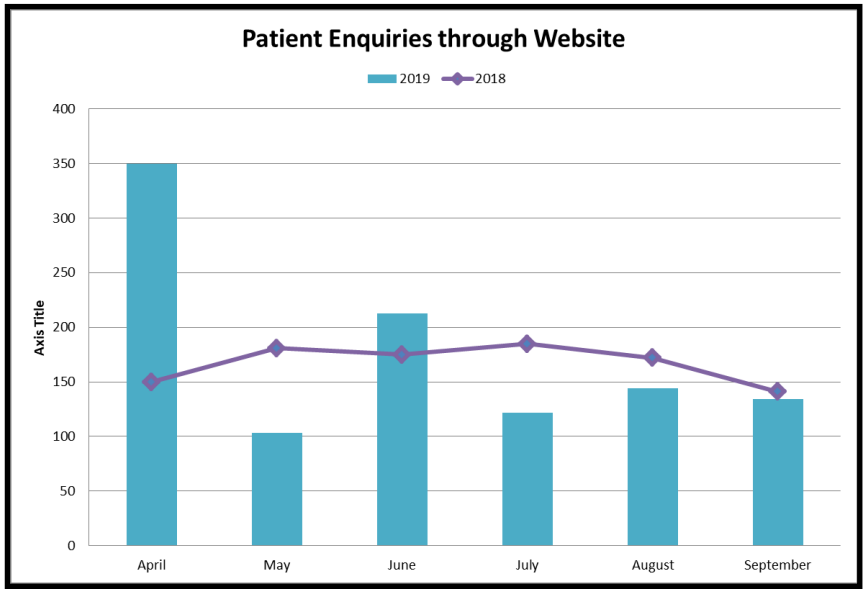


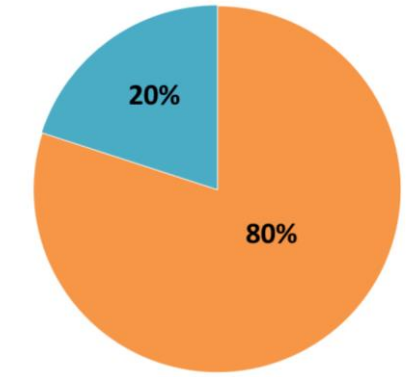
WHH Website:

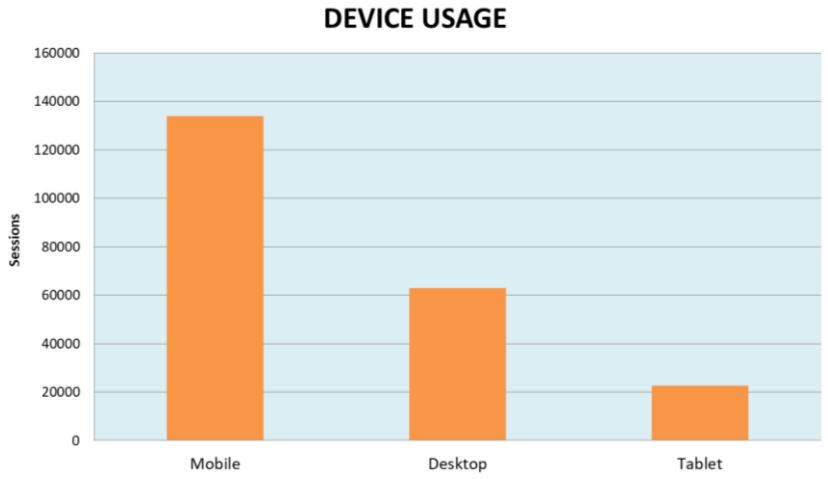
April 2019 – September 2019

Warrington and Halton Hospitals NHS Foundation Trust





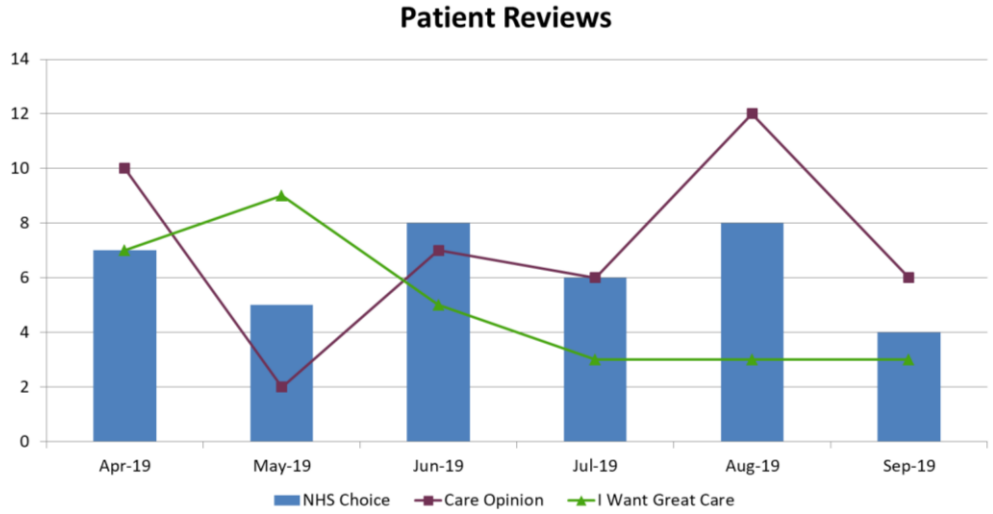


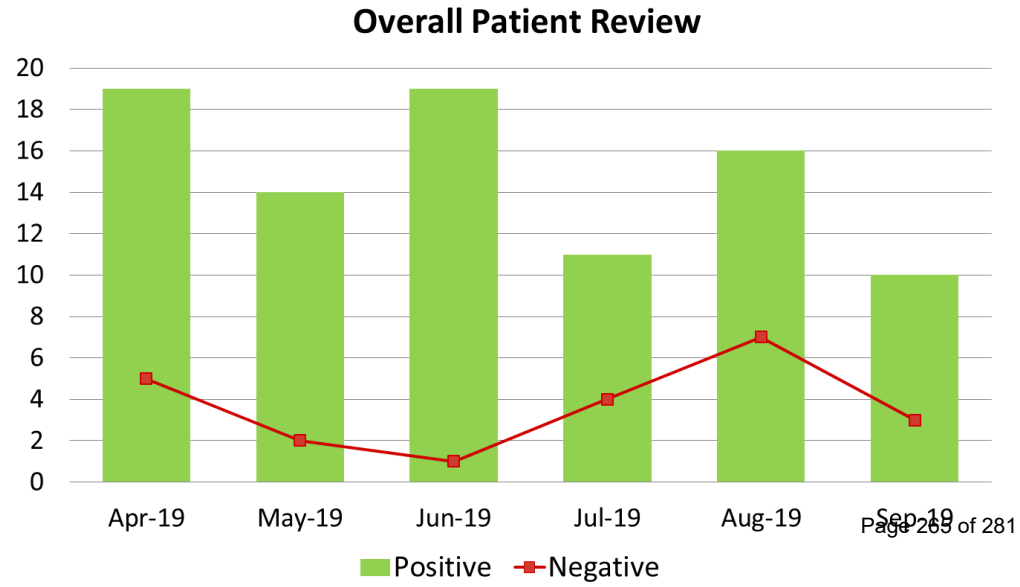


Patient Experience:

April 2019 – September 2019

Warrington and Halton Hospitals NHS Foundation Trust





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Feedback Rating by NHS Choices

4.5
Average rating at Warrington

5
Average rating at Halton

5
Average rating at CMTC

Feedback Rating by Care Opinion

3.5
Average rating at Warrington

4
Average rating at Halton

4
Average rating at CMTC

Feedback Rating by iWantGreatCare

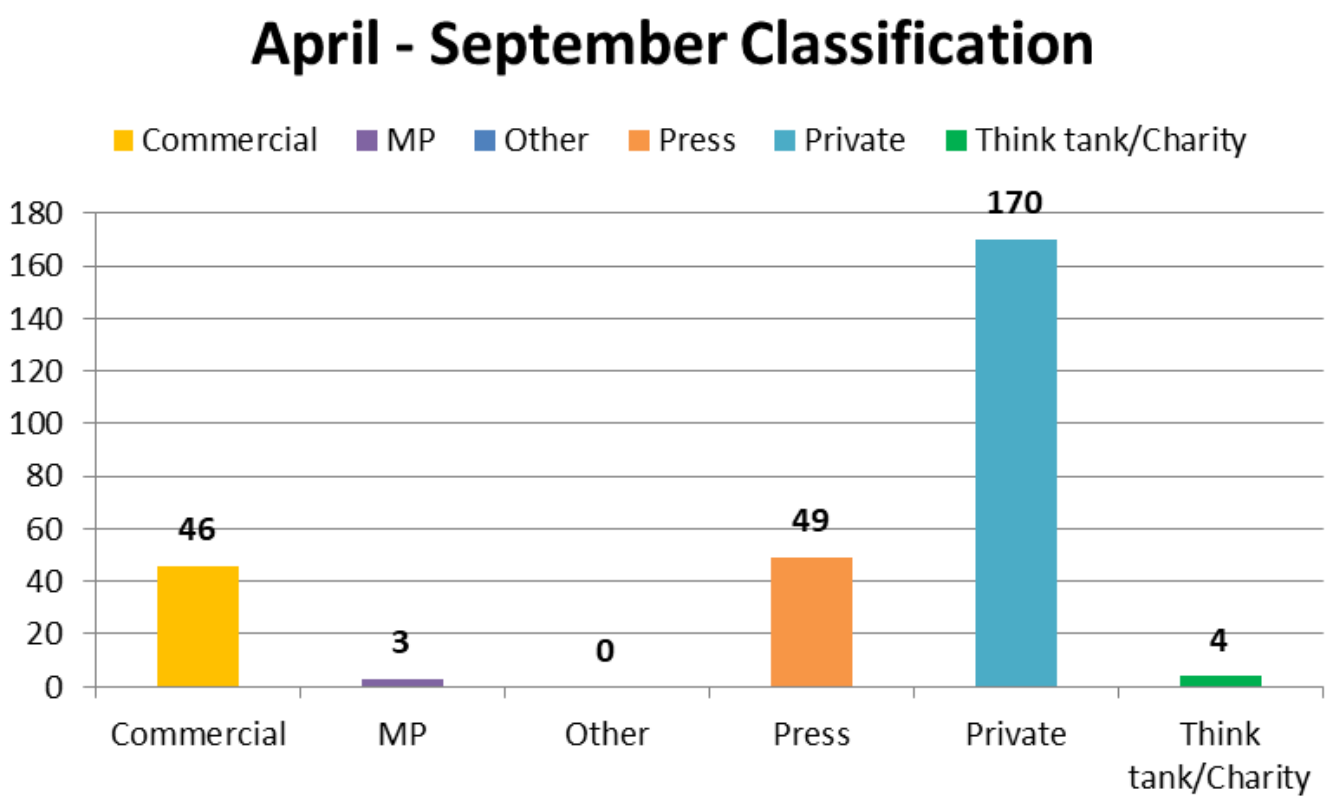
5
Average rating at Warrington

5
Average rating at Halton

5
Average rating at CMTC

Freedom of Information Requests:
April 2019 – September 2019

Warrington and Halton Hospitals NHS Foundation Trust



Total Freedom of Information request from April 2019:
272 (unaudited)

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NHS Warrington and Halton Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/19/11/117**			
SUBJECT:	**Freedom to Speak up**			
DATE OF MEETING:	27 November 2019			
AUTHOR(S):	Jane Hurst, Deputy Director of Finance, Strategy			
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse			
LINK TO STRATEGIC OBJECTIVES:	SO1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience			
	SO2: We will .. Be the best place to work with a diverse, engaged workforce that is fit for the future			
EXECUTIVE SUMMARY (KEY ISSUES):	The purpose of this paper is to update the Trust Board on the activity of the Freedom to Speak Up (FTSU) Team during National FTSU Month of October.			
PURPOSE: (please select as appropriate)	Information	Approval	To note x	Decision
RECOMMENDATION:				
PREVIOUSLY CONSIDERED BY:	**Committee**	Strategic People Committee		
	Agenda Ref.			
	Date of meeting	20 November 2019		
	Summary of Outcome	noted		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

TRUST BOARD

SUBJECT	Freedom to Speak Up	AGENDA REF:	BM/19/11/117

1. BACKGROUND/CONTEXT

The purpose of this paper is to update the Trust Board on the activity of the Freedom to Speak Up (FTSU) Team during National FTSU Month October.

2. KEY ELEMENTS

In 2019/20 (April to 17 October 2019) the FTSU team received the following disclosures.

Table 1 Disclosures in 2019/20

Quarter 1	5
Quarter 2	2
October	13
Total	**20**

The significant increase in October relates to the additional activity undertaken by the team during October. The cases can be grouped as follows:-

Table 2 Types of disclosures in 2019/20

Behaviour and relationships	12
Patient safety	2
Staffing levels	1
Health and Safety	3
Patient Experience	1
Estates	1
Total	**20**

The issues have been across different operational areas and all have been managed through discussion or support from HR or senior nursing. All the behaviour issues have been shared with HR for further review and investigation were appropriate.

There have been 2 patient safety concerns, 1 was reviewed and ward manager was made aware of concern of record keeping issue. The second has just been raised and is being investigated by the Deputy Director of Nursing.

The estates and communications issues have been passed on to the relevant departments.

3. ACTIVITY UNDERTAKEN

The team continues to attend meetings and training sessions across the Trust but recognises the number of disclosures dropped in quarter 2. The group embraced the national FTSU

month and in October has visited many of the wards and department, delivering posters, information, sweets, chocolates, FTSU pens and post it notes. FTSU was the hot topic at the safety huddle week commencing 7th October 2019 and had a stand at Warrington on the 8th October and 21st October at Halton.




The communications and visits in October have resulted in 14 new potential champions and 13 disclosures in the month of October. The team is also working with the HR department to identify the best options to roll out training in FTSU across the Trust, in line with the latest guidance from the national team.

Given the increase in cases in October the Team will continue to monitor the number of disclosures and assess the resource in place to manage the workload. It has been advised nationally that the role should be covered by a dedicated member of staff, our Trust approach has been to increase the number of Champions to raise awareness across the Trust rather than one individual.

4. RECOMMENDATIONS

The Trust Board is asked to note the progress of Freedom To Speak Up.

We are WHH

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/19/11/118**			
SUBJECT:	**Flu Programme 2019**			
DATE OF MEETING:	27 November 2019			
AUTHOR(S):	Deborah Smith, Deputy Director of HR and OD Caroline Eardley, Workplace Health and Wellbeing Lead Nurse			
EXECUTIVE DIRECTOR SPONSOR:	Michelle Cloney, Director of HR & OD			
LINK TO STRATEGIC OBJECTIVES:	SO2: We will .. Be the best place to work with a diverse, engaged workforce that is fit for the future			
	SO1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience			
EXECUTIVE SUMMARY (KEY ISSUES):	This paper provides an update to Trust Board on the Influenza Vaccination Programme for 2019 and provides assurance that the Trust is meeting the requirements set out by NHS England / Improvement.			
PURPOSE: (please select as appropriate)	Information x	Approval	To note	Decision
RECOMMENDATION:	Trust Board are asked to note the report			
PREVIOUSLY CONSIDERED BY:	**Committee**	1T		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

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NAME OF COMMITTEE

SUBJECT	Flu Programme 2019	AGENDA REF:	BM/19/11/118

1. BACKGROUND

This paper provides an update to Trust Board on the Influenza Vaccination Programme for 2019 and provides assurance that the Trust is meeting the requirements set out by NHS England / Improvement.

In September 2019 Trust Board received a paper detailing the evaluation of the Influenza Vaccination Programme for 2018 and the programme for 2019. The Trust has since received a letter from NHS England / Improvement setting out a requirement to undertake an assessment against a best practice checklist and submit to Board by December 2019.

2. KEY ELEMENTS

2.1. Flu Programme 2019 Progress to Date

The 2019 Flu Programme launched in September 2019. The programme is being delivered as set out in the Trust Board paper submitted in September 2019 and includes:

- Regular Communications
- Employee Incentives
- Peer Vaccinators
- Accessible Clinics
- Visible Leadership

The Occupational Health Team has introduced Peer Vaccinators across the Trust to target front line staff. The Occupational Health Team continues to offer vaccines to all staff, including Corporate staff. This approach has been particularly successful. Current uptake of frontline staff is 61% and it is anticipated that the 80% uptake requirement will be met.

2.2. NHSI/E Best Practice Checklist- Self Assessment

NHSI/E has published the best practice checklist below. The Trust is required to undertake a self-assessment against the checklist and Board are asked to note the progress against each requirement.

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NHS Warrington and Halton Hospitals NHS Foundation Trust

A	Committed leadership	Evidence	Trust self-assessment
A1	Board record commitment to achieving the ambition of 100% of front line healthcare workers being vaccinated, and for any healthcare worker who decides on the balance of evidence and personal circumstance against getting the vaccine should anonymously mark their reason for doing so.	Board received a paper in September 2019 and recorded their commitment.	
A2	Trust has ordered and provided the quadrivalent (QIV) flu vaccine for healthcare workers (1).	Quadrivalent influenza vaccines for adults up to the age of 64 (amount 2750) Trivalent influenza vaccines for adults over 65 (amount 100)	
A3	Board receive an evaluation of the flu programme from 2018-19, including data, successes, challenges and lessons learnt (2,6)	Board received a paper in September 2019 which included an evaluation of the flu programme 2018.	
A4	Agree on a board champion for flu campaign (3,6)	Michelle Cloney Director of Human Resources & Organisational Development identified as board champion	
A5	All board members receive flu vaccination and publicise this (4,6)	Board members offered the vaccine on the 30th October 2019	
A6	Flu team formed with representatives from all directorates, staff groups and trade union representatives (3,6)	The Occupational Health Team lead on the vaccination programme and are supported by 23 peer vaccinators, trained to the National Minimum Standards and vaccinating within a Patient Group Direction. Weekly reports are sent to the board champion to cascade.	
A7	Flu team to meet regularly from Sept 2019 (4)	Weekly meetings are held to review the uptake and issues and any support required. Attendees include Occupational Health Team, HR Team and Staff Side.	
B	**Communications plan**		

B1	Rationale for the flu vaccination programme and facts to be published – sponsored by senior clinical leaders and trade unions (3,6)	This information is being published regularly throughout the programme as part of the Communications Plan.	
B2	Drop in clinics and mobile vaccination schedule to be published electronically, on social media and on paper (4)	Accessibility across a 24/7 programme with open access to all employees via peer vaccinator teams in each CBU and the Occupational Health team.	
B3	Board and senior managers having their vaccinations to be publicised (4)	This information is being published regularly throughout the programme as part of the Communications Plan.	
B4	Flu vaccination programme and access to vaccination on induction programmes (4)	Availability of vaccinations on induction programmes has been limited due to delivery of the vaccines however Peer Vaccinators are in place to target front line staff.	
B5	Programme to be publicised on screensavers, posters and social media (3, 5,6)	This information is being published regularly throughout the programme as part of the Communications Plan.	
B6	Weekly feedback on percentage uptake for directorates, teams and professional groups (3,6)	This information is being published regularly throughout the programme as part of the Communications Plan and is shared with the Board Champion and senior leadership team.	
C	**Flexible accessibility**		
C1	Peer vaccinators, ideally at least one in each clinical area to be identified, trained, released to vaccinate and empowered (3,6)	23 peer vaccinators, trained to the National Minimum Standards and vaccinating within a Patient Group Direction, working within each CBU, supporting the OH team. These are supported by the Chief Nurse to be released within the CBU to vaccinate	
C2	Schedule for easy access drop in clinics agreed (3)	All clinics offer ‘no appointment needed’ drop in format	
C3	Schedule for 24 hour mobile vaccinations to be agreed (3,6)	Effective utilisation of peer vaccinators to support coverage 24 hour 7 day operation, including early mornings, nights and weekends	
D	**Incentives**		

D1	Board to agree on incentives and how to publicise this (3,6)	Prize Draw for the lead peer vaccinator, logo pens, stickers showing visible support, chocolate and fruit vouchers for all vaccinated staff	
D2	Success to be celebrated weekly (3,6)	This information is being published regularly throughout the programme as part of the Communications Plan.	

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3. MEASUREMENTS/EVALUATIONS

Monthly returns will be submitted to Public Health England which will set out uptake and benchmark WHH against other Trusts. A full evaluation of the Flu Programme 2019-20 will be conducted in April 2020.

4. RECOMMENDATIONS

Trust Board are asked to:

- Note progress to date for the Flu Programme 2019;
- Note the self-assessment against the NHSI/E Best Practice Checklist

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/19/11/119**	
SUBJECT:	**Board Assurance Framework and Strategic Risk Register report**	
DATE OF MEETING:	27th November 2019	
AUTHOR(S):	John Culshaw, Head of Corporate Affairs	
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Chief Executive	
LINK TO STRATEGIC OBJECTIVE: (*Please select as appropriate*)	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience.	✓
	SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future.	✓
	SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.	✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): (*Please DELETE as appropriate*)	All	
EXECUTIVE SUMMARY *(KEY ISSUES):*	This is an update of strategic risks on the Trust Strategic Risk Register. It has been agreed that the Board receives an update on all strategic risks and any changes that have been made to the strategic risk register, following review at Quality Assurance Committee. A Risk Review Group has been established reporting to Quality Assurance Committee, for oversight and scrutiny of strategic risks and for a rolling programme of review of CBU risks, to ensure risks are being managed and escalated appropriately. Since the last meeting: • There are no new risks that are proposed for addition to the BAF; • There are no proposed amendments to the ratings of any risks currently on the BAF is reduced; • There are no proposed amendments to risk descriptions. • There no risks proposed for de-escalation from the BAF; Also included in the report are notable updates to existing risks.	
PURPOSE: *(please select as appropriate)*	Information	Approval ✓ / To note / Decision
RECOMMENDATION:	Discuss and approve the changes and updates to the Board Assurance Framework and Strategic Risk Register	
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee
	Agenda Ref.	QAC 19/11/177
	Date of meeting	5th November 2019
	Summary of Outcome	The Committee reviewed, discussed and approved the amendments
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None	

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

SUBJECT	Board Assurance Framework and Strategic Risk Register report	AGENDA REF:	BM/19/11/119

1. BACKGROUND/CONTEXT

This is an update of strategic risks on the Trust Strategic Risk Register. It has been agreed that the Board receives an update on all strategic risks and any changes that have been made to the strategic risk register, following review at Quality Assurance Committee. A Risk Review Group has been established reporting to Quality Assurance Committee, for oversight and scrutiny of strategic risks and for a rolling programme of review of CBU risks, to ensure risks are being managed and escalated appropriately.

The latest Board Assurance Framework (BAF) is included as Appendix 1.

2. KEY ELEMENTS

2.1 New Risks

There are no new risks that are proposed for addition to the BAF.

2.2 Amendments to risk ratings

There are no proposals to amend the ratings of any of the risks that are currently on the BAF

2.3 Amendments to risk titles

There are no proposals to amend the descriptions of any of the risks that are currently on the BAF.

2.4 Removal of Risks

There are no proposals to de-escalate any of the risks that are currently on the BAF

2.5 Existing Risks - Updates

Detailed below are the updates that have been made to the risks since the last meeting.

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
115	Failure to provide adequate staffing levels in some specialities and wards, caused by inability to fill vacancies, sickness, resulting in pressure on ward staff, potential impact on patient care and impact on Trust access and financial targets.	• September intake of nurses – 45 new recruits • 18 HCAs currently going through pre-employment checks • Further reduction in RN turnover – now 11.77% reduction of 3.22% since Nov 2018 • WHH are finalists in 3 categories in Burdett National Retention awards	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
		in London, presentations on the 19th Nov.	
134	Risk: Financial Sustainability a) Failure to sustain financial viability, caused by internal and external factors, leading to potential impact to patient safety, staff morale and enforcement/regulatory action being taken. b) Failure to deliver the financial position and a surplus places doubt over the future sustainability of the Trust. There is a risk that current and future loans cannot be repaid and this puts into question if the Trust is a going concern.	• Regular system assurance meeting taking place with the Regulator. • Hospital Infrastructure Programme (HIP) announcement. WHH not included in with phase 1 or phase 2 funding allocation. • Submitted 5 Year Plan on 1st Nov 2019, jointly with Warrington & Halton CCGs & Bridgewater Community Healthcare NHS FT and accepted the control total for the next 4 years. Support provided from CCGs to enable stability while undertaking the transformational changes required to improve sustainability. • Awaiting response from Administrators in relation to bad debt.	No impact on risk rating
135	Failure to retain medical trainee doctors caused by lack of recruitment resulting in risk to reputation and service provision	• IT Senior Leadership team including Capital Planning and budget reviews has submitted a range of investment needs including EPR procurement funding. • Digital 7 Year investment profiling	No impact on risk rating
224	Failure to meet the emergency access standard caused by system demands and pressures. Resulting in potential risk to trust reputation, financial impact and below expected Patient experience	• Trajectory achieved in Month 1, Month 2, Month 3, Month 4, Month 5 (84.97%) and Month 6 (81.67%) • 8 IMC live from 27th September 2019 • Integrated discharge Team now in place • Urgent Care Improvement Committee – 1 regulatory breach complete and 15/35 actions complete • Winter plan developed with system support	No impact on risk rating
701	Failure to provide continuity of services caused by the scheduled March 2019 EU Exit resulting in difficulties in procurement of medicines, medical devices and clinical and non-clinical consumables. The associated risk of increase in cost.	• Brexit Daily Sit Rep commencing 21st October 2019 • EU Exit Operation Plan – Pre & Post Brexit Escalation plan in place • Following the extension to the Article 50 period to 31 January 2019, daily SitReps have been suspended. NHSE/I have amended Brexit preparation timetables to further enhance preparedness. •	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
145	Influence within Cheshire & Merseyside a. Failure to deliver our strategic vision, including two new hospitals and vertical & horizontal collaboration, and influence sufficiently within the Cheshire & Merseyside Healthcare Partnership and beyond, may result in an inability to provide high quality sustainable services may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position. b. Failure to fund two new hospitals may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position.	• DoH launched Health Infrastructure Programme (HIP) announcing a £2.8b investment. WHH not included in the first 2 phases of investment. 27 Trusts have received funding with a further 13 TBC. The Trust has written to NHSP to seek support in raising the profile of our needs. • Pathology OBC received by the Trust Board and feedback provided has been included in the re-issued draft • Response received from Eastern Sector Cancer Hub SRO – Further clarification requested. • Detailed BCH/WHH Collaboration plan developed and received at the Joint Executive Meeting • In relation to Health Infrastrucrure Programme (HIP) funding, NHSP have agreed to use the Trust as a case study in their national campaign • In relation to the Eastern Sector Cancer Hub, Lead CCG Awaiting results from the NHSE stage 2 assurance process. Consultation now unlikely to take place before January 2020 at the earliest. A Decision is therefore not anticipated until mid 2020 • Confirmation received from the CCG that the procurement process re: UTC is no longer being pursued. Requirement to deliver the UTC specification at Runcorn by January 2020	No impact on risk rating
143	Failure to deliver essential Digital services, caused by a successfully executed Cyber Attack, resulting in loss of access to data and vital IT systems, resulting in potential patient harm, loss in productivity and damage to the Trust reputation.	• Responses to MIAA IT Health Check and Vulnerability Assessment Application Vulnerability Technical Report successfully completed. • Upgrading of all assets to Windows 10 are reporting 83% complete by NHS Digital leaving 17% to complete.	No impact on risk rating
241	Failure to retain medical trainee doctors caused by lack of recruitment resulting in risk to reputation and service provision	• Enhanced monitoring position to be reviewed in Q4 2019/20 when HEE visit Medicine	No impact on risk rating

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Warrington and Halton Hospitals NHS Foundation Trust

2.6 Risk Management Strategy Updates

We will continue to review the Board Assurance Framework, streamlining it to highlight focused strategic risks, against the Trust's revised clinical strategy and operational plan that will emphasise the matters that pose the most significant threat to the Trust. This process will continue to take place with appropriate input from the Committees of the Board and their Sub-Committees, with considerations of risk appetite and risk tolerance.

Corporate Risk Register

The Corporate Risk registers is now being shared across several Committees and Groups.

The Corporate risk register is a list of all the risks which may prevent the Trust from achieving its' Corporate objectives.

The risk register is comprised of all risks on the CBU and corporate risk registers which are identified as likely to affect the organisation at a corporate level.

The risk register is produced on a monthly basis and is presented at the following Committees:

- Risk Review Group
- Finance and Sustainability Committee
- Strategic People Committee
- Quality Assurance Committee
- Patient Safety and Effectiveness Sub Committee
- Operational Board

along with any oversight Committees of Strategic/Corporate risks.

3 RECOMMENDATIONS

Discuss and approve the changes and updates to the Board Assurance Framework and Strategic Risk Register

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

Trust Board

DATES 2019-2021

All meetings to be held in the Trust Conference Room

Date of Meeting	Agenda Settings	Deadline For Receipt of Papers	Papers Due Out
2019			
Wednesday 27 November	Thursday 7 Nov (EXECS)	Monday 18 November	**Wednesday 20 November**
2020			
Wednesday 29 January	Thursday 9 January (EXECS)	Monday 20 January	**Wednesday 22 January**
Wednesday 25 March	Thursday 5 March (EXECS)	Monday 16 March	**Wednesday 18 March**
Wednesday 27 May	Thursday 7 May (EXECS)	Monday 18 May	**Wednesday 20 May**
Wednesday 29 July	Thursday 9 July (EXECS)	Monday 20 July	**Wednesday 22 July**
Wednesday 30 September	Thursday 10 September (EXECS)	Monday 21 September	**Wednesday 23 September**
Wednesday 25 November	Thursday 5 November (EXECS)	Monday 16 November	**Wednesday 18 November**
2021			
Wednesday 27 January	Thursday 7 January (EXECS)	Monday 18 January	**Wednesday 20 January**
Wednesday 31 March	Thursday 10 March (EXECS)	Monday 22 March	**Wednesday 24 March**