WHH Board of Directors Meeting Part 1

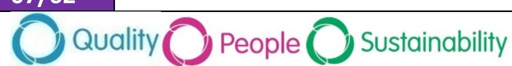
Wednesday 25 July 2018
9.30am-12.45pm
Trust Conference Room

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

Wednesday 25 July 2018 **9.30am - 12.45pm**

Trust Conference Room, Warrington Hospital

REF BM/18	ITEM	PRESENTER	PURPOSE	TIME	
BM/18/ 07/57	Junior Doctor Update/Trainee Engagement		Presentation	09.30	N/A
BM/18/ 07/58	Welcome, Apologies & Declarations of Interest	Terry Atherton, Deputy Chairman	N/A	09.50	Verbal
BM/18/ 07/59	Minutes of the previous meeting held 27 June 2018 PAGE 4	Terry Atherton, Deputy Chairman	Decision	09.52	Encl
BM/18/ 07/60	Actions & Matters Arising PAGE 8	Terry Atherton, Deputy Chairman	Assurance	09.55	Encl
BM/18/ 07/61	Chief Executive's Report incl PAGE 10 (a) CQC Steering Group update (b) Summary of NHS Providers Board papers	Mel Pickup, Chief Executive	Assurance	10:00	Verbal
BM/18/ 07/62	Chairman's Report	Terry Atherton, Deputy Chairman	Information	10:15	Verbal



BM/18/ 07/63	Integrated Performance Dashboard M3 and Assurance Committee Reports PAGE 23	All Executive Directors	Assurance	10.20	Enc
(a)	Quality Dashboard incl: PAGE 58 - Monthly Nurse Staffing Report April, May,June	Kimberley Salmon-Jamieson Chief Nurse			Enc
(b)	- Key Issues report Quality and Assurance Committee (3.07.2018) PAGE 77	Margaret Bamforth, Committee Chair			Enc
(c)	- Sustainability Dashboard				
(d)	- Finance and Sustainability Committee (23.05.2018 + 20.06.2018) PAGE 81	Terry Atherton, Committee Chair			Enc
(e)	- Workforce Committee 22.05.208, 19.06.2018 + 17.07.2018) PAGE 85	Michelle Cloney Director of HR&OD			Enc
BM/18/ 07/64	Proposed amendments to Trust IPR – Quality Section PAGE 96	Kimberley Salmon-Jamieson Chief Nurse	Assurance	10.50	Enc
BM/18/ 07/65	Spinal Services Update	Simon Constable Deputy Chief Executive/ Executive Medical Director		11.00	Verbal

Quality

BM/18/ 07/66	Annual Complaints Report PAGE 98	Kimberley Salmon-Jamieson Chief Nurse	Assurance	11.10	Enc
BM/18/ 07/67	Learning from Experience Summary Report Q4 (report sent under separate cover)	Kimberley Salmon-Jamieson Chief Nurse	Assurance	11.20	PPT
BM/18/ 07/68	CQC Update Report PAGE 112	Kimberley Salmon-Jamieson Chief Nurse	Assurance	11.30	Enc

BM/18/ 07/69	Medicines Management Annual Report PAGE 124	Simon Constable Deputy Chief Executive/ Executive Medical Director	Assurance	11.40	Enc

Sustainability

BM/18/ 07/70	Progress on Carter Report Recommendations & Use of Resource Assessment PAGE 134	Andrea McGee Director of Finance + Commercial Development	Assurance	11.45	Enc
BM/18/ 07/71	Scan 4 Safety PAGE 167	Andrea McGee Director of Finance + Commercial Development	Information	11.55	Enc

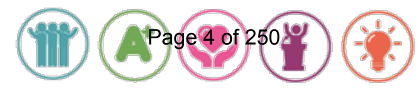
People

BM/18/ 07/72	Patient Experience Survey PAGE 170	Kimberley Salmon-Jamieson Chief Nurse	Assurance	12.05	Enc

GOVERNANCE

BM/18/ 07/73	Governance Review – People PAGE 182	Michelle Cloney Director of HR & OD	Assurance	12.15	Enc
BM/18/ 07/74	Strategic Risk Register + BAF PAGE 210	John Culshaw Head of Corporate Affairs	Assurance	12.25	Enc
BM/18/ 07/75	Chairs Annual Report - Quality Assurance Committee PAGE 223	Margaret Bamforth, Committee Chair	Assurance	12.30	Enc
BM/18/ 07/76	ToR and Annual Cycle of Business for ratification: (i) Council of Governors PAGE 235 (ii) Finance Resources Group PAGE 243	John Culshaw Head of Corporate Affairs	Assurance	12.35	Enc

BM/18/ 07/77	Any Other Business / Close	Terry Atherton, Deputy Chairman	N/A	12.40	Verbal
	Date of next meeting: 26 September 2018				



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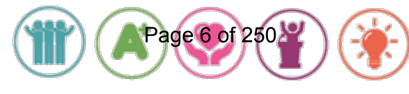
Warrington and Halton Hospitals NHS Foundation Trust
Minutes of the Board of Directors meeting held in Public on Wednesday 27 June 2018
Trust Conference Room, Warrington Hospital

Present	
Steve McGuirk (SMcG)	Chairman
Terry Atherton (TA)	Deputy Chair, Non-Executive Director
Simon Constable (SC)	Executive Medical Director/ Deputy Chief Executive
Andrea McGee (AMcG)	Director of Finance and Commercial Development
Kimberley Salmon-Jamieson (KSJ)	Chief Nurse
Jean-Noel Ezingeard (JNE)	Non-Executive Director
Ian Jones (IJ)	Non-Executive Director / Senior Independent Director
Anita Wainwright (AW)	Non-Executive Director
Margaret Bamforth (MB)	Non-Executive Director
In Attendance	
Michelle Cloney (MC)	Director of HR + OD
Alex Crowe (AC)	Medical Director and Chief Clinical Information Officer
Jason DaCosta (JDaC)	Director of IM&T
Lucy Gardner (LC)	Director of Transformation
Pat McLaren (PMcL)	Director of Community Engagement
Dan Moore (DM)	Deputy Chief Operating Officer
John Culshaw (JC)	Head of Corporate Affairs
Julie Burke (JB)	Secretary to Trust Board (Minutes)
Observing	
Alison Kinross	Governor
Cllr Peter Lloyd-Jones	Public Governor, Halton Borough Council
Apologies	
Mel Pickup (MP)	Chief Executive
Chris Evans (CE)	Chief Operating officer

Agenda Ref BM/18/06/	
BM/18/06/	**Welcome, Apologies & Declarations of Interest** The Chairman opened the meeting, and welcomed those in attendance. Apologies: as above. Declarations of Interest: None were noted
BM/18/06/53	**Minutes of the meeting held 24 May 2018 Part 1a and 1b** Part 1a, page 8 BM/18/05/44 penultimate sentence of first paragraph to read .. to a maximum value of £24,444k. With this amendment, the minutes of 24 May 2018 were agreed as an accurate record of proceedings.
BM/18/06/54	**Actions and Matters Arising** Actions closed since the last meeting were noted and outstanding actions reviewed. BM/17/04/59. Support from University of Chester to incorporate 'teaching' element into Branding for WHH. Proposals to be shared with Governors Engagement Group with final proposals to a future COG for approval. Action Closed. BM/17/01/12. PMcL reported that the refreshed WHH Charity Strategy had been discussed at the Charitable Funds Committee today. Changes agreed to be discussed at Executive Time Out 6 July and circulated to Charitable Funds Committee for approval through Chairs Action

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

	ahead of formal ratification at the CFC on 16 August.
BM/18/06/55	**Briefing on outcomes of the Royal College of Surgeons (RCS) Invited Service Review** The Executive Medical Director provided an update to Board on the RCS Review which had been reported and discussed at previous Board meetings. - On 22nd September 2017, following an Executive Safety Review Panel, the Trust took the decision to voluntarily suspend all spinal surgery at WHH pending completion of a comprehensive internal investigation. The decision was taken following four serious (but apparently unrelated) incidents. The incidents involved different pathologies, different indications for surgery, different operations and subsequently different post-operative complications. All index cases had been subject to a multi-disciplinary team process. On 27th September 2017 NHS Warrington CCG issued a formal suspension notice. - The Trust, NHS Warrington CCG and NHS England Specialist Commissioning jointly commissioned an independent expert review from the Royal College of Surgeons through the RCS Invited Review Mechanism. A desktop review of documents and interviews were undertaken over two days by the RCS team on 2nd and 3rd November 2017, followed by subsequent further document reviews. - The Trust received the report in February which contained patient identifiable information. Due to data protection regulations and Duty of Candour, all commissioning organisations sought their own legal advice to agree the information that could be shared with patients and families and an agreed redacted version of the report had been received. SC advised that patients/families had received their own full unredacted section of the report. - Key findings of the RCS review included the 'hub and spoke' relationship with The Walton Centre had not been functioning sufficiently well to ensure it was capable of providing the necessary reassurance in relation to clinical decision-making. This was one of the key recommendations by the Chair of the Clinical Reference Group (CRG) in 2015 and that outcome data had not been uploaded systematically into the British Spine Registry. The Trust did make efforts to implement the CRG recommendations and all action points pertaining solely to the Trust were introduced. However, it is accepted that a more structured approach from the outset would have better allayed any concerns from commissioning partners. The report does not conclude that any direct harm flowed from any suggested deficiency in full implementation of the CRG recommendations. - The RCS suggested a future 'road map' for the recommencement of services should the Trust and its Commissioners wish to do so which would provide robust governance arrangements. However this has been superceded as WHHFT is now part of discussions with all spinal providers in Cheshire and Merseyside as the aspiration is for provision of a high quality, single spinal surgery service for the region, with the intention of keeping access for patients as local as possible with 2 workstreams, one for specialist spinal trauma and one for complex deformity and cancer work. Learning from the report will be disseminated through the C&M Spinal Network.



We are WHH

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	- SC re-assured the Board that the Trust had already strengthened governance processes, strengthened recording of incidents and mortality and embedded processes to share learning and best practice. - The Chairman thanked SC and informed those present that the Board had debated the full report in Private session due to Freedom of Information and Data Protection restrictions whilst showing complete transparency within these restrictions. - With reference to the 2015 A Cole report, SC commented the report had been commissioned by NHSE (Specialised Commissioning) relating to clinical access and cost effectiveness, not patient safety. It had reviewed patient access to complex services and waiting times at The Walton Centre and WHH to bring different clinical practices together at the Walton Centre which are neurological and orthopaedic spinal services respectively. The Board noted the actions taken to date and SC reassured the Board that the Trust had implemented 19 of the 24 recommendations within the A Cole Report. - In relation to continued suspension of the service at WHH, SC reassured the Board that patients are being looked after by other providers including the Walton Centre which is monitored on a monthly basis. Two consultants continue to providing consultancy advice at WHH for spinal emergencies. - SC and the Chairman, on behalf of the Trust emphasised its regret and sincere apologies to those patients and families whose serious incidents prompted the suspension of the service, together with the many patients who have experienced inconvenience by the ongoing suspension of the service and the need for them to be transferred to alternative providers. • **The Board noted the report.**
BM/18/06/56	**Resubmission of Operational Plan 2018-19** The Director of Finance + Commercial Development highlighted key areas for the Board to note following the re-submission of the Operational Plan. The Plan had been presented, reviewed and supported at the Finance and Sustainability Committee on 20 June. - The Trust had submitted the 2018/19 Operational Plan to NHSI on 30 April 2018 who had subsequently provided feedback on the plan and given the Trust the opportunity to resubmit the plan on 20 June 2018. One significant issue to note is the acceptance of the control total, which is driving the requirement to resubmit the plan. The feedback had been reviewed the changes incorporated in the revised Plan. In addition there is a triangulation tool that had been signed off by the Director of Finance. The Chief Executive and Director of Finance had signed off the plan for the deadline of 20 June as required by NHSI. The key changes were highlighted: - Acceptance of control total of £16.9m deficit - Change in A&E Trajectory as asked to consider revising the trajectory to show winter dip in

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	performance as seen in 2017/18. - Included reference to the plans in place for patients with length of stay longer than 21 days. - A table relating to change in income from 2017/18 In addition in line with the feedback the Trust reviewed:- - The workforce plan to ensure it is safe realistic and will deliver forecast activity and - The intra NHS and Whole Government Accounting trading. • **The Board noted and approved the Operational Plan.** • **The Revised Plan will be presented to Council of Governors in August.**
	Any Other Business MC reported that the National Pay Award is due to be signed off today and will be reflected in July pay with back-pay reflected in August pay. SMcG reminded colleagues of many events taking place across the Hospital to mark the NHS 70th Birthday and encouraged colleagues to attend where possible, in addition to the Trust Annual Dragon Boat Race on 1 July.
	Next meeting to be held: Wednesday 25 July, Trust Conference Room

BOARD OF DIRECTORS ACTION LOG

AGENDA REFERENCE:	BM/18/07/60	SUBJECT:	TRUST BOARD ACTION LOG	DATE OF MEETING	25 July 2018

1. ACTIONS ON AGENDA

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
BM/18/03/22	28/03/2018	Learning from Experience Summary Q3 Report	A presentation slide deck to be available to the Board as opposed to the report, as the report is discussed in depth at Quality Committee.	**Chief Nurse**	25/07/2018		14.06.2018. To be presentd to July Board meeting.	

2. ACTIONS COMPLETED AND CLOSED SINCE LAST MEETING

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

ROLLING TRACKER OF OUTSTANDING ACTIONS

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
BM/18/01/01	31.01.2018	Partnership with King Edward Memorial Hospital Mumbai	Update Report to November Trust Board	**Medical Director**	28/11/2018		27.6.2018. AC advised that Certificate of Sponship submitted monthly to date had been rejected. It is hoped that these will be accepted in July following recent government legilsation. 3 visa applications submitted and outcome awaited following recent government legislation.	
BM/18/05/34 ii	24.05.2018	HEE visit 29 June	Report following the visit on 29 June	**Medical Director**	26/09/2018			
BM/18/05/39 c	24.05.2018	IPR Dashboard – Workforce Indicators	Split of all absences categories including stress to be provided to JNE outside of the provide to JNE outside of the meeting.	**Director of HR and OD**	When information received		June 2018 Information shared with JNE 27.6.2018. MC reported that national benchmarking information is still awaited and this will be forwarded when available.	

BM/18/06/56	27.06.2018	Resubmission of Operational Plan	To be presented to CoG in August.	**Director of Finance + Commercial Development**	16.08.2018		28.06.2018. Added to CoG agenda.	

RAG Key

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

Summary of board papers – statutory bodies

Joint NHS England and NHS Improvement board meeting

NHS England (NHSE) and NHS Improvement (NHSI) have for the first time held a board meeting in common as part of their move to closer organisational working. The board papers for this meeting are available here.

Next steps on aligning the work of NHS England NHS Improvement

NHSI and NHSE have published a board paper which sets out the detail of how NHSI intends to shift its primary focus from regulating the trust sector to supporting improvement and how the two organisations will work together to provide more joined-up, effective, leadership to the NHS. NHS Providers has produced an on the day briefing that provides a brief overview and our view on the proposals which are a combination of changes to how NHSI will operate and how NHSI and NHSE work together.

Operational planning refresh for 2018/19

- The board received an update on the operational planning refresh for 2018/19. The plans submitted by commissioners and providers are currently under review and summaries of these plans will soon be published.
- Provider plans are currently being reviewed to ensure all appropriate seasonal trends in workforce, activity and beds are planned for, ensure that changes in staffing are aligned with activity and financial plans, ensure that provider cost improvement plans (CIPs) "take up the opportunities" of operational productivity, assure the impact of the plans on the quality of patient care (including CIPs), and ensure that provider plans are internally consistent between activity, finance and workforce plans.
- The review of commissioner plans will ensure that the mental health investment standard will be met by each CCG, cancer services and primary care are being appropriately funded in order to transform services, and that the level and profile of expenditure and efficiency savings has been set realistically.

Next steps on development of integrated care systems

- NHSE and NHSI have confirmed four new integrated care systems:
  - Gloucestershire STP
  - Suffolk and North East Essex STP
  - West, North and East Cumbria STP
  - West Yorkshire and Harrogate STP
- The paper also provides an update and short overview of the 10 existing systems. It accepts there isn't a strict binary distinction between STPs and integrated care systems: "it is more a progression or evolutionary journey".
- A financial regime for ICSs in 2018/19 is being finalised, and details will be confirmed with the existing 10 systems in the next few weeks.

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NHS England board meeting – 24 May 2018

For more detail on any of the items outlined in this summary, the board papers for this meeting are available here.

Chief executive's verbal update

- Simon Stevens said it's clear that accelerating the move to joined up integrated care is what future proofing the NHS will require. He spoke of the creation of an NHS Assembly, drawing together local leaders including doctors, nurses, staff and patients,, that will co-design and take forward the future NHS 10 year plan. This will of course be underpinned by the closer alignment of NHSE and NHSI.

Health inequalities

- NHSE will be setting out a strategy for health inequalities that will form part of the 'all-encompassing' longer term strategy (i.e. settlement) being developed in partnership with the Government. An action plan has also been developed for the next twelve to eighteen months. In terms of next steps, NHSE will look to develop and enhance data collection and detail how progress will be measured.

Increasing the impact of Academic Health Science Networks

- The board confirmed that the funding for AHSNs will increased from £41.7m in 2018/19 to £84.6m in 19/20. This funding primarily comes from the Office of Life Sciences.
- The AHSNs have been relicensed with a new contract and governance arrangements. A new legal agreement is being drawn up to cover a five year period.

Financial report (month twelve)

- CCGs finished the year £251m overspent. This position includes the £440m risk reserve, as well as the £71m unearned quality premium. The underlying deficit for the CCG sector is therefore £761m. This is despite CCGs delivering efficiencies worth 3.1% of their allocations. At month eleven the year to date overspend was £624m, however this did not take into account unspent risk reserve. Last year the CCG sector finished £150.3m underspent, therefore 2017/18 represents the first overspend in the sector since 2015/16. The position is offset by underspends in direct commissioning (£227.9m) but more even more so in NHSE running and central programme costs (£891m).

Net Expenditure	Month 12 Outturn				System Risk Reserve	Exc Risk Reserve	
	Plan	Actual	Under/(over) spend			Under/(over) spend	
	£m	£m	£m	%	£m	£m	%
CCGs	80,995.9	81,246.4	(250.5)	(0.3%)	440.0	(690.5)	(0.9%)
Direct Commissioning	24,485.8	24,257.9	227.9	0.9%	0.0	227.9	0.9%
NHSE Running & central programme costs (excl. depreciation)	4,064.6	3,173.6	891.0	21.9%	200.0	691.0	17.0%
Other including technical and ringfenced adjustments	(10.3)	(97.2)	86.9		0.0	86.9	
Total non-ringfenced RDEL under/(over) spend	**109,536.0**	**108,580.7**	**955.3**	**0.9%**	**640.0**	**315.3**	**0.3%**

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NHS Improvement board meeting – 24 May 2018

For more detail on any of the items outlined in this summary, the board papers are available here.

Chief executive's report

- In response to Dr Kirkup's recommendations, NHSI will, among other things:
  - be more proactive in supporting providers to improve clinical and financial sustainability
  - support trusts to produce credible but realistic plans
  - strengthen their role in helping the NHS use its estates and clinical support services more effectively
  - play a stronger role in recruiting, retaining and developing today's workforce, and supporting talent management, leadership development and succession planning.
- The NHS is still behind where it was this time last year in terms of national performance on the 4-hour standard. NHSI will publish its review of winter in the coming weeks.
- NHSI is reviewing final plans for 2018/19 that were submitted on 30 April. To suppor the credibility of these plans, NHSI will have a major focus on reducing the length of stay at hospital of the longest stay patients.

Kirkup update

- The board received an update on the actions taken by NHSI in response to Dr Kirkup's recommendations, including:
  - a greater role for NHSI in talent management and a review of their role in board appointments
  - developing scenarios by which to stress test NHSI's current oversight approach
  - a rapid review by the regional teams of the level of risk and experience in community trusts, where in the vast majority of cases no significant issues were raised. NHSI proposes to undertake a more in-depth review which should inform changes to the oversight and support model for community trusts.

Quality dashboard

- More trusts (127) are rated good or outstanding than inadequate or requires improvement (115) by CQC. This is the first time this has been the case.
- NHSI is at the vanguard of designing the outputs the NHS needs from the new Community Services Data Set (CSDS). The southern regions are bringing together providers and commissioners to discuss this. The first priority is wound care. NHSI is considering including measures for the CSDS in the Single Oversight Framework for 2019.

Improvement report

- NHSI is working on benchmarking outpatient RTT across 120 trusts, and is looking at digital flow.

Lord Carter's review into mental health and community health services

- The report identifies unwarranted variations in workforce productivity and utilisation, and the efficient use of resources for non-pay goods and services. Improvements to these areas should release up to £1bn. The review makes 16 recommendations to NHSI, trusts and other national bodies.

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Care Quality Commission board meeting – 16 May 2018

For more detail on any of the items outlined in this summary, the board papers for this meeting are available here.

Performance report Q4 and end of year

- The board received a summary of the Annual Provider Survey results, which CQC describe as pleasing overall, but says there is room for improvement in areas including how CQC encourages services to improve, coordinates with others and accommodates new and complex care models.
- Most respondents agreed that inspection judgements are fair and evidence-based (73% strongly agreed or agreed) and CQC inspections and reports help services to improve (63%). However, one of the top 3 impacts for those rated Requires Improvement or Inadequate was a demotivation of staff.
- There was varying awareness of CQC publications (ranging from 30% to 57%).
- The survey results supported the National Audit Office finding that some stakeholders are concerned about CQC's consistency (25% disagreed or strongly disagreed CQC is consistent across inspections).
- CQC continues to marginally improve its performance against its inspection reports target for hospitals (to publish 90% within 50 working days, or 65 days for reports with 3 or more core services). At the end of the year this stood at 30% within 50 days and 49% within 65 days.
- CQC has undertaken 86% of its target 1,311 Mental Health Act monitoring visits this year.
- The finance report shows that CQC underspent against budget by £6.3m in 2017/18.

Chief Executive's report – May 2018

- CQC will publish a briefing on *Sharing best practice on safely managing demand in emergency departments* in late May.
- While enforcement of the General Data Protection Regulation is the role of the Information Commissioner's Office, CQC will continue to monitor how trusts assure themselves that they are meeting their obligations to protect data and the privacy and dignity of people who use their services.

Healthwatch England update and business plan

- Healthwatch continues to work with the Department for Health and Social Care to review progress against existing NHS Mandate commitments, such as the NHS doing more to demonstrate what it has learnt from complaints and feedback. The government has confirmed they are now actively working with NHSE to bring back 'emergency readmissions' as a key measure of how well health and care services are doing.
- Healthwatch have called for the introduction of a new metric that tracks the progress of each STP in engaging their communities, and highlighted the need for independent STP board chairs to be appointed to overcome vested interests in the STP process.

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Health Education England – 15 May 2018

For more detail on any of the items outlined in this summary, the full agenda and papers are available here.

Q4 performance report

- The latest performance report confirmed more nurses are being attracted back into the NHS workforce through the Return to Nursing Practice programme – 1,115 were commissioned against a 983 target.
- Fill rates for medical specialty posts are higher for the new cycle recruitment, compared to the same period last year.
- There are only 3 business practice domains (out of 67) in which HEE is facing challenges. The deliverables include:
  - Train 200 clinical **endoscopists** by December 2018 – only around 105 individuals have completed or are currently in training.
  - Publish a careers in **mental health** narrative from support staff to consultants – expected delivery is now March 2019.
  - Further develop the **physician associate** (PA) role in general practice towards 1,000 PAs in primary care by 2020. HEE is however commissioning PA training programmes of 2 year duration and some publicity work is also being undertaken.
- Investment and training update
  - Medical Fill Rates – medical recruitment rates remain strong with further recruitment for Round 1B planned in a variety of specialties. Round 2 – ST3/ST4 recruitment posts are starting from August 2019.
  - Nursing Associates – development around the establishment of the apprenticeship route continues. To date, 4,100 trainee places have been identified and three new test site applications have been received.

Governance and Board Effectiveness Review

- Despite the changes in the Local Education and Training Boards (LETBs) – primarily a reduction in their numbers from 13 to 4 – the review has not identified any diminution in the quality of oversight and reporting.
- You can access the full report here.

The Commission on Wellbeing and Mental Health of Staff and Learners

- A paper was submitted to the Board on progress made with the Wellbeing and Mental Health of Staff and Leaners Commission. This programme was announced alongside the publication of the draft workforce strategy in December 2017.
- There are 3 phases to this work. Phase 1 is focused on scoping parameters and reviewing the evidence. This will be followed by a panel review and finally a review launch and implementation of the recommendations from January2019 onwards.

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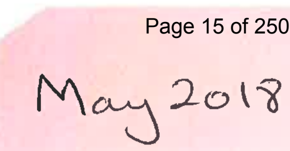


Next steps on aligning the work of NHS England and NHS Improvement

NHS Improvement (NHSI) and NHS England (NHSE) have published a board paper which sets out the detail of how NHSI intends to shift its primary focus from regulating the trust sector to supporting improvement and how the two organisations will work together to provide more joined-up, effective, leadership to the NHS. This briefing provides a brief overview and our view on the proposals which are a combination of changes to how NHSI will operate and how NHSI and NHSE work together.

Background

Local health and care systems are responding to the challenges of a growing and ageing population by collaborating across organisational boundaries and developing more integrated models of care. NHSI and NHSE recognise that they need to adapt and transform the way they work to create an operating model that best supports local health systems and the people they serve and provide more joined up national system leadership. NHSI is also seeking to change its primary focus from regulation to supporting improvement.

NHSI and NHSE acknowledge that primary legislation sets out the need for separate board governance, chairs and CEOs for the two organisations and that the statutory frameworks assign NHSI (Monitor) and NHSE distinctive functions. In addition, under the statutory framework, clinical commissioning groups (CCGs) and NHS trusts and foundation trusts have different, distinct, functions which are reflected in the functions of NHSI and NHSE, including those Secretary of State functions delegated to the NHS Trust Development Authority (TDA). However, the board paper sets out ways that the two bodies can enhance joint working within the current legislative framework.

Proposals

Joint governance, systems and processes

NHSI and NHSE will establish a new NHS Executive Group, co-chaired by the two CEOs and comprising membership of all national directors and Regional Directors from the two organisations (see below for more details of these posts). A new NHS Assembly (provisional title) will be created to ensure better engagement with the wider NHS and its users, and its membership will include a wide range of statutory and non-statutory organisations. It will become the forum that oversees progress on the NHS Five Year Forward View and will help co-design the proposed upcoming NHS 10 Year Plan.

NHSI and NHSE will align their core processes so that all interactions with the frontline NHS are conducted once. This includes establishing a single financial and operating planning process for the NHS, a single

performance management process and the alignment of regulatory interventions, a single internal management process and a single process for establishing and reviewing national strategic programmes such as cancer, mental health and digital. The two bodies will establish a joined up and aligned approach to reporting and sharing information about the system.

The NHSI and NHSE boards will also be considering, over the next several months, the extent to which some of NHSE's and NHSI's non-executive led board committees might be reshaped and aligned.

Regional level changes

The proposed structure involves a potentially very significant change at regional level through the creation of seven integrated (i.e. spanning both NHSI/NHSE) Regional Directors with much wider responsibilities and greater power compared to the current structure. The new regional teams will have a major leadership role driving improvement and transformation for local health systems and providing joined-up oversight across the NHS in their region. They will act as 'translators' between the national level and local health and care systems, helping to ensure that national work is responsive to local system needs.

The Regional Directors will have full responsibility for the performance of all NHS organisations in their region. They will make decisions about how best to support and assure performance within their region as well as support the development and identity of local STPs and ICSs. The regional teams will decide when and how to intervene in systems, providers or CCGs in their region, or - where required - make the relevant recommendations to the national NHS Executive Group. They will also be responsible for creating clear strategic visions for how the pattern of services and the pattern of provider configuration (e.g. mergers etc.) should develop within their regions.

The Regional Directors will report to the two NHSE and NHSI CEOs and be full members of the national NHS Executive Group, with responsibility for working with the national directors to develop the overarching strategy and architecture for the NHS as well as translating that into operational plans.

The integrated regional teams will deliver a number of core functions, including: performance, improvement and intervention; strategy and system transformation; commissioning; operational management; finance; specific quality responsibilities; workforce and leadership; information, digital and technology; estates and procurement; analysis and insight; communications and engagement; and corporate functions (including HR). There will be a particular emphasis on developing a much more proactive approach to senior leadership talent management within each region. The plan is for Regional Directors to oversee a more planned approach to Chair, CEO and executive board appointments and development, though the details of this are still being worked through.

In this structure, the current functions of NHSI's central Regulation Directorate are devolved to the Regional Directors as, for example, are the NHSI Medical Director's current responsibilities for special measures trusts. These changes are emblematic of the proposed scale of devolution from "central NHSI" to the integrated new Regional Directors.

It is important to note that the shift to seven regions, rather than four, is designed to enable Regional Directors to exercise these functions effectively. There are concerns that the existing four region structure gives regional directors an impossibly large number of providers within their region. 230 trusts divided by four regions equates to 58 trusts per region. 230 trusts across seven regions equates to 33 trusts per region. The intention is to enable the seven Regional Directors to have a much closer and deeper relationship with every trust in their region as opposed to only being able to concentrate on those that most require attention.

National level changes

As part of the devolution of power and responsibility to the more powerful Regional Directors, the role of the national level arms-length bodies' functions changes to being one of supporting the regional directors and working with them to create the national level strategic framework. Within NHSI the new national level structure, combined with the new approach to the regional directors, is designed to enable the change of primary focus from regulation to improvement support.

There will be a number of national director roles, which will report to both CEOs:

- A single NHS Medical Director
- A single NHS Nursing Director/Chief Nursing Officer for England
- A single Chief Financial Officer, who will have responsibility for a single NHS financial and operational planning framework and performance oversight process
- A single National Director for Transformation and Corporate Development – who will lead most corporate operations across both organisations including people and organisational development functions, both internally and with respect to system transformation.

A number of 'do-once' functions will be led by individual national directors in NHSE and NHSI, including:

- NHS England Deputy CEO – national service programmes such as cancer and mental health, implementation of the Five Year Forward View, and leadership of NHSE's distinct responsibilities including commissioning specialized services and primary care
- National Director for Strategy and Innovation (NHSE) – strategic programmes such as life sciences, commissioning development, patient choice and personalization, innovation and research
- Chief Provider Strategy Officer (NHSI) – a new strategic approach to configuration of the provider landscape
- Chief People Officer (NHSI) – a new post based in NHSI which is designed to develop a more systematic approach to leadership and development and people management issues+
- Chief Improvement Officer (NHSI) – a senior level post designed to support improvements in quality, access and efficiency with particular emphasis on supporting trusts to deliver improvements in these areas
- Chief Commercial Officer (NHSI) – supporting improvements to estates, procurement, back office services and clinical support services

- National Director for Emergency and Elective Care (NHSI) – shared approach to urgent and emergency care and elective care.

Taken together, the last five of these posts are designed to enable the shift in primary NHSI focus from regulation to supporting improvement. These post holders, working with the regional directors, will be seeking to support improvement at a trust level as well as at a sector wide level.

The effect of these changes is that the two organisations will be increasingly be working in a combined way on a single set of system priorities, covering most key functions, including:

- System strategy
- Planning and performance
- Supporting STPs and ICSs
- Service transformation
- Improvement
- NHS leadership and workforce
- NHS information and digital technology
- NHS estates, procurement, back office services and clinical support services.

There will however be some functions that remain distinct to each organisation. NHSI's regulatory functions in relation to pricing, competition and patient choice, and its hosting of the Healthcare Safety and Investigation Branch, and NHSE's responsibility for tariff currency development, commissioning of specialised services and primary care, and Emergency Preparedness, Resilience and Response (EPRR), will remain separate and distinct.

STPs and ICSs

Under the new integration regional model, STPs and ICSs will relate to a single Regional Director. As they develop and mature, the national bodies envisage ICSs holding more responsibility, including:

- Developing a system vision, strategy and plans to meet operational, financial and quality requirements
- Developing and maintaining relationships with local people, staff, local government, voluntary and independent sectors
- Leading on provider transformation including integrated providers and primary care networks
- Providing first line support to organisations within their system, drawing down national and regional expertise where needed
- Some commissioning (including current direct commissioning) not performed at national level.

Implementing the proposals

Changes to the most senior roles will be made by September and to the roles at the next level during the autumn. The aim is for all changes to be made by the end of this financial year. NHSI and NHSE recognise that this work requires a reshaping of the culture, mind-sets and ways of working for the two organisations so that they collectively see their role and purpose as providing system leadership to the NHS, and are not

defined by traditional boundaries. The implementation of this change programme has been titled 'Project 70'.

It is worth noting that there are major structural, cultural and behavioural shifts required to make this proposed approach work, including:

- Genuine commitment to devolve power from the centre to the regions
- Much greater alignment between NHSI and NHSE to work as a single system leader than at present
- Finding ways to overcome the natural split between commissioning and provision inherent in the 2012 Act, the ongoing need for separate boards and CEOs and the way the Act requires the NHS to work e.g. the NHS budget formally being allocated to NHSE.

NHS Providers' view

These proposals represent a significant change for NHSE, NHSI and the wider NHS. Over time they could herald a profound shift in the way the NHS is led at national and regional level and how trusts experience that leadership on the ground.

Trusts have consistently told us, for example via our latest regulation survey and informal feedback, that:

- They want the two organisations to work more closely together and provide single, integrated, system leadership of the NHS
- They want NHSI to provide more support and focus less on regulation, recognising there are inherent tensions between the two roles
- They want access to a more empowered and integrated regional structure that can give them clear, rapid and trusted guidance on issues such as whether it is worth them pursuing a merger, reconfiguration or capital project, confident in the knowledge that, if positive, the appropriate support will quickly follow
- They want more help, where needed, to create the right strategic framework for the larger regional and sub regional geographic footprints in which they work, helping resolve issues that affect multiple trusts or local systems where there may be competing interests.

NHSI has told us that these proposals are designed to address these concerns. We think they offer significant potential benefits, but there are also significant risks, and a lot depends on successful implementation and some major cultural/behavioural changes that are far from assured. We set out the potential benefits, the risks and the critical success factors, as we see them, in three short sections below.

Potential benefits

Reduce duplication and eliminate contradictory messaging / activity

The "do it once" new structure offers potential to eliminate the duplicative interactions trusts currently report in their dealings with NHSI and NHSE as different national and regional teams, both within and across the two organisations, act in an uncoordinated way on the same issue – for example asking for the same information or promoting contradictory approaches. A single approach to finances and contracting,

for example, offers the chance to solve financial challenges collaboratively rather than pit providers and commissioners unhelpfully against each other.

Single system framework

As the NHS moves to local system working, with the distinctions between CCGs and providers starting to blur, the new structure offers the opportunity to create a single, aligned, local system focussed, NHS performance, financial and operational framework.

An effective empowered regional level offering support

This structure offers the opportunity to create empowered integrated regional teams that really understand the problems and challenges facing local providers and can then provide appropriate advice and support on a systematic and trusted basis. That could include:

- Providing advice and guidance and then acting as a champion on issues that require arms length body or national system level input, approval or support such as capital projects, reconfigurations and transactions.
- Acting as solution facilitator for regional or sub regional issues where competing provider/local system interests or competing provider / commissioner issues occur;
- Regional Directors providing CEOs and boards with high quality, effective, advice and personal support and helping develop a more systematic approach to senior NHS talent.

Greater value for money

Greater joint working between NHSI and NHSE has the potential to deliver better value for money and increase efficiency. Given current NHS financial pressures, it is more important than ever that the national bodies are realising potential efficiencies and that any cost savings are diverted to frontline care.

Risks

Importance of provider sector understanding and influence

The NHS national strategic framework over the last few years has been the product of an explicit, often hard fought, private, negotiation between a provider-focussed NHSI and a commissioner-focussed NHSE. Whilst this is potentially wasteful, the duality inherent in this structure has ensured that the provider sector has had a robust and effective champion in NHSI arguing the provider cause in these negotiations. Trusts tell us that they don't always feel that NHSE understands the provider perspective or scale of challenge. For example there is a strong perception that excessive financial and performance risk has been loaded on to providers and this would have been even greater had there not been strong provider sector/NHSI pushback. It is important that this proposed joint venture is therefore a genuine joint venture of equal partners. For example, the single NHS finance and planning framework needs to be led by a single Finance Director who understands provider needs, will ensure an appropriate level of provider risk and will be committed to creating a provider task that is genuinely achievable.

The need for the right behaviours from regional leaders

This structure devolves power to the new Regional Directors that needs to be used in the right way. Trusts tell us that the behaviours exhibited in these or similar roles have sometimes been inappropriate and short of supportive. The desire for a support-led, rather than regulation-led, approach to the national arms length body/local trust relationship must be consistently expressed in the right behaviours, particularly in a context where the NHS will continue to experience considerable financial and operational pressures.

Potential loss of provider autonomy

Trusts tell us that the burden of regulation is significant and growing. Integrated regional teams with greater powers and a smaller number of trusts within each region creates risk as well as opportunity. Trusts will welcome appropriate, effective, extra support, particularly if it is provided in areas where the support is requested. Trusts will be less comfortable with unwanted activity that adds burden and complexity, intervenes unnecessarily or unreasonably curtails provider freedom and autonomy.

The creation of an unmanageable monolith

NHSI and NHSE together create a very large organisation that is likely to be significantly more difficult to manage and lead.

Critical success factors

In our view, successful implementation of this new structure will therefore require the following:

Much greater alignment between NHSI and NHSE than is currently the case. Dual reporting lines are difficult to manage and the existence of two boards and two CEOs will bring difficult tensions (though we would argue they also bring the potential advantage of a guaranteed strong, equal, voice for providers/frontline delivery organisations).

Genuine commitment to devolving power to Regional Directors and their teams. Trusts tell us they feel that executive power is currently strongly concentrated at the top of both organisations. There has to be a genuine and equal commitment across both organisations to devolve power to the new integrated regional structure.

The right appointments, skills, behaviours and appointment process. Effective, powerful, Regional Directors require senior level appointments who can carry the required credibility and authority with provider CEOs, Chairs and boards. We will struggle to make this system work effectively without them. It is also important NHSI/E are seen to go through due process in making these and the national director level appointments – setting out proper job descriptions and person specifications which frontline leaders can help shape, and then running open competitions. Understanding of the frontline delivery challenge and what is needed to support leaders to meet that challenge will be crucial in whoever is appointed.

The right single planning, finance and performance framework and process that is also based on a proper understanding of what provider leaders need to deliver effectively and is not an over ambitious, impossible to deliver, commissioner-led framework. The approach of the new joint Finance Director will be crucial here.

Effective management of a difficult change process, without adversely impacting other major priorities like the new, post PM funding commitment, NHS plan and the financial/planning reset required in 2019/20.

Genuine commitment to involve frontline leaders in the details of these changes as they develop. This new structure and approach will only work if local leaders feel they own and support it too.

Greater clarity on the relationship between the new regional structures and the STPs/ICSs that sit within their region and assurance that we are not creating new layers of bureaucracy for local leaders to navigate.

Next steps for NHS Providers

We have, as you would expect, been inputting the provider sector perspective as this work has developed. This included a successful member roundtable ten days ago as today's Board paper was being drafted, where members shared the concerns and welcomed the opportunities we set out above.

We would welcome your feedback on our views above and will continue to try to influence this process. NHSI have told us that they are strongly committed to involving providers in the detail of this work as it progresses.

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/18/07/63**
SUBJECT:	**Integrated Performance Dashboard**
DATE OF MEETING:	25th July 2018
ACTION REQUIRED	**For Discussion**
AUTHOR(S):	Marie Garnett – Head of Contracts and Performance
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse Alex Crowe – Acting Medical Director & Chief Clinical Information Officer Michelle Cloney – Director of Human Resources & Organisational Development Andrea McGee - Director of Finance & Commercial Development Lucy Gardner – Director of Transformation Chris Evans - Chief Operating Officer
LINK TO STRATEGIC OBJECTIVES:	All
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	All
STRATEGIC CONTEXT	To provide the Trust Board with assurance in relation to performance in the following areas: • Quality • Access and Performance • Workforce • Finance Sustainability
EXECUTIVE SUMMARY (KEY ISSUES):	**Quality** There were 2 medication safety incidents relating to harm in month, these are currently under review. The Trust continues to work through the backlog of incidents and complaints. There were 5 mixed sex accommodation breaches in month; the escalation process has been reviewed. **Access & Performance** The 6 week diagnostic standard has not been met due to capacity issues with Cardiac CT and Stress Echos, there are plans to address. A&E 4 hour performance

	continues to improve as do Ambulance handover times over 60 minutes with work continuing to improve the number of patients taking over 30 minutes to handover. There has been improvement in the number of Discharge Summaries sent within 24 hours. **Workforce** The Trust continues to reduce sickness absence and has implemented several initiatives to reduce further. Agency nurse spend remains higher than 2017/18. The Trust is working to convert agency staff to bank staff and recruit to substantive vacancies. This will also help reduce the average cost and length of service of the top 10 agency workers. **Finance** The Trust has signed up to a control total of £16.9m deficit which includes Provider Sustainability Funding (PSF) of £4.9m. The planned deficit for the quarter ending 30th June 2018 of £6.7m has been achieved. This position does not include PSF monies of £0.2m for the A&E 4 hour performance target as the requirement to achieve 90% for Quarter 1 was not delivered (89.6% was achieved).
RECOMMENDATION:	The Trust Board is asked to: **1.** Note the contents of this report.

PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	
FREEDOM OF INFORMATION STATUS (FOIA):	Choose an item.	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.	

We are
WHH

SUBJECT	Integrated Performance Dashboard	AGENDA REF:	BM/18/07/63

1. BACKGROUND/CONTEXT

The RAG rating for all 66 indicators from July 2017 to June 2018 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

2. KEY ELEMENTS

In month, there has been a movement in the RAG ratings as follows:

- Red - 26 in June decreased from 27 in May.
- Amber – 11 in June the same number as May.
- Green – 26 in June the same number as May.
- Not RAG rated – 3 in June an increase from 2 in May.

Due to validation timescales for Cancer, VTE and Sepsis data, the dashboard and RAG rating is based on May's validated position.

Quality

Quality KPIs

There are 10 Red indicators in June, a reduction of 1 in month.

The 8 indicators which were Red in May and remain Red in June are as follows:

- Incidents – the Trust has 108 open incidents which are over 40 days, a decrease from 114 in May.
- Safety Thermometer – The Trust achieved 96.2% for Adults, 96.6% for Children and 81.8% for Maternity against a 95% target.
- Healthcare Acquired Infections – the Trust reported 1 case of MRSA in April 2018 against a national threshold of zero tolerance; therefore this indicator will be Red for the remainder of the year.
- VTE Assessment – the Trust achieved 93.4% in May (validated position) a decrease from Aprils' performance of 95% and against a target of 95%.

- Medication Safety – there were 2 incidents of harm in June up from 1 in May, there is zero tolerance against this indicator.
- Complaints – there was 1 open case which was over 6 months old, the same number as May.
- Friends & Family Test (A&E and UCC) – The Trust achieved 83% in June, a decrease from May's performance of 86% against a target of 87%.
- Mixed Sex Accommodation Breaches (MSA) – there were 5 Mixed Sex Accommodation Breaches in June, an increase from 2 in May.

There are 2 indicators which have moved from Green to Red in month as follows:

- Sepsis Anti-biotic AED – the Trust achieved 82% (May's validated position) against a target of 90%.
- Total Falls & Harm Levels – the Trust did not achieve the 10% reduction in June, there were 83 falls against a baseline of 86. The Trust has signed up to a Falls Collaboration with NHS Improvement with the aim to prevent inpatient falls across the NHS.

There are 2 indicators which have moved from Red to Green in month as follows:

- Duty of Candour – there were no breaches in relation to DoC in month.
- Friends & Family Test (Inpatient & Daycase) – the Trust achieved 95% in June, (target 95%) an improvement from May's performance of 94%.

There is 1 Sepsis indicator which cannot be RAG rated this month.

Access and Performance

Access and Performance KPIs

There are 8 Access and Performance indicators rated Red in June, the same number as May.

The 7 indicators which were Red in May and remain Red in June are as follows:

- Diagnostic waiting times – the Trust achieved 98.2% in June, a decrease from May's performance of 98.5% (target 99%).
- A&E Waiting Times 4 hour national target – the Trust achieved 91% including walk ins and 89.5% excluding walk ins in June (target 95%), which is the same as May's performance.
- Breast Symptoms 14 days – the Trust achieved 84.75% in May (validated position) a decrease from April's performance of 88.7% (target 93%).
- Ambulance Handovers 30>60 minutes – there were 91 patients who experienced a delayed handover in June, an increase from 80 in May.

- Ambulance Handover at 60 minutes or more – the Trust seen an improvement in the number of patients experiencing a delayed handover in month from 30 in May to 12 in June.
- Discharge Summaries % sent within 24 hours – the Trust has achieved 84.4% in June (target 95%), an improvement from May's performance of 75.1%.
- Cancelled operations on the day (for non-clinical reasons) – there were 18 cancelled operations in June, an increase from 10 in May.

There is 1 additional Red indicator in month as follows:

- Cancer 62 days urgent – the Trust achieved 81.65% in May (validated position) a decrease from April's validated position of 90.4% (target 90%).

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

- Discharge Summaries Sent within 7 days – all discharge summaries required to meet the 95% target were sent within 7 days in month.

PEOPLE

Workforce KPIs
There are 4 indicators rated Red in June, the same number as May.

The 3 indicators which were Red in May and remain Red in June are as follows:

- Sickness Absence – 4.65% in June (target below 4.2%) an improvement from May's performance of 4.95%.
- Agency Nurse Spend – £0.26m in June, increase from the 2017/18 baseline of £0.2m.
- Average Cost of the Top 10 Agency Workers - £0.047m in June, increased from May's baseline of £0.04m.

There is 1 additional indicator rated Red in month as follows:

- Average Length of Service for Top 10 Agency Workers – has increased from 24 months in May to 27 months in June.

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

- Non Contracted Pay – was £0.13m less than budget in June, a reduction of £0.38m from May.

SUSTAINABILITY

Finance and Sustainability KPIs
There are 4 Red rated and 3 Amber rated Finance and Sustainability indicators in June, the same number as May.

The 4 indicators which were Red in May remain Red in June as follows:

- Capital Programme – the actual year to date spend is £1.7m which is £0.9m above the planned spend of £0.8m. This in part is due to £0.7m spend resulting from the Kendrick Wing fire that had been incurred earlier than anticipated.
- Better Payment Practice Code (BPPC) – the challenging cash position results in a year to date performance of 31% which is 64% below the national standard of 95%.
- Agency Spending – the actual year to spend is £2.7m which is £0.5m above the year to date ceiling of £2.2m
- Cost Improvement Programme – the year to date savings are £0.3m which is £0.3m below the £0.6m planned savings.

The Income, Activity Summary and Use of Resources Rating Statement as presented to the Finance and Sustainability Committee is attached in Appendix 3. The Trust is currently forecasting achievement of the planned deficit and control total.

The Trust is working with Commissioners on a shared 3 year plan to improve sustainability using CEP lite (Capped Expenditure Process) as a framework.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

KPI's that are underperforming will be 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
- KPI Sub-Committee

5. RECOMMENDATIONS

1. Note the contents of this report.

Appendix 1 – KPI RAG Rating July 2017 – June 2018

	KPI	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18
	QUALITY												
1	Incidents												
2	CAS Alerts												
3	Duty of Candour												
4	Safety Thermometer												
5	Healthcare Acquired Infections												
6	VTE Assessment*												
7	Safer Surgery												
8	CQUIN Sepsis AED Screening*												
9	CQUIN Sepsis Inpatient Screening*												
10	CQUIN Sepsis AED Antibiotics*												
11	CQUIN Sepsis Inpatient Antibiotics*												
12	CQUIN Sepsis Antibiotic Review*												
13	Total Falls & Harm Levels												
14	Pressure Ulcers												
15	Medication Safety												
16	Staffing – Average Fill Rate												
17	Staffing – Care Hours Per Patient Day												
18	Mortality ratio - HSMR												
19	Mortality ratio - SHMI												
20	Total Deaths												
21	NICE Compliance												
22	Complaints												
23	Friends & Family – Inpatients & Day cases												
24	Friends & Family – A&E and UCC												
25	Mixed Sex Accommodation Breaches												
26	CQC Insight Indicator Composite Score												

Appendix 1 – KPI RAG Rating July 2017 – June 2018

	ACCESS & PERFORMANCE												
27	Diagnostic Waiting Times 6 Weeks												
28	RTT - Open Pathways												
29	RTT – Number Of Patients Waiting 52+ Weeks												
30	A&E Waiting Times – National Target												
31	A&E Waiting Times – STP Trajectory												
32	Cancer 14 Days												
33	Breast Symptoms 14 Days												
34	Cancer 31 Days First Treatment*												
35	Cancer 31 Days Subsequent Surgery*												
36	Cancer 31 Days Subsequent Drug*												
37	Cancer 62 Days Urgent*												
38	Cancer 62 Days Screening*												
39	Ambulance Handovers 30 to <60 minutes												
40	Ambulance Handovers at 60 minutes or more												
41	Discharge Summaries - % sent within 24hrs												
42	Discharge Summaries – Number NOT sent within 7 days												
43	Cancelled Operations on the day for a non-clinical reason												
44	Cancelled Operations on the day for a non-clinical reason – Not offered a date for readmission within 28 days of the cancellation												

Appendix 1 – KPI RAG Rating July 2017 – June 2018

	WORKFORCE												
45	Sickness Absence												
46	Return to Work												
47	Recruitment												
48	Turnover												
49	Non Contracted Pay												
50	Agency Nurse Spend												
51	Agency Medical Spend												
52	Agency AHP Spend												
53	Core/Mandatory Training												
54	PDR												
55	Average cost of the top 10 highest cost Agency Workers												
56	Average length of service of the top 10 longest serving agency workers												
	FINANCE												
57	Financial Position												
58	Cash Balance												
59	Capital Programme												
60	Better Payment Practice Code												
61	Use of Resources Rating												
62	Fines and Penalties												
63	Agency Spending												
64	Cost Improvement Programme – Performance to date												
65	Cost Improvement Programme – Plans in Progress (In Year)												
66	Cost Improvement Programme – Plans in Progress (Recurrent)												

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

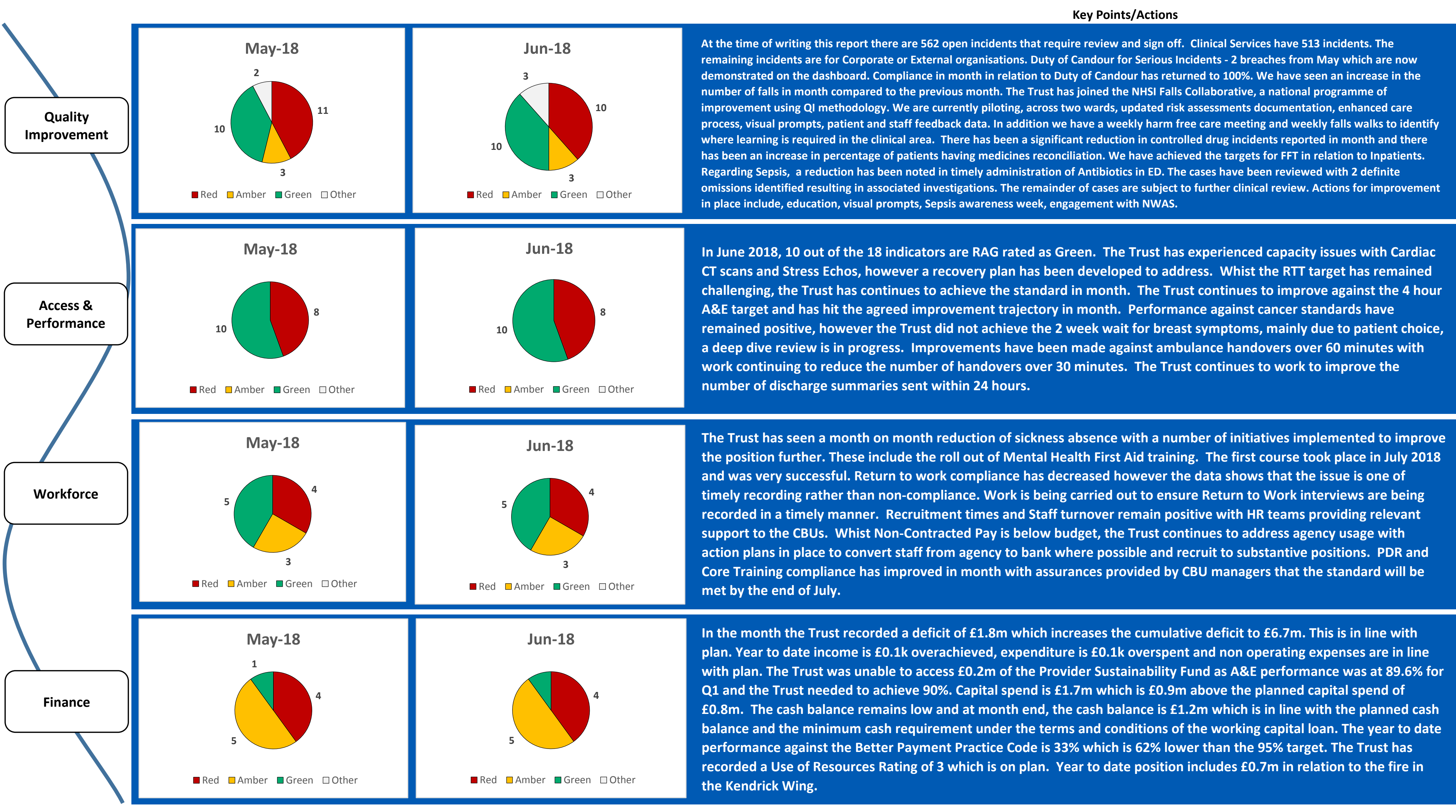
Warrington and Halton Hospitals NHS Foundation Trust

Appendix 2

Integrated Dashboard - June 2018

Key

Use of Resources Indicator UoR



Key Points/Actions

At the time of writing this report there are 562 open incidents that require review and sign off. Clinical Services have 513 incidents. The remaining incidents are for Corporate or External organisations. Duty of Candour for Serious Incidents - 2 breaches from May which are now demonstrated on the dashboard. Compliance in month in relation to Duty of Candour has returned to 100%. We have seen an increase in the number of falls in month compared to the previous month. The Trust has joined the NHSI Falls Collaborative, a national programme of improvement using QI methodology. We are currently piloting, across two wards, updated risk assessments documentation, enhanced care process, visual prompts, patient and staff feedback data. In addition we have a weekly harm free care meeting and weekly falls walks to identify where learning is required in the clinical area. There has been a significant reduction in controlled drug incidents reported in month and there has been an increase in percentage of patients having medicines reconciliation. We have achieved the targets for FFT in relation to Inpatients. Regarding Sepsis, a reduction has been noted in timely administration of Antibiotics in ED. The cases have been reviewed with 2 definite omissions identified resulting in associated investigations. The remainder of cases are subject to further clinical review. Actions for improvement in place include, education, visual prompts, Sepsis awareness week, engagement with NWAS.

In June 2018, 10 out of the 18 indicators are RAG rated as Green. The Trust has experienced capacity issues with Cardiac CT scans and Stress Echos, however a recovery plan has been developed to address. Whist the RTT target has remained challenging, the Trust has continues to achieve the standard in month. The Trust continues to improve against the 4 hour A&E target and has hit the agreed improvement trajectory in month. Performance against cancer standards have remained positive, however the Trust did not achieve the 2 week wait for breast symptoms, mainly due to patient choice, a deep dive review is in progress. Improvements have been made against ambulance handovers over 60 minutes with work continuing to reduce the number of handovers over 30 minutes. The Trust continues to work to improve the number of discharge summaries sent within 24 hours.

The Trust has seen a month on month reduction of sickness absence with a number of initiatives implemented to improve the position further. These include the roll out of Mental Health First Aid training. The first course took place in July 2018 and was very successful. Return to work compliance has decreased however the data shows that the issue is one of timely recording rather than non-compliance. Work is being carried out to ensure Return to Work interviews are being recorded in a timely manner. Recruitment times and Staff turnover remain positive with HR teams providing relevant support to the CBUs. Whist Non-Contracted Pay is below budget, the Trust continues to address agency usage with action plans in place to convert staff from agency to bank where possible and recruit to substantive positions. PDR and Core Training compliance has improved in month with assurances provided by CBU managers that the standard will be met by the end of July.

In the month the Trust recorded a deficit of £1.8m which increases the cumulative deficit to £6.7m. This is in line with plan. Year to date income is £0.1k overachieved, expenditure is £0.1k overspent and non operating expenses are in line with plan. The Trust was unable to access £0.2m of the Provider Sustainability Fund as A&E performance was at 89.6% for Q1 and the Trust needed to achieve 90%. Capital spend is £1.7m which is £0.9m above the planned capital spend of £0.8m. The cash balance remains low and at month end, the cash balance is £1.2m which is in line with the planned cash balance and the minimum cash requirement under the terms and conditions of the working capital loan. The year to date performance against the Better Payment Practice Code is 33% which is 62% lower than the 95% target. The Trust has recorded a Use of Resources Rating of 3 which is on plan. Year to date position includes £0.7m in relation to the fire in the Kendrick Wing.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - June 2018

Quality Improvement - Trust Position

Description	Aggregate Position	Trend	Variation

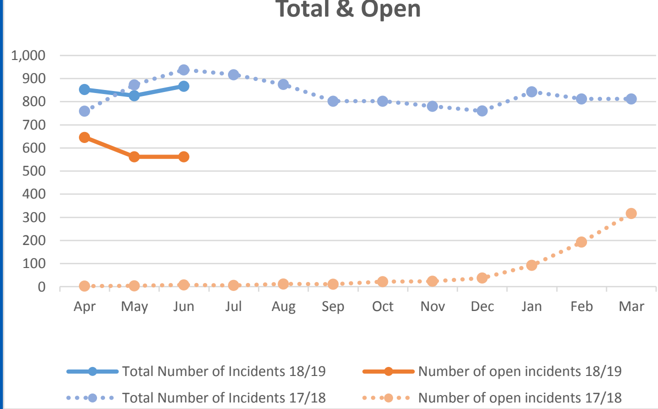
Patient Safety

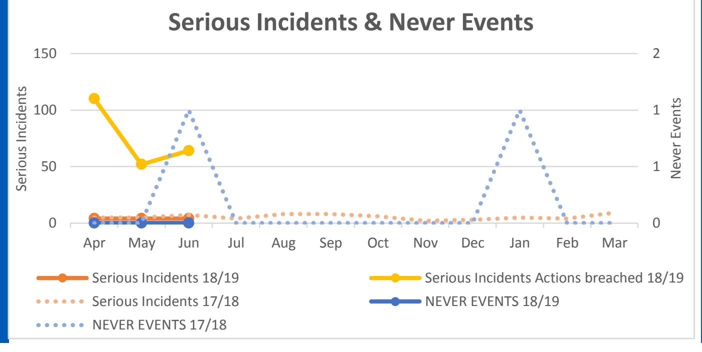
Incidents

Red: 1 or more Never Events or open incidents outside 40 day timeframe .
Amber: Zero Never Events and open incidents between 20 - 40 days old.
Green: Zero Never Events and open incident within timeframe of 20 days.

Number of Never Events (Never Events are serious patient safety incidents that should not occur).
Number of Serious Incidents and actions breached.
Number of open incidents is the total number of incidents that we have awaiting review.

The target for Never Events is a zero tolerance.
Green: open incidents within timeframe (within 20 working days)
Amber: open incidents outside of timeframe (within 40 working days)
Red: open incidents outside of timeframe (over 40 working days old).



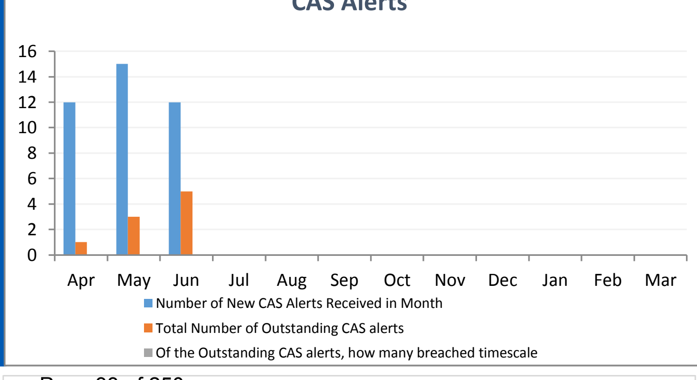


There are 562 open incidents which require review and sign off. This represents a downward trajectory in line with the CQC action to close all backlog incidents. The indicator is rated red as we still have a number of incidents (n=108) over 40 days old.

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

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 dependant upon the specific CAS alerts.

All CAS alerts should be reviewed and actioned within their individual timeframes.



We received 12 alerts in June, of which 7 have been closed.
There are 5 open alerts within the CAS system for the Trust.
We have no alerts past the close by date.

Integrated Dashboard - June 2018

Quality Improvement - Trust Position

Description	Aggregate Position	Trend	Variation

Duty of Candour

Red: <100%
Green: 100%

Description: 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.

Aggregate Position: Duty of Candour has to be completed within 10 working days.

Trend:

Duty of Candour

Number: 0, 2, 4, 6
Percentage: 0%, 20%, 40%, 60%, 80%, 100%
Apr, May, Jun, Jul, Aug, Sep, Oct, Nov, Dec, Jan, Feb, Mar

Number of serious incidents - DoC applies 18/19
Number of moderate harm incidents - DoC applies 18/19
% Compliance rate with DoC (serious incidents) 18/19
% Compliance rate with DoC (moderate incidents) 18/19

Variation: There have been 2 breaches in relation to DoC. Both patients/families have been subsequently contacted but this was outside of the 10 working day timeframe and therefore have been declared as breaches. These happened in May and are retrospectively being reported to the Board. June's performance is 100% of duty of candour delivered for those incidents confirmed as being moderate harm or above.

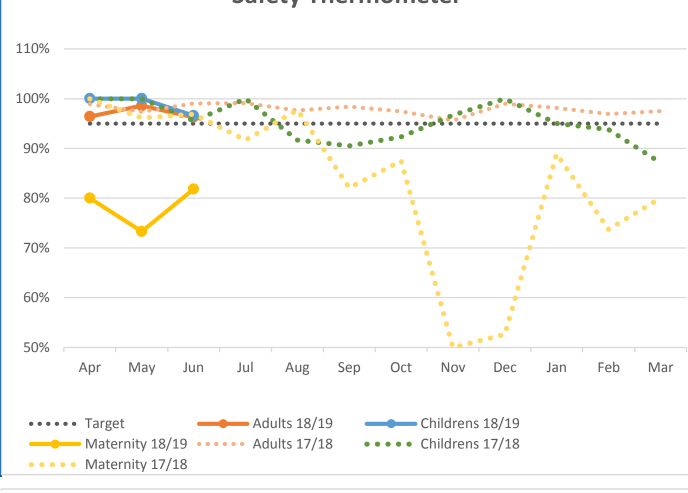
Safety Thermometer

Red: Less than 90%
Amber: 90% to 94%
Green: 95% or more

Description: 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.

Aggregate Position: The target for all areas is to achieve over 95%.

Trend:



Variation: In June the Adult Classic Safety Thermometer shows 6 pressure ulcers, 6 CAUTIs & 6 VTEs with no individual ward being of concern. The matrons have a process in place to validate the data from their areas to ensure correct recording of harm. Overall this meant a harm free percentage of 96.25%. The Maternity ST showed 81.8% harm free. Following a review of the data this was found to be as a result of babies being admitted to the Neonatal Unit. The team are making improvements in Transitional Care facilities to ensure that as many babies as possible remain on the ward during the post natal period. The mothers' perception of their safety was 100% positive. The Children's ST was 96.6% harm free, this was due to 1 baby in Neo-Natal Unit with an extravasation incident.

Integrated Dashboard - June 2018

Quality Improvement - Trust Position

Healthcare Acquired Infections

MRSA
Red: 1 or more

Green: 0

C-Difficile
Red: More than 2
Amber: 1 to 2
Green: 0

Description

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.

Aggregate Position

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 A national objective has been set to reduce gram negative bloodstream infections (GNBSI) by 50% by March 2021.

Trend

Variation

MRSA bacteraemia - 1 hospital onset case reported by ward A7 in April 2018 this was considered avoidable. Work is in progress with AED to promote timely blood culture sampling.

Clostridium difficile - 3 hospital onset cases reported in June 2018. Root cause analysis investigations are in progress. Ward A8 has had an increased incidence in cases. Ribotyping results to date indicate these cases are different. This is a cluster of cases not an outbreak. Review of antibiotic prescribing is in place.

MSSA - 5 hospital onset case reported in June 2018. Investigations are in progress. 2 of the 7 cases FYTD are peripheral cannula related and additional training has been organised.

Gram negative bloodstream infections in June: E. coli - 5 hospital onset case; Klebsiella - 0 hospital onset case and Pseudomonas aeruginosa 1 hospital onset case reported. A GNBSI action group is being established to review key themes from surveillance data and identify preventative action. Use of investigation toolkits has been implemented from start of Q2.

Integrated Dashboard - June 2018

Quality Improvement - Trust Position

	Description	Aggregate Position	Trend	Variation
VTE Assessment Red: <95% Green: 95% or above based on previous months' figures due to timescales for validation of data	Venous thromboembolism (VTE) is the formation of blood clots in the vein. This data looks at the % of assessments completed in month and the incidents of preventable harm. We also look at the number of RCA's completed in relation to VTE's.	The target for completion and documentation of VTE risk assessment on admission is 95%. Regarding the VTE backlog, weekly meetings are being held, chaired by the Medical Director where it has been agreed that additional capacity to clear the backlog from 15/16, 16/17, 17/18 (risk assessed by harm and occurrence of PE).	VTE Assessment; Root Cause Analysis (charts)	Compliance with VTE standards for assessment in May for the Trust is 95.45%. Daily reminders are sent to ward areas to ensure assessment is completed within the required timeframe, and the Trust has a action plan in place for further improvement. There are currently a number of outstanding moderately graded RCA cases being reviewed through MDT workshops, the first workshop highlighted the requirement for further clinical assessment, a second workshop has been arranged to complete the reviews and identify any harm caused.
Safer Surgery Red: <100% Green: 100%	The Safe Surgery check list is monitored through OMIS BI and checked and validated via 20 case per month by Head of theatre services.	The target is to achieve 100%.	Safer Surgery (chart)	Total number of operations 1220, total number of WHO checklist started 1220, this gives a percentage of 100%.

Integrated Dashboard - June 2018

Quality Improvement - Trust Position

	Description	Aggregate Position	Trend	Variation
CQUIN - Sepsis AED Screening Red: Less than 90% Green: 90% or more CQUIN - Sepsis Inpatient Screening Red: Less than 90% Green: 90% or more CQUIN - Sepsis AED Antibiotics Administration Red: Less than 90% CQUIN - Sepsis Inpatient Antibiotics Administration Red: Less than 90% CQUIN - Sepsis Antibiotic Review	Screening of all eligible patients - acute inpatients. Screening of all eligible patients admitted to emergency areas AED. Inpatient received treatments and empiric review within three days of prescribing antibiotics. Emergency patients received treatment and empiric review within three days of prescribing the antibiotics.	The target is to achieve 90%	CQUIN - Sepsis Screening CQUIN - Sepsis Antibiotics & Empiric Review	A reduction is noted in timely administration of Antibiotics in ED. The cases have been reviewed with 2 definite omissions identified resulting in associated investigations. The remainder of cases are subject to further clinical review. Actions for improvement in place include; education, visual prompts, Sepsis awareness week and engagement with NWAS.

Integrated Dashboard - June 2018

Quality Improvement - Trust Position

	Description	Aggregate Position	Trend	Variation
Total number of Falls & harm levels	Total number of falls per month and their relevant harm levels.	10% reduction in falls in 2018/19 using 2017/18 data as a baseline.	Number of Falls (chart: Total falls 18/19, Total falls 17/18, Apr-17 to Mar-18); Number of Falls - Moderate, Severe & Death (chart: Moderate Harm 18/19, Severe Harm & Death 18/19, Moderate Harm 17/18, Severe Harm & Death 17/18)	An increase in falls across the Trust was noted in June, with 2 noted to be severe resulting in hip fractures, those falls occurred on ward A8 and A4. A further 2 falls were recorded as moderate with a further 19 graded as minor and the remaining with no harm. The areas with the highest number of falls were Specialist Medicine, Digestive Diseases and Urgent and Emergency Care. The Trust has joined the NHSI Falls Collaborative, a national programme of improvement using Quality Improvement methodology. We are currently piloting, across two wards, updated risk assessments documentation, enhanced care processes, visual prompts, and patient and staff feedback data, as part of this work. In addition we have a weekly harm free care meeting and weekly falls prevention walks to identify where learning is required in the clinical area.
Pressure Ulcers Grade 4 Red: 1 or more Grade 3 Red: More than 3 Green: 3 or less Grade 2 Red: More than 7 Green: 7	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.	Grade 4 hospital acquired (avoidable and unavoidable) Grade 3 hospital acquired(avoidable and unavoidable) Grade 2 hospital acquired (avoidable and unavoidable)	Pressure Ulcers (chart: Grade 4 un-avoidable 18/19, Grade 4 avoidable 18/19, Grade 3 un-avoidable 18/19, Grade avoidable 18/19, Grade 2 unavoidable 18/19, Grade 2 avoidable 18/19, Grade 4 avoidable 17/18, Grade 3 avoidable 17/18, Grade 2 avoidable & unavoidable 17/18; Apr to Mar)	The number of grade 2 pressure ulcers noted to have acquired in hospital in June is 4, following the RCA review panel 2 were recorded as avoidable. Themes noted were lack of communication, assessment and timely provision of preventative kit. The Trust has joined a TV collaborative through NHSI using ward C21 as a pilot area for improvement, focussing on the avoidance of heel pressure ulcers utilising QI methodology.

Integrated Dashboard - June 2018

Quality Improvement - Trust Position

	Description	Aggregate Position	Trend	Variation
Medication Safety Red - any incidents of harm. Green - no incidents of harm.	Overview of the current position in relation to medication, to include; medication reconciliation, controlled drugs incidents and medication incidents relating to harm.	The target for Medication Safety is a zero tolerance for incidents of harm.	Medication Safety (chart: Number / Percentage, Apr–Mar; Controlled drugs incidents 18/19; Controlled drugs incidents 17/18; % Medication reconciliation 18/19; Medication Incidents relating to harm 18/19; Medication Incidents relating to harm 17/18; % Medication reconciliation 17/18)	The June medicines reconciliation position includes maternity and children. June is showing an increase in total and % MRs completed when compared with the previous 2 months. 27.9% of MRs were completed within 24 hours of admission and 48% within 48 hours of admission. There has been a reduction in CD incidents comparing non-audit months (16->8). There was 1 incident re-categorised as a harm incident in May and 2 have been reported in June. These are undergoing review to enable learning to be identified and disseminated.
Staffing - Average Fill Rate Red: 0-79% Amber: 80-89% Green: 90-100%	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.	Staffing - Average Fill Rate (chart: 80%–110%, Apr–Mar; Day - registered nurses/midwives 18/19; Night - registered nurses/midwives 18/19; Day - registered nurses/midwives 17/18; Night - registered nurses/midwives 17/18; Day - care staff 18/19; Night - care staff 18/19; Day - care staff 17/18; Night - care staff 17/18)	The majority of areas are above the 90% target YTD and it is acknowledged that the percentage of registered nurses/midwives in the day is below the target. However, mitigation and responsive plans are in place to ensure that the safe delivery of patient care is discussed at every bed meeting and escalated as appropriate. Shift fill rates have decreased, due to seasonal trend. Bank incentives and escalated rates for critical areas have been put in place to improve the shift fill rate.

Integrated Dashboard - June 2018

Quality Improvement - Trust Position

Description	Aggregate Position	Trend	Variation
Staffing - Care Hours Per Patient Day (CHPPD) Care Hours Per Patient Day = (Hours of registered nurses + Hours of healthcare support workers) / Total number of inpatients	The data produced excludes CCU, ITU and Paediatrics and does not have an associated target.	Staffing - Care Hours Per Patient Day (CHPPD)	We continue to monitor CHPPD as part of the daily responsive plans regarding care delivery.
Mortality ratio - HSMR Red: Greater than expected Green: As or under expected 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.	Target for Green would be to be within expected ranges.	HSMR	We are as expected for HSMR. Our HSMR is below 100, work continues regarding implementation of our Learning from Deaths Policy via our Mortality Review Group.
Mortality ratio - SHMI Red: Greater than expected Green: As or under expected 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.	Target for Green would be to be within expected ranges.	SHMI	SHMI source data is not currently available. NHS Digital has not been able to provide HED with the normal raw data used to produce SHMI related modules. They have also not been able to provide HED with any further information regarding when this data will become available so we continue to use the last known position of 104.70 which is within the expected range.

Integrated Dashboard - June 2018

Quality Improvement - Trust Position

	Description	Aggregate Position	Trend	Variation
Total Deaths	Total Deaths (including A&E) - We screen all deaths within the Trust to ascertain if any harm has been caused. If harm has been caused it is subject to a further review by the Mortality Review Group.	There is no target against this indicator.	In-Hospital Deaths (chart: Total Hospital Deaths 18/19; Total Hospital Deaths 17/18; Apr–Mar; 0–140)	All the Standard Judgment Reviews (SJRs) are being tracked through Mortality Review Group, reporting to Patient Safety & Effectiveness Sub Committee. The Trust will be reporting avoidable mortality in the Quality Accounts, which are currently being prepared. Any review conducted where they may be potentially avoidable mortality, is reported as a Serious Incident and subject to a full Root Cause Analysis before avoidability is confirmed.
NICE Compliance Red: <75% Amber: 75% to <100% Green: 100%	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.	The target is to achieve 100% compliance against all NICE guidance.	NICE Compliance (chart: Target; Compliance 18/19; Compliance 17/18; Apr–Mar; 0%–100%)	There are currently 3 pieces of NICE Guidance which are outside the 90 day assessment period: Hypothermia, Asthma and the Quality Standard for Patient Experience. The next stage of our NICE improvement work has started looking at guidance where we are partially compliant and assessing action plans for full compliance.

Integrated Dashboard - June 2018

Quality Improvement - Trust Position

	Description	Aggregate Position	Trend	Variation
Patient Experience				
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.	Red - Trust not meeting improvement trajectories or complaints open over 6 months old. Amber - No complaints over 6 months old, Trust meeting backlog improvement targets Green - No backlog, complaints responded to within agreed timescales. Please note that the above RAG rating will be reviewed following the completion of the complaints improvement plan.	Complaints (chart): Received within month 18/19; Received within month 17/18; Open awaiting 1st resp + dissatisfied 18/19; Cases over 6 months old 18/19; Cases in backlog (where breached) 18/19; Closed in month 18/19 Complaints (chart): Responded to within timeframe within month 18/19; Complainants dissatisfied within month 18/19; PHSO cases open at time of reporting 18/19; Complainants dissatisfied within month 17/18	In June, there was one case over 6 months which was a complex case and involved several areas. The amount of breached complaints has been halved within the month with cases being responded to on time more frequently. There has been an increase in the number of dissatisfied complainants. This is mainly due to the amount of responses that were sent out in the month, as this was much higher than previous months. The Trust has opened significantly less new complaints within the month.
Friends and Family (Inpatients & Day cases) Red: Less than 95% Green: 95% or	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?	The target set is to achieve over 95%.	Friends and Family (Inpatients & Daycases) (chart): Target; % Recommended 17/18; Number of responders 17/18; % Recommended 18/19; Number of responders 18/19	The Trust has achieved the target of 95% of patients who would recommend the Trust which is an increase from 94% last month. The response rate has also continued to improve with a significant 35.8%.

Integrated Dashboard - June 2018

Quality Improvement - Trust Position

	Description	Aggregate Position	Trend	Variation
Friends and Family (A&E and UCC) Red: Less than 87% Green: 87% or more	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?	The target set is to achieve over 87%.	Friends and Family (A&E and UCC) % recommending the Trust: 100%, 95%, 90%, 85%, 80%, 75%, 70% Number of responders: 1800, 1600, 1400, 1200, 1000, 800, 600, 400, 200, 0 Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Target; % Recommended 18/19; % Recommended 17/18; Number of responders 18/19; Number of responders 17/18	The target for the Trust is 87%, in June both the recommendation and response rates reduced to 83% and 17.6% respectively. An urgent review of the process in ED has been undertaken and improvement measures include adding FFT to care and comfort rounds and the daily nursing huddle. The co-ordinator will oversee progress with this and address any lapses on a daily basis, with an associated action plan to be developed by ED.
Mixed Sex Accommodation Breaches Red: 1 or more Green: Zero	We submit data to NHS England in relation to the number of occurrences of unjustified mixing in relation to sleeping accommodation.	There is a target of zero tolerance.	Mixed Sex Accommodation Breaches 20, 18, 16, 14, 12, 10, 8, 6, 4, 2, 0 Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Actual 18/19; Actual 17/18	There have been 5 MSA breaches in June 2018, an increase from 2 in May 2018. The escalation process has been reviewed, to ensure there are robust measures in place that potential breaches in ICU & CCU are escalated and patients are prioritised and moved to the most appropriate ward. Mini RCAs are completed after each breach and a summary sent to the CCG as per national requirements. Themes from MSA breaches are to be discussed at critical care and patient flow governance meetings to ensure there is learning.

Integrated Dashboard - June 2018

Quality Improvement - Trust Position

	Description	Aggregate Position	Trend	Variation

CQC

	Description	Aggregate Position	Trend	Variation
CQC Insight Composite Score Red (inadequate): <-3 Amber (req improvement): >-2.9 - 1.5 Green (good/outstanding): >1.5	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.	The RAG rating is based on the thresholds within the CQC Insight Report. Scores Below -3 are rated as "Inadequate", between -2.9 and 1.5 scores are rated as "Requires Improvement", scores between 1.5 - 4.9 are rated "Good" , scores of above 5 are rated "Outstanding"	CQC Insight Composite Score (chart)	The Trust is currently rated as -1.3 by the CQC which means that we currently score in the spectrum of those Trusts that "Requires Improvement". It is important to note that a lot of the data in this report is out of date and is being constantly refreshed.

Integrated Dashboard - June 2018

Mandatory Standards - Access & Performance - Trust Position

	Description	Aggregate Position	Trend	Variation
Diagnostic Waiting Times 6 Weeks Red: Less than 99% Green: 99% or above	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.	The Trust achieved 98.18% in June 2018.	Diagnostic Waiting Times 6 Weeks	The diagnostic target deteriorated further in month and therefore was not achieved. The failure is associated with the lack of capacity for CT scans and stress echo's which represents the majority of the breeches recorded. The new Diagnostic CBU manager has developed a recovery plan to bring performance back in line by the end of August 2018 and this remains on track. The business case for additional support and equipment has been agreed.
Referral to treatment Open Pathways Red: Less than 92% Green: 92% or RTT - Number of patients waiting 52+ weeks Green = 0, otherwise Red	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.	The Trust achieved 92.13% in June 2018.	Referral to treatment Open Pathways	The Trust achieved the 18 week referral to treatment target, achieving 92.13% against a target of 92%; this is a difficult target which remains challenging given the continued pressure experienced by the Trust and cancellations. Additional validation support is continuing to assist the central team and all specialities not achieving this standard have individual recovery plans in place for the remainder of the year. These are already showing improvement especially in those challenged areas such as MSK.
Four Hour Standard - National Target Red: Less than 95% Green: 95% or above Four Hour Standard Waiting Times - STP Trajectory Red: Less than trajectory Green: Trajectory or	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.	The Trust achieved 91.00% (including walk in) and 89.53% (excluding walk in) in June 2018.	A&E Waiting Times - 4hr target	The Trust has seen a progressive improvement in 4 hour performance since April 2018 in line with our internal NHSI trajectories. Unfortunately, the Provider Sustainability Fund (PSF) criteria was not met for Q1. Notification was received on the 27th June 2018 that the threshold was to achieve outturn of 17/18 performance or 90% for this period. This has been challenged with NHSI. Escalated beds have continued to decrease with the further reduction of beds on C20 to allow for the development of GAU. There remain circa 42 additional beds still open and being utilised, although plans are now in place to reduce this to 8 in the coming months. A silver command rota remains in place which provides senior management presence in the patient flow office to ensure that there challenges are actioned in a timely manner. There is a zero tolerance on non-admitted breeches for 18/19 and these are reviewed on a daily basis.

Integrated Dashboard - June 2018

Mandatory Standards - Access & Performance - Trust Position

	Description	Aggregate Position	Trend	Variation
Cancer 14 Days Red: Less than 93% Green: 93% or above	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.	The Trust achieved 93.51% in May 2018 - please note cancer validation is not completed until 8 weeks after the end of the reporting period.	Cancer 14 Days	The Trust achieved the Cancer 14 Day target in May. The June data is in draft format and will only be released once fully validated and uploaded in July.
Breast Symptoms 14 Days Red: Less than 93% Green: 93% or above	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.	The Trust achieved 84.75% in May 2018 - please note cancer validation is not completed until 8 weeks after the end of the reporting period.	Breast Symptoms 14 Days	The 2 week wait for breast symptomatic failed in May and this was mainly attributed to breeches associated with patient choice. As a consequence of this, it is likely that Q1 overall will fail. The Womens & Childrens CBU has undertaken a deep dive review and action has been taken with additional capacity has been made available.
Cancer 31 Days First Treatment Red: Less than 96% Green: 96% or above	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.	The Trust achieved 97.62% in May 2018 - please note cancer validation is not completed until 8 weeks after the end of the reporting period.	Cancer 31 Days First Treatment	The Trust achieved this target in May 2018.
Cancer 31 Days Subsequent Surgery Red: Less than 94% Green: 94% or above	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.	The Trust achieved 100% in May 2018 - please note cancer validation is not completed until 8 weeks after the end of the reporting period.	Cancer 31 Days Subsequent Surgery	The Trust achieved this target in May 2018.

Chart legend: No. of Patients 18/19; No. of Patients 17/18; Target; % 18/19; % 17/18. Axes: % Performance; Number of patients; Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar

Integrated Dashboard - June 2018

Mandatory Standards - Access & Performance - Trust Position

	Description	Aggregate Position	Trend	Variation
Cancer 31 Days Subsequent Drug Red: Less than 98% Green: 98% or above	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.	The Trust achieved 100% in May 2018 - please note cancer validation is not completed until 8 weeks after the end of the reporting period.	Cancer 31 Days Subsequent Drugs No. of Patients 18/19; No. of Patients 17/18; Target; % 18/19; % 17/18	The Trust achieved this target in May 2018.
Cancer 62 Days Urgent Red: Less than 85% Green: 85% or above	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.	The Trust achieved 81.65% in May 2018 - please note cancer validation is not completed until 8 weeks after the end of the reporting period.	Cancer 62 Days Urgent No. of Patients 18/19; No. of Patients 17/18; Target; % 18/19; % 17/18	The Trust did not hit the threshold in May 2018 for the reallocated position. The Open Exeter position is 85.58% for May 2018 which is the reportable position and this did achieve the standard. From Q3 the Trust will be monitored against the reallocated position.
Cancer 62 Days Screening Red: Less than 90% Green: 90% or above	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.	The Trust achieved 100% in May 2018 - please note cancer validation is not completed until 8 weeks after the end of the reporting period.	Cancer 62 Days Screening No. of Patients 18/19; No. of Patients 17/18; Target; % 18/19; % 17/18	The Trust achieved this target in May 2018.

Integrated Dashboard - June 2018

Mandatory Standards - Access & Performance - Trust Position

	Description	Aggregate Position	Trend	Variation
Ambulance Handovers 30 to <60 minutes Red: More than 0 Green: 0	Number of ambulance handovers that took 30 to <60 minutes (based on the data record on the HAS system).	There were 91 patients where the ambulance handover was between 30 and 60 minutes in June 2018.	Ambulance Handovers at 30 to <60 minutes	Ambulance handovers remain a challenge particularly when we have peaks in attendances within an hour, however the number of handovers greater than 60 minitues has improved again in June. Work continues to focus on reducing number waiting over 30 minitues. A successful pilot with a handover practitioner is to be made substantive to ensure continued high performance in this area. The compliance score has decreased in June and a deep dive will be undertaken to improve the number of handovers to ensure a return to 90%. June was the first month this occurred however Q1 was achieved.
Ambulance Handovers at 60 minutes or more Red: More than 0 Green: 0	Number of ambulance handovers that took 60 minutes or more (based on the data record on the HAS system).	There were 12 patients where the ambulance handover was more 60 minutes in June 2018.	Ambulance Handovers at 60+ minutes	Ambulance handovers remain a challenge particularly when we have peaks in attendances within an hour, however the number of handovers greater than 60 minutes has improved again in June. Work continues to focus on reducing number waiting over 30 minutes. A successful pilot with a handover practitioner is to be made substantive to ensure continued high performance in this area. The compliance score has decreased in June and a deep dive will be undertaken to improve the number of handovers to ensure a return to 90%. June was the first month this occurred however Q1 was achieved.
Discharge Summaries - % sent within 24hrs Red: Less than 95% Green: 95% or above	The Trust is required to issue and send electronically a fully contractually complaint Discharge Summary within 24 hrs of the patients discharge.	The Trust achieved 84.44% in June 2018.	Discharge Summaries	The Trust continues to drive compliance improvement across all CBUs. This is monitored via the weekly & monthly KPI meetings.
Discharge Summaries - Number NOT sent within 7 days Red: Above 0	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.	All discharge summaries were sent within 7 days in June 2018.	Discharge Summaries - Number NOT sent within 7 days (target = 0)	The Trust achieved this target in June 2018.

Integrated Dashboard - June 2018

Mandatory Standards - Access & Performance - Trust Position

Indicator	Description	Aggregate Position	Trend	Variation
Cancelled Operations on the day for a non-clinical reason **Red: Above zero**	Number of operations cancelled on the day or after admission for a non-clinical reason.	There were 18 operations cancelled on the day due to non-clinical reasons in June 2018.	Cancelled operations on the day for non-clinical reason	This has remained a challenge in June with bed pressures at peak times continuing.
Cancelled Operations on the day for a non-clinical reason - Not offered a date for readmission within 28 days of the cancellation	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.	There was no patients whose operation was cancelled on the day for non-clinical reasons whom was not readmitted within 28 days in June 2018.	Cancelled operations on the day for non-clinical reason - Not offered date for readmission within 28 days	There were no breeches of the 28 day target recorded this month. This is a significant improvement from previous months.

Integrated Dashboard - June 2018

Workforce

	Description	Aggregate Position	Trend	Variation
Sickness Absence Red: Above 4.5% Amber: 4.2% to 4.5% Green: Below 4.2%	UoR Comparing the monthly sickness absence % with the Trust Target (4.2%) previous year, and North West average	Sickness absence has decreased again slightly in June 2018. Sickness absence remains above target at 4.65%.	Monthly Sickness Absence (chart: 6%, 5%, 4%, 3%; Jul-17, Aug-17, Sep-17, Oct-17, Nov-17, Dec-17, Jan-18, Feb-18, Mar-18, Apr-18, May-18, Jun-18; Target, Current Yr, Previous Yr, NW Avg)	Key actions to address continue from last month: > Review of current policy continues. > Benchmarking against similar neighbouring Trust is taking place to understand and implement best practice in relation to stress. Ideas from other Trust sare now being reviewed and considered for implementation > HR team delivering bespoke actions and coaching with hotspot areas. > Mental Health First Aider Training - first training course has been a huge success.
Return to Work Red: Below 75% Amber: 75% to 85% Green: Above 85%	A review of the completed monthly return to work interviews.	The RTW Interview compliance for June is currently reported at 81.10%.	Monthly Return to Work % (chart: 100%, 90%, 80%, 70%, 60%, 50%; Jul-17, Aug-17, Sep-17, Oct-17, Nov-17, Dec-17, Jan-18, Feb-18, Mar-18, Apr-18, May-18, Jun-18; Actual, Target)	To be noted is the increase in the May position (now at 87.46% compared to the reported position of 76.83%). This is due to retrospective inputting of RTW data since the last report. This data highlights the need for more timely completion of the RTW interview and inputting of the data on to either E-Rostering or ESR. The HRBP team continue to work with the CBUs to raise this importance of this aspect of the attendance policy. In addition, the Nursing Workforce Improvement Lead has undertaken a deep dive into the nursing figures, has verified the accuracy of the data and has confirmed that the issue is the timeliness of recording.
Recruitment Red: 76 days or above Amber: 66 to 76 days Green: 65 days or	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	Average time to hire has increased slightly to 73 days (up from 70.1).	Recruitment (chart: 120, 100, 80, 60, 40, 20, 0; 9 - 12 Months ago, 6 - 9 Months ago, 3 - 6 Months ago, Last 3 Months; Avg Days between Advert Closure and Interview, Avg Days for Pre Employment Checks, Avg Total Days of Recruitment, Advert Closure and Interview (Shortlisting) Target, Pre-Employment Checks Target, Total Recruitment Days Target)	Although there has been a slight increase in time to hire, the trend of achieving around 71-74 days is maintained.

Integrated Dashboard - June 2018

Workforce

	Description	Aggregate Position	Trend	Variation
Turnover Red: Above 15% Amber: 13% to 15% Green: Below 13%	UoR A review of the turnover percentage over the last 12 months	Trust Turnover remains below target at 11.95%.	Turnover % Target / Turnover Jul-17 – Jun-18; 0% – 14%	The HR team continue to provide tailored support to areas with high turnover and work is on-going across the Trust in relation to specific staff groups, including Nursing and Midwifery staff and AHPs. The Trust now has access to Peer average turnover data and the Trust's current turnover rate is above average. This data will be monitored over the next quarter to establish trends.
Non Contracted Pay Red: Greater than Budget Green: Less than Budget	UoR A review of the Non-Contacted pay as a percentage of the overall pay bill year to date	Expenditure on pay in June was less than the previous month by £381k and was less than the budget by £133k.	Non Contracted Spend vs Budget Contracted / Overtime / Bank / Agency / WLI / Budget Jul-17 – Jun-18; £10,000,000 – £16,000,000	There were reductions in all 4 pay elements as follows: contracted (£108k), bank (£134k), agency £110k and WLIs (£28k). FSC continue to monitor all elements of expenditure.
Agency Nurse Spend Red: Greater than Previous Yr Green: Less then	UoR A review of the monthly spend on Agency Nurses	Agency Nurse Spend was £263k and Bank Nurse Spend was £333k in June 2018.	Agency & Bank Nurse Spend Current Yr Bank Spend / Current Yr Agency Spend / Previous Yr Agency Spend Jul-17 – Jun-18; £0.00 – £600,000.00	Agency Nurse Spend remained stable in month whist Bank Nurse Spend has reduced slightly in month.

Integrated Dashboard - June 2018

Workforce

	Description	Aggregate Position	Trend	Variation
Agency Medical Spend Red: Greater than Previous Yr Green: Less then	UoR A review of the monthly spend on Agency Locums	Medical Agency Spend was £476k and Bank Medical Spend was £207k in June 2018.	Agency & Bank Medical Spend	Medical and Bank Agency Spend have both reduced slightly in month.
Agency AHP Spend Red: Greater than Previous Yr Green: Less then Previous Yr	UoR A review of the monthly spend on AHP Locums	AHP Agency Spend was £75k in month.	Agency & Bank AHP Spend	AHP Agency Spend has reduced in month and remains lower than the same period last year.
Core/Mandatory Training Red: Below 70% Amber: 70% to 85% Green: Above 85%	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 Safegarding.	Core Skills Mandatory Training Compliance was 84.86% in June 2018.	Core/Mandatory Training	CBU triumvirates have given assurance to Trust Operational Board that 85% compliance will be achieved by 31/07/2018.

Integrated Dashboard - June 2018

Workforce

Key	Description	Aggregate Position	Trend	Variation
PDR Red: Below 70% Amber: 70% to 85% Green: Above 85%	A summary of the PDR Compliance rate	PDR Compliance was 83.2% in June 2018.	PDR (chart: Target, Actual; Jul-17 to Jun-18; 40%–90%)	CBU triumvirates have given assurance to Trust Operational Board that 85% compliance will be achieved by 31/07/2018.
Average cost of the top 10 highest cost Agency Workers Red: Greater than previous month Green: Less than	UoR Monthly costs for the top 10 highest cost Agency Workers	The monthly cost for the top earning agency workers ranged from £72k to £31k. The average cost was £47k.	Average cost of the top 10 highest cost agency workers (chart: Monthly Cost, £0–£50,000; Sep-17 to Jun-18)	The high cost agency workers data is scrutinised monthly and work is on-going to produce exit plans for each worker, as well as short term mitigation plans such as renegotiating rates. This work is reported through to the Premium Pay Spend Review Group.
Average length of service of the top 10 longest serving agency workers Red: Greater than previous month	The length of service (months) of the Top 10 agency workers who have been working at the trust for a minimum of 3 shifts per week for a consecutive period of 6 weeks.	The length of service for the longest serving agency workers ranged from 50 months to 17 months. The average length of service was 27 months.	Average length of service of the top 10 longest serving agency workers (chart: Length of service (months), 0–30; Sep-17 to Jun-18)	The length of service for agency workers is reported on a weekly basis to NHSI. The current length of service poses low risk to the organisation.

Integrated Dashboard - June 2018

Sustainability & Mandatory Standards - Finance

	Description	Aggregate Position	Trend	Variation
Financial Position Red: Deficit Position Amber: Actual on or better than planned but still in deficit Green: Surplus	UoR Surplus or deficit compared to plan	The actual deficit in the month is £1.8m which increases the cumulative deficit to £6.7m.	Financial Position (chart)	The cumulative deficit of £6.7m is in line with plan.
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	UoR Cash balance at month end compared to plan (excluding cash relating to the hosting of the Sustainability and Transformation Partnership).	The current cash balance of £1.2m equates to circa 2 days operational cash.	Cash Balance (chart)	The current cash balance of £1.2m is in line with the plan. Due to the operating position additional working capital loans are required to maintain liquidity and meet financial obligations. The value of working capital loans drawn down to 30th June 2018 is £40.9m.
Capital Programme Red: Off plan <80% - >110% Amber: Off plan 80-90% or 101 - 110% Green: On plan 90%-100%	UoR Capital expenditure compared to plan (The capital plan has been increased to £7.3m as a result of additional funding from the Department of Health for A&E Primary Care Streaming and WiFi infrastructure upgrade and capital donations from Can treat, Health Education England and Charitable Funds.	The actual capital spend in the month is £1.0m which increases the cumulative spend to £1.7m.	Capital Programme (chart)	The cumulative capital spend of £1.7m is £0.9m above the planned capital spend of £0.8m.

Financial Position (chart): £m axis 5.0 to -20.0; months Apr–Mar. Legend: In month Plan 18/19; In month Actual 18/19; Actual 17/18; Cumulative Plan 18/19; Cumulative Actual 18/19.

Cash Balance (chart): left axis 0.0–2.5 (£m), right axis 20–80 (£m); months Apr–Mar. Legend: Plan 18/19; Actual 17/18; Actual 18/19; Loans 18/19.

Capital Programme (chart): £m axis 0.0–12.0; months Apr–Mar. Legend: Plan 18/19; Actual 17/18; Actual 18/19.

Integrated Dashboard - June 2018

Sustainability & Mandatory Standards - Finance

Key	Description	Aggregate Position	Trend	Variation
Better Payment Practice Code Red: Cumulative performance below 85% Amber: Cumulative performance between 85% and 95% Green: Cumulative performance 95% or	UoR **Payment of non NHS trade invoices within 30 days of invoice date compared to target.**	**In month, the Trust has paid 28% of suppliers within 30 days which results in a year to date performance of 31%.**	Better Payment Practice Code (chart)	**The cumulative performance of 31% is 64% below the national standard of 95%, this is due to a challenging cash position. Cash is managed closely on a daily basis.**
Use of Resources Rating Red: Use of Resource Rating 4 Amber: Use of Resource Rating 3 Green: Use of Resource Rating 1 and 2	UoR **Use of Resources Rating compared to plan.**	**The current Use of Resources Rating is 3. Capital Servicing Capacity, Liquidity, I&E margin are scored at 4 whilst Agency Ceiling is scored at 2 and performance against control total is scored at 1.**	Use of Resources Rating (chart)	**The current Use of Resources Rating of 3 is in line with the planned rating.**
Fines and Penalties Red: Greater than zero Green: Zero	**Monthly fines and penalties**	**Fines and Penalties are levied by commissioners as outlined in the contracts.**	Fines and Penalties (chart)	**The Trust is awaiting notification of any fines or penalties levied by commissioners during Q1. The Trust has agreed with commissioners in Warrington & Halton to reinvest any fines and penalties as part of the sustainability contract.**

Better Payment Practice Code
100%
80%
60%
40%
20%
0%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
Plan Actual 18/19 Actual 16/17 Cumulative 18/19

Use of Resources Rating
5
4
3
2
1
0
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
Actual 18/19 Actual 17/18

Fines and Penalties
Thousands
0
0
0
0
0
0
-
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar

Integrated Dashboard - June 2018

Sustainability & Mandatory Standards - Finance

Rating	Description	Aggregate Position	Trend	Variation
Agency Spending Red: More than 105% of ceiling Amber: Over 100% but below 105% of ceiling Green: Equal to or less than agency ceiling.	UoR Agency spend compared to agency ceiling	The actual agency spend in the month is £0.9m which increases the cumulative spend to £2.7m.	Agency Spending	The cumulative agency spend of £2.7m is £0.5m (22%) above the cumulative agency ceiling of £2.2m.
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	Cost savings delivered compared to plan.	CIP savings delivered in M3 are £0.15m which is below the M3 target of £0.24m. YTD £0.34m has been delivered against the target of £0.60m. In addition, £0.03m of cost avoidance has been delivered YTD.		The Trust is reporting on CIP delivery to NHSI every 2 weeks. The Executive Team has reviewed existing CIP schemes and is assessing the viability of potential schemes to address the shortfall.
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	Planned improvements in productivity and efficiency - In Year forecast vs £7m target.	An assessment of existing ideas/schemes has been undertaken. The latest forecast delivery in year has been assessed at between £4.6m and £2m.	Trustwide Cumulative In Year Position vs. Plan submitted to NHSI	Delivery of £7m CIP programme presents a significant challenge and is under constant review and assessment by the Executive Team.

Integrated Dashboard - June 2018

Sustainability & Mandatory Standards - Finance

	Description	Aggregate Position	Trend	Variation
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	**Planned improvements in productivity and efficiency - Full Year Forecast vs. £7m target.**	**The latest forecast delivery of recurrent CIP is between £6.2m and £1.7m.**	FYE Recurrent Position vs. Plan submitted to NHSI £8,000,000 £7,000,000 £6,000,000 £5,000,000 £4,000,000 £3,000,000 £2,000,000 £1,000,000 £0 FYE Recurrent Ideas Hopper High Risk Medium Risk Low Risk Delivered Plan submitted to NHSI	**The recurrent nature of the CIP programme falls under the review and mitigation of the Executive Team.**

Appendix 3

Income Statement, Activity Summary and Use of Resources Ratings as at 30th June 2018

Income Statement	Month			Year to date			Forecast		
	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Operating Income									
NHS Clinical Income									
Elective Spells	2,813	2,664	-149	8,306	7,858	-448	33,894	33,894	0
Elective Excess Bed Days	8	44	36	25	73	48	101	101	0
Non Elective Spells	4,820	5,366	546	14,770	15,621	851	59,030	59,030	0
Non Elective Excess Bed Days	164	238	73	504	613	110	2,013	2,013	0
Outpatient Attendances	2,782	2,830	47	8,215	8,279	64	33,522	33,522	0
Accident & Emergency Attendances	1,133	1,248	115	3,371	3,661	290	13,451	13,451	0
Other Activity	5,573	4,956	-616	16,731	15,799	-931	69,120	69,120	0
Sub total	**17,294**	**17,346**	**52**	**51,921**	**51,905**	**-17**	**211,131**	**211,131**	**0**
Non NHS Clinical Income									
Private Patients	5	5	-1	15	67	52	152	152	0
Non NHS Overseas Patients	4	13	9	11	25	14	44	44	
Other non protected	95	62	-33	285	187	-98	1,135	1,135	0
Sub total	**104**	**80**	**-24**	**311**	**279**	**-32**	**1,331**	**1,331**	**0**
Other Operating Income									
Training & Education	641	641	0	1,923	1,923	0	7,693	7,693	0
Donations and Grants	0	0	0	0	0	0	0	0	0
Provider Sustainability Fund	741	519	-222	741	519	-222	4,942	4,942	0
Miscellaneous Income	1,575	1,850	275	4,724	5,123	399	20,503	20,503	0
Sub total	**2,957**	**3,010**	**53**	**7,388**	**7,565**	**177**	**33,138**	**33,138**	**0**
Total Operating Income	**20,355**	**20,435**	**81**	**59,621**	**59,749**	**128**	**245,600**	**245,600**	**0**
Operating Expenses									
Employee Benefit Expenses	-15,060	-15,037	23	-45,245	-45,636	-390	-179,196	-179,196	0
Drugs	-1,419	-1,260	160	-4,278	-3,786	492	-17,026	-17,026	0
Clinical Supplies and Services	-1,744	-1,790	-45	-5,243	-5,285	-42	-20,582	-20,582	0
Non Clinical Supplies	-3,101	-3,314	-213	-9,303	-9,529	-226	-36,874	-36,874	0
Depreciation and Amortisation	-501	-486	15	-1,502	-1,458	44	-6,007	-6,007	0
Restructuring Costs	0	0	0	0	0	0	0	0	0
Total Operating Expenses	**-21,825**	**-21,886**	**-61**	**-65,571**	**-65,693**	**-122**	**-259,686**	**-259,686**	**0**
Operating Surplus / (Deficit)	**-1,470**	**-1,451**	**19**	**-5,950**	**-5,944**	**6**	**-14,086**	**-14,086**	**0**
Non Operating Income and Expenses									
Profit / (Loss) on disposal of assets	0	0	0	0	0	0	0	0	0
Interest Income	3	5	2	9	14	5	36	36	0
Interest Expenses	-136	-154	-18	-244	-244	0	-813	-813	0
PDC Dividends	-203	-203	0	-544	-544	0	-2,174	-2,174	0
Net Impairments	0	0	0	0	0	0	0	0	0
Total Non Operating Income and Expenses	**-337**	**-352**	**-15**	**-779**	**-773**	**5**	**-2,951**	**-2,951**	**0**
Surplus / (Deficit)	**-1,807**	**-1,803**	**4**	**-6,729**	**-6,718**	**11**	**-17,037**	**-17,037**	**0**
Less Donations & Grants Income	0	0	0	0	0	0	0	0	0
Less Depreciation on Donated & Granted Assets	13	14	1	39	40	1	156	156	0
Control Total	**-1,794**	**-1,789**	**5**	**-6,690**	**-6,677**	**13**	**-16,881**	**-16,881**	**0**
Activity Summary	**Planned**	**Actual**	**Variance**	**Planned**	**Actual**	**Variance**	**Planned**	**Actual**	**Variance**
Elective Spells	2,999	2,834	-165	8,855	8,183	-672	36,135	36,135	0
Elective Excess Bed Days	34	182	147	102	297	195	415	415	0
Non Elective Spells	3,029	2,908	-121	9,280	8,510	-770	37,091	37,091	0
Non Elective Excess Bed Days	676	1,019	343	2,072	2,556	484	8,283	8,283	0
Outpatient Attendances	25,938	25,761	-177	76,579	76,434	-145	312,490	312,490	0
Accident & Emergency Attendances	9,678	9,973	295	28,792	29,511	719	114,866	114,866	0
Use of Resources Ratings	**Planned Metric**	**Actual Metric**	**Variance Metric**	**Planned Metric**	**Actual Metric**	**Variance Metric**	**Planned Metric**	**Actual Metric**	**Variance Metric**
Metrics									
Capital Servicing Capacity (Times)				-5.64	-5.17	0.47	-2.69	-2.69	0.00
Liquidity Ratio (Days)				-16.4	-38.1	-21.7	-14.3	-14.3	0.0
I&E Margin (%)				-11.22%	-11.18%	0.05%	-6.87%	-6.87%	0.00%
Performance against control total (%)				0.00%	-0.07%	-0.07%	0.00%	0.00%	0.00%
Agency Ceiling (%)				0.00%	21.98%	21.98%	0.00%	0.00%	0.00%
Ratings									
Capital Servicing Capacity (Times)				4	4	0	4	4	0
Liquidity Ratio (Days)				4	4	0	4	4	0
I&E Margin (%)				4	4	0	4	4	0
Performance against control total (%)				1	1	0	1	1	0
Agency Ceiling (%)				1	2	1	1	1	0
Use of Resources Rating				**3**	**3**	**0**	**3**	**3**	**0**

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/18/07/63 a(i)**	
SUBJECT:	**Safe Staffing Assurance Report - April 2018**	
DATE OF MEETING:	25 July 2018	
ACTION REQUIRED	**The Board of Directors are asked to note the contents of the report**	
AUTHOR(S):	**Rachael Browning – Associate Chief Nurse**	
EXECUTIVE DIRECTOR SPONSOR:	**Kimberley Salmon –Jamieson –Chief Nurse**	
LINK TO STRATEGIC OBJECTIVES:	SO1: To ensure that all care is rated amongst the top quartile in the North West of England for patient safety, clinical outcomes and patient experience	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	BAF2.2: Nurse Staffing	
	BAF1.3: National & Local Mandatory, Operational Targets	
	BAF1.1: CQC Compliance for Quality	
STRATEGIC CONTEXT	SO1: To ensure that all care is rated amongst the top quartile in the North West of England for patient safety, clinical outcomes and patient experience.	
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 actual falls below 90% of planned staffing levels. It is recommended that the Board of Directors receive a monthly Safe Staffing paper highlighting areas where average fill rates fall below 90% of actual versus planned, along with mitigation to ensure safe, high quality care is consistently delivered.	
RECOMMENDATION:	It is recommended that the Board of Directors note and approve the monthly Safe Staffing Assurance Report.	
PREVIOUSLY CONSIDERED BY:	**Committee**	
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	
FREEDOM OF INFORMATION STATUS		
FOIA EXEMPTIONS APPLIED: *(if relevant)*		

Warrington and Halton Hospitals NHS Foundation Trust

Safe Staffing Assurance Report

The purpose of this paper is to provide transparency with regard to the nursing and midwifery ward staffing levels during April 2018. It forms part of the expectation set out in the National Quality Board (NQB) guidance published in 2016 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.

The Trust has a duty to ensure nursing and midwifery staffing levels are sufficient to maintain safety and provide quality care. This paper provides assurance that any shortfalls on each shift were reviewed and addressed as required with mitigating actions, including staffing levels and skill mix. 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.

All Trusts are to 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 of 90% and over is considered acceptable nationally.

The April Trust wide staffing data was analysed and cross referenced for validation by the Deputy Chief Nurse, Lead Nurses, and the Associate Chief Nurse (clinical effectiveness).

Key Messages

Although some areas are above the 90% target year to date, it is acknowledged that the percentage of registered nurses/midwives in the day is below the target. However, mitigation and responsive plans are in place to ensure that the safe delivery of patient care is discussed at every bed meeting and escalated as appropriate. Shift fill rates have improved from the previous month, however to maintain safe staffing levels bank incentives and escalated rates for critical areas have been put in place to improve the shift fill rate.

Recruitment remains a priority for the senior nursing team with further recruitment open days planned for registered nurses and HCSW.

The number of additional beds open across the trust has reduced, with the closure of Daresbury Ward. The Trust currently has an additional 46 beds in use, 22 beds on Ward C22, with escalation beds on Ward A3 (10) AMU (8) C20 (6) and A5 (1), which are reviewed daily to determine the additional staffing required to ensure patient safety.

We reported 9 grade 2 pressure ulcers in April, which is shown by ward in (Appendix 1). Each of these cases are being reviewed by the Tissue Viability nurse and the Associate Chief Nurse, Patient Safety to identify themes and shared learning.

Two moderate harm falls this month, have been reported, one on ICU and one on Ward B12, both of which are currently being investigated.

Appendix 1 identifies the fill rates for staff across the Trust for April 2018. The table also triangulates this information by illustrating the harms reported within each area

Appendix 2 identifies the mitigating actions taken in April respectively in areas where the actual numbers of registered nurses and health care support staff were below 90% of the planned numbers of staff.

This report demonstrates the planned versus actual staffing data and provides assurance of the divisional actions taken to provide adequate staffing levels on a day to day / shift by shift basis.

Warrington and Halton Hospitals NHS Foundation Trust

Appendix 1 MONTHLY SAFE STAFFING REPORT – April 2018

Monthly Safe Staffing Report – April 2018

		Day	Day	Day	Day	Day	Day	Night	Night	Night	Night	Night	Night	Patient Harm by ward			
Division	Ward	Planned RN hours	Actual RN hours	Planned CS hours	Actual CS hours	% RN fill rate	% CS fill rate	Planned RN hours	Actual RN hours	Planned CS hours	Actual CS hours	% RN fill rate	% CS fill rate	Falls (Mod and Above)	Cdiff	MRSA	Pressure Ulcers
	(blue)	= above 100%	(green)	= above 90%		(amber)	= above 80%		(red)	= below 80%							
SWC	SAU	907	884.5	668.75	639	97.5%	95.6%	0	0	0	0	-	-				
SWC	Ward A5	1725	1276.5	1260	1195	74.0%	96.7%	1035	925.75	690	793.5	89.4%	115.%				
SWC	Ward A6	1725	1334	1260	1316.75	77.3%	104.5%	1035	885.5	690	851	85.6	123.3		1		
SWC	Ward CMTC	1276.5	1227.5	816.5	669.5	96.2%	82%	690	690	690	517.5	100%	75%				
SWC	Ward B4	1114	1094.5	468	456.5	98.2%	97.5%	345	345	345	414	100%	97.5%				
SWC	Ward A9	1725	1422.5	1380	1225	82.5%	88.8%	1035	931.5	1035	1104	90%	106.7%				
SWC	Ward B11	1869	1678.4	757.3	752.3	89.6%	99.3%	1596	1466	0	0	91.9%	-				
SWC	NCU	1725	1368.5	345	276	79.3%	80%	1725	1367.5	345	310.5	79.3%	90%				
SWC	Ward C20	921	833	690	622.5	90.4%	90.2%	581.4	581.4	0	345	100%	-				
SWC	Ward C23	1380	1069.7	690	611	77.5%	88.6%	736	724.5	690	632.5	98.4%	91.7%				
SWC	Delivery Suite	2415	1992	345	348	82.5%	100.9%	2415	2079	345	345	86.1%	100%				
ACS	Ward A1	1875	1612	2212.5	2212.5	86%	100%	1575	1197	630	787	76%	124.9%				1
ACS	Ward A2	1380	1134.5	1490	1531.5	82.2%	102.8%	1035	996	690	874	93.3%	126.7%				1
ACS	Ward A3	1454.5	1036.5	1725	1721.5	71.3%	99.8%	997.5	759	1380	952	76.1%	69%				1
ACS	Ward A4	1621	1248.5	1380	1284	77%	93%	1035	885.5	1035	920	85.6%	88.9%				2
ACS	Ward A8	1725	1224	1725	1517.5	71%	88%	1035	851	1725	1529.5	82.2%	88.7%		1		1
ACS	Ward B12	1035	1014	2415	1999.5	98%	82.8%	690	688	1725	1644.5	99.7%	95.3%	1			
ACS	Ward B14	1380	1166.5	1380	1380	84.5%	100%	690	690	690	690	100%	100%				
ACS	Ward B18	1380	1188	1380	1218	86.1%	88.3%	1035	768	1035	1144	74.2%	110.5%				
ACS	Ward B19	1035	977.4	1380	1253	94.4%	90.8%	690	690	1035	1046.5	100%	101.1%				1
ACS	Ward A7	1725	1433	1932	1440	83.1%	74.5%	1380	1138	1587	1357	82.5%	85.5%			1	1
ACS	Ward C21	1035	1236	690	802	119.4%	116.2%	690	690	690	942.9	100%	136.7%				
ACS	CCU	1380	1368.5	345	210.9	99.2%	61.1%	1035	10.5	0	0	100%	-				
ACS	ICU	4830	4134	4830	4197.5	85.6%	86.9%	1035	517.5	690	414	50%	60%	1			1

Appendix 2

April 2018 - Mitigating Actions

	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	97.5%	95.6%	0	0	SAU closes at night, therefore no requirement for staff after 10pm.
Ward A5	74%	94.8%	89.4%	115%	Nights remain a priority this month due to vacancies and Mat leave, staff moved from other areas to support. When the trained numbers have been reduced there has been additional HCSW to support the ward.
Ward A6	77.3%	104.5%	85.6%	123.3%	Challenges on nights in this month due to mat leave and vacancies. When the trained numbers have been reduced there has been additional HCSW to support the Ward. RN vacancies out to advert.
CMTC	96.2%	82%	100%	75%	Staffing levels reviewed daily against activity and acuity, staffing has improved in month. HCA out to advert as part of the Trust wide recruitment campaign.
B4	98.2%	97.5%	100%	120.%	Ward reviewed daily, increased number of HCSW to support the step down patients on the ward. HCA out to advert trust wide
Ward A9	82.5%	88.8%	90%	106.7%	1 F/T vacancy and 1 F/T mat leave on the ward. The ward is assessed daily by the matron and staff moved from other areas to support, based on the ward acuity. HCA out to advert and 4 HCSW vacancies have been recruited to.
NCU	79.3%	80%	79.3%	90%	5 staff long term sick, being managed in line with Trust policies, 2 maternity leave. 1.6 band 5 vacancies. The unit is reviewed daily by the lead nurse, which includes an acuity assessment.
Ward C20	90.4%	90.2%	100.0%	-	The ward remains escalated overnight and temporary staffing is used to support the ward.
Ward A1 - AMU	86%	100%	76%	124.9%	Staffing reviewed daily by the matron, staff are moved from other areas to support when required. Additional HCSW required to

					increase staffing levels, particularly on night duty and to support enhanced care needs.
Ward A2	82.2%	102.8%	93.3%	126.7%	The ward has a number of RN vacancies, local recruitment programme in place. Any unfilled shifts filled by NHSP and agency, additional carer shifts used for enhanced care needs and to support staffing. Short term sickness is being managed appropriately.
Ward A3 Opal	71.3%	99.8%	76.1%	69%	The ward currently has an additional 10 beds, in use taking the ward to 34 beds. Additional shifts requested on NHSP and staff are moved from other areas to support. Ward manager supporting the ward clinically. Enhanced care needs regularly assessed and additional shifts requested.
Ward A4	77%	93 %	85.6%	88.9%	RN vacancies out to advert. Daily review by the matron to review staffing levels and acuity, staff moved from other areas to support.
Ward A8	71%	88%	82.2%	88.7%	High number of vacancies on the ward, 5 Band 5 vacancies, 1 full time RN maternity leave, 1 RN secondment. The ward is reviewed daily and staff are moved from other areas to support. Long term sickness of HCSW staff . Additional staff provided by NHSP and agencies to cover short fall of RN hours. Local recruitment programme in place.
Ward B12 (Forget-me-not)	98%	82.8%	99.7%	95.3%	Ward continues to risk assess to establish requirements for enhanced care hours needed. These hours requested via NHSP. Ward manager supports the ward daily to ensure safety.
Ward B14	84.5%	100%	100%	100%	Ward manager working clinically to support the ward when required. Additional shifts requested to cover vacancy and sickness, fill rates good.. Enhanced care needs assessed daily & additional shifts requested where needed.
Ward B18	86.1%	88.3%	74.2%	110.5%	Additional shifts requested via NHSP to cover sickness & vacancies to allow patients to be cohorted as required. Ward manager supports ward clinically to ensure safety.
Ward B19	94.4%	90.8%	100%	101.1%	Additional shifts requested via NHSP

					to cover vacancy, maternity leave and sickness. Ward manager working clinically to support ward.
Ward A7	83.1%	74.5%	82.5%	85.5%	Staffing reviewed daily and staff moved from other areas to support the ward. Ward Manager continues to support working clinically.
Ward C21	119.4%	116.2%	100.0%	136.7%	Staffing levels have improved this month and staff have been supporting other areas as required. Enhanced care in place to support patients individual needs.
Coronary Care Unit	99.2%	61.1%	100%	-	Daily assessment by senior nursing team, the team continue to support other areas when they are able to. Ward Manager continues to support clinically when required. 2 x RN remain on maternity leave.
Intensive Care Unit	85.6%	86.9%	50%	60%	2.96 wte Band 5 vacancy. Recruitment completed and awaiting start dates. 1.84 wte RN Long-Term RN seconded to Governance has now returned to the unit. Temporary Staffing accessed when required and utilised to maintain safe nurse:patient ratios.

Rachael Browning
Associate Chief Nurse, (clinical effectiveness)
April 2018

Warrington and Halton Hospitals NHS
NHS Foundation Trust

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/18/07/63 aii**
SUBJECT:	**Safe Staffing Assurance Report – May 2018**
DATE OF MEETING:	25 July 2018
ACTION REQUIRED	**The Board of Directors are asked to note the contents of the report**
AUTHOR(S):	**Rachael Browning – Associate Chief Nurse**
EXECUTIVE DIRECTOR SPONSOR:	**Kimberley Salmon –Jamieson –Chief Nurse**
LINK TO STRATEGIC OBJECTIVES:	SO1: To ensure that all care is rated amongst the top quartile in the North West of England for patient safety, clinical outcomes and patient experience
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	BAF2.2: Nurse Staffing
	BAF1.3: National & Local Mandatory, Operational Targets
	BAF1.1: CQC Compliance for Quality
STRATEGIC CONTEXT	SO1: To ensure that all care is rated amongst the top quartile in the North West of England for patient safety, clinical outcomes and patient experience.
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 actual falls below 90% of planned staffing levels. It is recommended that the Board of Directors receive a monthly Safe Staffing paper highlighting areas where average fill rates fall below 90% of actual versus planned, along with mitigation to ensure safe, high quality care is consistently delivered.
RECOMMENDATION:	It is recommended that the Board of Directors note and approve the monthly Safe Staffing Assurance Report.

PREVIOUSLY CONSIDERED BY:	**Committee**	
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	
FREEDOM OF INFORMATION STATUS		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***		

Safe Staffing Assurance Report

The purpose of this paper is to provide transparency with regard to the nursing and midwifery ward staffing levels during May 2018. It forms part of the expectation set out in the National Quality Board (NQB) guidance published in 2016 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.

The Trust has a duty to ensure nursing and midwifery staffing levels are sufficient to maintain safety and provide quality care. This paper provides assurance that any shortfalls on each shift were reviewed and addressed as required with mitigating actions, including staffing levels and skill mix. 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.

All Trusts are to 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 of 90% and over is considered acceptable nationally.

The May Trust wide staffing data was analysed and cross referenced for validation by the Deputy Chief Nurse, Lead Nurses, and the Associate Chief Nurse (clinical effectiveness).

Key Messages

Although some areas are above the 90% target year to date, it is acknowledged that the percentage of registered nurses/midwives in the day is below the target. However, mitigation and responsive plans are in place to ensure that the safe delivery of patient care is discussed at every bed meeting and escalated as appropriate. Shift fill rates have improved from the previous month, however to maintain safe staffing levels bank incentives and escalated rates for critical areas have been put in place to improve the shift fill rate.

Recruitment remains a priority for the senior nursing team with further recruitment open days planned for registered nurses and HCA's.

The number of additional beds open across the trust has reduced, with the closure of Daresbury Ward. The Trust currently has an additional 46 beds in use, 22 beds on Ward C22, with escalation beds on Ward A3 (10) AMU (8) C20 (6) and A5 (1), which are reviewed daily to determine the additional staffing required to ensure patient safety.

We reported 4 grade 2 pressure ulcers in May, which is shown by ward in (Appendix 1). Each of these cases are being reviewed by the Tissue Viability nurse and the Associate Chief Nurse, Patient Safety to identify themes and shared learning.

One moderate harm fall this month has been reported. This was reported on ward C22 (winter ward) and is currently being investigated.

Appendix 1 **MONTHLY SAFE STAFFING REPORT – May 2018**

Monthly Safe Staffing Report – May 2018

Division	Ward	Day Planned RN hours	Day Actual RN hours	Day Planned HCA hours	Day Actual HCA hours	Day % RN fill rate	Day % HCA fill rate	Night Planned RN hours	Night Actual RN hours	Night Planned HCA hours	Night Actual HCA hours	Night % RN fill rate	Night % HCA fill rate	Patient Harm by ward: Falls (Mod and Above)	Cdiff	MRSA	Pressure Ulcers
	(blue)	= above 100%	(green)	= above 90%		(amber)	= above 80%		(red)	= below 80%							
SWC	SAU	930	930	697.5	622.5	100%	89.2%	0	0	0	0	-	-				
SWC	Ward A5	1782.5	1479.5	1302	1132	83%	86.9%	1069	989	713	690	92.5%	96.8%				1
SWC	Ward A6	1782.5	1483.5	1302	1282.25	83.2%	98.5%	1069	1058	713	713	98.9%	100%				1
SWC	Ward CMTC	1345.5	1343	839.5	774	99.8%	92.2%	724.5	724.5	713	667	100%	93.5%				1
SWC	Ward B4	1058.5	1049.5	534	518.5	99.1%	97.1%	356.5	356.5	356.5	992.5	100%	278.4%				
SWC	Ward A9	1782.5	1479	1426	1368	83%	96%	1069.5	1058	1069.5	1069.5	98.9%	100%				
SWC	Ward B11	1931.3	1857.8	781.9	781.9	96.2%	100%	1584.4	1519.2	0	0	95.9%	-				
SWC	NCU	1782.5	1399	356.5	310.5	78.5%	87.1%	1782.5	1299.5	356.5	322	72.9%	90.3%				
SWC	Ward C20	944	887	713	606	94%	85%	713	713	0	276	100%	-				
SWC	Ward C23	1426	1021	713	563.5	71.6%	79%	770.5	759	713	644	98.5%	90.3%				
SWC	Delivery	2495.5	2261	356.5	363.5	90.6%	102%	2495.5	2383	356.5	363.5	95.5%	102%				
ACS	Ward A1	1937.5	1775	2325	2325	91.6%	100%	1627.5	1407	651	874	86.5%	134.3%				
ACS	Ward A2	1426	1169	1610	1619.5	82%	100.6%	1069.5	1058	713	874	98.9%	122.6%			1	
ACS	Ward A3	1538.5	1078.5	1782.5	1540	70.1%	86.4%	1069.5	1009	1426	1449	94.3%	101.6%				
ACS	Ward A4	1690.5	1305.15	1426	1374.25	77.2%	96.4%	1069.5	1069.5	1069.5	977.5	100%	91.4%		1		
ACS	Ward A8	1782.5	1258.5	1782.5	1575	70.6%	88.4%	1069.5	897	1782.5	1426	83.9%	80%		2		
ACS	Ward B12	1069.5	985.5	2495.5	2061.25	92.1%	82.6%	713	713	1782.5	1745	100%	97.9%				
ACS	Ward B14	1426	1278	1426	1422	89.6%	99.7%	713	713	713	862.5	100%	121%				
ACS	Ward B18	1426	1171	1426	1361	82.1%	95.4%	1069	839.5	1069.5	1132	78.5%	105.8%				
ACS	Ward B19	1069.5	979	1414.5	1172	91.5%	82.9%	713	724.5	1069.5	1046.5	101.6%	97.8%				
ACS	Ward A7	1782.5	1484.5	1426	1477	83.3%	103.6%	1426	1219	1069.5	1242	85.5%	116.1%				
ACS	Ward C21	1695	1200	713	921	70%	129.2%	713	713	713	989	100%	138.7%				
ACS	CCU	1426	1360.5	356.5	174.5	95.4%	48.9%	1069.5	1046.5	0	0	97.8%	-				
ACS	ICU	4830	4680.5	1035	523.25	96.9%	50.6%	4830	4611.5	690	276	95.5%	40%				1

Appendix 2

May 2018 - Mitigating Actions

	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	100%	89.24%			SAU closes at night, therefore no requirement for staff after 10pm.
Ward A5	83%	86.94%	92.47%	96.77%	Challenges due to 3.90 band 5 vacancies and Mat leave, staff moved from other areas to support. When the trained numbers have been reduced there has been additional HCA to support the ward.
Ward A6	83.22%	98.48%	98.92%	100%	Challenges due to mat leave and 4.92 band 5 vacancies. When the trained numbers have been reduced there has been additional HCA to support the Ward. RN vacancies out to advert.
CMTC	99.81%	92.19%	100%	93.54%	Staffing levels reviewed daily against activity and acuity, staffing has improved in month. HCA out to advert as part of the Trust wide recruitment campaign.
B4	99.14%	97.09%	100%	278.40%	Ward reviewed daily, increased number of HCA to support the step down patients on the ward. HCA out to advert trust wide
Ward A9	83%	96%	98.9%	100%	2 F/T vacancy and 1 F/T mat leave on the ward. The ward is assessed daily by the matron and staff moved from other areas to support, based on the ward acuity. HCA out to advert and 4 HCA vacancies have been recruited to.
NCU	78.5%	87.1%	72.9%	90.3%	5 staff long term sick, being managed in line with Trust policies, 2 maternity leave. 1.6 band 5 vacancies. The unit is reviewed daily by the lead nurse, which includes an acuity assessment.
Ward C20	94%	85%	100%	-	The ward remains escalated overnight and temporary staffing is used to support the ward.
Ward A1 - AMU	91.6%	100%	86.5%	134.3%	Staffing reviewed daily by the matron, staff are moved from other areas to support when required. Additional HCA required to increase staffing levels, particularly on night duty and to support enhanced care

					needs.
Ward A2	82%	100.6%	98.9%	122.6%	The ward has a 5.82 band 5 vacancies, local recruitment programme in place. Any unfilled shifts filled by NHSP and agency, additional carer shifts used for enhanced care needs and to support staffing. Short term sickness is being managed appropriately.
Ward A3 Opal	70.6%	86.4%	94.3%	101.6%	The ward currently has an additional 10 beds, in use taking the ward to 34 beds. Additional shifts requested on NHSP and staff are moved from other areas to support. Ward manager supporting the ward clinically. Enhanced care needs regularly assessed and additional shifts requested.
Ward A4	77.2%	96.4%	100%	91.4%	7.99 band 5 vacancies. RN vacancies out to advert. Daily review by the matron to review staffing levels and acuity, staff moved from other areas to support.
Ward A8	70.60%	88.35%	83.91%	80%	10.66 band 5 vacancies on the ward, maternity leave, 1 RN secondment. The ward is reviewed daily and staff are moved from other areas to support. Long term sickness of HCA staff . Additional staff provided by NHSP and agencies to cover short fall of RN hours. Local recruitment programme in place.
Ward B12 (Forget-me-not)	92%	82.58%	100%	97.89%	Ward continues to risk assess to establish requirements for enhanced care hours needed. These hours requested via NHSP. Ward manager supports the ward daily to ensure safety.
Ward B14	89.62%	99.71%	100%	120.96%	Ward manager working clinically to support the ward when required. Additional shifts requested to cover vacancy and sickness, fill rates good.. Enhanced care needs assessed daily & additional shifts requested where needed.
Ward B18	82.11%	95.44%	78.48%	105.89%	Additional shifts requested via NHSP to cover sickness & vacancies to allow patients to be cohorted as required. Ward manager supports ward clinically to ensure safety.
Ward B19	91.53%	82.85%	101.61%	97.80%	Additional shifts requested via NHSP to cover vacancy, maternity leave

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					and sickness. Ward manager working clinically to support ward.
Ward A7	83.28%	103.57%	85.48%	116.18%	Staffing reviewed daily and staff moved from other areas to support the ward. Ward Manager continues to support working clinically.
Ward C21	70.79%	129.17%	100%	138.70%	Staffing levels have improved this month and staff have been supporting other areas as required. Enhanced care in place to support patients individual needs.
Coronary Care Unit	95.51%	48.94%	97.84%	-	Daily assessment by senior nursing team, the team continue to support other areas when they are able to. Ward Manager continues to support clinically when required. 2 x RN remain on maternity leave.
Intensive Care Unit	96.90%	50.56%	95.47%	40%	7.97 Band 5 vacancy. Recruitment completed and awaiting start dates. 1.84 wte RN Long-Term Temporary Staffing accessed when required and utilised to maintain safe nurse:patient ratios.

Rachael Browning
Associate Chief Nurse, (clinical effectiveness)
May 2018

Warrington and Halton Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/18/07/63 aiii**
SUBJECT:	**Safe Staffing Assurance Report - June 2018**
DATE OF MEETING:	25 July 2018
ACTION REQUIRED	**The Board of Directors are asked to note the contents of the report**
AUTHOR(S):	**Rachael Browning – Associate Chief Nurse**
EXECUTIVE DIRECTOR SPONSOR:	**Kimberley Salmon –Jamieson –Chief Nurse**
LINK TO STRATEGIC OBJECTIVES:	SO1: To ensure that all care is rated amongst the top quartile in the North West of England for patient safety, clinical outcomes and patient experience
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	BAF2.2: Nurse Staffing
	BAF1.3: National & Local Mandatory, Operational Targets
	BAF1.1: CQC Compliance for Quality
STRATEGIC CONTEXT	SO1: To ensure that all care is rated amongst the top quartile in the North West of England for patient safety, clinical outcomes and patient experience.
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 actual falls below 90% of planned staffing levels. It is recommended that the Board of Directors receive a monthly Safe Staffing paper highlighting areas where average fill rates fall below 90% of actual versus planned, along with mitigation to ensure safe, high quality care is consistently delivered.
RECOMMENDATION:	It is recommended that the Board of Directors note and approve the monthly Safe Staffing Assurance Report.
PREVIOUSLY CONSIDERED BY:	**Committee**
	Agenda Ref.
	Date of meeting
	Summary of Outcome
FREEDOM OF INFORMATION STATUS	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	

Safe Staffing Assurance Report

The purpose of this paper is to provide transparency with regard to the nursing and midwifery ward staffing levels during June 2018. It forms part of the expectation set out in the National Quality Board (NQB) guidance published in 2016 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.

The Trust has a duty to ensure nursing and midwifery staffing levels are sufficient to maintain safety and provide quality care. This paper provides assurance that any shortfalls on each shift were reviewed and addressed as required with mitigating actions, including staffing levels and skill mix. 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.

All Trusts are to 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 of 90% and over is considered acceptable nationally.

The June Trust wide staffing data was analysed and cross referenced for validation by the Deputy Chief Nurse, Lead Nurses, and the Associate Chief Nurse (clinical effectiveness).

Key Messages

Although some areas are above the 90% target year to date, it is acknowledged that the percentage of registered nurses/midwives in the day is below the target. However, mitigation and responsive plans are in place to ensure that the safe delivery of patient care is discussed at every bed meeting and escalated as appropriate. Shift fill rates have improved from the previous month, however to maintain safe staffing levels bank incentives and escalated rates for critical areas have been put in place to improve the shift fill rate.

Recruitment remains a priority for the senior nursing team, we have seen some positive results during the past month, with 50 Health Care Assistants and 20 Registered Nurses recruited as part of the staffing business case.

The number of additional beds open across the trust has reduced further. The Trust currently has an additional 40 beds in use, 22 beds on Ward C22, with escalation beds on Ward A3 (10) AMU (7) and A5 (1), which are reviewed daily to determine the additional staffing required to ensure patient safety.

We reported 2 grade 2 pressure ulcers in June, which is shown by ward in (Appendix 1). Each of these cases are being reviewed by the Tissue Viability nurse and the Associate Chief Nurse, Patient Safety to identify themes and shared learning.

Four moderate harm falls have been reported this month, on ward A5, A1 and A8 and are currently being investigated.

Three cases of CDT have been reported in June on wards A5, A6 and A4. Each of these cases are currently being investigated.

Appendix 1 MONTHLY SAFE STAFFING REPORT – June 2018

Monthly Safe Staffing Report – June 2018

	Day		Day	Day	Day	Day	Day	Night	Night	Night	Night	Night	Night	Patient Harm by ward			
Division	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	Falls (Mod and Above)	Cdiff	MRSA	Pressure Ulcers
		= above 100%		= above 90%			= above 80%			= below 80%							
SWC	SAU	900	900	675	550	100%	81.5%	-	-	-	-	-	-				
SWC	Ward A5	1725	1293.8	1260	1230.5	75%	97.5%	1035	983.3	690	724.5	95%	105%	2			
SWC	Ward A6	1725	1357	1260	1253	78.6%	99.4%	1035	1035	690	693.5	100%	100.5%		1		
SWC	Ward CMTC	1196	1164.5	851	837.5	97.3%	98.41%	690	690	690	678.5	100%	98.3%				
SWC	Ward B4	822.5	901.5	280	391	109.6%	139.6%	345	345	345	644	100%	186.7%				
SWC	Ward A9	1725	1386.5	1380	1157	80.4%	83.7%	1035	1012	1035	1058	97.8%	109.5%				
SWC	Ward B11	1869	1782.4	756.9	703.4	95.4%	92.9%	1596.6	1520.4	-	-	95.2%	-				
SWC	NCU	1725	1378.5	345	276	79.9%	80%	1725	1345.5	345	241.5	78%	70%				
SWC	Ward C20	921	874	690	667	94.9%	96.7%	690	690	0	161	100%	-				
SWC	Ward C23	1380	1091.5	690	598	79%	86.41%	736	701.5	690	644	95.3%	93.3%				
SWC	Delivery Suite	2415	2077.5	345	241.5	86%	70%	2415	2265.5	345	345	93.8%	100%				
ACS	Ward A1	1875	1812.5	2250	2162.5	96.7%	96.1%	1575	1501.5	630	876	94.7%	139%	1			
ACS	Ward A2	1380	1101.5	1550	1398.5	79.81%	90.2%	1035	1011	690	874	97.7%	126%				2
ACS	Ward A3	1500	987	1725	1301.5	65.8%	75.4%	1035	920	1380	1426	88.9%	103%				
ACS	Ward A4	1621.5	1371	1380	1300	84.5%	94.2%	1035	919.5	1035	1158	88.9%	111.9%				
ACS	Ward A8	1725	1219	1725	1665	70.66%	96.5%	1035	1035	1725	1656	100%	96%	1	1		
ACS	Ward B12	1035	940	2415	1817	90.8%	75.2%	690	690	1725	1649.5	100%	95.6%				
ACS	Ward B14	1380	1209	1380	1287.5	87.60%	93.3%	690	690	690	759	100%	109.7%				
ACS	Ward B18	1426	1144.5	1426	1231	80.3%	86.3%	1069.5	851	1069	1052	79.6%	98.4%		1		
ACS	Ward B19	1035	929.5	1380	1196	89.8%	86.7%	713	690	1035	1046.5	96.8%	101.1%				
ACS	Ward A7	1725	1436	1380	1388.5	83.2%	100.6%	1380	1288	1035	1138.5	93.2%	110%				
ACS	Ward C21	1035	1170	1035	869.9	113%	84%	690	690	1035	1000.5	100%	96.7%				
ACS	CCU	1380	1264.5	345	171.5	91.5%	49.7%	1035	1023.5	0	0	98.9%	%				
ACS	ICU	4830	4352.8	1035	644	90%	62.2%	4830	4301	690	322	89%	46.5%				

Appendix 2

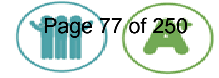
June 2018 - Mitigating Actions

	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	100%	81.5%			SAU closes at night, therefore no requirement for staff after 10pm.
Ward A5	75%	97.5%	95%	105%	The ward has a number of band 5 vacancies, 1 band 4 and a number of staff on maternity leave. Staff are moved from other areas to support and maintain safe staffing levels. When the trained numbers have been reduced there has been additional HCA to support the ward.
Ward A6	78.6%	99%	100%	100.5%	The ward has maternity leave and band 5 vacancies (5.31wte) . When the trained numbers have been reduced there has been additional HCA to support the Ward.
CMTC	97.3%	98.41%	100%	98.3%	Staffing levels reviewed daily against activity and acuity.
B4	109.6%	139.6%	100%	186.7%	Ward reviewed daily, increased number of HCA to support the step down patients on the ward. The HCA numbers have been increased on nights to support the additional patient care needs.
Ward A9	80.4%	83.7%	97.8%	109.5%	2 WTE band 5 vacancies have recently appointed commencing in Sept 18. The ward has 1wte maternity leave on the ward. The ward is assessed daily by the matron and staff are moved from other areas to support, based on the ward acuity.
NCU	79.9%	80%	78%	70%	5 staff on long term sick leave, they are being managed in line with Trust policy. 2 staff are currently on maternity leave, and there are 1.6wte band 5 vacancies. The unit is reviewed daily by the lead nurse, which includes an acuity assessment.
Ward C20	94.9%	96.7%	100%	%	The ward was escalated overnight in Jun, however with the opening of the GAU this has now ceased. Staffing is

					reviewed daily, which includes an acuity assessment.
Ward A1 - AMU	96.7%	96.1%	94.7%	139%	Staffing is reviewed daily by the matron, staff are moved from other areas to support when required. Additional HCA required to increase staffing levels, particularly on night duty and to support enhanced care needs.
Ward A2	79.81%	90.2%	97.7%	126%	The ward has 5.82wte band 5 vacancies, Any unfilled shifts filled by NHSP and agency, and additional HCA shifts are used for enhanced care needs and to support staffing. Short term sickness is being managed appropriately.
Ward A3 Opal	65.8%	75.4%	88.9%	103%	The ward currently has an additional 10 beds in use, taking the ward to 34 beds. Additional shifts requested on NHSP and staff are moved from other areas to support. Ward manager supporting the ward clinically. Enhanced care needs regularly assessed and additional shifts requested.
Ward A4	84.5%	94.2%	88.9%	111.9%	The ward has 1.2wte band 5 vacancies. Daily review by the matron to review staffing levels and acuity, staff moved from other areas to support. Additional HCA staff are used to support enhanced care needs.
Ward A8	70.66%	96.5%	100%	96%	There are 2wte band 6 vacancies on the ward, and a staff member on maternity leave. The ward is reviewed daily and staff are moved from other areas to support. Additional staff provided by NHSP and agencies to cover short fall of RN hours. Local recruitment programme in place.
Ward B12 (Forget-me-not)	90.8%	75.2%	100%	95.6%	Ward continues to risk assess to establish requirements for enhanced care hours needed. These hours requested via NHSP. Ward manager supports the ward daily to ensure safety.
Ward B14	87.6%	93.3%	100%	109.7%	Ward manager working clinically to support the ward when required. Additional shifts requested to cover vacancy and sickness, fill rates are good. Enhanced care needs assessed daily & additional shifts requested where needed. The ward will be

					fully established by Sept 18
Ward B18	80.3%	86.3%	79.6%	98.4%	Additional shifts are requested via NHSP to cover sickness & vacancies, particularly when the cohorting of patients is required. Ward manager supports ward clinically to ensure safety. Staffing is reviewed daily and staff are moved to support when required.
Ward B19	89.8%	86.7%	96.8%	101.1%	Additional shifts requested via NHSP to cover vacancy and sickness. Ward manager working clinically to support ward.
Ward A7	83.2%	100.6%	93.2%	110%	Staffing reviewed daily and staff moved from other areas to support the ward. Ward Manager continues to support working clinically.
Ward C21	113%	84%	100%	96.7%	Staffing levels have improved this month and staff have been supporting other areas as required. Enhanced care in place to support patients individual needs.
Coronary Care Unit	91.5%	49.7%	98.9%	%	Daily assessment by senior nursing team, the team continue to support other areas when they are able to. Ward Manager continues to support clinically when required, particularly as RN fill rates are low.
Intensive Care Unit	90%	62.2%	89%	46.5%	Band 5 vacancies to be converted to Band 6 to ensure adequate skill mix. Staffing assessed daily and support provided by NHSP and agency when required to maintain safe nurse:patient ratios.

Rachael Browning
Associate Chief Nurse
June 2018



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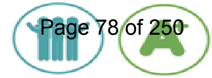
Warrington and Halton Hospitals NHS Foundation Trust

BOARD OF DIRECTORS CHAIR'S KEY ISSUES REPORT

AGENDA REFERENCE:	BM 18 07 63 (b)	COMMITTEE OR GROUP:	Trust Board	DATE OF MEETING	25th July 2018

Date of Meeting	3rd July 2018
Name of Meeting + Chair	Quality Assurance Committee, Chaired by Margaret Bamforth
Was the meeting quorate?	Yes

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/ mandate to receiving body	Follow up/ Review date
QAC/18/07/74	**Action Log** Mandatory Training Compliance update	The report included a compliance report, correct at May 2018 for Core Skills Framework mandatory training modules and training requirements for staff together with a Training Needs Analysis for the 4 levels of Resuscitation Training. Assurance was not received in respect of staff compliance with mandatory training across the Trust. Concerns were noted that the data did not provide a current position in addition to the 2 week 'lag' to update the system with valid data.	The Committee requested a specific training compliance update to be included in the G2G High Level Briefing Report.	**QAC Sept 2018**



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QAC/18/07/77	**DNACPR Deep Dive Review**	• Improvement reported in verification of completed forms by Senior Doctors • Issues identified relating to recording and accessing data on Lorenzo to support correct completion of forms. • Compliance reported for 24 hour clinician rotas where required. • Resus trollies – some checklists reviewed were Equipment lists, not Resus trolley checklists and this had been feedback to CQC.	The Committee requested an update following further review of completed forms including Resus Trolley audit after findings of September review are concluded and reported through G2G High Level Briefing.	**QAC Sept 2018**
QAC/18/07/76	**Getting to Good (G2G) Steering Group**	• Of the 206 actions due for completion, 133 completed and 73 outstanding. • Emerging risks were reported in training and fundamental breaches	The Committee requested a breakdown of fundamental breaches into individual elements to help understand further the outstanding elements.	**QAC Sept 2018**
QAC/18/07/78	**Maternity Update/Maternity Safety Champion update**	An overview was provided of progress against the 10 maternity safety actions and highlights from the Maternity Dashboard. Of note was: • Audit of Indications of Labour (IOL) cases identified compliance with local guidance relating to IOL for Induction but reduced compliance with offering outpatient IOL • The Trust is using National Review tool to review Perinatal deaths and recommendations from these reviews implemented following completion of the process	• The Committee to receive a report following Perinatal Mortality Review at a future meeting. • To provide additional assurance the Chief Nurse requested a review to be undertaken of Maternity Services and staffing using BirthRate Plus by the Deputy CN and Associate CN Clinical Effectiveness, findings to be reported in Maternity HLB.	**QAC Sept 2018**

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QAC/18/07/85	**Ward Accreditation Scheme**	The Key elements of the scheme were outlined. Of note was: • The Programme had commenced in May 2018 and 4 Ward Accreditation visits had taken place, with outcomes due to be announced on 4 July • Learning and best practice will be shared across wards to support set standards to be replicated.	• The Committee reviewed and noted the report and approved the roll out and implementation of the Ward Accreditation Programme across the Trust. • The Committee to receive a quarterly report and cycle of business to be updated.	**QAC Sept 2018**
QAC/18/07/86	**Research and Development Quarterly Report**	An overview of the current activity in the Trust was provided. Notable achievements within the last year include development of communication streams, awareness raising to support further engagement and establishment of a Clinical Trials Unit in Pharmacy.	The Committee to receive future quarterly reports, cycle of business to be updated.	**QAC Nov 2018**
QAC/18/07/87	**National Inpatient Survey results for 2017**	The Committee received overview of the survey results. • There had been a significant improvement on 42 questions overall. • The associated action plan continues to be reviewed and monitored at the Patient Experience Committee with escalation to QAC.	The Committee reviewed and noted the report and the associated action plan.	**QAC Sept 2018**

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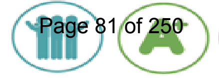
QAC/18/07/88 (b)	**IPR Amendments**	The report provided details of how the Governance department wished to amend information to the Quality Section of the Board Integrated Performance Report in order to provide further assurance in certain work streams.	The Committee supported and approved the proposed amendments for recommendation to the July Trust Board for formal ratification	**Trust Board July 2018**
QAC/18/07/80 QAC/18/07/81 QAC/18/07/82 QAC/18/07/83	**Annual Reports**	The Committee received the following Annual Reports: • Health & Safety • DIPC Infection Control • Medicines Management / Controlled Drugs • Clinical Audit	The Committee received the reports	**QAC July 2019**



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CHAIR'S KEY ISSUES REPORT

AGENDA REFERENCE:	BM/18/07/63di	COMMITTEE OR GROUP:	Board of Directors	DATE OF MEETING	25 July 2018

Date of Meeting	23rd May 2018
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/18/05/60	**Lorenzo Digital Exemplar Bid**	• Received presentation • Reviewed costing	Assurance that additional costs would be covered from capital budget.	
FSC/18/05/61	**Lorenzo Benefits**	• Reviewed		
FSC/18/05/62	**Pay Assurance Dashboard Monthly Report**	• Overspend £218k linked to winter ward continued with 46 escalation beds • Review activity v pay graph • Noted bank increase and agency reduction • Nurse recruitment continues with 112 interviews to date – 40 to 50 planned to start in September.	Continue to monitor agency and bank reduction as vacancies reduce	**June 2018 FSC Committee**

FSC 18/05/63	**Corporate Performance Report**	• 4 hour performance standard –
		    o April 86.73% against trajectory of 85%
		    o May to date 90.43% against trajectory of 85%
			The Committee reviewed, discussed and noted the report.	**June 2018 FSC Committee**

		• RTT and cancer achieved in April • Diagnostic 98.57% target missed in April plan to hit by June		
FSC/18/05/66	**Monthly Finance report**	• Month 1 position reviewed • Use of resources is 4 caused by exceeding agency ceiling • Fire discussed – received confirmation NHS resolution liability for damage. • Noted Cheshire and Mersey financial position for month 12 • Month 1 CIP underachieved and discussed profile and gap in plan	The Committee reviewed, discussed and noted the report and the financial challenges faced. Creditors position noted regular review needed	**June 2018 Board**
FSC 18/05/68	**AOB – Trust Control Total**	• Reviewed offer to improve Trust financial position and access PSF. • Considered benefits, risks and pressures in the system	Endorsed and recommend to Board	**May 2018 Board**

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CHAIR'S KEY ISSUES REPORT

AGENDA REFERENCE:	BM/18/07/63dii	COMMITTEE OR GROUP:	TRUST BOARD	DATE OF MEETING	25 July 2018

Date of Meeting	20th June 2018
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/18/06/79	**Warrington Care Record**	• Received presentation on financial implications • Considered benefits • Operational risks regarding future funding and take up / change management mitigated by 2 year project plan	Recommend financial element to Board	
FSC/18/06/73	**Pay Assurance Dashboard Monthly Report**	• Overspend £0.2m linked to escalation beds • Review activity v pay graph • Noted bank decrease and agency increase • Vacancy levels higher due to new posts added to budget • Nurse recruitment continues on 10th July	Continue to monitor agency and bank reduction as vacancies reduce	**July 2018 FSC Committee**
FSC/18/06/80	**Scan for safety presentation**	• Received presentation • Costs will be identified through feasibility study	Assurance of process received, finances will be reviewed when available	**Future FSC Committee**

FSC 18/06/75	**Corporate Performance Report**	• 4 hour performance standard –
		  o April 86.73% against trajectory of 85%
		  o May 90.91% against trajectory of 85%
		  o June to date 92.03% against trajectory of 85%
			The Committee reviewed, discussed and noted the report.	**July 2018 FSC Committee**

		• RTT and cancer achieved in May • Diagnostic target missed in April plan to hit by August with activity coming back in house		
FSC/18/06/76	**Monthly Finance report**	• Month 2 position reviewed • Use of resources is 3 • Aged creditors has increased by £0.7m • Fire conversations about whole cost not just the roof • There is £0.8m in the budget for job planning and this will be discussed further at the next meeting • Month 2 CIP underachieved, discussed profile and gap in plan	The Committee reviewed, discussed and noted the report and the financial challenges faced.	**July 2018 FSC Committee**
FSC/18/06/77	**Operational Plan resubmission**	• Reason for resubmission and change to control total noted • Additional changes to trajectory and narrative to workforce, activity and finance section	The Committee received overview of changes made to the resubmission of the operational plan	**June Trust Board**
FSC/18/06/78	**CIP Presentation / Transformation Reporting**	• Highlighted possible tactical CIP gap of £1.1m • Risk of transformational CIP creating costs out with escalation beds still open and current RTT pressures • Committee mindful of time implications and fortnightly monitoring. • Reviewed the Strategy map and noted alignment to the work streams • Reporting programmes of work aligned to sustainability as a dashboard will come to FSC • Welcome the strategy but noted cannot take our eye off the operational issues	The Committee needs assurance to give to the Board on CIP	**July 2018 FSC Committee**

CHAIRS KEY ISSUES REPORT

AGENDA REF	BM/18/07/63e	COMMITTEE OR GROUP:	Trust Board of Directors	DATE OF MEETING	25 July 2018	CHAIR:	

Date of Meeting	22 May 2018
Name of Meeting	Workforce Committee
Was the Meeting Quorate	Yes

REF	AGENDA ITEM	LEAD OFFICER	Issue / Exception Report	Recommendation / Assurance/ Action/Decision	Follow up/ Review date
WC/18/ 05/82	**CBU Trajectory Reports**	**CBUs**	Representatives from the Leadership Triumvirates from the following CBUs: • DD, SM, UEC, WCH, DIA, SS Purpose for attendance was to receive feedback on their trajectory reports. MSK were not required to attend as their exception report and trajectories provided assurance that the required compliance will be achieved.	**Assurance:** **Return to Work Interviews** The exception reports and the trajectories provided, as well as the April 18 compliance figures, gave assurance that the required compliance will be achieved. **Action:** **PDRs and Mandatory Training** • The exception reports and the trajectories provided did not give assurance that the required compliance will be achieved. Some CBUs had already completed PDR trajectories for the G2G, M2O meeting but they were not included in the reports to Workforce Committee therefore MCl will review those trajectories. • Communications to clarify the difference between ESR and the full reports.	**May 2018** **May 2018**

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				• Full, detailed report will be provided in July 2018. • A big piece of work is on-going to input competencies into ESR and train managers to pull reports for their areas. **Decision:** **PDR and Mandatory Training** Decision not to reinstate People Measures Meeting, rather to ensure that the exception reports provided to TOB are more detailed in order to provide the assurance required.	**July 2018** **September 2018**
WC/18/ 05/83	**PDR Review**	**Liz Pritchard, OD Manager**	Presentation and recommendations delivered to Workforce Committee. Note: the outcome of the NHS pay deal could have a significant impact on the PDR process. Workforce Committee - Apprais	**Decision:** • Recommendations 1-5 to be paused until the outcome of the pay deal is known. • Recommendations 6-10 to be taken forward and plans developed up to be brought back to the June 2018 Workforce Committee.	**July 2018** **June 2018**
WC/18/ 05/84	**Apprenticeships**	**Sandra McCann, Apprenticeship Lead**	Presentation delivered to Workforce Committee PPT Think Apprentice.Workforce	**Assurance**	
WC/18/ 05/86	**Annual Report**	**Michelle Cloney, Director of HR and OD**	Annual report presented to the Committee The following items were identified as priorities going forward: • HENW Streamlining Project • Job Planning • CQUIN	**Assurance**	

			• Time Off for Union Activities Review of People Strategy		
WC/18/ 05/87	**Director of HR and OD Report**	**Michelle Cloney, Director of HR and OD**	The Director of HR and OD updated the Committee on the following: • Draft WHH Strategy • The Perfect Day (Staff Engagement) • Listening into Action – Call to Arms – Pulse Check Survey • Cultural Change and Leadership • Kendrick Wing Fire – March 2018	**Assurance**	
WC/18/ 05/88	**BAF and Risk Register**	Mick Curwen, Head of Strategic HR Projects	The Workforce Committee were updated on risks relating to workforce.	**Assurance**	
WC/18/ 05/89	**People Strategy Report and Dashboard**	**Heads of Service, HR and OD**	The Workforce Committee were updated on the KPIs which demonstrate progress against the People Strategy: PDF WHH People Strategy Dashboard.p	**Action:** • TNAs for role specific training – must be completed by 8.6.18	**8 June 2018**
WC/18/ 05/91	**Employee Relations Report**	**Helen Dixon, Head of HR Business Partners**	1 key case for escalation to the Committee – work is on-going with Director of Finance and Director of HR and OD with MIAA	**Assurance**	
WC/18/ 05/92	**Policies and Procedures**	**Mick Curwen, Head of Strategic HR Projects**		**Decision :** The following policies were approved: • Training and Development Policy • Apprenticeship Policy • Annual Leave Policy	
WC/18/ 05/93	**Guardian of Safe Working Report**	**Mick Curwen, Head of Strategic HR Projects**	The Committee were updated on the most recent report on safe working hours for junior doctors. Issues identified: Number of outstanding exception report and	**Assurance**	

			timeliness of educational supervisors in completing them.		
WC/18/ 05/95	**Engagement and Recognition Report**	**Head of HR Business Partners and Head of Communications**	The Workforce Committee were updated on the activity in relation to Engagement and Wellbeing in the last month.	**Assurance**	
WC/18/ 05/98	**Contemporary Ward**	**Head of Workforce Transformation**	Terms of reference for the steering group were presented for approval	**Decision:** Terms of reference approved	
WC/18/ 05/104	**Staff Engagement and Wellbeing Group**	**Head of Communications**	Terms of reference for the steering group were presented for approval	**Decision:** Terms of reference approved	

CHAIRS KEY ISSUES REPORT

AGENDA REF	BM/18/06 63 e	COMMITTEE OR GROUP:	Trust Board	DATE OF MEETING	25 July 2018	CHAIR:	Deborah Smith, Deputy Director HR&OD

Date of Meeting	19 June 2018
Name of Meeting	Workforce Committee
Was the Meeting Quorate	Yes

REF	AGENDA ITEM	LEAD OFFICER	Issue / Exception Report	Recommendation / Assurance/ Action/Decision	Follow up/ Review date
WC/18/ 06/109	Annual Cycle of Business	Carl Roberts, Head of Workforce Transformation	Proposed amendments to the annual cycle of business were approved by the Committee.	To note	
WC/06/ 18/117	Workforce Race Equality Standard (WRES)	Michelle Halliwell, Equality and Diversity Specialist	The attached WRES report was approved for submission with some minor amendments. Actions will be monitored vie Equality and Diversity Sub-Group. WRES REPORT 2018.docx	To note	
WC/06/ 18/111	Agenda for Change Pay Award	Mick Curwen, Head of Strategic HR Projects	The Committee received a paper detailing the key elements of the Agenda for change pay award including: • Increase in starting salaries across all bands; • Increase in value point of each pay band;	Action: Further updates to be provided to the Workforce Committee following NHS Staff Council 'sign off' of the pay deal on 27 June 2018. To Note:	July 2018

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			• Reduction in the number of pay points across all bands; • Bands 8c, 8d and 9 retain an element of re-earnable pay; • Minimum basic pay rate of £17,460; • Band 1 closed to new entrants from 1.12.2018; • New progression framework from 1.4.2019; • Work programme focused on attendance management; • New provisions around child bereavement leave, shared parental leave, bullying and harassment and buying/selling annual leave; • Amendments to the eligibility for unsocial hours payments during occupational sick leave. • New provision on Apprentice pay to be negotiated by NHS Staff Council as a priority.	The Committee approved back pay in August 2018.	
WC/18/ 06/113	People Strategy Dashboard	Heads of Service	The Committee received the People Strategy Dashboard. Key messages included: • A focus on mental health related absence; • Return to work interview (RTWI) compliance had reduced significantly to 76.8%;	Escalation: • Mental Health First Aider training is being launched in June 2018 but only 4 staff have signed up so far. 2 day training: 28.6.18 and 6.7.18. • RTWI are an essential part of supporting staff back to work after absence. Trust Operational Board are asked to escalate	June 2018 Monthly

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			• Vacancies had increased following additional investment in nursing – the HR and OD team are working with Nursing Leadership to attract and recruit; • PDR compliance increased from 74% in April 2018 to 82.3% in May 2018 • Mandatory Training compliance was 83.6% - Resuscitation Training level 2 was only 52%	to managers the importance of completion and 'live' recording. • Level 2 Resuscitation Training is provided in house – 8 sessions per week. Trust Operational Board are asked to escalate to managers the importance of ensuring staff are released to attend, as well as the importance of completion of levels 3 and 4 resuscitation training, where appropriate.	Monthly
WC/18/ 06/115	Policies and Procedures	Mick Curwen, Head of Strategic HR Projects	The following policies were ratified: • Annual Leave • Training and Development • Apprentice • Job Planning	To note	
WC/18/ 06/118	Facilities Time Off Annual Report	Mick Curwen, Head of Strategic HR Projects	The attached Facilities Time Off report was approved for submission. Facilities Time Off.docx	To note	

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Warrington and Halton Hospitals NHS
NHS Foundation Trust

CHAIRS KEY ISSUES REPORT

AGENDA REF	BM/18/07/63 e	COMMITTEE OR GROUP:	Trust Board of Directors	DATE OF MEETING	25 July 2018	CHAIR:	Deborah Smith, Deputy Director HR&OD

Date of Meeting	17 July 2018
Name of Meeting	Workforce Committee
Was the Meeting Quorate	Yes

REF	AGENDA ITEM	LEAD OFFICER	Issue / Exception Report	Recommendation / Assurance/ Action/Decision	Follow up/ Review date
WC/18/07/131	FTSU Update/Board Self-Assessment Requirements linked to Well Led	Jane Hurst, FTSU Guardian	Jane Hurst, FTSU Guardian, gave a presentation to update the Committee on FTSU progress to date and action plan to meet requirements going forward. FTSU Workforce Committee 17 july 18	**Action:** Trust Operational Board is asked to escalate to managers the importance of promoting FTSU amongst staff. Managers are asked to contact Jane Hurst to invite her to attend any relevant meetings to reach staff.	
WC/18/07/132	Director of HR and OD Report	Michelle Cloney, Director of HR and OD	Mental Health First Aiders – the Committee recognised the success of the first course. Demand for future courses is high and so additional dates will be provided. Strategic People Committee (SPC) and Operational People Committee (OPC) – the Committee were updated on proposals to create a Strategic and an Operational People Committee. A paper is being taken to Trust Board (25 July 2018) and should this be approved this will be the last Workforce	**To note**	

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			Committee with the SPC having its first meeting in September 2018. People Strategy Update – the Committee were updated on the progress of refreshing the People Strategy, the drivers for this refresh (National Workforce Strategy consultation & new trust Strategy) and the engagement activities undertaken to date to inform the refresh. The E&D Strategy is also being updated in line with the new Trust Strategy which clearly highlights the importance of diversity and inclusiveness. Listening into Action – the Committee were updated on the success of phase 1 in achieving the best national update and the next steps following the survey.		
WC/18/07/133	BAF & Risk Register	Mick Curwen, Head of Strategic HR Projects	The Committee reviewed the Employee Engagement risk. DS recommended that the risk score is reduced from 12 as the most recent engagement score was 3.72 / 5. National average was 3.79.	**Decision:** The Committee approved for the Employee Engagement risk score to be reduced to 4 (consequence) x 2 (likelihood). The Committee acknowledged that this is a key work stream and the Trust ambition is to lead the way with engagement.	
WC/18/07/134	People Strategy Report and Dashboard	Deborah Smith, Deputy Director of HR and OD	**Engage:** Sickness absence reduced but remained above target at 4.65% Return to work interviews - 81.10% in June – below target. The Workforce Committee will task the Staff Engagement and Wellbeing Committee to lead on a plan to address RTWI compliance.	**Action:** RTWI were reported as 77% in May. Refreshed data shows May at 85%. This is due to retrospective inputting of RTW data since the last report was run. This data highlights the need for more timely completion of the RTW interview and inputting of the data on	

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			Retain: Turnover is below Trust target. Previously had benchmarked against NW average. More recently are benchmarking against peer group average (via model hospital). Trust turnover is above peer average. Committee will review over the next quarter to establish trend. PDR Compliance is 82.8% Resuscitation Training: Level 2 compliance remains very low at 52%	to either E-Rostering or ESR. The HRBP team continue to work with the CBU/Depts to raise this importance of this aspect of the attendance policy. Further support has also been provided by the Head of Workforce Transformation to support the nursing teams to understand the data better. Action: Trust Operational Board is asked to escalate to managers the importance of completing PDRs in a timely manner and also emailing the training team immediately to confirm completion. Assurance: The HR and OD Directorate have undertaken the following additional actions on top of usual training capacity: • Flyer clarifying expectations for Medics • Changes to funding arrangements for Medical Staff • Supporting MD with individual correspondence to Medics • Additional training sessions – early mornings • Additional training sessions - evenings	

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				Trust Operational Board are asked to note that there has been no attendance at the first 2 early morning sessions – these sessions were specifically requested by CBUs in G2G, M2O.	
WC/18/07/135	Employee Relations Report	Helen Dixon, Head of HRBPs	The Committee received the Employee Relations update report. 5 high risk cases were escalated to the Committee.	Assurance	
WC/18/07/137	Engagement and Recognition Report	Helen Dixon, Head of HRBPs/Candice Ryan, Head of Communications	The Committee discussed the importance of increasing response rates to staff FFT. The Workforce Committee will task the Staff Engagement and Wellbeing Committee to lead on a plan to address RTWI compliance.	Assurance	
WC/18/142	Any other business – Facilities Time	Mick Curwen, Head of Strategic HR Projects	Staff side have challenged the inclusion of job matching in the facilities time submission and have produced a document which indicates that a national agreement has been reached with regards to this. This will be reviewed and any changes in the submission will be signed off by WFC via chair's action to ensure that the deadline of 31.7.18 can be met.	Assurance	

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/18/07/64**
SUBJECT:	**Amendments to the Quality Section of the Board Integrated Performance Report**
DATE OF MEETING:	**25th July 2018**
ACTION REQUIRED	**The Board are asked to discuss the paper and agree the recommendations within**
AUTHOR(S):	**Hayley McCaffrey, Head of Clinical Effectiveness & Quality**
EXECUTIVE DIRECTOR	**Kimberley Salmon-Jamieson, Chief Nurse**
EXECUTIVE SUMMARY	A summary of key points for discussion are described below: The Governance department wishes to amend information to the Quality Section of the Board Integrated Performance Report in order to provide further assurance in certain work streams.
RECOMMENDATIONS	Discuss and approve the recommendations within the paper.
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None

SUBJECT	Amendments to the Quality Section of the Board Integrated Performance Report

1. BACKGROUND/CONTEXT

The Governance department wishes to amend information to the Quality Section of the Board Integrated Performance Report in order to provide further assurance in certain work streams.

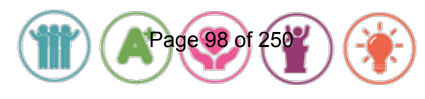
2. KEY ELEMENTS

The following suggested amendments require approval;

- Remove the Cancelled Operations section from the Quality section as this is monitored via Access & Performance.
- Remove the Dementia section as this is monitored via the Forget Me Not Steering Group, Patient Safety and Effectiveness Sub Committee and Patient Experience Sub Committee along with the Specialist Medicine CBU.
- Remove the Discharge section from the Quality section as this is monitored via Access & Performance.
- Split the Safety Thermometer section into three separate tables and RAG ratings as they nationally have varying targets.
- Split the RAG rating for Healthcare Acquired Infections as the targets vary and the RAG rating is therefore not a true reflection of current performance.
- Amend the Falls target to reflect current Trust target which is to reduce the overall number of falls by 20% compared to 2017/18.
- Amend the description of the Incidents section to include details of the 2018/19 Quality Priority relating to Increasing Incident Reporting.
- Utilise SPC charts for some areas of the Quality section to show upper, central and lower lines for control limits.
- NHSI provider bulletin has highlighted the requirement for Trust Boards to have robust oversight and regular monitoring of Gram negative blood stream infections. Therefore we wish to add the following 2 Gram negative blood stream infections (which are being reported to PHE) to the integrated dashboard:-
    - Klebsiella
    - Pseudomonas aeruginosa

3. RECOMMENDATION

The Board are asked to discuss the paper and agree the recommendations within.



REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/18/07/66**
SUBJECT:	**Annual Complaints Report**
DATE OF MEETING:	25th July 2018
ACTION REQUIRED	**Note the report and include on Trust Annual Report**
AUTHOR(S):	Ursula Martin, Director Integrated Governance + Quality Laurence Bond, Head of Complaints and PALS
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse
LINK TO STRATEGIC OBJECTIVES:	All
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	All
STRATEGIC CONTEXT	This report includes a summary of Formal Complaints raised by Service Users between 01 April 2017 and 31 March 2018 (the period).
EXECUTIVE SUMMARY (KEY ISSUES):	• The Trust put in place a significant improvement plan in this period following recognition that there were significant numbers of complaints that had breached Trust, regulatory and statutory frameworks. • Significant work was also undertaken regarding training of staff in complaints handling, investment in the Trust Datix system and monitoring and follow up of action plans. • Performance for complaints and PALS in year is as follows • 456 complaints were received during the period, an increase of 6% from 2016/2017 (430); • 656 complaints were closed during the period of which 203 were Upheld, 263 were Partially Upheld, and 190 were Not Upheld; • 17 complaints were withdrawn during the period; • 17 complaints were found on review to be Serious Incidents; • 66 complaints were open at the end March 2018, with 21 in backlog i.e. breached timeframes against Trust policy; • 8 PHSO cases are currently being investigated; and • 1397 PALS cases have been received. These figures are correct on the date of reporting 04/04/2018.
RECOMMENDATION:	Note the report

PREVIOUSLY CONSIDERED BY:	**Committee**	Quality + Assurance Committee
	Agenda Ref.	QAC/18/05/58
	Date of meeting	1st May 2018
	Summary of Outcome	Noted
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None	

NAME OF COMMITTEE

SUBJECT	Annual Complaints Report	AGENDA REF:	BM/18/07/66

1. BACKGROUND/CONTEXT

The purpose of the annual complaints report is to satisfy the requirements of the NHS complaints procedure in England, effective from 1 April 2009, and to analyse and identify trends in the occurrence of complaints. The report is prepared annually, and analyses the activity relating to 'formal' complaints data received in the period covering the past financial year.

Warrington and Halton Hospitals NHS Foundation Trust is committed to providing high standards of patient centred care. The Trust encourages a culture that seeks and then uses peoples' experience of care to improve quality and welcomes feedback from the people who use our services.

The Trust recognises that there are times when its actions do not meet the expectations of those that use our services. When that happens, the Trust has a policy which sets out the procedure to make sure that we listen and respond to complaints and concerns from patients, their relatives and carers and that complaints are properly investigated and monitored.

The Trust understands that by listening to people about their experiences of our services, staff can learn new ways to improve, and prevent the same issues from happening in the future. By seeking, monitoring and acting upon feedback, we are able to make improvements in areas that patients, their relatives and carers say matter most to them.

Effective complaints handling is a cornerstone of the patient experience and the Trust aims at all times to provide local resolutions to complaints and takes all complaints seriously. By listening and responding to complaints we aim to remedy the situation as quickly as possible and ensure that the individual is satisfied with the response they receive. The learning from complaints is used to improve services for the people who use them as well as for the staff working in them.

In accordance with the NHS complaints procedure, the annual complaints report is made available to the public. It is publishable as part of the Freedom of Information Act publication scheme.

The following key principles must be applied:

- Complaints and concerns will be dealt with in a fair, flexible and conciliatory manner, encouraging open communication between all parties;

- High standards of conduct are expected from all staff at all times to ensure that service users/representatives will be treated respectfully, courteously and sympathetically;
- The requirement to maintain confidentiality during the complaints process will be absolute (unless indicated otherwise);
- All patients and their families will be advised how they can raise a concern or make a formal complaint via information leaflets available on all wards and clinical service units and the internet;
- All people who make complaints will be advised of the various independent support agencies that are available to assist them in making their complaint;
- As far as possible, people who make complaints will be involved in decisions about how their complaints are handled and considered;
- The Trust will aim to resolve complaints within the Trust as part of local resolution (first stage of the national complaints procedure), wherever possible;
- Complainants receive a meaningful apology when appropriate;
- The Trust will identify appropriate learning and implement change as the result of a complaint where appropriate;
- The Trust will co-operate with other organisations when a complaint involves other outside organisations;
- No person who makes a complaint will be discriminated against on the grounds of religion, gender, race / ethnicity, disability, age or sexual orientation or because they have made a complaint.

2. KEY ELEMENTS

Following a review undertaken in 2016/2017 into the complaints function at the Trust, the Trust invested significantly in an improvement plan to ensure:

- The backlog of complaints in the Trust was reduced,
- The timeliness of responses to complainants improved,
- A new policy and a new process was developed on how the Trust deals with complaints, to ensure it was more person centred,
- Training was provided to staff to ensure they were trained on the Trust's new complainants policies and processes and on good complaints handling,
- A Quality Assurance Group led by the Trust Chairman was developed to review the quality of our complaints responses and to promote accountability of leading the complaints agenda at senior management level within the clinical services,
- An improvement in how the Trust responds to PALS concerns,
- To reduce the number of dissatisfied complainants and PHSO referrals,
- Improve the system (Datix) used to log complaints, to make it more accessible and create an environment of visible data, and
- Improve the lesson learning from complaints and compliance of actions arising through audits.

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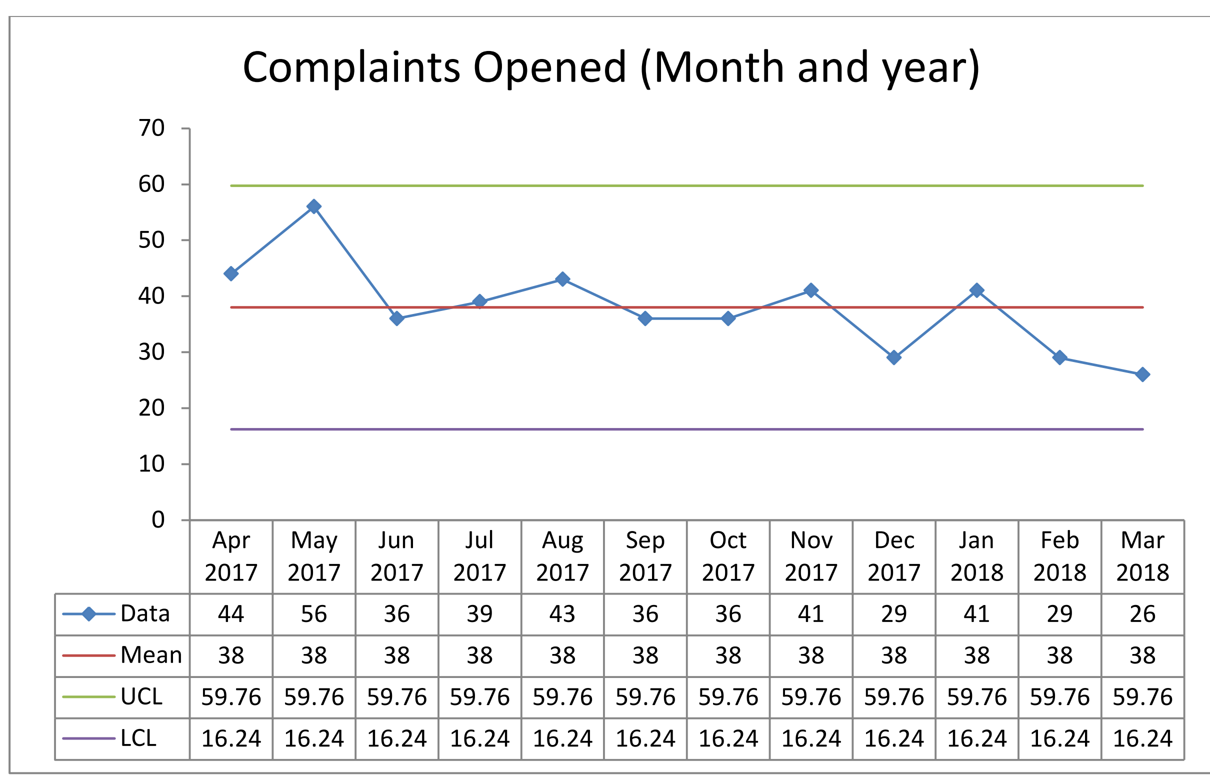
2.1 Complaints received

The Trust uses complaints to listen, learn and improve our services from the feedback given by the service users.

456 complaints were received during the period, an increase of 6% from 2016/2017 (430). The graph below details the amount of complaints opened over time:



2.2 Complaint themes

Formal complaints can be received for a variety of reasons. The below chart shows the primary subjects of complaints opened during this period. It should be noted that due to updating of the Datix system, the codes have changed slightly as of 1 January 2018 and therefore there will be some codes that will not be as used as others.

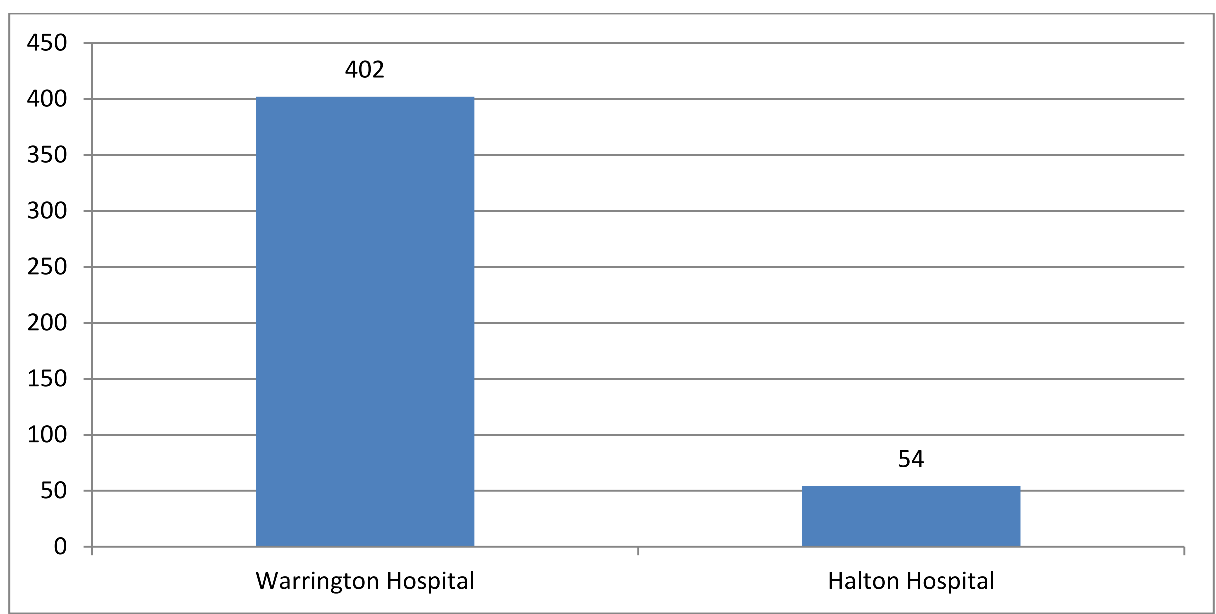
Subjects	Amount
Care (-2017)	82
Clinical treatment	59
Treatment (-2017)	50
Diagnosis (-2017)	49
Attitude (-2017)	39
Communication Problems (-2017)	30
Cancellations (-2017)	28

Subjects	**Amount**
Discharge Problems (-2017)	20
Medication (-2017)	18
Waiting Times (-2017)	14
Attitude and behavior	12
Communication (oral)	8
Medical Records (-2017)	7
Environment Problems (-2017)	6
Date for appointment	4
Date of admission / attendance	4
Falls (-2017)	3
Transfer Problems (-2017)	2
Referral to other services (-2017)	2
Information (-2017)	2
Cleanliness / laundry	2
Medical Equipment (-2017)	2
Nutrition (-2017)	2
Admissions / transfers / discharge procedure	1
Premises	1
Competence	1
Other (-2017)	1
Privacy & Dignity (-2017)	1
Patient privacy / dignity	1
End of Life Care (-2017)	1
Patient property / expenses	1
Bed shortages	1
Personal records	1
Failure to follow agreed procedures	1
Total	**456**

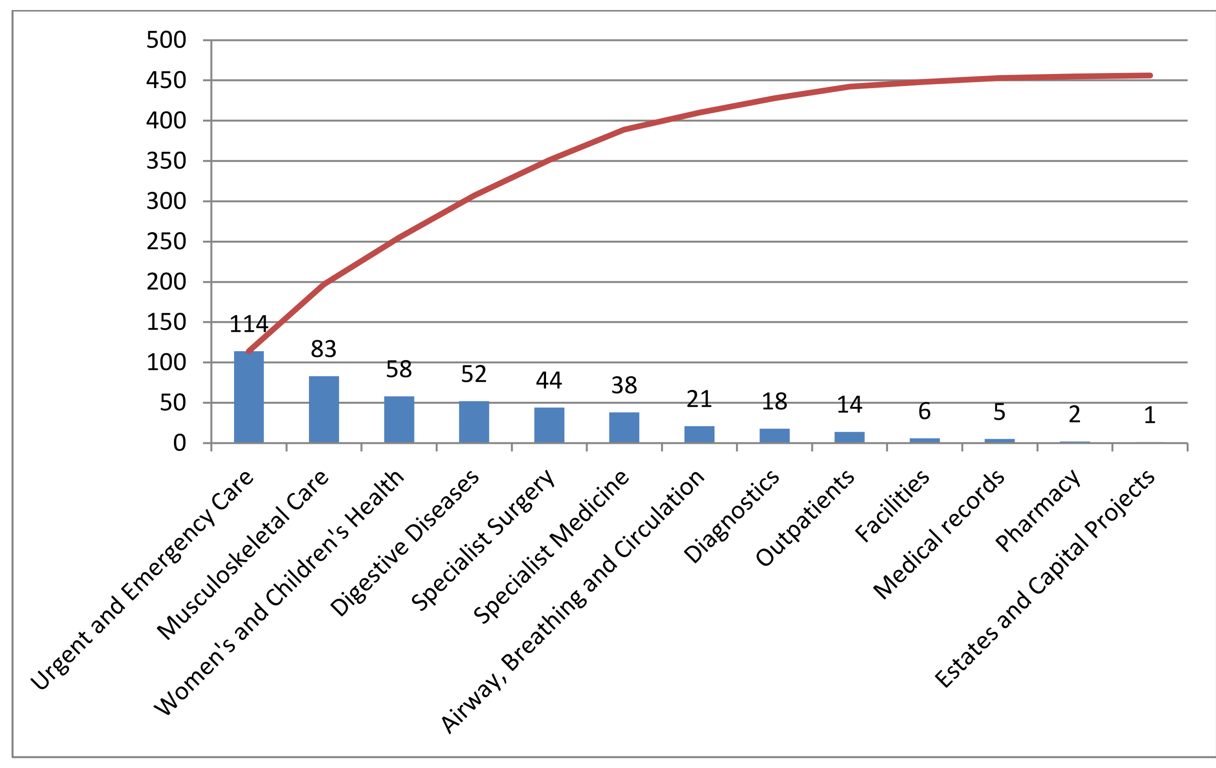
The most common cause for people to complain was that elements of their clinical care did not meet their expectations. The Trust has revised the way that complaints are investigated and responded to putting more ownership on individual areas to investigate concerns. As you can see from the graph above, early indications are that this is decreasing the amount of complaints that are being opened by the Trust.

2.1 Complaints received by Locations/Service

The below graph details which Site complaints have been attributed to:



The below graph details the complaints opened by Clinical Business Unit and Trustwide service:

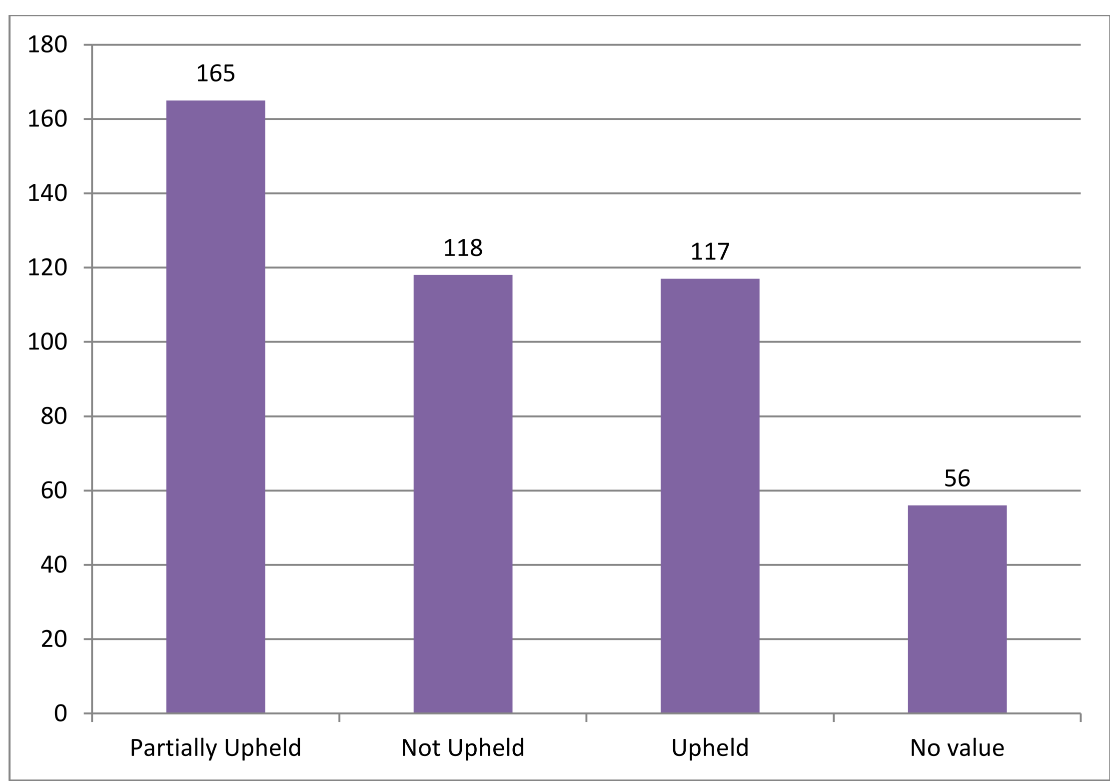


Urgent and Emergency Care received the most complaints followed by Musculoskeletal Service. This is in line with the pressures seen national in the Urgent and Emergency Care

Sector. The rise in MSK complaints is due to the area having a higher volume of patients, and an increase in complaints regarding the suspension of the Spinal services at the Trust.

2.4 Complaints upheld

Once a complaint has concluded (either following a local resolution meeting or once a formal written response has been sent) the outcome will be recorded in line with the findings of the investigation. A complaint will be "upheld", "upheld in part" or "not upheld". Those not yet concluded or those to which we have not yet received consent at the time of writing this report, are categorised as "No value".



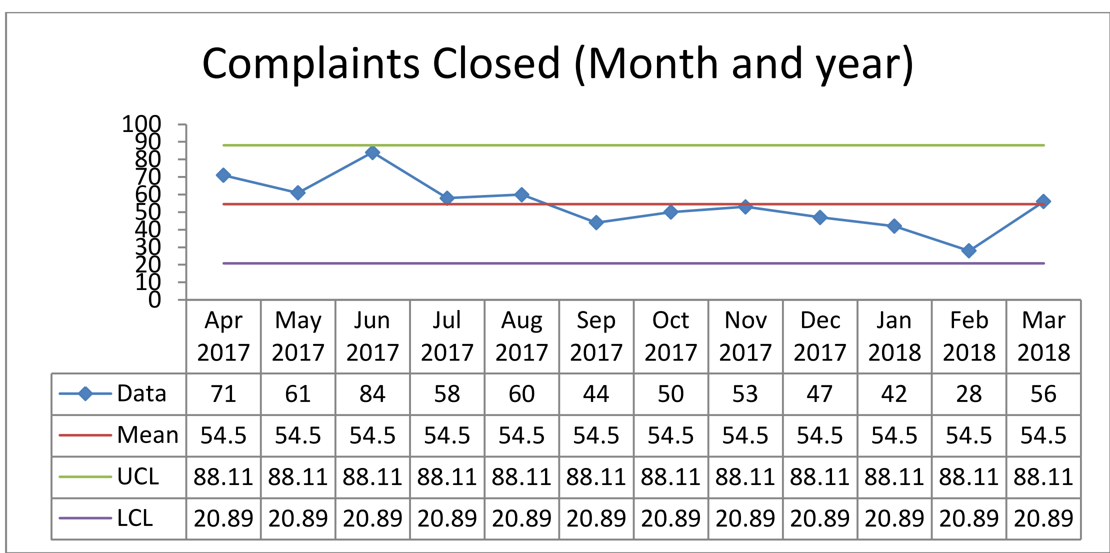
2.5 Complaints Improvement Plan

In 2017 the Trust identified that there were several issues relating to the way complaints were being handled and responded to, which included untimely responses creating a backlog, poor quality responses to complainants and a lack of robust actions and learning from complaints. During the last period the Trust has implemented several measures in order to improve complaints handling:

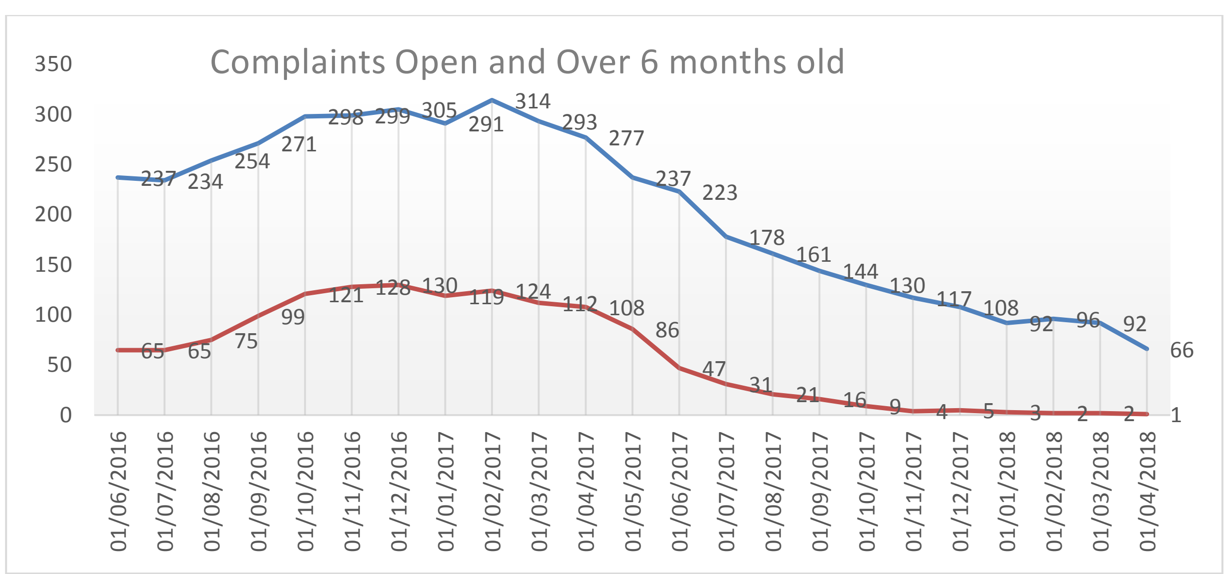
- Developed a training package and toolkit for all staff on how to investigate complaints;
- Developed a new Policy for complaints and concerns so there is a standardised approach on how to respond;

- Reviewed the complaints and PALS systems and process to make them more efficient and user friendly for complainants;
- Reviewed the systems used to log complaints and concerns in order to make them streamlined and efficient;
- Fully resourced the complaints and PALS teams so that the service can run effectively;
- Developed a Quality Assurance Group, which is led by the Chairman to scrutinise complaints performance and quality of the complaints responses;

In the period the Trust closed 656 complaints. Below is a graph to show the closed complaints over time and a graph to demonstrate complaints held by the Trust and those over 6 months:



	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018
Data	71	61	84	58	60	44	50	53	47	42	28	56
Mean	54.5	54.5	54.5	54.5	54.5	54.5	54.5	54.5	54.5	54.5	54.5	54.5
UCL	88.11	88.11	88.11	88.11	88.11	88.11	88.11	88.11	88.11	88.11	88.11	88.11
LCL	20.89	20.89	20.89	20.89	20.89	20.89	20.89	20.89	20.89	20.89	20.89	20.89



In order to improve the experience of complainants, one of the major initiatives within the Complaints and PALS team has been to improve the timeliness of responses. The below table shows the timeliness of the responses for the CBUs over the period:

Totals by Division	% on time Q1	% Q2	% Q3	% Q4
Acute Care Services	25.0	23.1	50.8	45.2
Corporate Departments	37.5	16.7	100.0	100.0
Surgery and Womens and Childrens	25.0	32.5	50.0	53.5
Total	26.7	28.3	51.3	50.4
Airway, Breathing and Circulation	12.5	0.0	42.9	16.7
Diagnostics	25.0	50.0	55.6	40.0
Urgent and Emergency Care	29.4	15.4	43.3	56.1
Specialist Medicine	21.4	33.3	54.5	0.0
Medical records			100.0	
Outpatients			100.0	100.0
Estates and Capital Projects	0.0		100.0	
Medical records	20.0		100.0	
Outpatients	44.4	20.0		
Pharmacy	50.0			
Facilities	50.0	0.0		100.0
Corporate Nursing	0.0			
Digestive Diseases	25.0	31.3	45.5	50.0
General Surgery	100.0			
Musculoskeletal Care	23.1	44.8	65.0	59.1
Specialist Surgery	25.0	11.1	36.4	42.9
Womens and Childrens Health	23.8	35.3	40.0	57.1

There has been a huge improvement in timeliness over the period within the Trust. Urgent and Emergency Care and MSK have consistently improved in relation to timeliness despite the large volume of complaints that are made against the areas.

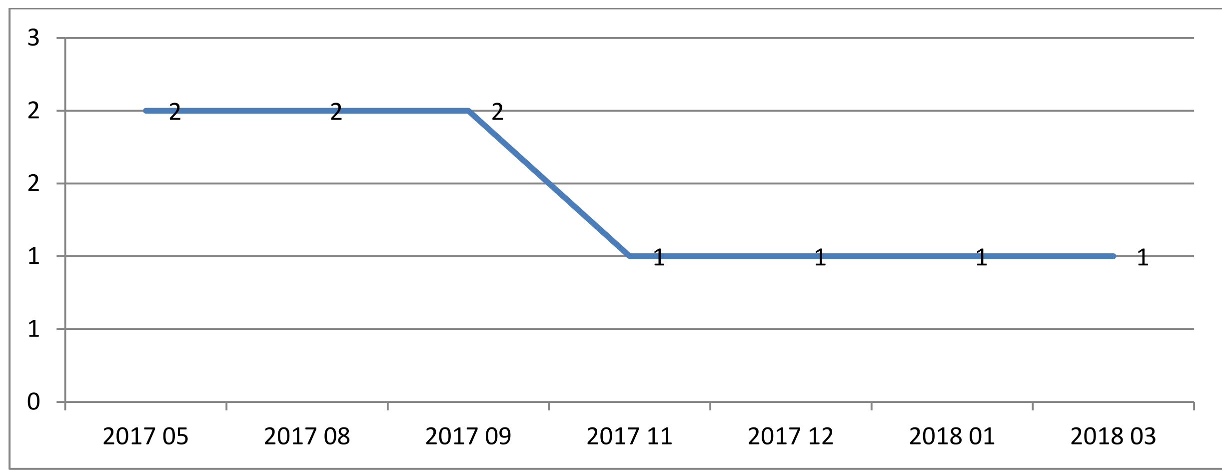
a. Referrals to Parliamentary Health Service Ombudsman

Complainants dissatisfied with the Trust's response have the right to ask the Parliamentary Health Service Ombudsman (PHSO) to consider their complaint. However, the complainant must be able to provide reasons for their continued dissatisfaction (in writing) to the PHSO. The Trust may also refer the complainant to the PHSO if they feel that the response has been thoroughly investigated and responded to.

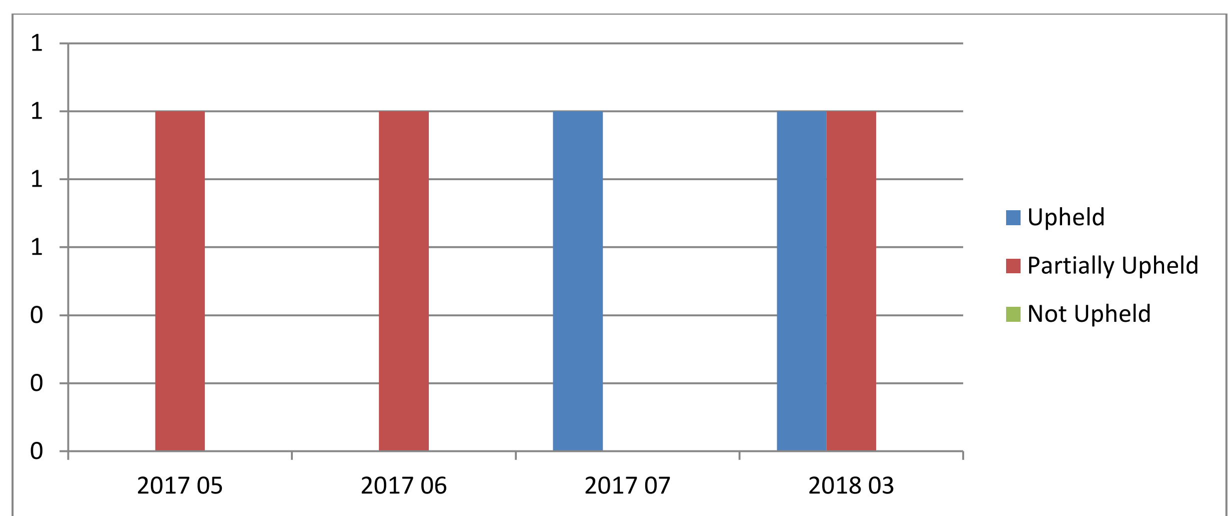
The PHSO will consider the complaint file, medical records and any other relevant information as necessary. The PHSO may decide not to investigate further and no further action will be required from the Trust. Alternatively, recommendations might be made for the Trust to consider. The PHSO may decide to conduct a full investigation which might

result in the Trust being required to make an apology, pay compensation and / or produce an action plan to describe what actions are planned to rectify the situation and prevent further occurrences.

The below graph shows the amount of investigations the PHSO has commenced at the Trust over the period:



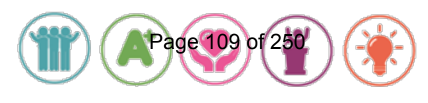
The below graph shows the PHSO grading and outcome following their final report over the period:



The PHSO has upheld or partially upheld every complaint review it has closed this year. Areas for improvement have been identified by the PHSO including complaints handling. As these cases are historic, the new systems and processes for dealing with complaints should eliminate this.

2.7 Learning from Complaints

It is paramount that the Trust continues to learn from complaints and that this is reflected in service improvements. Detailed below are some examples of how learning from complaints has led to changes:

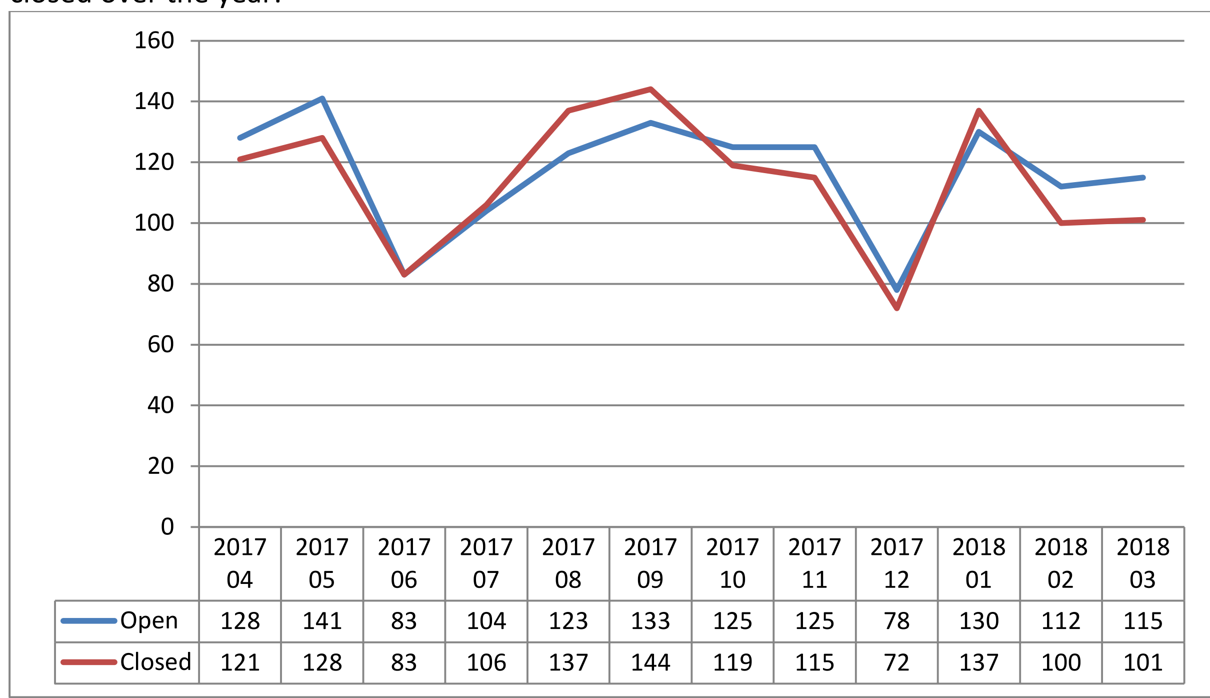


- Shared learning – complaints have highlighted issues in relation to end of life. Due to the revision of the governance structures this learning can now be shared through the End of Life Steering Group and the Speciality M&M meetings. This allows for learning to be shared through these speciality meetings and also through to the wards and staff involved. This is turn allows for greater learning from complaints.
- Attitude - following a complaint regarding the attitude and manner of the Emergency Department Reception Staff all reception staff employed within the department had to attend further Customer Service Training during September and October 2017. During these training sessions, topics of discussion included attitudes and behaviours.
- Diagnosis issues - following a complaint regarding the detailed diagnosis of an abscess on a patients breast, an education session was organized for new Junior Doctors on the management of mastitis and breast abscesses in both breastfeeding and non-breastfeeding ladies. This formed part of the formal Junior Doctor Education Programme during September 2017.
- Poor maternity experience – following a complaint regarding a poor experience specifically around breast feeding, training has been arranged for the staff in relation to breast feeding and the complaint will be shared at the Maternity Mandatory Study Day.

2.8 Patient Advice and Liaison Service (PALS)

In the period, PALS received 1397 enquires, which is a decrease from 2016/2017 (PALS received a total of 1694 enquiries).

The graph below shows the PALS cases that have been opened against those that have been closed over the year:



	2017 04	2017 05	2017 06	2017 07	2017 08	2017 09	2017 10	2017 11	2017 12	2018 01	2018 02	2018 03
Open	128	141	83	104	123	133	125	125	78	130	112	115
Closed	121	128	83	106	137	144	119	115	72	137	100	101

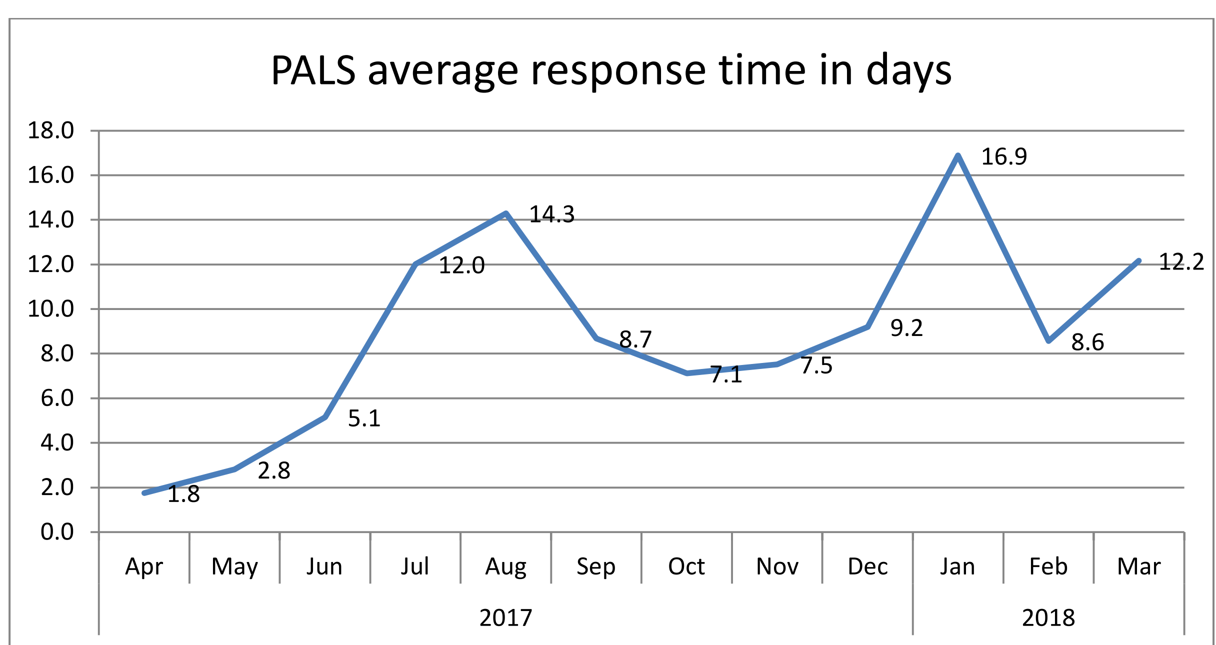
The top 5 themes during this period were:

Information	295
Communication Problems	248
Waiting Times	245
Cancellations	132
Care	107

The top 5 reporting Departments were:

Musculoskeletal Care	253
Specialist Surgery	222
Urgent and Emergency Care	178
Digestive Diseases	150
Specialist Medicine	103

Of the 1397 PALS received, 1365 of them have been closed to date. The graph below shows the average response time in days per month of this opened and closed within the period:



Going forward, the Trust will continue to ensure that the PALS team in order to try and resolve as many concerns as possible in a timely way, without the need for service users to make formal complaints if they would not choose to, therefore improving their experience.

3. Concluison

During the next Financial Year, the Trust will continue to improve its timeliness in responding to concerns and improve the quality of actions leading out of complaints. The Trust will also be inviting complainants to discuss their

experience of the complaints process with the Director of Governance and Quality and the Head of Complaints and PALS, to further improve the service the complaints team offer and make the service more patient focused. A further PALS Officer has been recruited in order to further improve the timeliness of PALS concerns. The Trust will continue to monitor complaints improvement through the Quality Assurance Group, chaired by the Chairman.

4. RECOMMENDATIONS

The Board are asked to note the report

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/18/07/68**	
SUBJECT:	**CQC Update report**	
DATE OF MEETING:	25 July 2018	
ACTION REQUIRED	**Review, Discuss and approve**	
AUTHOR(S):	Ursula Martin, Director of Governance & Quality	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse Choose an item.	
LINK TO STRATEGIC OBJECTIVES:	All	
EXECUTIVE SUMMARY (KEY ISSUES):	The following are key issues to highlight within the report: • An update is given regarding progress against the CQC action plan. A significant number of actions have been actioned with 154 actions out of 271 being compliant. • Work continues on the fundamental breaches within the CQC report, with all actions showing progress. A position statement is included within the report. • The Trust is in the process of completing an internal audit reviewing compliance/evidence with those actions which have been signed off as compliant on the action plan. This is to ensure that there is internal assurance in place and sustainable actions.	
RECOMMENDATION:	Discuss and note the Report	
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Committee
	Date of meeting	June 2018
	Summary of Outcome	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None	

BOARD OF DIRECTORS

SUBJECT	CQC Update Report	AGENDA REF:	BM/18/07/68

1. BACKGROUND/CONTEXT

The Trust received its CQC report in November 2017, following the inspection in March 2017.

An action plan has been developed, which is being overseen by the Trust's Getting to Good Steering Group, which is chaired by the Chief Executive.

The following report gives an update of the action plan progress to date, an analysis of work that has been undertaken against the fundamental breaches that were highlighted within the report and an update on the Use of Resources framework.

2. KEY ELEMENTS

2.1 CQC action plan performance

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

- We were due to have received 226 reports by end June 2018 - we have received 162 reports by 4th July 2018 that we can either state compliance for, or have asked for further information as almost compliant.
- We have amended dates requested and approved for a further 44 reports, which were due to be completed by end June 2018, some of which we have received reports for.
- We have not received reports or requests for extension for 16 actions which were due by end June 2018 (as at 4th July)

Status	Number
No report provided	16
Report completed - Compliant	154
Report completed - further evidence requested	8
Report completed - further action requested	2
Action closed-merged with another	2
Amended dates agreed	44
Grand Total	**226**

The following shows performance of each action type from the overall action plan (n=271 actions)

Action status	Report completed - Compliant	Report completed - further evidence requested	On Track	Amended date agreed	No report	Action closed	Report completed – further action needed	Grand Total
However	92	3	19	29	12	2		157
Must	29	2	12	8	2		2	55
Should	33	3	10	11	2			59
Grand Total	**154**	**8**	**41**	**48**	**16**	**2**	**2**	**271**

The following shows compliance at core service level

	However	Must	Should	Grand Total
Children and Young People	**9**	**2**	**3**	**14**
On Track	2	1	1	4
Report completed - Compliant	7		2	9
Report completed - further evidence requested		1		1
Critical Care	**22**	**6**	**10**	**38**
Amended date agreed	4		2	6
On Track	6	3	1	10
Report completed - Compliant	12	3	6	21
Report completed - further evidence requested			1	1
End of Life	**2**		**3**	**5**
Amended date agreed	2		3	5
Maternity and Gynae	**33**	**12**	**17**	**62**
Amended date agreed	5	2	1	8
No report provided	2	1	2	5
On Track	3	3	2	8
Report completed - Compliant	21	5	11	37
Report completed - further evidence requested	2	1	1	4
Medical Care (inc Older People's care)	**40**		**6**	**46**
Amended date agreed	12		3	15
No report provided	5			5
On Track	4		1	5
Report completed - Compliant	17		2	19
Action closed-merged with another	2			2
Outpatients and Diagnostic imaging	**26**	**10**	**7**	**43**
Amended date agreed	4	1	1	6
No report provided	1	1		2

	However	Must	Should	Grand Total
On Track	1	1	1	3
Report completed - Compliant	20	7	5	32
Surgery	**19**	**6**	**5**	**30**
Amended date agreed			1	1
No report provided	4			4
On Track	2		1	3
Report completed - Compliant	12	6	2	20
Report completed - further evidence requested	1		1	2
Trustwide		**14**	**2**	**16**
Amended date agreed		3		3
On Track		3	1	4
Report completed - Compliant		6	1	7
Report completed - further action added		2		2
Urgent and Emergency Care	**6**	**5**	**6**	**17**
Amended date agreed	2	2		4
On Track	1	1	2	4
Report completed - Compliant	3	2	4	9
Grand Total	**157**	**55**	**59**	**271**

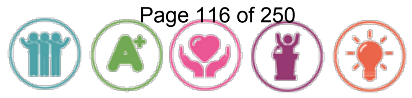
The Trust is in the process of completing an internal audit reviewing compliance/evidence with those actions which have been signed off as compliant on the action plan. This is to ensure that there is internal assurance in place and sustainable actions.

2.2 Fundamental breach Analysis

Within the Trusts CQC report, there were a number of fundamental breaches listed within the CQC report. Appendix 1 of this report outlines the breaches and position, with actions taken to date. All breaches have actions in place and are being monitored by Executive leads and Getting to Good Workstream.

The position is as follows

Number of breaches in total – 9 fundamental breaches (with a number of actions within each).



RAG status of breaches	Number	Details	To note
RED	**3**	Regulation 12 – medical devices training Regulation 12 – equipment and checks in radiology Regulation 18 – a) staffing b) APLS training for staff	Significant improvement has been made in Regulation 12 – checks in radiology – with 1 breach regarding recording checks on warning lights. Monthly audits to continue. A Trustwide improvement programme in place regarding recording of medical devices training.
AMBER	**5**	Regulation 11- Consent and Mental Capacity Regulation 12- checks in theatre Halton to prevent Never Events Regulation 13- Safeguarding training Regulation 15 – premises (radiology, gynae, maternity) Regulation 17 – Governance a) Risk Management b) record keeping c) IG and records being maintained securely	Significant improvement in all areas of these breaches. Awaiting evidence of audits to demonstrate improvement in mental capacity practise and record keeling.
GREEN	**1**	Regulation 12 – checks of equipment trollies and anaesthetics machines	

3 RECOMMENDATIONS

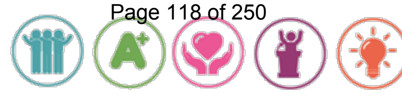
Trust Board are asked to discuss and note the

- CQC action plan progress and update
- The update on fundamental breache

Appendix 1 – Fundamental Breach Action Updates

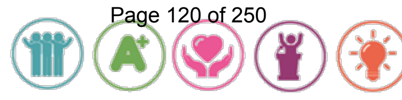
To note – RAG rating will move to green when evidence/assurance is given that we have sustained actions in place.

Fundamental breach	Action/Progress	Executive Lead	RAG Assessment- May 2018
Regulation 11- Consent and Mental Capacity	Action was put in place at the time of the CQC assessment and after, regarding training and increased surveillance. An audit of MCA and consent is being presented to G2G Steering Group April 2018 to assess current compliance Update May 2018 – audit undertaken December 2017, which showed poor compliance in some areas. Training is being rolled out - Trust still has training gaps, which are being addressed. Spot check audits to be undertaken as part of nursing walkrounds – a further Trustwide audit being undertaken – which is reporting to Getting to Good meeting July 2018 Update June 2018 – audit being presented to G2G meeting August 2018. Training compliance improving	Chief Nurse	
Regulation 12 – medical devices training	A medical devices training database has been purchased, inventories and training needs analysis are underway. Trust Medical Devices Policy has been approved. Update on paediatrics medical devices to be given to April G2G Steering Group Update May 2018 - this is a Trust wide issue and a workstream is in place. A risk has been escalated to Board re this via Strategic Risk Register. Action	Chief Nurse	



Fundamental breach	Action/Progress	Executive Lead	RAG Assessment- May 2018
	plan in place- starting to be implemented. June 2018 – action ongoing. Work commenced regarding inventories, competency assessments and recording training.		
Regulation 12- checks in theatre Halton to prevent Never Events	We have implemented training, observational audits and are now auditing 100% of WHO checklist completion every month. We are also completing an assurance framework against the new Never Events list published to look at our policies and controls in place. This is being presented to PSESC March 18. Update May 2018– NatSSIPs/LocSSIPS being presented to May Patient Safety and Effectiveness Sub Committee. This is amber/green June 2018 – MIAA audit commenced and LocSSIPs work continuing.	Medical Director	
Regulation 12 – checks of equipment trollies and anaesthetics machines	Additional controls were put in place at the time of the inspection and audits are being undertaken – presented at April Getting to Good meeting Update May 2018. Green in theatres (6 months' worth of evidence given, showing 100% compliance) Maternity not showing 100% compliance – increased scrutiny and oversight	Chief Nurse	

Fundamental breach	Action/Progress	Executive Lead	RAG Assessment- May 2018
	at Getting to Good meeting June 2018 – maternity agreed as compliant		Green
Regulation 12 – equipment and checks in radiology	1. CR reader in Halton – resolved 2. IRR99 compliance – audit presented at G2G Steering Group March 2018 showing 97% compliance (significant improvement) – not closed as not 100% compliant – further audits being undertaken 3. Ultrasound machines in radiology – resolved Update May 2018 – 1 radiation safety breaches still not 100% compliant (warning lights). Other 5 breaches- audits show 100%. Increased scrutiny and oversight at Getting to Good meeting – update to be given at G2G meeting June 2018. June 2018 – Significant improvement in compliance. 1 breach in place re handover forms. Being re-audited and presented to August G2G meeting. Is Red/Amber	Chief Operating Officer Medical Director (radiation safety lead)	Red
Regulation 13- Safeguarding training	A review of safeguarding training has been undertaken, with each CBU to report to April G2G meeting a trajectory for compliance Additional training capacity being commissioned	Chief Nurse	Amber



Fundamental breach	Action/Progress	Executive Lead	RAG Assessment- May 2018
	Update May 2018 – training compliance showing improvement – need to assess where requires further improvement work. CBUs have been asked to report performance and improvement trajectories to Workforce Committee and to getting to Good Steering Group monthly. June 2108- Significant improvement – some areas to be yet compliant.		
Regulation 15 – premises (radiology, gynae, maternity)	A review and options appraisal is underway regarding maternity and gynae. Radiology review is also underway. Halton – actions taken at the time and audit reports being presented to Getting to Good Steering Group in April to ensure sustainable actions in place • Treatment couches were not wiped down in between patients in outpatient treatment rooms. • Portable x-ray equipment was found to be covered in a thick layer of dust. • Both phlebotomy chairs in outpatients were broken: one had cracked covering on the armrests and the other had a large tear in the seat covering. • Clinic areas were congested and there was inadequate seating for some areas, with patients needing to stand in corridors whilst waiting. Update May 2018 – need to review environmental work and determine	Chief Operating Officer	

Fundamental breach	Action/Progress	Executive Lead	RAG Assessment- May 2018
	preferred options and mitigations for Induction of Labour and Radiology. Reviews have been undertaken and papers being written for presentation at Getting to Good Steering Group. June 2018- Discussion at G2G meeting regarding taking forward.		
Regulation 17 – Governance a) Risk Management b) record keeping c) IG and records being maintained securely	a) The risk processes have been reviewed and Datix web for risk is being rolled out, with training in place. All risk registers are due to be on the system by end April 2018. b) There is a records audit being undertaken reporting to Getting to Good Steering Group. There is an IG audit underway and results, with an options appraisal regarding records storage which will be presented to Getting to Good Steering Group Update May 2018 – risk registers on Datix – will be reviewed by end July to ensure quality checked June 2018- work progressing on risk registers. Information governance – storage audit undertaken. Need to implement preferred option following discussion with nursing team. Need to have training/awareness campaign re information governance, which has been	Chief Nurse/Medical Director /Director of Informatics	

Fundamental breach	Action/Progress	Executive Lead	RAG Assessment- May 2018
	requested by Getting to Good Steering Group. Need to undertake a clinical audit regarding records - storage audit component undertaken. Information governance is amber/red. June 2018 – clinical audit commenced		
Regulation 18 – a) staffing b) APLS training for staff	a) Staffing - Acuity and dependency review been undertaken and business case being presented to the Board of Directors for nurse staffing Medical staffing meeting and actions implemented Audit of staffing escalation underway The neonatal unit did not have sufficient numbers of suitably qualified staff. There was no dedicated paediatric pharmacist. A review of neonatal staffing underway. Paediatric pharmacy provision addressed. b) APLS training – additional capacity for APLS training in paediatrics and critical care and recovery in theatres. An update being presented to April G2G Steering Group Update May 2018 – nurse staffing business case approved – need evidence of implementation plan.	Chief Nurse/Medical Director	

Fundamental breach	Action/Progress	Executive Lead	RAG Assessment- May 2018
	Staffing escalation processes have been audited and a survey undertaken- awaiting report, which is being presented to Getting to Good Steering Group in June 2018. Report provided of actions taken to improve medical staffing- need further evidence of effectiveness. Re APLS – clarification of standards raised to CQC as there is some confusion as to the standards assessed. CBUs have been asked to report performance and improvement trajectories to Workforce Committee and to getting to Good Steering Group monthly. June 2018- plans in place for resus training – clarification of training with CQC will take place 11th July. Nurse staffing business case – plans in place to implement at every ward level Medical staffing report provided – further evidence required.		

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/18/07/69**	
SUBJECT:	**Medicines and Controlled Drugs Annual Report**	
DATE OF MEETING:	25th July 2018	
ACTION REQUIRED	**For information/assurance**	
AUTHOR(S):	Diane Matthew, Chief Pharmacist	
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable Deputy Chief Executive	
LINK TO STRATEGIC OBJECTIVES:	SO1: To ensure that all care is rated amongst the top quartile in the North West of England for patient safety, clinical outcomes and patient experience	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	BAF1.1: CQC Compliance for Quality	
	BAF1.2: Health & Safety	
	Choose an item.	
STRATEGIC CONTEXT	The Trust Board must receive an annual report regarding medicines management including specific reference to controlled drugs. Proper and safe use of medicines is a key line of enquiry in relation to how medicines and related stationery are ordered, transported, stored, prescribed, supplied, administered and disposed of safely and securely and how use is monitored in line with national guidance. Reported incidents provide an indication of how well medicines are managed by the organisation and whether lessons are identified, learned and improvements implemented.	
EXECUTIVE SUMMARY (KEY ISSUES):	This report provides an overview of Medicines and Controlled Drugs for the period April 2017 to March 2018.	
RECOMMENDATION:	The Board is asked to note the content of the report.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality + Assurance Committee
	Agenda Ref.	QAC/18/07/82
	Date of meeting	3rd July 2018
	Summary of Outcome	Reviewed and approved
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.	

SUBJECT	Medicines and Controlled Drugs Annual Report	AGENDA REF:	QAC/18/07/82

1. BACKGROUND/CONTEXT

Proper and safe use of medicines is a key line of enquiry in relation to how medicines and related stationery are ordered, transported, stored, prescribed, supplied, administered and disposed of safely and securely and how use is monitored in line with national guidance.
Reported incidents provide an indication of how well medicines are managed by the organisation and whether lessons are identified, learned and improvements implemented.

2. KEY ELEMENTS

This report provides an overview of the incidents arising between April 2017 and March 2018.

Table 1: Review of Incidents reported as involving medication or controlled drug (1 April 2017 to 31 March 2018)

Incident Location	Severity	Q1	Q2	Q3	Q4	Total incidents reported	% no harm	% minor harm	% moderate harm
Digestive Diseases	1	26	25	16	23	100	90%	10%	0%
	2	0	3	0	7				
Muskuloskeletal	1	19	30	11	7	78	86%	14%	0%
	2	4	2	1	4				
Specialist Surgery	1	3	0	2	1	8	75%	25%	0%
	2	1	0	0	1				
Women's & Childrens	1	15	14	14	28	91	78%	22%	0%
	2	6	2	3	9				
Airways, breathing & circulation	1	21	22	28	15	112	77%	23%	0%
	2	6	7	9	4				
Diagnostics & Outpatients	1	5	9	3	3	24	83%	17%	0%
	2	1	0	2	1				
Specialist medicine	1	22	17	20	22	119	68.1%	31.1%	0.8%
	2	14	6	11	6				
	3	0	0	0	1				
Urgent & Emergency Care	1	36	45	41	46	214	79%	21%	0%
	2	13	8	11	14				
Pharmacy	1	32	51	41	40	194	84.5%	14.9%	0.5%
	2	11	11	4	3				
	3	0	0	0	1				

Trust Sub-total		235	252	217	236	940	80.1%	19.7%	0.2%
External to the Trust	1	2	5	5	4	19	84%	16%	0%
	2	2	0	0	1				
Total		239	257	222	241	959	80.2%	19.6%	0.2%

Of the 959 medication and controlled drug incidents reported in 2017/18, 940 related to the Trust and 19 were reported as interface issues. In quarter 1 (Q1) there were 235, quarter 2 (Q2) 252, quarter 3 (Q3) 217 and quarter 4 (Q4) 236 Trust related medication and controlled drug incidents. 753 (80.2%) were reported as no harm or near miss incidents, 185 (19.7%) as minor harm incidents and 2 (0.2%) as moderate harm incidents. There was a modest reduction in harm incidents compared with the previous two years and this reflects the work undertaken by the Trust Medicines Safety Officer in the latter half of this year to review the grading of incidents, an area that requires ongoing review and improvement.

Table 2 below shows the controlled drug subset of the incident data. Controlled drug incidents made up 15% of the Trust medication related incidents. In Q1 there were 37, Q2 49, Q3 33 and Q4 29 Trust related controlled drug incidents. 85% were classed as near miss or no harm incidents and 15% as minor harm incidents.

Urgent and Emergency Care had the most reported incidents followed by Pharmacy, Specialist Medicine and then Airways, Breathing and Circulation. This reflects where there is a greater intensity of prescribing, dispensing and administration of medicines.

We are
WHH

Table 2: Review of Incident Reports relating only to Controlled Drugs (1 April 2017 to 31 March 2018)

Incident Location	Severity	Q1	Q2	Q3	Q4	Total incidents reported	% no harm	% minor harm
Digestive Diseases	1	7	8	4	2	28	75%	25%
	2	0	3	0	4			
Musculoskeletal	1	6	8	2	1	19	89%	11%
	2	0	1	0	1			
Specialist Surgery	1	0	0	0	0	0		
	2	0	0	0	0			
Women's & Childrens	1	1	1	2	6	12	83%	17%
	2	1	1	0	0			
Airways, breathing & circulation	1	7	2	6	1	20	80%	20%
	2	2	1	0	1			
Diagnostics & Outpatients	1	0	2	0	0	2	100%	0%
	2	0	0	0	0			
Specialist medicine	1	1	3	4	5	15	87%	13%
	2	1	1	0	0			
Urgent & Emergency Care	1	6	11	9	2	31	90%	10%
	2	1	0	0	2			
Pharmacy	1	2	6	6	4	20	90%	10%
	2	2	0	0	0			
Trust Sub-total		37	48	33	29	147	85%	15%

External to the Trust	1	0	1	0	0	1	100%	0%
	2	0	0	0	0			

Total	37	49	33	29		148
	15%	19%	14%	13%		

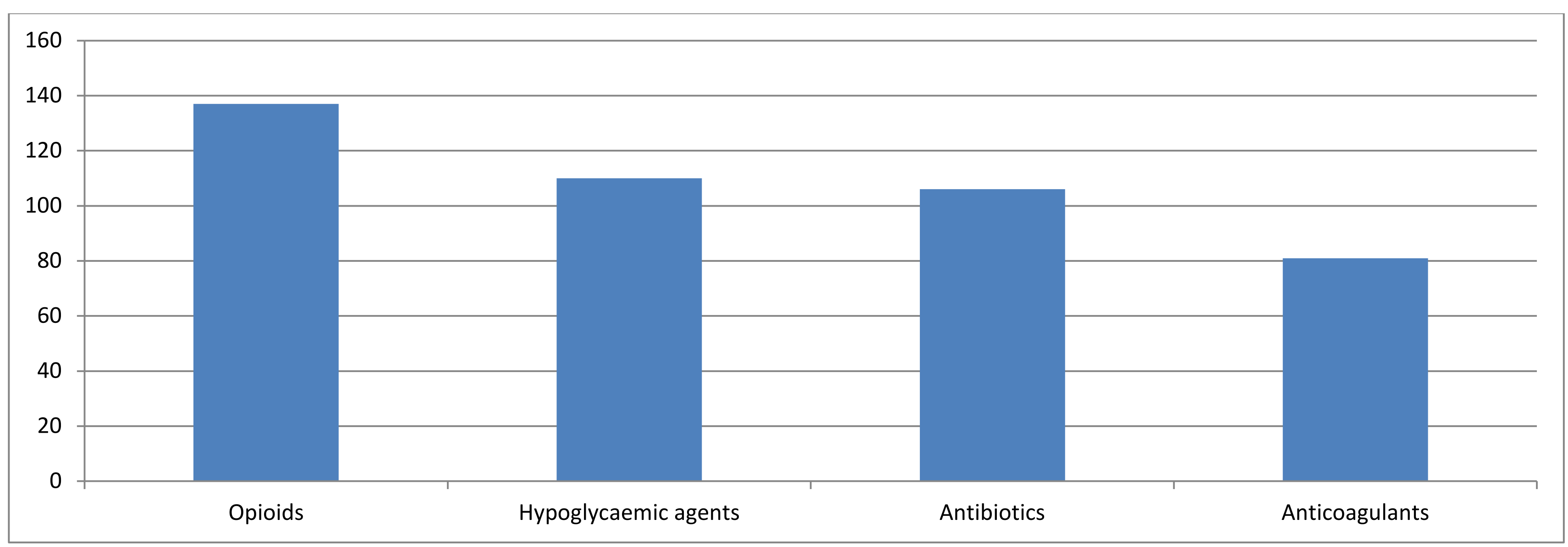
Table 3: Chart of the Main Medication/CD Incident Sub-Categories

160
140
120
100
80
60
40
20
0

Omitted medication
Prescribing issue
Administration issue
Dispensing or checking issue
Controlled drug spillage, discrepancy or ...
Discharge medication delay
Issue resulting from audit
Homecare issue
Staffing issue
Missing prescription issue

The top 3 sub-categories: prescribing, administration and omission of medication, accounted for 409 (43.5%) of incidents.

Table 4: Chart of the Main Medication/CD Incident Sub-Categories



The top 4 medication types: opioids, hypoglycaemic agents, antibiotics and anticoagulants accounted for 434 (46.2%) of incidents and reflect the areas where attention is being focussed for learning and improvement work.

Overview of actions undertaken to disseminate learning and improvement:

1. Education sessions delivered to medical staff by the medical education pharmacist where prescribing incidents are discussed with FY1 and FY2s – feedback received indicates these are useful and informative.
2. Presentations at Grand Round – Diabetic Dilemmas – to identify issues that are encountered when managing diabetic patients on wards. The Stanford Team is working with the Diabetes Team to implement actions that address the issues identified.

We are
WHH

3. Safety alerts: Insulin cartridges to only be used in pen devices; importance of checking patient's identity prior to prescribing to avoid wrong patient errors.
4. Use of the tools provided through the Stanford Project – Use of padlet to identify issues and themes with diabetic medication and potential solutions.
5. Audit of gentamicin dosing following the Stanford work in ED – This resulted in review and improvement of the gentamicin guidelines which included the production of an easier to use dose calculator which was then piloted by the junior doctors before inclusion in the Antibiotic formulary
6. Sepsis and AMR CQUIN work – staff communications to support timeliness of first dose, recording of indication for treatment, choice of therapy, review within 72 hours and conservation of supplies of meropenem and piperacillin/tazobactam
7. Presentation of reports at Medicines Governance
8. Sharing of learning from the controlled drugs audits with nursing leads and development of improvement action plans
9. Sharing of learning from incidents with the nursing team
10. Sharing of learning within the Pharmacy teams
11. Following one moderate harm incident Pharmacy SOPs in relation to medicines reconciliation were reviewed, updated and shared to reduce the likelihood of incidents associated with patients who manage their medication with a compliance aid.
12. Following the second moderate harm incident the importance of clinicians completing medication charts to undertake complete checks on the patient identifiers before prescribing. Clinicians should be aware of interruptions involved in the pressurised environment of the emergency department and where possible complete the task in hand before reacting to the interruption. The need for an EPMA system that links with the SCR information is essential for protecting clinicians from human errors when completing first clerking. An action included the review of the medical on call when in escalation and any extra support that needs to be put in place to strengthen the clerking process. Audit of the level of interruptions. Wider learning through acute medicine morbidity and mortality meetings to increase awareness of the potential for errors when admitting patients into the Trust.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

1. Stanford work to continue and focus on identified high risk drug groups (A Robinson)
2. Submit business case to provide capacity for the Medicines Safety Officer work (D Matthew)
3. Implement EPMA taking account of and incorporating learning from incidents (D Matthew/R Bhati)
4. Continue to disseminate learning from incidents to all staff groups (all)
5. Utilise the Safety Huddle to support communication of medication and controlled drug issues (all)

4. IMPACT ON QPS?

Intended aims: Improving patient care/experience by improving the quality and safety of medicines, supporting staff to get medication related processes right first time and supporting efficient and effective ways of working.

5. MEASUREMENTS/EVALUATIONS

Use of Stanford Tools, Audit, evaluation of information reports and incident reports

6. TRAJECTORIES/OBJECTIVES AGREED

Continuous improvement, review progress in 12 months.

7. MONITORING/REPORTING ROUTES

Medicines Governance Committee
Patient Safety and Clinical Effectiveness Committee
Controlled Drug Local Intelligence Network

8. TIMELINES

Quarterly and annual updates

9. ASSURANCE COMMITTEE

Quality and Assurance Committee

10. RECOMMENDATIONS

Committee to approve the contents of the Report.

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/18/07/70**
SUBJECT:	**Progress on Lord Carter Report Recommendations & Use of Resource Assessment (UoRA)**
DATE OF MEETING:	25th July 2018
ACTION REQUIRED	**For Discussion**
AUTHOR(S):	Marie Garnett, Head of Contracts & Performance
EXECUTIVE DIRECTOR SPONSOR:	Andrea Mcgee, Director of Finance & Commercial Development
LINK TO STRATEGIC OBJECTIVES:	All
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	BAF1.3: National & Local Mandatory, Operational Targets
	BAF1.4: Business Continuity
	BAF3.3: Clinical & Business Information Systems
STRATEGIC CONTEXT	The purpose of this report is to update the Board of Directors on the latest position regarding progress made against the recommendations contained in Lord Carter's report "Operational productivity and performance in English NHS acute hospitals" issued in February 2016. The report has been updated to incorporate progress against the Use of Resources indicators in readiness for the Use of Resources Assessment (UoRA).
EXECUTIVE SUMMARY (KEY ISSUES):	A UoRA workstream was established in May 2018 and has developed a dashboard based on data from the model hospital. The dashboard shows how the Trust is performing against peers and the national median.
RECOMMENDATION:	The Board of Directors is requested to note the contents of the 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

PROGRESS ON THE CARTER REPORT RECOMMENDATIONS & USE OF RESOURCE ASSESSMENT

1. PURPOSE

The purpose of this report is to update the Board of Directors on the latest position regarding the progress made against the recommendations contained in Lord Carter's report "Operational productivity and performance in English NHS acute hospitals" issued in February 2016 and to update on progress and preparation towards the Use of Resource Assessment (UoRA) which will form part of the Trust CQC inspection rating.

2. BACKGROUND,

In June 2014, Lord Carter was asked by the Secretary of State for Health to assess what efficiency improvements could be generated in hospitals across England.

In June 2015, an interim report was published which outlined that potentially £5 billion of operational efficiency savings could be delivered in the acute sector by 2020 by improving workforce costs, hospital pharmacy medicines optimisation and estates and procurement management.

In February 2016 the final report was published and based on the work of 32 acute Trusts, it was estimated that if "unwarranted variation" was removed from Trust spend then that £5 billion could be saved by 2020 as summarised in the table below.

Table: The breakdown of the £5 billion savings:

Narrative	£ billion
Improved workflow and containing workforce costs	2.0
Improved hospital pharmacy and medicines optimisation	1.0
Better estates management and optimisation	1.0
Better procurement management	1.0
Total	**5.0**

In May 2018, as part of the Trust's Getting to Good, Moving to Outstanding programme, a UoRA workstream was established. The UoRA will be carried out by CQC and NHSI and is designed to improve understanding of how effectively and efficiently the Trust uses its resources. During the next 12 months, the Trust will take part in an assessment day at which executive and operational leads will evidence the Trust's progress in improving its use of resources. Prior to the assessment day, the Trust will submit evidence and narrative. 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 will form the basis 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 UoRA stamp:

The UoRA 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 has been selected by the Trust and uses Trusts which are a similar size to WHH or have two main sites.

3. Progress

This paper presents the quarterly update report for Quarter 1. Performance against each UoRA KLOE is set out in **Appendix 1**, the full detail for each KLOE indicator and the 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.

4. Conclusion

The Trust continues to make progress against the Lord Carter recommendations. This is the first report which contains UoRA KLOE performance and it is anticipated that this report will developed further during the course of the next 12 months. It is vital that the leads for each KLOE fully understand their performance and identify and monitor actions for improvement.

5. Recommendation

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

Andrea McGee
Director of Finance and Commercial Development
17th July 2018

Appendix 1 – Benchmarking Performance against the National Median

KLOE Indicator	Quarter 1	Quarter 2	Quarter 3	Quarter 4
KLOE 1 - Clinical				
Pre Procedure Elective Bed Days				
Pre Procedure Non Elective Bed Days				
Emergency Readmission (30 Days)				
Did Not Attend (DNA) Rate				
KLOE 2 - People				
Staff Retention Rate				
Sickness Absence Rate				
Pay Costs per Weighted Activity Unit				
Medical Costs per WAU				
Nurses Cost Per WAU				
AHP Cost per WAU (community adjusted)				
KLOE 3 – Clinical Support Services				
Top 10 Medicines - Percentage Delivery of Savings				
Pathology - Overall Costs Per Test				
KLOE 4 – Corporate Services				
Non Pay Costs per WAU				
Finance Costs per £100m Turnover				
Human Resource Costs per £100m Turnover				
Procurement Process Efficiency and Price Performance Score Clinics				
Estates Costs Per Square Meter				
KLOE 4 - 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.

Key

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

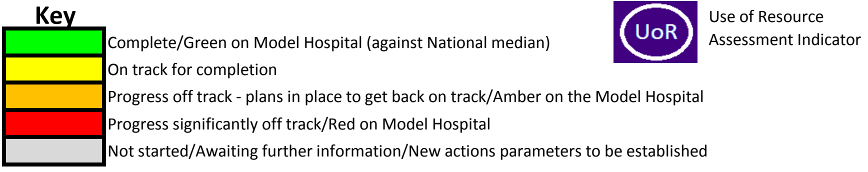
UoR — Use of Resource Assessment Indicator

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 1 2018/19

Recommendation 1 - NHS Improvement 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

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Development and approval of people strategy and dashboard	• The people strategy and dashboard has been developed and data is refreshed monthly. • The dashboard is reviewed by the Workforce committee and any areas of concern are addressed.	• Ongoing monitoring and management of the dashboard. • During Q2 the Trust's People's strategy will be refreshed to align with the new Trust and Quality strategies and the new national workforce strategy by Public Health England.	Trust Board, TOB, Workforce 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, Workforce Committee	Complete
HR polices reviewed to ensure they are clear and simple	• The HR & OD Directorate has a policies and procedures group with management and staff side members. All HR policies are taken through this group and then progressed to JNCC followed by the Workforce committee.	• During Q2, work will commence review and further simplify identified policies.	Workforce Committee	Ongoing Monitoring
"Fit to Care" Heath & Wellbeing Strategy	• As part of national CQUIN, support for a wide range of wellbeing approaches aimed at supporting staff back into work have been established. • A programme of exercise classes has been created. • The Trust is trialled a weight management clinic, which was popular. • Health topics have focused on the different effects of stress both physically and mental. • Drop in sessions have been held for staff on healthy hearts and stress management. • The Trust has had a Wellbeing clinic on site for staff to access. Over 1000 people accessed its information on BMI, blood pressure and body fat within the first week. • Activity includes heath topics on exercise and movement at work and hydration. May's health focus was hydration and will be supported by our NHS 70th water bottles which will be given to all our staff. • Q1 saw the Trust launch of its Mental Health first aid courses which aim to help mangers spot the signs of mental health and signpost colleagues to support. • A Financial wellbeing clinic was held on site for staff.	• Wellbeing initiatives will continue to be offered and monitored for effectiveness. • Planning for 2018/19 flu vaccination campaign has commenced and will continue throughout Q2.	Workforce Committee	Rolling Programme



Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 1 2018/19

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Development of Workforce Streaming Programme across the North West	• The Trust continues to work with colleagues across the North West to agree unified ways or working and to reduce bureaucracy. • Key actions to date include: o Implementation of factual references. o Streamlining of notice periods for new starters. o Agreed honorary contract process and streamlining of mandatory training across the region. o Values based recruitment. • The HR Director/Deputy Director networks have agreed milestones for year 3. • Region wide TUPE guidelines have been agreed.	• The programme has agreed milestones for year 3 for each of the 5 workstreams (Training, Occupational Health, PREP, Medical Staffing and Systems). Each workstream will continue to work through their milestones which are overseen internally by the Trust Implementation Group and externally by HR Directors or HR Deputy Directors groups. • The Trust will continue time to hire reporting regionally.	Workforce Committee	Ongoing
Staff Opinion Survey	• The Staff Opinion Survey (SOS) closed in December 2017. The Trust response rate was 46% compared to 38% for the 2016 survey. • Results from the SOS have been received by the Trust and a proposed change in approach was presented to and approved by the Trust board in March 2018. • A staff engagement event "the perfect day" took place in early May 2018.	• Outputs of the event have been analysed and themed and will be linked in with the Listening in Action (LIA) pulse check which was carried out during June.	Trust Board, TOB, Workforce Committee	Rolling Programme
Reduction in the high rates of bullying and harassment with a sustained campaign led personally by each trust Chief Executive	• Bullying and harassment is a key element of the Staff Opinion Survey and is measured by a number of metrics. • In the 2016 staff survey, the Trust scored either average or better than average for all metrics related to Bullying and Harassment, compared with other Trusts nationally. • The Freedom to Speak Up Guardian has a network of champions to support staff to raise concerns. Links have been made with Junior Doctors and the People Champions as this agenda continues to embed. • The Trust performed in the upper quartile in the 2017 staff survey in relation to bullying and harassment in comparison with other Acute Trusts. The survey did highlight a need to look into the number of staff experiencing physical violence from other staff; work is ongoing to look at how this correlates with other employee relations metrics. • The Trust has reviewed the staff opinion survey 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 will be 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.	• The Dignity at Work policy will be refreshed with a focus on prevention and being proactive. • HR will work with the Trust's communications team to ensure staff know who to raise concerns with and how they would go about this.	Workforce Committee	Ongoing Monitoring

Key

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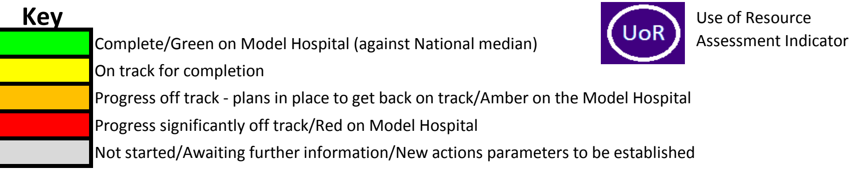
UoR — Use of Resource Assessment Indicator

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 1 2018/19

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Ensure Staff have regular performance reviews	• The number of staff with a valid PDR is 82.29% (May 2018) against a target of 85%. • HR Business Partners have worked with CBUs to develop a recovery plan, although this people measure continues to create challenges across clinical and non-clinical staff groups with the exception of medical workforce. • The PDR process has been reviewed, with a particular focus on engaging staff and condensing timescales to avoid winter pressures. Focus groups took place with staff and management in April with recommendations took to the Workforce committee in May 2018. • Proposals around strengthening reporting arrangements for nursing staff have been made.	• HR Business Partners will continue to work with the CBU managers to further improve PDR compliance. PDR compliance is closely monitored and reported to TOB and the Workforce committee. CBU managers have confirmed they are on target to meet their improvement trajectories. • The Trust understands the new pay award is linked to performance and will review the detailed guidance on implementation once this becomes available.	Trust Board, TOB, Workforce Committee	Ongoing Monitoring
Improving Sickness Absence	• Sickness absence was 4.82% in May 2018. • An audit has been completed on compliance with the Trust's Attendance Management Policy and a number of recommendations are being implemented. • Promotion and improvement of flu vaccination uptake took place in Q3/4. • Mental Health "Train the Trainer" training is complete.	• Mental Health first aid training will continue to be rolled out across the Trust. • There will be a focus on mental health and MSK related absence in the new people's strategy. • A new clinical supervision framework is to be rolled out which will help to address some of the stress/anxiety related absences.	Trust Board, TOB, Workforce Committee	Ongoing Monitoring



UoR Use of Resource Assessment Indicator

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 1 2018/19

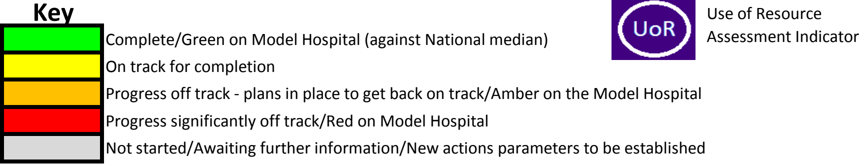
	Progress/Performance			Actions to Improve Position/Actions for Next Quarter	Assurance	Status

KLOE 2 - People

Indicator	Description	National/Peer	Period / Ranking	Assurance
Sickness Absence Rate	Percentage of staff FTE sick days.	National Median = 4.38% Peer Median = 4.62% 1. STHK: 3.44% 2. Salisbury: 3.84% 3. CoC: 4.31% 4. Mid Cheshire: 4.34% 5. Airdale: 4.56% 6. Barnsley: 4.58% 7. Harrogate: 4.6% 8. Aintree: 4.64% Source: HSCIC - NHS Digital iView Stability Index	February 2018 (UoR) 9. Wirral: 4.85% 10. South Warwick: 4.95 11. Gateshead: 5.04% 12. WHH: 5.06% 13. Tameside: 5.39% 14. East Cheshire: 5.92% 15. Southport: 6.59%	Absence remains above the Trust target. Key actions to address this include: > Review of current policy continues. > Benchmarking against similar neighbouring Trust is taking place to understand and implement best practice in relation to stress. > The HR team will be delivering bespoke actions and coaching within hotspot areas.
Staff Retention Rate	The percentage of staff that remained stable over 12 months period.	National Median = 85.6% Peer Median = 86.3% 1. Wirral: 90.7% 2. Gateshead: 90.4% 3. Mid-Cheshire: 89.3% 4. Barnsley: 89.1% 5. Aintree: 89% 6. Tameside: 88.6% 7. WHH: 88.1% 8. East Cheshire: 86.6% Source: HSCIC - NHS Digital iView Stability Index	March 2018 (UoR) 9. Chesterfield: 86.3% 10. CoC: 86.3% 11. Harrogate: 86.2% 12. South Warwick: 85.5% 13. Airdale: 85% 14. Salisbury: 83.1% 15. STHK: 79.6% 16. Southport: 75.1%	Trust Retention remains high and is also above the peer/national median. The HR team continue to provide tailored support to areas with high turnover and work is on-going across the Trust in relation to specific staff groups, including Nursing and Midwifery staff and AHPs. The recruitment and retention action plan is currently being refreshed.

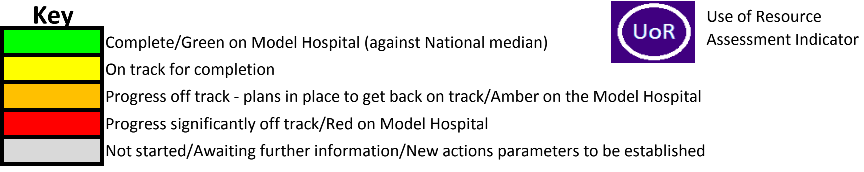
Sickness absence rate (chart: My Trust, National Median, Peers (My Peers))

Staff retention rate (chart)



Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 1 2018/19

	Progress/Performance			Actions to Improve Position/Actions for Next Quarter	Assurance / Status
Pay Costs per Weighted Activity Unit	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 = £2157** Peer Median = £2256 1. Salisbury: £2052 2. South Warwick: £2094 3. Chesterfield: £2109 4. Aintree: £2208 5. Countess of Chester: £2219 6. STHK: £2244 7. Barnsley: £2253 8. Gateshead: £2256 **Source: Trust consolidated annual accounts and reference cost data.**	**2016/17** 9. Wirral: £2269 10. Mid-Cheshire: £2338 11. WHH: £2337 12. Airedale: £2392 13. Tameside: £2439 14. East Cheshire: £2499 15. Harrogate: £2584 16. Southport: £2715	Total pay cost per WAU, National Distribution	Pay Costs per WAU exceeds the Peer Median and it is believed is largely down to the temporary staffing reliance of 13%. The Trust awaits to see the impact of the Nursing investment, and work continues to complete a similar review of our Medical Workforce. We continue to increase our substantive staff numbers, therefore we need to be sure to see a reduction in the temporary staffing reliance.
Medical Costs per WAU	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 = £526** Peer Median = £485 1. South Warwick: £416 2. Mid-Cheshire: £419 3. Gateshead: £431 4. Tameside: £435 5. East Cheshire: £450 6. WHH: £465 7. Countess of Chester: £475 8. Wirral £485 **Source: ESR, Trust consolidated annual accounts and reference cost.**	**2016/17** 9. Aintree: £487 10. Barnsley: £494 11. Southport: £510 12. Salisbury: £517 13. Airedale: £569 14. Harrogate: £583	Medical staff cost per WAU, National Distribution	The Trust is below the peer median, however the large number of vacancies within this workforce could have contributed to this. Work is ongoing to reduce both reliance on temporary staffing, through recruitment and skill mixing with Physician Associates; and also where temporary staffing is the only option, ensuring it is at best value, ideally through the growing medical bank.



Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 1 2018/19

	Progress/Performance		Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Nurses Cost Per WAU	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 = £718** **2016/17** UoR Peer Median = £812 1. Aintree: £618 2. Salisbury: £643 3. WHH £764 4. Countess of Chester: £775 5. Gateshead: £787 6. STHK: £800 7. South Warwick: £810 8. Wirral: £811 9. Barnsley: £814 10. Mid-Cheshire: £832 11. Airedale: £840 12. Tameside: £878 13. East Cheshire: £938 14. Southport: £951 15. Harrogate: £1027 **Source: ESR, Trust consolidated annual accounts and reference cost.**	Nursing staff cost per WAU, National Distribution	The Trust is below the peer median for our Nursing Costs per WAU. This is testament to the all the recruitment work in the last 12 months where vacancies reduced by 50%. The nursing investment should assist in driving this down further as we seek to appoint substantive support staff, reducing the reliance on high cost nursing staff.	
AHP Cost per WAU (community adjusted)	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 = £127** **2016/17** UoR Peer Median = £148 1. Salisbury: £105 2. STHK: £112 3. Barnsley: £123 4. Wirral: £124 5. Countess of Chester: £127 6. Mid-Cheshire: £131 7. Gateshead: £145 8. Aintree: £152 9. Tameside: £165 10. WHH: £188 11. Airedale: £198 12. Harrogate: £213 13. Southport: £224 14. South Warwick: £225 15. East Cheshire: £246 **Source: ESR, Trust consolidated annual accounts and reference cost.**	AHP staff cost per WAU, National Distribution	WHH have pockets of AHPs with a ongoing reliance on agency staff, which will push up costs. Our new staffing models and the Therapy review might increase demand for AHPs. WHH could therefore find itself with higher AHP cost per WAU, resulting in a lower Nurse cost per WAU.	

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UoR — Use of Resource Assessment Indicator

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 1 2018/19

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

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Care hours per patient	• 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.	• Care Hours are reviewed each month as part of the IPR at Trust and CBU Level. • Data is submitted monthly to NHS(I) via the Trust Performance team.	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-roster team is now co-located within the patient flow team in a centralised location. • Operational capacity and demand meetings are attended by the e-roster team to ensure staffing is matched to operational demand, along with ensuring staff are deployed to areas of high acuity in conjunction with the Matron and Lead Nurse. • 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 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 2 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 Theatres, Outpatient Nursing, Administration Staff, Medical Staff and Corporate Functions. • E-rostering team will support the Trust's Ward Accreditation programme with the use of the reporting from SafeCare and HealthRoster.	Trust Board	Ongoing development and daily monitoring

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UoR — Use of Resource Assessment Indicator

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 1 2018/19

	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	• Job planning using Allocate software now includes Specialty and Associate Specialists. • 85.64% of job plans completed for 2017/18 annual round although if we discount those who are unavailable for review due to long term absence the figure increases slightly to 86.59%. • The deadline for completion of job plans as at 1st April 2017 is overdue. • The Medical Director has written to those whose job plan has yet to reach completion giving a final deadline of 30th June 2018. • Any Job plan plans still outstanding will be subject to mediation. • The project around a corporate budget for programmed activities, medical leadership, education and research, quality governance and appraisal and revalidation is nearing conclusion with all non-core SPA and non-direct clinical care PAs being transferred from the CBUs to one of four medical budgets. Meetings are on-going to discuss further. • An updated draft job planning policy is progressing and has been shared with the Medical Cabinet, JLNC, JNCC and Workforce Committee for consideration. There are 4 outstanding queries raised by Staff Side which are currently being considered. • The Job Planning Project Manager established 'drop-in sessions' throughout March 2018 to support CBU Managers and continues to provide support on an ad hoc basis.	• Job planning progress will continue to be monitored on a weekly basis. • Job planning compliance is scrutinised at a weekly HR meeting when data is presented to the Deputy Director of HR & OD. • Mediation meetings will be convened to ensure all residual 2017/18 job plans reach conclusion. • The Staff side queries relating to the draft job planning policy will be considered as a matter of urgency so the policy can be ratified. • Proposed 2 sign offs for 2018/19 and 2019/20: by CBU managers/Clinical Directors (1st sign off) and again by consistency panel (2nd sign off). The timeline for future job planning rounds have been improved.	Workforce Committee	Ongoing development and daily monitoring

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UoR — Use of Resource Assessment Indicator

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 1 2018/19

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

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Hospital Pharmacy Transformation Programme - developing HPTP plans at a local level	• Developed and approved HPTP Plan, nominated Directors, Board sign off and submission of final plan to NHS Improvement.	• Completed in May 2017. • A update paper has been produced for the Medicines Governance Committee and the Quality and Assurance Committee for July 2018.	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 has been 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. • A project board has been established with terms of reference and schedule of meetings. • A project plan has been developed. • Preparatory work and testing has identified several issues for which solutions have been identified by the system supplier. • 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 upgraded to version 2.14 in April 2018 and included several fixes and developments.	• The Trust is working with the ePMA supplier on further developments to ensure flow between A&E and non-elective wards is robust. Lorenzo is due to be upgraded to version 2.15 in July, this contains further enhancements and bug fixes. Version 2.16 is due in September and v2.17 in 2019. When v2.17 is available, the required system improvements should be in place to be able to implement ePMA across the emergency admissions pathways. • The ePMA rollout plan has been drafted and is due to be presented/signed off by the Digital Operational Group and the IM&T Committee in July 2018. • If this plan is approved ePMA will be implemented on Halton wards beginning with B1 in July, followed by CMTC and B4 from September. Learning from these implementations will facilitate rapid roll out on the Warrington site, once v2.17 is available.	Trust Board/IM&T Committee	Project expected completion – March 2020

Warrington and Halton Hospitals NHS
NHS Foundation Trust

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Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 1 2018/19

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Ensuing that coding of medicines are accurately recorded.	• The JAC pharmacy system was upgraded to enable use of DM+D codes in July 2017. • Pharmacy drug files were updated where possible with DM+D codes in August 2017. • Review of and improvement of quality of data sets submitted to NHS England, CCGs & PHE completed in September 2017. • 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. • A Blueteq drop in presentation day to be held in January 2018 to demonstrate the system and inform clinicians about the contractual requirements to get prior approval for the patient pathway before commencing treatment and the review process – commencing 1st April 2018. • A meeting with NHSE's medicine management lead took place to review issues regarding DM+D codes which the Trust believes will further improve data quality when addressed, the meeting also helped us to understand the areas that we can target to further improve data quality. Informal feedback received from NHSE indicates that they are happy with the progress that has been made. • The Trust met with CCG commissioners to agree an implementation plan for Blueteq from 1st April 2018. Technical issues were addressed as well as issues with the structure of the forms. • Q1 2018/19 – Blueteq was implemented for endocrinology drugs. • Following receipt of a letter by Finance, confirmation has been given to Wigan CCG that a plan is in place to roll out Blueteq across specialities using high cost drugs. This has been noted by their Medicines Management Team.	• Monitor the contents of the Schedule 6 schema report. • Robust processes are to be developed and implemented with finance colleagues to ensure data is shared and updated on a monthly basis to keep on top of data quality issues. • Further work with the Information team to minimise the need for report modifications and manual data entry. • Review to ensure that cancer drug fund submissions comply with the data requirements. • Implementation of Blueteq plan includes: o Q2 – Rheumatology drugs o Q3 – Gastroenterology drugs o Q4 – Ophthalmology drugs	IM&T Committee/ Medicines Governance	Ongoing Work Programme
80% of trusts' pharmacist resource utilised for direct medicines optimisation activities, medicines	• The Trust is achieving the recommendation for pharmacists. • The Trust is aiming to increase time that pharmacy assistants and technicians spend on ward / with inpatients. • All Pharmacy technicians have now been upskilled to carry out medicines reconciliation with new starters being trained as they commence in post. • A plan is in place to train more pharmacy technicians to administer medicines. • The ward medicines management technician role has been reviewed with the Associate Directors of Nursing.	• The ongoing training program continues to upskill pharmacy technicians on medicines optimisation and administration. • Three wards now have a pharmacy technician administering medicines to patients. A plan in place to increase this to in accordance with the nursing recruitment plans. • A draft business case for a 7 day emergency admissions Pharmacy service has been developed and will be presented to the executive team during Q2.	Quality & Assurance Committee	Ongoing Monitoring

Warrington and Halton Hospitals NHS Foundation Trust

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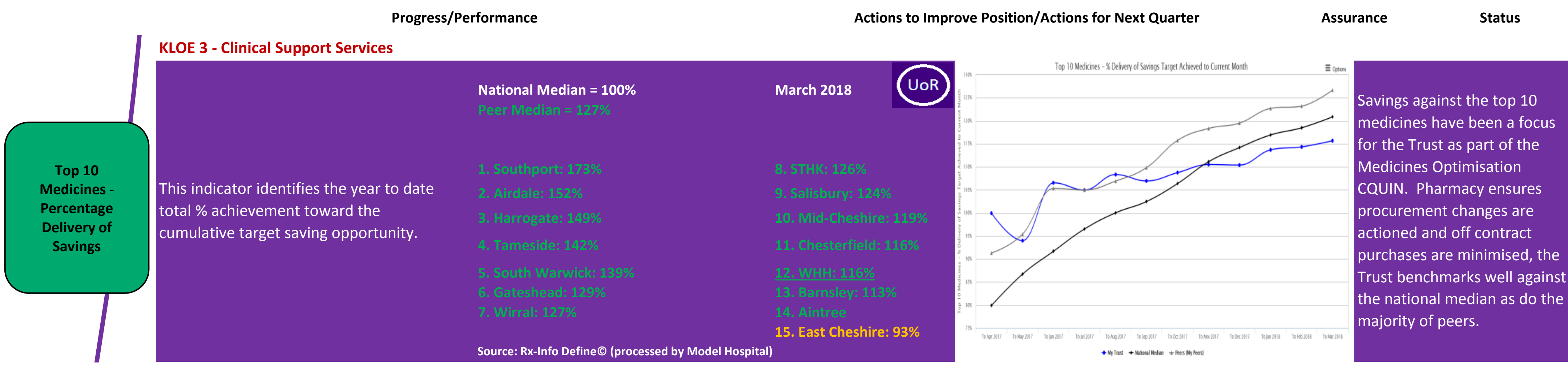
Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 1 2018/19



	Progress/Performance			Actions to Improve Position/Actions for Next Quarter	Assurance	Status

KLOE 3 - Clinical Support Services

Top 10 Medicines - Percentage Delivery of Savings

This indicator identifies the year to date total % achievement toward the cumulative target saving opportunity.

National Median = 100%

Peer Median = 127%

March 2018

UoR

1. Southport: 173%	8. STHK: 126%
2. Airdale: 152%	9. Salisbury: 124%
3. Harrogate: 149%	10. Mid-Cheshire: 119%
4. Tameside: 142%	11. Chesterfield: 116%
5. South Warwick: 139%	12. WHH: 116%
6. Gateshead: 129%	13. Barnsley: 113%
7. Wirral: 127%	14. Aintree
	15. East Cheshire: 93%

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

Savings against the top 10 medicines have been a focus for the Trust as part of the Medicines Optimisation CQUIN. Pharmacy ensures procurement changes are actioned and off contract purchases are minimised, the Trust benchmarks well against the national median as do the majority of peers.

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UoR — Use of Resource Assessment Indicator

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 1 2018/19

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 Transformation

Milestone	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
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. The first meeting was held on 21st November 2017. • Three main working groups have been established (Blood Sciences, Microbiology & Cellular Pathology). The Pathology Manager for WHH is leading on the Cellular Pathology workgroup. • STP Cheshire & Mersey Pathology Board met in Q12018/19– CEO of Aintree Hospital NHS Trust has been named Executive lead for the relaunched group. The need for project management has been identified. It was agreed there will be 3 hubs across the footprint with WHH/STHK working together as one hub.	• The Trust is awaiting further communication from executive lead/pathology network for Cheshire and Mersey regarding the next steps. • Clarity required of what services each hub will be delivering.	Strategic Development and Delivery Committee	Project – expected completion 2020
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	• A Pathology Quality Assurance Dashboard (PQAD) has been developed. • PQAD implemented in "shadow" form from November 2016.	• Monthly data indicators continue to be submitted. • POAQ data is reviewed monthly at the KPI sub-committee. • The Trust continues to review quarterly and bi-annual indicators, however, the Trust understands that the indicators are under review and a new dashboard is under development.	KPI Committee	Rolling Programme

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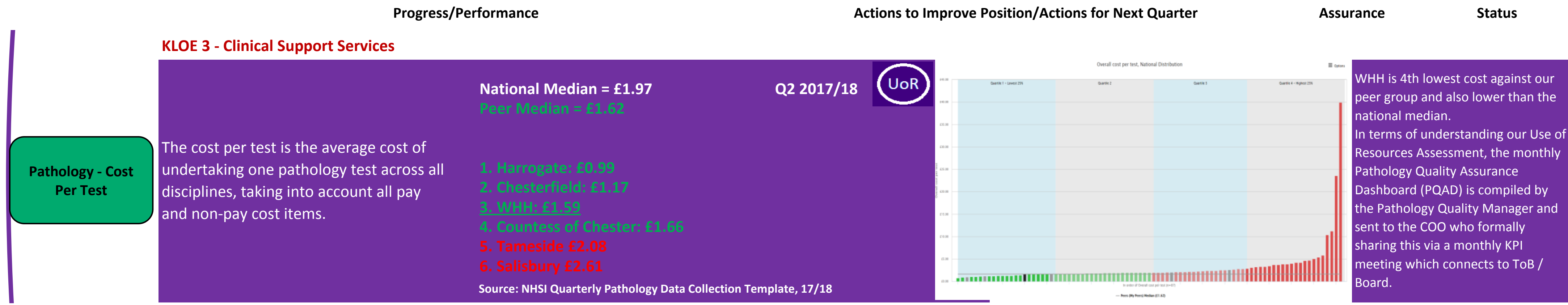
Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 1 2018/19

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status

KLOE 3 - Clinical Support Services



Pathology - Cost Per Test

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 = £1.97 **Q2 2017/18** UoR

Peer Median = £1.62

1. Harrogate: £0.99
2. Chesterfield: £1.17
3. WHH: £1.59
4. Countess of Chester: £1.66
5. Tameside £2.08
6. Salisbury £2.61

Source: NHSI Quarterly Pathology Data Collection Template, 17/18

WHH is 4th lowest cost against our peer group and also lower than the national median.
In terms of understanding our Use of Resources Assessment, the monthly Pathology Quality Assurance Dashboard (PQAD) is compiled by the Pathology Quality Manager and sent to the COO who formally sharing this via a monthly KPI meeting which connects to ToB / Board.

Key

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Green	Complete/Green on Model Hospital (against National median)
Yellow	On track for completion
Amber	Progress off track - plans in place to get back on track/Amber on the Model Hospital
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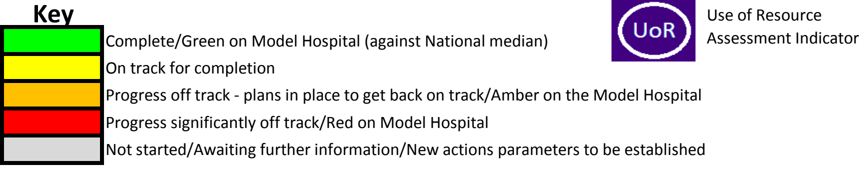
UoR – Use of Resource Assessment Indicator

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 1 2018/19

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): Chief Operating Officer & Director of Transformation

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
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 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 new report of the Top 25 variances has been produced which compares the Trust nationally and against peers. Actions will be produced to address variance where it is possible to do so. This will be run and reviewed on a monthly basis.	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 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.	• The PTP, which was developed in 2016 will be refreshed due to changes in the procurement landscape since it was originally re-written, a draft has been completed and will be finalised during Q2. • A briefing paper will be presented to the Trust board to highlight any changes to the plan. • The Trust will continue to measure progress against the PTP.	Finance & Sustainability Committee	Project Implementation
Adoption plan for Scan4Safety	• The Trust adoption plan for Scan4Safety (formally the Global Standard: GS1) and pan European Public Procurement Online (PEPPOL) standards has been drafted. • The Trust has recruited a Supply Chain Manager who will lead on the Scan4Safety project. • The Deputy Head of Procurement presented Scan4Safety to the Finance & Sustainability Committee and Trust Operational Boards.	• A feasibility study will commence in Q2 which will outline the options for the scope of the project and include initial detail around costs. A briefing paper will then by presented to the Trust Board for approval.	Trust Board/ Scan4Safety Project Board	Project Implementation
NHS Standards of Procurement - to achieve level 1 by October 2016, develop improvement plan to meet target by	• The Trust has achieved NHS Standards of Procurement Level 1 accreditation.	• The Trust is working towards level 2 accreditation for review in 2018.	Finance & Sustainability Committee	Project Implementation



Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 1 2018/19

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Benchmarking – Model Hospital Procurement	• The Trust is currently ranked 50/136 Trusts – placing the Trust in the middle of upper quartile. • Benchmarking data is submitted for the Model Hospital. • 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 Trust will work with NHSI to understand how we can work differently to improve our ranking within the model hospital. • The procurement team is in the process of producing a strategy to look at the feasibility of the Trust reaching the upper quartile for each metric and actions needed to get there.	Finance & Sustainability Committee	Ongoing
Key Procurement Metrics	• Target of 80% addressable spend transaction volume on catalogue - Trust currently at 92% (Q1 2018/19). • Target of 90% addressable spend transaction volume with a purchase order - Trust currently at 95% (Q1 2018/19). • 90% addressable spend by value under contract - Trust currently at 63% (Q1 2018/19).	• 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. • Addressable Spend under Contact The procurement team has recently reviewed processes around the Contract Register with a view to improve addressable spend under contract. This review has highlighted a number of issues, which has resulted in the % being reduced. During Q2, the procurement team will review each contract and address any required actions to improve the position. The review will ensure more robust plans are in place going forward.	Finance & Sustainability Committee	Ongoing Monitoring

KLOE 4 - Corporate Services

Procurement Process Efficiency and Price Performance Score Clinics

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.

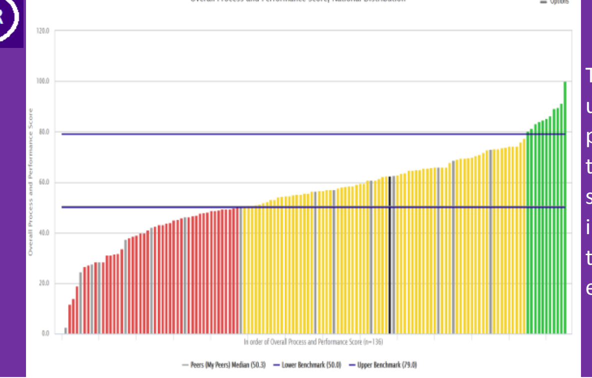
National Median = 79.0
Peer Median = 50.3

Q4 2016/17

UoR

1. Countess: 73.2
2. Barnsley: 68.7
3. Salisbury: 66.1
4. Wirral: 62.6
5. WHH: 62.5
6. Southport: 60.9
7. Harrogate: 57.0
8. Chesterfield 56.6
9. Mid-Cheshire: 50.3
10. STHK: 46.3
11. Aintree: 42.2
12. Tameside: 37.3
13. South Warwick: 28.6
14. East Cheshire: 27.7
15. Airedale: 24.6
16. Gateshead: 2.6

Source: Purchase Price Index and Benchmark (PPIB) tool



The procurement team has undertaken a review of all procurement metrics and is in the process of producing a strategy and actions for improving the Trust's position to reach the upper quartile for each metric.

Key

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Green	Complete/Green on Model Hospital (against National median)
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Red	Progress significantly off track/Red on Model Hospital
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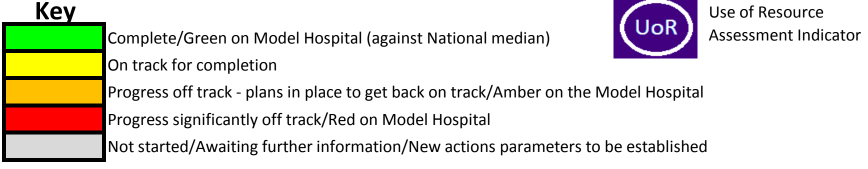
UoR – Use of Resource Assessment Indicator

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 1 2018/19

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

Indicator	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Strategic estates strategy inc cost reduction for 16/17 based on benchmarks and in the longer term plan for	• 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 the local clinical strategy and STP estates strategy.	• The Trust continues to explore internal and H&SC partnership collaboration opportunities for relocation of back and clinical support services. • The Trust will align the estates and facilities strategy to the new clinical strategy which is in the process of being developed.	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	• 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 invested in Combined Heat.	• The CHP contract to be monitored for performance and savings, the Trust should see savings in July 2018.	Estates and Facilities Sub-Committee	Complete
Estates and facilities costs embedded into trusts' patient costing and service line	• Estates and Facilities costs are incorporated into PLICS system. Quarterly service lines 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. Model Hospital data for 2016/17 has been published and benchmarks appear to be inaccurate due to discrepancies in data from other NHS trusts which has been confirmed by NHSI.	• PLACE assessment took place in June 2018; results from the survey will be developed into an action plan. • Model hospital metrics are continually monitored and the Trust has recently established a work stream around Use of Resource Assessment as part of the Getting to Good, Achieving Outstanding programme. Where improvements can be made against specific metrics, these will be developed into an action plan.	Estates and Facilities Sub-Committee/TOB	Ongoing Monitoring



Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 1 2018/19

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
All trusts (where appropriate) have 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	• Model hospital data for 2016/17 reports the Trust utilises 41% of its estate for non-clinical use and has 2.2% of empty space. Whilst efforts to minimise the use of trust accommodation for non-clinical purposes have been made it difficult given the complexities of the numerous corporate functions.	• The current estate strategy aims to address the under-utilised space by rationalising the estate. Better use of under-utilised estate will result a reduction in the size of the estate and the amount of estate used by non-clinical functions. The data available for 2017-18 demonstrates improvement in the use of space for non-clinical activity- down to 36%	Strategic Development and Delivery Committee	Ongoing Monitoring

KLOE 4 - Corporate Services

Estates Costs Per Square Meter

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.

The occupied floor area is the total internal floor area of all buildings that are in operational use and required for the purpose of delivering the function/activities of the organisation. It includes embedded education and training facilities and university accommodation which are occupied.

National Median = £308

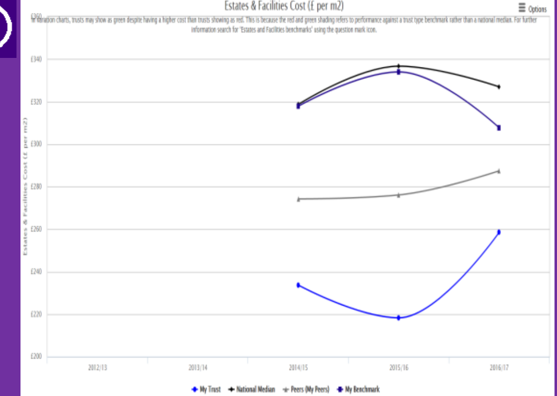
Peer Median = £287

2016/17

UoR

1. Wirral: £199
2. Mid-Cheshire £212
3. Aintree: £226
4. Chesterfield: £233
5. Salisbury: £286
6. WHH: £259
7. Countess of Chester: £266
8. Gateshead: £281
9. Airedale: £320
10. Harrogate: £323
11. Tameside: £324
12. East Cheshire: £352
13. STHK: £397

Source: ERIC 2016-17 Total Estates and Facilities Running Costs



The Trust has invested capital 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 an adverse effect on overall estates and facilities costs.

Key

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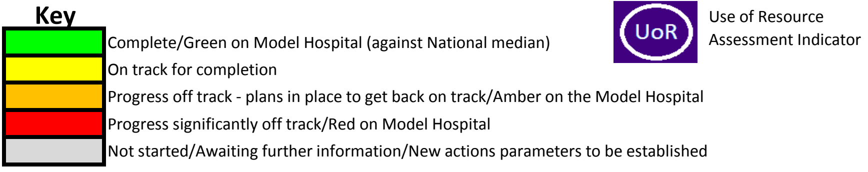
UoR — Use of Resource Assessment Indicator

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 1 2018/19

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): Chief Operating Officer and Director of Transformation

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Rationalisation of corporate and administration functions	• The Trust's corporate and administration functions current costs are 7.7% of income based on planned income as of Q1 2018/19. • 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. • A series of workshops were held during 2017 to discuss and explore ideas for collaboration and financial efficiency with corporate functions from each LDS organisation participating. • Subsequent changes to the STP/LDS configuration have meant that momentum around this particular piece of work has been lost (largely from an external perspective). Therefore, the focus of this work has now shifted internally. • Reports for each corporate function have been compiled using the latest NHSI Model Hospital data and distributed to corporate service leads for them to use as a start point for internal service reviews.	• The LDS has appointed new Director of Finance who will be tasked with leading this piece of work across the LDS. • Potential schemes of how rationalisation of services can happen have been developed and will be taken to the executive team for discussion. • Schemes will also be developed as part of the work with commissioners at the collaborative and sustainability group.	Strategic Development and Delivery Committee	Rolling Programme
Corporate CIP Targets	• All corporate divisions have been assigned costs savings targets in 2017/18. 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 Q1 - £0.08m against the target for the year of £0.52m.	Finance & Sustainability Committee	Rolling Programme
Corporate Services A&C Review	• Following ICIC in December, a named Trust Lead (Acting Deputy Chief Operating Officer) appointed to lead on the Admin & Clerical review together with Director of IM&T as Executive Lead. • In 2018/19, the Trust's financial efficiency across its corporate functions will be monitored as part of the revamped CQC "Use of Resources" assessment. The Trust Director of Finance is the named Executive Lead overseeing this work and the organisation's position as per the NHSI Model Hospital metrics will be the basis for much of the measurement of progress. • Use of Resources group established meeting monthly and reporting to the Trust's "Getting to Good" steering group.	• A full review of Corporate and A&C services is still required, due to changes in personnel, discussions will take place with the new Deputy COO and new executive lead of agree how to take this forward.	Strategic Development and Delivery Committee/ GTGM2O programme	Ongoing



Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 1 2018/19

	Progress/Performance		Actions to Improve Position/Actions for Next Quarter	Assurance / Status
KLOE 4 - Corporate Services				
Non Pay Costs per WAU	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 = £1301** **2016/17** (UoR) **Peer Median = £1190** 1. Harrogate: £1007 2. WHH: £1066 3. Airedale: £1067 4. Countess of Chester: £1079 5. Mid-Cheshire: £1088 6. Wirral: £1096 7. South Warwick: £1162 8. Southport: £1181 9. STHK: £1190 10. Salisbury: £1202 11.Tameside: £1218 12. Gateshead: £1224 13. Chesterfield: £1248 14. Barnsley: £1254 15. Aintree: £1354 16. East Cheshire: £1439 **Source: Trust consolidated annual accounts and reference cost data.**	Total non-pay cost per WAU, National Distribution (chart)	Whilst WHH costs are lower than it's peer group ways of reducing costs whilst maintaining quality are continually reviewed.
Finance Costs per £100m Turnover	Total finance cost divided by trust turnover multiplied by a £100m	**National Median = £671k** **2016/17** (UoR) Peer Median = £712k 1. Aintree: £591k 2. Barnsley: £600k 3. CoC: £670k 4. Mid-Cheshire: £673k 5. Wirral: £682k 6. Chesterfield: £695k 7. STHK: £702k 8. Salisbury: £722k 9. Tameside: £772k 10. Gateshead: £799k 11. Airedale: £808k 12. South Warwick: £843k 13. Southport: £858 14. WHH: £962k 15. East Cheshire: £1.05m **Source: Trust consolidated annual accounts and NHSI improvement 16/17 data collection template.**	Finance function cost per £100m turnover, National Distribution (chart)	For 2016/17 trust actual £961.86k – national median for same year £889.35k and peer median £803.20k. Work is underway to break down these costs by finance function and compare these to peers.

Key

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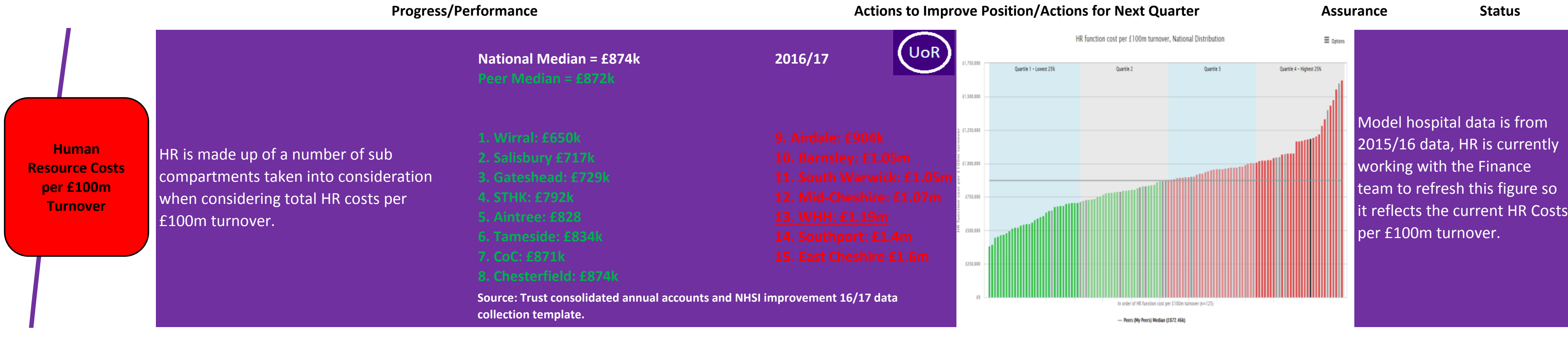
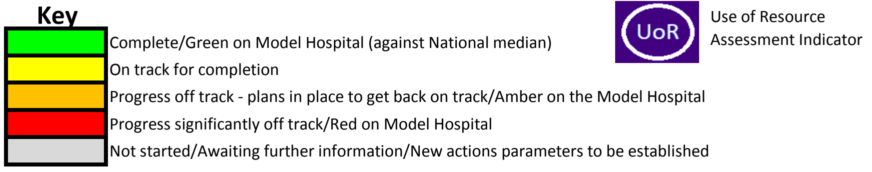
UoR – Use of Resource Assessment Indicator

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 1 2018/19



	Progress/Performance			Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Human Resource Costs per £100m Turnover	HR is made up of a number of sub compartments taken into consideration when considering total HR costs per £100m turnover.	**National Median = £874k** Peer Median = £872k 1. Wirral: £650k 2. Salisbury £717k 3. Gateshead: £729k 4. STHK: £792k 5. Aintree: £828 6. Tameside: £834k 7. CoC: £871k 8. Chesterfield: £874k **Source: Trust consolidated annual accounts and NHSI improvement 16/17 data collection template.**	**2016/17** 9. Airdale: £904k 10. Barnsley: £1.05m 11. South Warwick: £1.05m 12. Mid-Cheshire: £1.07m 13. WHH: £1.19m 14. Southport: £1.4m 15. East Cheshire £1.6m	UoR HR function cost per £100m turnover, National Distribution	Model hospital data is from 2015/16 data, HR is currently working with the Finance team to refresh this figure so it reflects the current HR Costs per £100m turnover.	



Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 1 2018/19

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 Transformation

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Variation in Theatres and Outpatients	• Unwarranted variation within theatres and outpatients is being addressed through the theatres and outpatient work streams of the transformation programme. • A new theatre scheduling process launched in November 2017 is designed to provide improved visibility and forward planning around utilising theatre and anaesthetic capacity. • Shortfalls in anaesthetic capacity have proved to be a bottleneck in terms of ensuring efficient use of theatre capacity. A business case has been approved for additional capacity and work ongoing to ensure available capacity is utilised as effectively as possible. • 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 introduced in October 2017 and are now fully established entering the financial year 2018/19. Theatre sessions are now 'locked down' at two weeks. • Capacity and Demand work for Outpatients commenced in December 2017 with the aim of understanding the exact clinic requirements for each specialty to deliver their activity plans and then ensuring we have robust monitoring systems in place to track delivery. • Analysis of Outpatient Capacity and Demand for the following specialties is now complete: Haematology, Colorectal, Breast, Orthotics, General Surgery, Gastroenterology, Upper GI, Anaesthetics, Cardiology, Respiratory, Pain Management, Vascular, Hepatology. • New list planning process has been 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. • The 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 will be developing the CBU dashboard to include theatre productivity metrics.	• During Q2 a new rota master system will be implemented with the aim of improving anaesthetic scheduling, this will be aligned with existing processes. • A Theatre Transformation Board to be chaired by the CBU Manager for Digestive Diseases has been established and will meet in Q2. • The Transformation Team have developed a capacity and demand summary which CBU managers will monitor.	Strategic Development and Delivery Committee	Ongoing

Key

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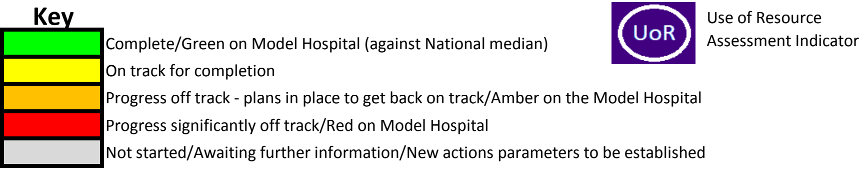
UoR — Use of Resource Assessment Indicator

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 1 2018/19

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Emergency Care Improvement Programme	• An Improvement Programme around inpatient flow has 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 now collected on all wards through daily board rounds and a process to share the data around patient delays with partner organisations is now in place with partner organisations expected to respond with actions in place to reduce the delays. • Frailty work stream – strategy document ratified by the Trust Board sub-committees in November 2017 and Frailty Assessment Unit completed. Frailty Assessment Unit opened in May as a pilot 2 days per week, early indications has shown a positive impact on patient experience and flow. • Significant work has been progressed via the Trust's Impact 5 event. Progress against the identified objectives will be monitored through the Trust's internal patient flow board. • Refreshed Patient Flow Steering Group will now move to govern a more strategic programme of work.	• The Trust will work with BCF and Commissioners to monitor the impact of the FAU, it is hoped that the pilot will be extended to include additional days that the unit is open. Outcomes will be continually monitored. • The Emergency Care Improvement Programme visited the Trust in May and June. There was an NWAS challenge for all conveyances and a walk through of the urgent/emergency care system. Positive informal feedback was received, the Trust is awaiting formal feedback and will work through any actions during Q2/3. • In Q2/3 a business case will be developed in association with Integrated Care Partnership/Better Care Fund for an Integrated Rapid Care Service. • The Trust will continue to work with One Halton and Warrington Together to ensure proposals are developed consistently with an integrated approach. • Venn Consulting has been appointed to carry out a system wide capacity and demand review, it is anticipated this will be complete during Q2.	A&E Delivery Board Flow Board	Ongoing
Specialty level reviews across local delivery system.	• The Trust is participating in a series of specialty level reviews across the Local Delivery System (LDS). • It has been agreed to produce and implement plans to reduce variation within pathways across the LDS. • Initial 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 is being developed and will be launched early in 2018/19. This will support delivery of the Trusts objectives by the clinical teams.	• The Trust is working with commissioners and St Helen's & Knowsley Teaching Hospitals NHS Trust to review and transform Stroke Pathways. • A GIRFT review of Paediatric Services across the Cheshire & Mersey footprint is in progress. • The Trust is working with AQuA to review Cancer Pathways with a view to implementing a "straight to test" model.	Strategic Development and Delivery Committee	Ongoing



Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 1 2018/19

	Progress/Performance			Actions to Improve Position/Actions for Next Quarter	Assurance	Status

KLOE 1 - Clinical

Pre Procedure Elective Bed Days

The number of bed days between the elective admission date and the date that the procedure taken place.

UoR

National Median = 0.13
Peer Median = 0.13

Q4 2017/18

1. Harrogate 0.04
2. Mid Cheshire 0.04
3. Chesterfield 0.05
4. Airdale: 0.06
5. WHH: 0.07
6. Tameside: 0.1
7. CoC: 0.1
8. South Warwick: 0.11
9. STHK: 0.13
10. East Cheshire: 0.2
11. Southport: 0.22
12. Aintree: 0.32
13. Barnsley: 0.36
14. Gateshead: 0.37
15. Salisbury: 0.44
16. Wirral: 2.13

Source: Hospital Episode Statistics

Pre-procedure elective bed days
(My Trust, National Median, Peers (My Peers))

The model hospital data indicates that WHH is performing better than the national and peer medians.

Pre Procedure Non Elective Bed Days

The number of bed days between an emergency admission date and the date the procedure taken place.

UoR

National Median = 0.81
Peer Median = 0.99

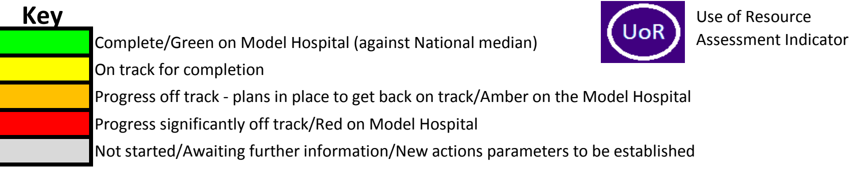
Q4 2017/18

1. Aintree 0.75
2. CoC: 0.77
3. Chesterfield: 0.79
4. Harrogate: 0.80
5. Mid Cheshire: 0.81
6. South Warwick: 0.88
7. WHH: 0.93
8. Airdale: 0.94
9. East Cheshire 0.99
10. Salisbury: 1.01
11. Barnsley: 1.02
12. STHK: 1.06
13. Gateshead: 1.11
14. Wirral: 1.12
15. Southport 1.19
15. Tameside: 1.45

Source: Hospital Episode Statistics

Pre-procedure non-elective bed days
(My Trust, National Median, Peers (My Peers))

The model hospital data is being reviewed to understand the reasons for the variance with actions being established and implemented to improve the Trust position.



Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 1 2018/19

Progress/Performance | Actions to Improve Position/Actions for Next Quarter | Assurance | Status

Did Not Attend (DNA) Rate

Rate of patients not attending their outpatient appointment.

UoR

National Median = 7.28%
Peer Median = 7.48%

Q4 2017/18

1. East Cheshire: 5.22%	8. Southport: 7.64%
2. South Warwick: 5.39%	9. Tameside: 7.71%
3. Salisbury: 5.39%	10. Airdale: 8.20%
4. Mid-Cheshire: 5.45%	11. Wirral: 8.30%
5. Harrogate: 6.60%	12. Gateshead: 8.73%
6. Countess of Chester: 6.62%	13: STHK: 9.63%
7. Barnsley: 7.48%	14. WHH: 10.84%
	15. Aintree: 11.55%

Source: Hospital Episode Statistics

Did not attend (DNA) rate

The data indicates WHH is in an improving position. In May 2018 the Trust reintroduced a text reminder service to support further improvement. The latest DNA data for June 2018 shows that DNA rates are running at 8%, almost a 3% improvements on the current position. The focus is now on reviewing and implementing further improvements across services in line with peers.

Emergency Readmission (30 Days)

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.

UoR

National Median = 7.19%
Peer Median = 6.96%

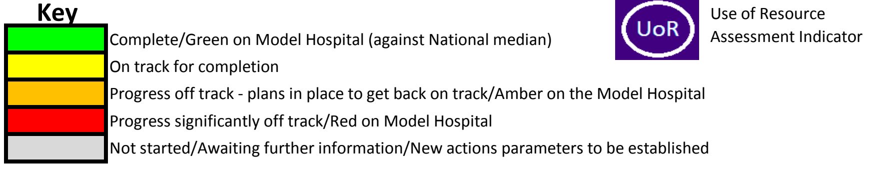
Q4 2017/18

1. Salisbury: 5.72%	8. South Warwick: 6.92%
2. Southport: 5.84%	9. Airdale: 6.96%
3. East Cheshire: 5.96%	10. Aintree: 7.21%
4. CoC: 6.13%	11. Gateshead: 7.65%
5. WHH: 6.38%	12. STHK 8.24%
6. Wirral: 6.71%	13. Mid-Cheshire: 8.28%
7. Harrogate: 6.89%	14. Chesterfield: 8.6%
	15. Tameside: 8.63%
	16. Barnsley: 8.95%

Source: Hospital Episode Statistics

Emergency Readmission 30 days

The model hospital data indicates that WHH is performing better than the national and peer medians.



Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 1 2018/19

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: Director of Information Management & Technology

	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 IM&T Project Board. • During Q4 the Trust has tested and implemented 2 upgrades of Lorenzo. • The Trust has introduced paperless referrals in Q4 and will optimise and review benefits during Q1. • Updates to outpatient letters took place during Q4. • The Trust has been selected as a Digital Exemplar for work relating to the use of the Electronic Patient Record and will review next steps during Q1 2018/19. • Business case for "patient knows best" the clinical portal for Warrington was signed off during Q1, it is anticipated this will be rolled out in 2019. • Work has commenced of the GP viewer which will give Trust clinicians access to Warrington GP records via Lorenzo.	• The Trust's business case has been submitted to NHS Digital as part of the Digital Exemplar programme. Feedback is expected during Q2. • The Trust has tested the GP viewer for Warrington GP records in Lorenzo. The software is not what the Trust expected in terms of providing all of the '10 tabs' that are available via the Medical Interoperability Gateway (MIG). The Trust is looking at an alternative solution and testing of this solution will take place during Q3 2018/19. Sharing agreements will be signed off for during Q2 2018/19.	IM&T Sub-Committee/ Trust Board	Project Implementation – expected completion – Plan up to 2020 on track.
Electronic Document Management	• A business case for an Electronic Document Management System has been developed. There has been some minor delays to the development of the full business case however, it is anticipated that the full business case will be approved during Q1 2018/19. • Due to the development of the LDE business case and the feedback received from clinicians and medical records staff a review of actual requirements now Lorenzo has been live for 3 years is to be undertaken to ensure the investment required is for the right solution • The CCIO has supported this work and we are renaming the project paperless 2020 strategy.	• The full business case to be signed off by the Trust Board during Q2 2018/19. • The Trust will tender for EDMS system; once this has been completed a full implementation plan will be developed with the successful bidder. • The CIO for Nursing and AHP has been looking at components of EDMS that are actually required to enable paperless by 2020 • This will lead to a revised business case to consider all elements outstanding to achieve paperless by 2020.	IM&T Sub-Committee	Project Implementation – Initiation
ePMA	• Electronic prescribing and medicines administration (EPMA) Business case and PID signed off by Trust Board and NHS Digital – outline business case was approved by the Trust board in October 2017, NHS Digital approved the business case in principle in November 2017. • ePMA pilot commenced on CDU in March with a further pilot in Halton Urgent Care centre commencing at the end of March. Learning from all pilots will be used in the development of new functionality and develop fixes to any issues identified.	• Further testing and build phases will be required throughout 2018/19 with further rollouts commencing in March 2019. • Key issue identified during pilot testing will be fixed in 2.15 release. Target date for 2.15 is expected during Q2 2018/19.	IM&T Sub-Committee	Project Implementation

Key

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

UoR — Use of Resource Assessment Indicator

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 1 2018/19

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Collaborative working across the healthcare economy	**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			
	Further information from national bodies is awaited.			
	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			
	• The Trust is working 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. • Pathway Integration and efficiency through the local health economy will be digitally enabled through the use of Care Record, risk stratification and patients accessing personal health records.			
Development of a Model Hospital	**Recommendation 12 - N**HS 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			
	• 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

Key

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

UoR — Use of Resource Assessment Indicator

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 1 2018/19

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

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
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.

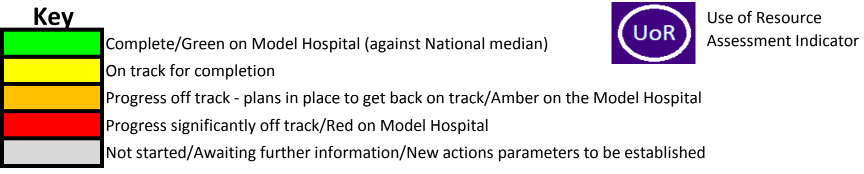
Lead Director: Not Applicable

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

Further information from national bodies is awaited.



UoR Use of Resource Assessment Indicator

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 1 2018/19

	Progress/Performance			Actions to Improve Position/Actions for Next Quarter	Assurance	Status
KLOE 5 - Finance						
Capital Services Capacity	The degree to which the provider's generated income covers its financial obligations	**WHH Model Hospital = -1.02** **Source: Provider returns**	**February 2018**	UoR	Capital services capacity – model hospital data still at February 2018 – WHH position May 2018 -6.9 times. The operating performance of the Trust results in an operating deficit so the Trust is focussing on improving its operating performance through income increase and cost reduction whilst maintaining the quality of healthcare.	
Liquidity (Days)	Days of operating costs held in cash or cash-equivalent forms, including wholly committed lines of credit available for drawdown.	**WHH Model Hospital = -44.66 days** **Source: Provider returns**	**February 2018**	UoR	Liquidity – model hospital at February 2018 – WHH position -37.1 days. The historic and current operating and financial performance has resulted in reduced cash and the need for additional working capital loans. The Trust manages the cash position very closely to maintain liquidity and meet its financial obligations.	

NHS Foundation Trust

Key

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

UoR — Use of Resource Assessment Indicator

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 1 2018/19

	Progress/Performance			Actions to Improve Position/Actions for Next Quarter	Assurance / Status
Income & Expenditure Margin	The income and expenditure surplus or deficit, divided by total revenue.	**WHH Model Hospital = -7.45%** (Source: Provider returns)	**February 2018**	UoR	I&E margin – model hospital as February 2018 – WHH position -12.4%. The operating performance of the Trust results in an operating deficit so the Trust is focussing on improving its operating performance through income increase and cost reduction whilst maintaining the quality of healthcare.
Distance from Financial Plan	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.	**WHH Model Hospital = 5.5%** (Source: Provider returns)	**February 2018**	UoR	Performance against plan – model hospital as February 2018 – WHH position 0.03%. The Trust is marginally ahead of the planned deficit but is focussing on improving its operating performance through income increase and cost reduction whilst maintaining the quality of healthcare.
Agency Spend - Cap Value	The extent to which the trust is meeting the target for the amount spend on agency workers for the financial year.	**WHH Model Hospital = 2.19%** (Source: Provider returns)	**February 2018**	UoR	Agency spend – cap value – model hospital as February 2018 – WHH position 23.7%. The Trust is ahead of the allocated agency ceiling due to the continued reliance of agency staff to cover gaps from vacancies and meet demand but is continuing to increase staffing levels through recruitment and utilising new staffing models.

Charts: Income and expenditure (I&E) margin - value; Distance from financial plan - value; Distance from agency spend cap - value (My Trust, Sep 2016 – Feb 2018).

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BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/18/07/71**	
SUBJECT:	**Scan 4 Safety (S4S) initiative**	
DATE OF MEETING:	25 July 2018	
ACTION REQUIRED	For approval	
AUTHOR(S):	Brian Burge, Deputy Head of Procurement	
EXECUTIVE DIRECTOR SPONSOR:	Andrea McGee, Director of Finance and Commercial Development	
LINK TO STRATEGIC OBJECTIVES:	All	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	BAF1.3: National & Local Mandatory, Operational Targets	
	BAF1.4: Business Continuity	
	BAF3.2: Monitor Undertakings: Corporate Governance & Financial Management	
STRATEGIC CONTEXT	The Scan 4 Safety (S4S) initiative is mandated as part of the Department of Health's e procurement strategy.	
EXECUTIVE SUMMARY (KEY ISSUES):	The Department of Health e procurement strategy mandates the use of GS1 standards (covering patient, product and location) by all healthcare providers.	
RECOMMENDATION:	The Trust Board is requested to approve the undertaking of a feasibility study to identify the costs, risks, benefits and timescales that would be involved in the implementation of Scan 4 Safety.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Finance and Sustainability Committee
	Agenda Ref.	FSC/18/06/80
	Date of meeting	20 June 2018
	Summary of Outcome	Supported
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None	

BOARD OF DIRECTORS

SUBJECT	Scan for Safety	AGENDA REF:	BM/18/07/71

1. Purpose

The purpose of this report is to update the Board of Directors regarding the Scan 4 Safety (S4S) initiative which has been mandated as part of the Department of Health's e procurement strategy.

2. Executive Summary

Lord Carter of Coles was commissioned by the Secretary of State for Health to look at what could be done to improve efficiency in hospitals in England. A report, looking at the operational efficiency of the NHS was commissioned, entitled 'Operational Productivity and Performance in English NHS acute hospitals: Unwarranted variations'. One section of the report covers procurement transformation and refers specifically for the need to drive adoption of the GSI (now known as Scan 4 Safety) coding standards throughout the healthcare sector and it's supporting supply chains.

3. Content

S4S, formerly known as Global Standards 1 (GS1), is a patient safety, quality and process improvement initiative based around the use of unique patient, product and location codes.

In 2014, the Department of Health mandated that by 2019/20 all NHS Trusts in England must adopt GS1 standards and all their suppliers must become GS1 compliant. GS1 involves a system of bar codes to identify every person, every product and every location involved in the provision of care. This is achieved through the following:

- Caregivers will have a barcode on their ID badge
- Patients will have a GS1 compliant wrist band
- Products will have a unique product identification barcode
- Locations will have a unique barcode identifier

Using a barcode scanner the caregiver will scan the barcode on their ID badge, scan the barcode on the patient's wrist band, scan the barcode on the product they intend to use to provide care and scan the location identifier barcode. This data will be uploaded into the Patients Administration System to reflect the provision of the care, the product the location.

The resulting clinical, operational and financial benefits include:

- Greater traceability of product usage.
- Improvements in the inventory management system that allows for enhanced stock usage, control and ordering to reduce waste and duplication of products.
- Greater accuracy in the cost of healthcare to support Service Line reporting and patient Level Costing.

The impact of this e procurement strategy will require the Trust to review and develop its processes and systems. The aim is to deliver improved value whilst ensuring better use of staff resource through the elimination of non value adding tasks together with the following benefits:

- Improved patient safety
- Better inventory management and stock control
- Reduced duplication and waste
- Asset tracking
- Accurate capture for costs for Service Line Reporting and Patient Level Costing
- Alignment with the Electronic Prescribing and Medicines (EPMA) project

The initiative requires adoption of GS1 standards by participating members. The majority of the Trust's suppliers have already adopted these standards.

In order to realise and maximise the benefits of this opportunity it is proposed that a feasibility study is undertaken to assess the potential benefits, costs, risks and timescales. This will include the production of an implementation plan that will require Board approval. It is proposed that this feasibility study will be led by the Trust's Deputy Head of Procurement and the Supply Chain Manager with support from key stakeholders including Pharmacy, Clinicians, Operational staff and IM&T.

4. Recommendations

The Trust Board is requested to approve the undertaking of a feasibility study to identify the costs, risks, benefits and timescales that would be involved in the implementation of Scan 4 Safety.

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/18/07/72**
SUBJECT:	**The National Inpatient Survey results for 2017**
DATE OF MEETING:	25th July 2018
ACTION REQUIRED	**For Assurance**
AUTHOR(S):	John Goodenough, Deputy Chief Nurse
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse
LINK TO STRATEGIC OBJECTIVES:	SO1: To ensure that all care is rated amongst the top quartile in the North West of England for patient safety, clinical outcomes and patient experience
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	BAF1.1: CQC Compliance for Quality
	Choose an item.
	Choose an item.
STRATEGIC CONTEXT	The following report describes the Trust's overall scores achieved in the National Inpatient Survey (2017).
EXECUTIVE SUMMARY (KEY ISSUES):	The results of the National In Patient Survey 2017 show an overall improvement on 42 of the survey questions compared with 8 questions in 2016. The Trusts response rate was 35%, slightly less than the 2016 response rate of 40% and 2015 of 44%. The Trust performed significantly better on 9 questions than the national average in the highest scoring 80% threshold compared to 1 question in 2016. There were no questions whereby the Trust worsened by 5% or more, which is significantly better than the 2016 survey, where 18 questions fell in this category. There has been improvement in the number of questions falling within the lowest 20% national threshold 8 in 2017 compared to 32 in 2016

<table>
<tr><td></td><td colspan="2">This report was initially reported to the Patient Experience Sub Committee on 08.05.18; however has since been updated following CQC correspondence from the Patient Survey Team received on the 29.05.18, indicating transcription errors by Quality Health who undertake the National In Patient Survey, as such Questions 55 and 61 have been removed from all Trusts data analysis</td></tr>
<tr><td>RECOMMENDATION:</td><td colspan="2">The Board of Directors are asked to receive the report and note the findings of the 2017 National In Patient Survey.</td></tr>
<tr><td rowspan="4">PREVIOUSLY CONSIDERED BY:</td><td>Committee</td><td>Quality + Assurance Committee</td></tr>
<tr><td>Agenda Ref.</td><td>QAC/18/07/87</td></tr>
<tr><td>Date of meeting</td><td>3rd July 2018</td></tr>
<tr><td>Summary of Outcome</td><td></td></tr>
<tr><td>FREEDOM OF INFORMATION STATUS (FOIA):</td><td colspan="2">Release Document in Full</td></tr>
<tr><td>FOIA EXEMPTIONS APPLIED:
(if relevant)</td><td colspan="2">None</td></tr>
</table>

NAME OF COMMITTEE

Board of Directors

SUBJECT	The National Inpatient Survey results for 2017	AGENDA REF:	BM/18/07/72

1. BACKGROUND/CONTEXT

1.1 The annual National In-Patient Survey is a Care Quality Commission (CQC) requirement with the aim of obtaining feedback to improve local services for the benefit of the patients and the public. Survey results are reported to the CQC who use the information as part of the Hospital Intelligent Monitoring. Patients were eligible for the survey if they were aged over 16 years or older and have spent at least one night in hospital and were not admitted to maternity or psychiatric units.

1.2 The survey was undertaken by Quality Health on behalf of the Trust, following the national methodology guidance determined by the survey co-ordination centre for the overall National Inpatient Survey Programme. Following stakeholder feedback, questions were added, modified and removed; there were 80 questions in the 2017 survey, four less than 2016. The survey covers all the inpatient specialties.

1.3 The survey included a sample size of 1250 consecutively discharged inpatients, working back from the last day of July 2017. The final response sample was 1199 due to changes in respondent's circumstances such as not known at address or deceased. The target response rate is 60%; Trust response rate was 35%, a decrease from 2016 response rate (40%) and 205 response rate (44%). The number of useable responses should be at least 750; the Trust had 423 usable responses from the final sample, a decrease from 2016 usable sample (482).

1.4 The survey covered aspects of the patient's admission, care and treatment, operations and procedures and discharge from hospital.

1.5 Respondents were 47% male and 53% female, illustrating an increase in male respondents compared to the previous year's statistics. The largest age range of respondents was 65-74yrs at 31% closely followed by the 75-84 year age range at 30% of respondents. Both these age groups response rate increased by 5% in 2017. 97% of respondents were in the English/Welsh/ Northern Irish ethnic group and 84% stated they were Christian with 10% stating they have no religion. These demographics reflect the local population.

1.6 The survey shows how the Trust scored for each question compared with a range of results from all other Trusts. The report provides benchmarking against similar organisations and rates against the lowest 20% threshold and the highest 20% threshold. Results of the survey are standardized by the age, sex and method of admission of respondents to ensure that no Trust will appear better or worse than another because of its responder profile. Eighty questions were asked and categorized into twelve domains as follows:

- Admission to hospital
- A&E Department
- Waiting List and Planned Admission
- All types of Admission
- The Hospital and Ward
- Doctors
- Nurses
- Your Care and Treatment
- Operations and Procedures
- Leaving Hospital
- Overall views on care and Services
- About you

N.B. *Higher is Better* in the results tables below. All the answers to the questions are weighted in 0, 5 and 10 points, converted to a %, so that the higher the result, the better the result.

2. KEY ELEMENTS

a. Analysis of the results

Table one provides details of where the Trust has improved on the following questions which are aligned to the domains as shown.

Table 1

The Trust has shown some improvement on the following questions: Higher is better		
	2016	**2017**
The Accident & Emergency Department		
While you were in the A&E department, how much information about your condition or treatment was given to you?	79.4%	81.5%
Were you given enough privacy when being examined or treated in the A&E department?	84.6%	89.4%
Waiting List or Planned admission		
How do you feel about the length of time you were on the waiting list before your admission to hospital?	78.9%	79.7%
In your opinion, had the specialist you saw in hospital been given all the necessary information about your condition or illness from the person who referred you?	90.1%	90.6%
All types of admission		

From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?	67%	70.5%	
The Hospital & Ward			
Were you ever bothered by noise at night from hospital staff?	79.9%	82.4%	
In your opinion how clean was the hospital room or ward you were in?	89.1%	91.3%	
Did you get enough help from staff to wash or keep yourself clean?	81.7%	83.4%	
If you brought your own medication with you to hospital, were you able to take it when you needed to?	60.7%	72.9%	
How would you rate the hospital food?	52.7%	57.7%	
Were you offered a choice of food?	80.7%	83.6%	
Did you get enough help from staff to eat your meals?	67.6&	72.2%	
Doctors			
When you had important questions to ask a doctor, did you get answers that you could understand?	81.9%	82.8%	
Did you have trust and confidence in the doctors treating you?	87.9%	91.0%	
Did doctors talk in front of you as if you weren't there?	85.1%	90.0%	
Nurses			
When you had important questions to ask a nurse, did you get answers that you could understand?	81.6%	85.2%	
Did you have trust and confidence in the nurses treating you?	86.7%	90.1%	
Did nurses talk in front of you as if you weren't there?	89.1%	92.5%	
In your opinion, were there enough nurses on duty to care for you in hospital?	68.3%	75.9%	
Your Care and Treatment			
In your opinion, did the members of staff caring for you work well together?	85.7%	90.5%	
Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you?	81.9%	84.3%	
Were you involved as much as you wanted to be in decisions about your care and treatment?	71.6%	74.4%	
Did you have confidence in the decisions made about your condition or treatment?	80.4%	87.1%	
Do you feel you got enough emotional support from hospital staff during your stay?	69.8%	75.7%	
Were you given enough privacy when discussing your condition or treatment?	83.5%	84.9%	
Were you given enough privacy when being examined or treated?	94.0%	94.7%	
Do you think the hospital staff did everything they could to	79.8%	83.0%	

help control your pain?			
Operations & Procedures			
Beforehand, did a member of staff answer your questions about the operation or procedure in a way you could understand?	88.7%	89.4%	↑
Beforehand, were you told how you could expect to feel after you had the operation or procedure?	68.8%	75.6%	↑
After the operation or procedure, did a member of staff explain how the operation or procedure had gone in a way you could understand?	76.6%	81.1%	↑
Leaving Hospital			
Did you feel you were involved in decisions about your discharge from hospital?	70.4%	72.0%	↑
Were you given enough notice about when you were going to be discharged?	68.7%	76.0%	↑
Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand?	79.8%	82.6%	↑
Did a member of staff tell you about medication side effects to watch for when you went home?	45.1%	48.8%	↑
Were you told how to take your medication in a way you could understand?	79.6%	84.4%	↑
Did hospital staff take your family or home situation into account when planning your discharge?	69.4%	75.2%	↑
Did the doctors or nurses give your family, friends or carers all the information they needed to help care for you?	57.6%	62.0%	↑
Did the hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	72.9%	77.6%	↑
Did hospital staff discuss with you whether you would need any additional equipment in your home, or any adaptations made to your home?	81.1%	81.4%	↑
Overall			
Overall, did you feel you were treated with respect and dignity while you were in the hospital?	89.5%	91.0%	↑
Overall how would you rate your experience?	79.0%	81.5%	↑
Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?	22.7%	22.9%	↑

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This year the Trust had performed significantly better than the national average on nine questions detailed in table 2.

Table 2

Trust results significantly better than the national average for the following questions: **Higher is better**				
	Trust 2016	**Highest 80% Threshold**	**Trust 2017**	
Doctors				
Did doctors talk in front of you as if you weren’t there?	85.1%	89.8%	90.0%	↑
Nurses				
Did nurses talk in front of you as if you weren’t there?	89.1%	92.2%	92.5%	↑
Care & Treatment				
Did you have confidence and trust in any other clinical staff treating you (e.g. physiotherapists, speech therapists, psychologists)?	n/a	88.9%	90.1%	↑
In your opinion, did the members of staff caring for you work well together?	85.7%	89.6%	90.5%	↑
Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you?	81.9%	83.6%	84.3%	↑
Did you have confidence in the decisions made about your condition or treatment?	80.4%	86.8%	87.1%	↑
Leaving hospital				
Were you given enough notice about when you were going to be discharged?	68.7%	75.2%	76.0%	↑
Before you left hospital, were you given any written or printed information about what you should or should not do after leaving hospital?	71.3%	67.3%	69.8%	↓*
Overall				
Did you feel well looked after by the non-clinical hospital staff (e.g. cleaners, porters, catering staff)?	n/a	93.7%	93.7%	↑

*Better than national average but a reduction at a local level at WHH from the previous year

This year there has been improvement in the number of questions falling within the lowest 20% national threshold (8 in 2017 compared to 32 in 2016) 3/8 of the questions, although featured in the lowest 20% national threshold, are in fact an

improvement on the previous 2016 survey, at WHH, which illustrates an improvement. However, there is a requirement for this to improve further. See table 3 below for the detail of the questions.

Table 3

Trust results within the lowest 20% national threshold Higher is better				
	Trust 2016	**Lowest 20% Threshold**	**Trust 2017**	
Waiting List or Planned Admission				
Was your admission date changed by the hospital?	90.6%	88.7%	88.5%	⬇
All types of admission				
From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?	67.0%	70.6%	70.5%	⬆ *
The hospital and ward				
Did the hospital staff explain the reasons for being moved in a way you could understand?	n/a	52.4%	52.3%	⬇
If you brought your own medication with you to hospital, were you able to take it when you needed to?	60.7%	68.5%	66.6%	⬆ *
Were you offered a choice of food?	80.7%	86.8%	83.6%	⬆ *
Leaving hospital				
Discharge delayed due to wait for medicines / to see doctor / for ambulance.	61.1%	60.8%	60.7%	⬇
How long was the delay?	61.9%	61.3%	61.3%	⬇
Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital?	82.2%	79.3%	78.0%	⬇

* In lowest 20% national threshold, but an improvement at a local level at WHH

3. RECOMMENDATIONS

There are positive outcomes from the 2017 survey, which illustrates the commitment at WHH to provide a positive and caring patient experience.

Where there has been less than positive results, the focus will be to ensure the recommendations and action plan, is concise, measurable and achievable. The actions will be aligned to the five work streams of the Trust patient experience strategy and monitored monthly.

The action plan (appendix 1) highlights the areas where the Trust scored outside of the expected, with identified leads. The progress of actions will be monitored monthly at the Patient Experience subcommittee

The report and action plan has been discussed at the Patient Experience subcommittee in May 2018 and amended as appropriate

The report and action plan was received by the Quality Assurance committee in July 2018

With regard to the 2018 National Inpatient Survey, information leaflets have been created and are planned to be inserted into the take home medications of all discharged patients to encourage them to respond to the survey if asked, with the aim of improving WHH response rates.

Appendix 1

Areas where Trust scored outside of expected	Recommendation/Action	Lead Person	Target Date for completion	Progress of Actions
1. Patients thought their admission date was changed by the hospital once or more than once (21%)	Review the reasons for the number of times there have been changes of admission dates (if two changes or more)	Deputy Chief Operating Officer - Dan Moore	01/02/2018	
2. Patients felt they had to wait a long time to get to a bed on a ward, from the time they arrived at the hospital	Ensure that the process for monitoring wait times and prioritising patients who are most at risk is robust and look for actions to improve the process	Patient Flow Matron – Michelle Thornhill via Patient Flow Steering Group	01/10/2018	
3. Patients felt hospital staff did not always explain the reasons for being moved in a way that they could understand	Ensure steps are taken so that patients who are moved at night are clear about the reasons why	Patient Flow Matron – Michelle Thornhill	01/11/2018	

Appendix 1

Areas where Trust scored outside of expected	Recommendation/Action	Lead Person	Target Date for completion	Progress of Actions
4. When patients brought their own medication into hospital, they felt they were not always able to take it when they needed to	Ensure that patients are asked about any medication they may have brought in with them and are supported in being able to take it when required	Ali Kennah via Medicines Governance meeting	01/12/2018	
5. Patients felt they were not always offered a choice of food	Look at why some patients still rate food as only fair or poor in relation to - Temperature - Timing of food arriving - Choice of food offered	Facilities manager (operations) – Julie McGreal via nutritional steering group	01/09/2018	
6. The main reason patients reported in the cause of delayed discharge was waiting for	Review the way in which discharge medication is ordered and delivered to the patient with a view to reducing delays or improving efficiency of the	Deputy Chief Operating Officer - Dan Moore via Patient Flow Steering Group	01/11/2018	

Areas where Trust scored outside of expected	Recommendation/Action	Lead Person	Target Date for completion	Progress of Actions
medicines (63% of the total reasons)	process			
7. Hospital staff did not always discuss with patients whether they may need further health or social care services after leaving hospital	Ensure that hospital staff discuss with patients any on-going needs, such as health and social care, they may have after leaving hospital	Deputy Chief Operating Officer – Dan Moore via Patient Flow Steering Group	01/08/2018	

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/18/07/73**
SUBJECT:	**Governance Review - People**
DATE OF MEETING:	25 July 2018
ACTION REQUIRED	**Approval**
AUTHOR(S):	Michelle Cloney, Director HR & OD
EXECUTIVE DIRECTOR SPONSOR:	Michelle Cloney, Director HR & OD
LINK TO STRATEGIC OBJECTIVES:	SO2: To have a committed, skilled and highly engaged workforce who feel valued, supported and developed and who work togther to care for our patients
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	BAF2.1: Engage Staff, Adopt New Working, New Systems
	BAF2.4: Engaging & Involving Workforce
	BAF2.5: Right People, Right Skills in Workforce
STRATEGIC CONTEXT	The Trust introduced a new Governance Structure in September 2017 in order to address the case for change: ▪ Governance model within the Trust needed clarifying ▪ Supporting the role of the Board – strategy, accountability/culture ▪ Balancing the role of Exec/Non Exec ▪ A review of how our Operational Board functions ▪ A more integrated joined up governance and meeting system with robust and simple information to enable decision making or scrutiny ▪ Enabling role out of Service Line Management and Performance Management Framework – meetings structure adapting to our revised governance structures A key change in governance was the dis-establishment of the Strategic People Committee (bi-monthly) as an Assurance Committee reporting to Trust Board with a monthly Workforce Committee chaired by an Executive Director reporting to Trust Operational Board.

	A key aspect of the implementation of the new Governance Structure in 2017 was that it would be evaluated and, subject to Trust Board approval, adapted. In February 2018 during a Trust Board Development Session the People Agenda was discussed and whether an Assurance Committee was required. The outcome of this discussion was an open invitation for a NED to attend the monthly Workforce Committee and the Chairs Log to be submitted to both Trust Operational Board and Trust Board from March 2018. In May 2018 Audit Committee requested a review of the Governance Structure introduced in September 2017, on the ***People Agenda*** and the perceived need for greater Trust Board oversight and assurance. Audit Committee will receive the review in July 2018 however it should be noted that this committee meets the day after Trust Board. Permission has been sought and given from the Chair of Audit Committee to present the paper and recommendations to Trust Board in advance of Audit Committee. If the recommendations are accepted these will be implementation in September 2018.
EXECUTIVE SUMMARY (KEY ISSUES):	Review Findings: ▪ Current Governance model within the Trust generally considered a positive change. ▪ The current Governance Structure is positively supporting the role of the Board – strategy, accountability, culture, and well-led. ▪ The clarity around assurance and operational performance has balanced the role of Exec/Non Exec along with the scheduling of meetings such as bi-monthly Trust Board meetings. ▪ Feedback from both NEDs and Execs that the People Agenda requires Trust Board oversight. This has led to an in year inclusion of Workforce Committee Chair's Log to Trust Board and Trust Operational Board. Opinions expressed that this has had limited success as there remains a view that the People agenda is brought into other committees inappropriately to fill the perceived 'assurance' gap.

<table>
<tr><td></td><td colspan="2">▪ Removing the Workforce Committee as a subgroup of TOB would not impact on the CBU reporting of performance against the Integrated Performance Report (QPS)</td></tr>
<tr><td>RECOMMENDATION:</td><td colspan="2">Trust Board are asked to approve:
• Establishment of a Strategic People Committee (SPC) as an Assurance Committee chaired by a Non-Exec Director – commencing September 2018
• Establishment of an Operational People Committee as a sub-committee to SPC chaired by the DHR & OD – commencing in October 2018
• Amendment to the Terms of Reference for Trust Operational Board to remove Workforce Committee as a subcommittee – effective September 2018 (subject to Trust Board approval)</td></tr>
<tr><td rowspan="4"></td><td>Committee</td><td>Not applicable.</td></tr>
<tr><td>Agenda Ref.</td><td></td></tr>
<tr><td>Date of meeting</td><td></td></tr>
<tr><td>Summary of Outcome</td><td></td></tr>
<tr><td>FREEDOM OF INFORMATION STATUS (FOIA):</td><td colspan="2">Release Document in Full</td></tr>
<tr><td>FOIA EXEMPTIONS APPLIED:
(if relevant)</td><td colspan="2">None</td></tr>
</table>

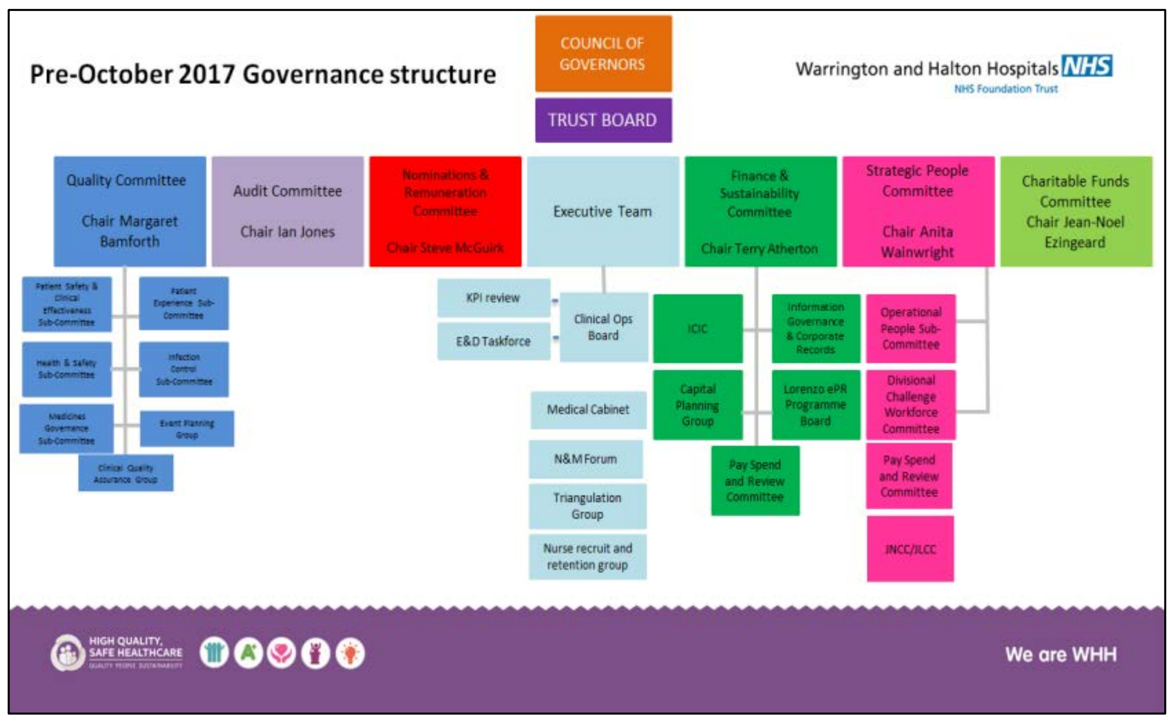
BOARD OF DIRECTORS

SUBJECT	Governance Review - People	AGENDA REF:	BM/18/07/73

1. BACKGROUND/CONTEXT

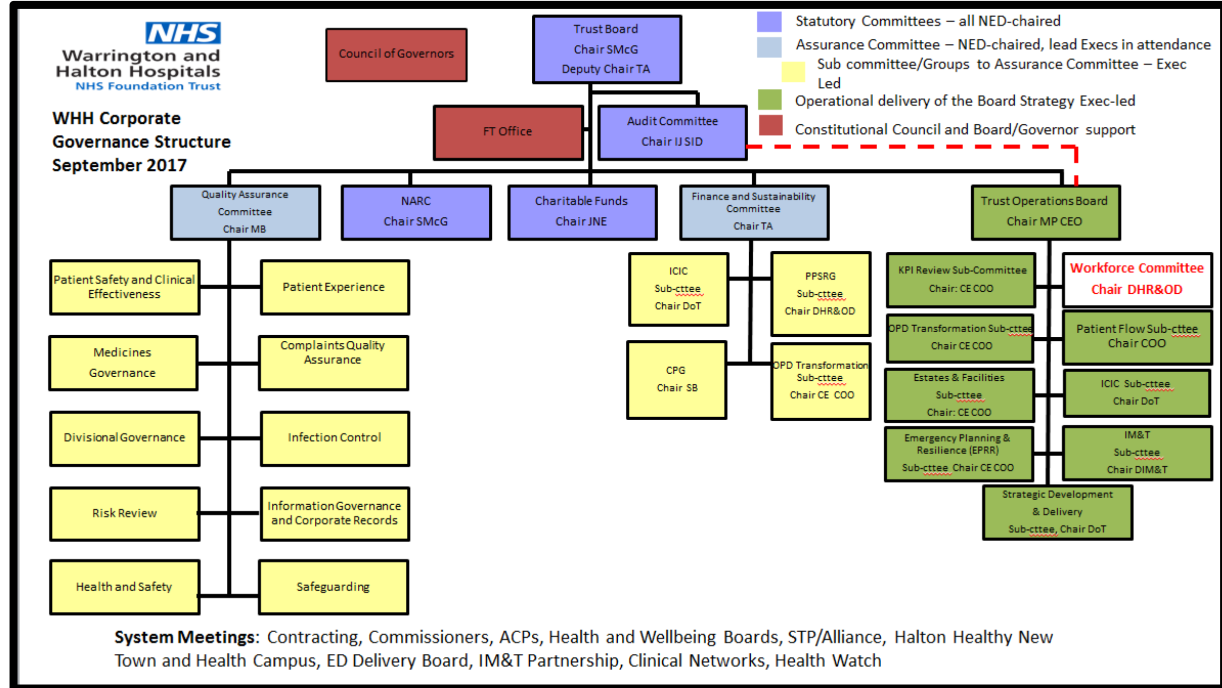
1.1 The Trust introduced a new Governance Structure in September 2017 due to the following:

- Governance model within the Trust needs clarifying
- Supporting the role of the Board – strategy, accountability/culture
- Balancing the role of Exec/Non Exec
- A review of how our Operational Board functions
- A more integrated joined up governance and meeting system with robust and simple information to enable decision making or scrutiny
- Enabling role out of Service Line Management and Performance Management Framework – meetings structure adapting to our revised governance structures



1.2 A key aspect of the implementation of the new Governance Structure in 2017 was that it would be evaluated and subject to Trust Board approval adapted.

1.3 A key change in governance was the dis-establishment of the Strategic People Committee (bi-monthly) as an Assurance Committee reporting to Trust Board with a monthly Workforce Committee chaired by an Executive Director reporting to Trust Operational Board.



1.4 In February 2018 during a Trust Board Development Session the People Agenda was discussed and whether an Assurance Committee was required. The outcome of this discussion was an open invitation for a NED to attend the monthly Workforce Committee and the Chairs Log to be submitted to both Trust Operational Board and Trust Board from March 2018.

1.5 In May 2018 Audit Committee requested a review of the Governance Structure introduced in September 2017, on the People Agenda and the perceived need for greater Trust Board oversight and assurance.

1.6 The proposal to re-establish Strategic People Committee was supported by the Executive Team (07.07.18), however it was noted that due to the scheduling of Audit Committee meaning the next meeting would be the day after July Trust Board, the Head of Corporate Affairs was asked by Exec Team to circulate the paper to the Chair of Audit Committee in order to gain approval to progress directly to Trust Board. Approval was granted by Chair of Audit Committee to proceed to present the paper to Trust Board and update Audit Committee of the outcome.

2 KEY ELEMENTS

2.2 Review Findings:

- Current Governance model within the Trust generally considered a positive change. This has been reviewed using the results from Committee Effectiveness Surveys; Committee Annual Reports; Work Schedules per Committee; Chairs Logs and Meeting content on 2 things that have gone well feedback.

- The current Governance Structure is positively supporting the role of the Board – strategy, accountability, culture, and well-led.

- The clarity around assurance and operational performance has balanced the role of Exec/Non Exec along with the scheduling of meetings such as bi-monthly Trust Board meetings.

- Feedback from both NEDs and Execs that the People Agenda requires Trust Board oversight. This has led to an in year inclusion of Workforce Committee Chair's Log to Trust Board and Trust Operational Board. Opinions expressed that this has had limited success as there remains a view that the People agenda is brought into other committees inappropriately to fill the perceived 'assurance' gap.

- Trust Operational Board functions well with positive evaluation received from members however the volume and diversity of items received per month means that the focus on the People Agenda is competing with other operational matters. A 'Meeting Review' is to be conducted July / August 2018 with an amendment to the scheduled work plan to enable focused decision making or scrutiny.

- Removing the Workforce Committee as a subgroup of TOB would not impact on the CBU reporting of performance against the Integrated Performance Report (QPS)

2.2 Proposed New Structure – From September 2018

- The Workforce Committee is currently a sub-committee of Trust Operational Board. The proposal is to dis-establish this meeting.

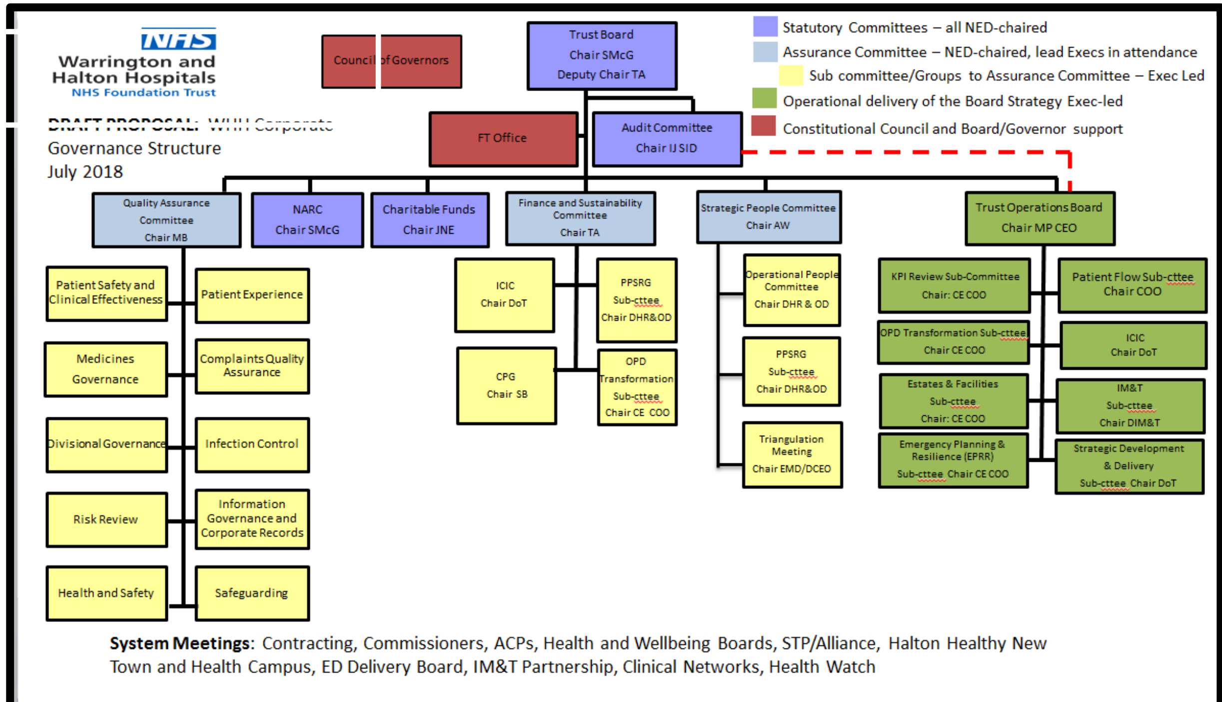
- In order to provide Trust Board with the assurance around the People Agenda the Strategic People Committee should be re-established, chaired by a NED.

- An Operational People Committee should replace the Workforce Committee as a sub-committee of the Strategic People Committee as opposed to Trust Operational Board

- Trust Operational Board should revise the Terms of Reference to remove reference to the Workforce Committee.

- The draft Strategic Workforce Committee Terms of Reference, Work Schedule and dates for 2018/19 are attached at Appendix A

- The draft Operational Workforce Committee Terms of Reference, Work Schedule and dates for 2018/19 are attached at Appendix B



3 Recommendation

3.1 This paper recommends the following:

- Establish a Strategic People Committee (SPC) as an *Assurance Committee* chaired by a Non-Exec Director – commencing September 2018

- Establish an Operational People Committee as a sub-committee to SPC chaired by the DHR & OD – commencing in October 2018

- Amend the Terms of Reference for Trust Operational Board to remove Workforce Committee as a subcommittee – effective September 2018 (subject to Trust Board approval)

4 APPENDICES

Appendix A ***DRAFT*** **TERMS OF REFERENCE**
STRATEGIC PEOPLE COMMITTEE

1. PURPOSE

The Strategic People Committee is accountable to the Trust Board and will maintain a strategic overview of the Trusts human resources and organisational development arrangements with a view to ensuring that these are designed to provide a positive working environment for colleagues, and that the Trust has in place at all levels the right people systems and processes to deliver, from a patient perspective, safe high quality care.

The Strategic People Committee will seek assurance on the:

- Trust's approach, plans and processes for the delivery of the People Strategy,
- Efficient and effective use of resources,
- CQC Well Led Domain specifically on culture, quality improvement and collaborative leadership development,
- Mechanisms in place to fully engage, listen and act on the feedback and suggestions from the workforce on its journey to CQQ Rating of Outstanding,
- Controls and systems in place to support line managers to make effective decisions in the deployment of staff,
- Redesign of the workforce so that it remains fit for the future, and
- Plans to recruit and retain staff at all levels and how this is reducing the reliance on temporary workers, and

The Committee will act as a catalyst to inspire action and innovation to enable the trust to deliver our quality outcomes of providing:

- Clinical effectiveness
- A safe organisation
- Excellent patient experience

The Committee will provide assurance to the Trust Board on the management of risks related to our people.

2. FREQUENCY OF MEETINGS

Meetings shall be held bi-monthly.

3. MEMBERSHIP

The following individuals, or their nominated Deputy, shall normally be in attendance at the meetings:

- Non-Executive Director (Chair)
- Non-Executive Director (Deputy Chair)
- Director of HR & OD
- Deputy Director HR & OD
- Chief Operating Officer
- Medical Director
- Chief Nurse
- Director of Transformation
- Director Finance & Commercial Development

Warrington and Halton Hospitals NHS
NHS Foundation Trust

- Director of Community Engagement
- Head of HR Strategic Projects

In attendance for specific agenda items scheduled in SPC annual workplan:
- Head of Education Development & Wellbeing
- Head of Medical Staffing and Education
- Head of HR Business Partners
- Head of Workforce Transformation

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

Other Directors including the Chief Executive or staff members may also be invited / expected to attend from time to time for appropriate agenda items; however, there is no requirement to attend the whole meeting.

4. QUORUM

Quorum shall be two NEDs, Director of HR & OD or Deputy Director HR & OD - plus 3 Executive Directors or their deputies.

5. AUTHORITY

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

6. REPORTING

Governance

The Strategic People Committee will have the following reporting responsibilities:

A Chairs Key Issues Report will be formally recorded and circulated to the Trust Board of items discussed. The Chair of the Strategic People Committee shall draw to the attention of the Trust Board any issues that require disclosure to it, or require a decision or escalation.

The Strategic People Committee will report to the Trust Board annually on its work and performance in the preceding year.

7. DUTIES & RESPONSIBILITIES

Duties – decision making:

- To provide overview and scrutiny in areas of workforce performance referred to the Strategic People Committee by the Trust Board
- Receive and consider the workforce plans and make recommendations as appropriate to the Trust Board.
- To provide overview and scrutiny to the development of the People Strategy

Warrington and Halton Hospitals NHS
NHS Foundation Trust

- To ensure the People Strategy is designed, developed, delivered, managed and monitored appropriately
- To ensure that appropriate clinical advice and involvement in the People Strategy is provided
- To receive, agree and monitor progress on the People Strategy through receipt of exception reports and updates
- To attract and retain our workforce using the principles of Model Employer to become the employer of choice.
- To ratify employment policies and procedures on behalf of the Trust
- To receive the annual National Staff Opinion Survey Results and to provide a set of recommendations for action by the Trust
- To receive, agree and monitor the staff engagement activity in the Trust and employee reward in order to be assured of the effectiveness of these activities on improved morale; increased Staff FFT results and improved patient experience.

Duties – advisory:

- Consider any relevant 'people' risks within the Board Assurance Framework and corporate level risk register as they relate to the remit of the Strategic People Committee, as part of the reporting requirements,
- To ensure that the framework for Education Governance is supporting the management of risks associated with our people and the quality of care provided to our patients.

Duties – monitoring:

- To monitor the Trust's performance against national standards so far as they relate to employment.
- To monitor the effectiveness of the Trust's workforce performance reporting systems ensuring that the Trust Board is assured of continued compliance through its annual reporting, reporting by exception where required.
- To review the performance indicators relevant to the remit of the Strategic People Committee
- To report any areas of significant concern to the Trust Board as appropriate via the Chair Key Issues Report.
- To receive and monitor progress on Employee Relations Cases and in particular those cases where suspension/exclusion is involved

Duties of members:

Ensuring, through agreed communication strategies, that key decisions and requirements are appropriately disseminated and that appropriate responses are implemented

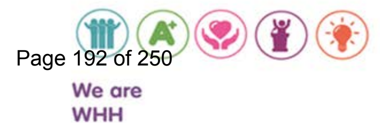
Sub-Committees (Groups):

- Operational People Committee
- Premium Pay Spend and Review Group

Each Sub-Committee will submit a Chair Key Issues Report detailing any items of escalation or items requiring decision or action rather than minutes.

8. ATTENDANCE

A record of attendance will be kept, attendance of 75% per year is expected. Members unable to attend must send a deputy who is able to make decisions on their behalf.



9. ADMINISTRATIVE ARRANGEMENTS

The Strategic People Committee will be supported by the Secretary to the Trust Board.

- The ToR will be reviewed annually by Trust Board
- A Cycle of Business (workplan) will be established

Papers to this Strategic People Committee must be submitted for inclusion one week in advance of the meeting. Papers will be distributed by 5pm on the Wednesday preceding the Strategic People Committee.

Papers are to be submitted in the following format:

1. Front sheet – with FOI exemptions duly applied if appropriate
2. Sub-Committees – Chairs key issues reports using the prescribed template
3. Members / HR & OD Service leads – reporting via the prescribed template
4. An Action Log will be maintained and distributed between meetings to enable members to respond.
5. Presentations must be sent to the Administrator ahead of the meeting
6. No tabled papers will be accepted unless in an emergency and with permission of the Chair of the Committee.

10. REVIEW / EFFECTIVENESS

The Strategic People Committee will undertake an annual review of its performance against its duties in order to evaluate its achievements. These terms of reference will be reviewed every 12 months by the Strategic People Committee.

Appendix A

NHS
Warrington and Halton Hospitals
NHS Foundation Trust

DRAFT PROPOSAL: WHH Corporate Governance Structure
July 2018

Statutory Committees – all NED-chaired
Assurance Committee – NED-chaired, lead Execs in attendance
Sub committee/Groups to Assurance Committee – Exec Led
Operational delivery of the Board Strategy Exec-led
Constitutional Council and Board/Governor support

Council of Governors

Trust Board
Chair SMcG
Deputy Chair TA

FT Office

Audit Committee
Chair IJ SID

- Quality Assurance Committee
  Chair MB
  - Patient Safety and Clinical Effectiveness
  - Patient Experience
  - Medicines Governance
  - Complaints Quality Assurance
  - Divisional Governance
  - Infection Control
  - Risk Review
  - Information Governance and Corporate Records
  - Health and Safety
  - Safeguarding
- NARC
  Chair SMcG
- Charitable Funds
  Chair JNE
- Finance and Sustainability Committee
  Chair TA
  - ICIC
    Chair DoT
  - PPSRG
    Sub-cttee
    Chair DHR&OD
  - CPG
    Chair SB
  - OPD Transformation
    Sub-cttee
    Chair CE COO
- Strategic People Committee
  Chair AW
  - Operational People Committee
    Chair DHR & OD
  - PPSRG
    Sub-cttee
    Chair DHR&OD
  - Triangulation Meeting
    Chair EMD/DCEO
- Trust Operations Board
  Chair MP CEO
  - KPI Review Sub-Committee
    Chair: CE COO
  - Patient Flow Sub-cttee
    Chair COO
  - OPD Transformation Sub-cttee
    Chair CE COO
  - ICIC
    Chair DoT
  - Estates & Facilities
    Sub-cttee
    Chair: CE COO
  - IM&T
    Sub-cttee
    Chair DIM&T
  - Emergency Planning & Resilience (EPRR)
    Sub-cttee Chair CE COO
  - Strategic Development & Delivery
    Sub-cttee Chair DoT

System Meetings: Contracting, Commissioners, ACPs, Health and Wellbeing Boards, STP/Alliance, Halton Healthy New Town and Health Campus, ED Delivery Board, IM&T Partnership, Clinical Networks, Health Watch

TERMS OF REFERENCE REVISION TRACKER

Name of Committee:	STRATEGIC PEOPLE COMMITTEE
Version:	DRAFT V4
Implementation Date:	September 2018
Review Date:	March 2019
Approved by:	TRUST BOARD
Approval Date:	

REVISIONS			
Date	**Section**	**Reason on Change**	**Approved**
May 2018	**Draft TORs v1**		Amendments – AW / MC
June 2018	**Draft TORs v2**		Amendments – AW / MC
July 2018	**Draft TORs v3 – to include Appendix A: Governance Flow Chart - for use to proceed to seek approval**		
July 2018	**Appendix A – Amendment to Key – Explanation of Sub Committee / Groups to Assurance Committees**		Amendments – AW / MC

TERMS OF REFERENCE OBSOLETE		
Date	**Reason**	**Approved by:**

We are
WHH

We are
WHH

Work Plan 2018 - 2020

DRAFT STRATEGIC PEOPLE COMMITTEE (SPC)											
Topic	Lead	September 2018	November 2018	January 2019	March 2019	May 2019	July 2019	September 2019	November 2019	January 2020	March 2020
Apologies for Absence	Chair	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Declarations of Interest	Chair	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Minutes of the last meeting	Chair	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Matters Arising	Chair	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Action Log	Chair	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Terms of Reference	Chair	✓			✓						✓
Annual Cycle of Business	Chair	✓			✓						✓
Committee Chairs Annual report to Trust Board	Chair				✓						✓
Director of HR & OD report	Director HR & OD	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
BAF & Risk Register – Staff	Head of HR Strategic Projects	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
WHH People Objectives and People Strategy Exception Reports	Deputy Director HR & OD / HR & OD SMT	✓			✓			✓			✓
CQC – Getting to Good, Moving to Outstanding - Staff	Director HR & OD	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Educational Governance Annual Report	Head of Education Development & Wellbeing					✓					
HENW/GMC Annual Reports: • GMC Patient Survey Response Report • HENW Local Education Provider (LEP) Report • HENW Monitoring Visit (Annual Assessment Visit) • GMC National Trainee Survey	Medical Director + Deputy CEO / Head of Medical Staffing & Education		✓ ✓ ✓ ✓								
Medical Appraisal + GMC Revalidation Annual Report	Medical Director + Deputy CEO / Head of Medical Staffing & Education	✓						✓			
Policies and Procedures Report (as required)	Head of HR Strategic Projects	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Pay and Terms & Conditions – National & Regional Policy Updates	Director HR & OD / Head of HR Strategic Projects	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
National Staff Opinion Survey	Deputy Director HR & OD /Head of HR Business Partners					✓					
Freedom to Speak Up	Chief Nurse / Head of HR Business Partners	✓				✓				✓	
Guardian Quarterly Report on Safe Working Hours for Junior Doctors in Training	Medical Director / Head of Medical Education & Staffing		✓		✓			✓			✓
Equality and Diversity – Strategy Update	Deputy Director HR & OD / Head of HR Business Partners		✓			✓			✓		
Equality and Diversity – Regulated Reports (as required)	Deputy Director HR & OD / Head of HR Business Partners	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Facilities Time Off Annual Report	Head of HR Strategic Projects						✓				
VIP + Celebrity Visits Policy Annual Report	Director of Community Engagement				✓						✓
Engagement and Recognition Annual Report	Director HR & OD / Director of Community Engagement				✓						✓
Trust Board Monthly Staffing Report – Key Issues Report	Chief Nurse	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Operational People Committee	Director HR & OD	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Premium Pay Spend + Review Sub Committee	Deputy Director HR & OD / Head of Workforce Transformation	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Triangulation Meeting	Executive Medical Director	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Strategic People Committee

Dates: 2018/19

19 September 2018

21 November 2018

23 January 2019

20 March 2019

Appendix B

DRAFT TERMS OF REFERENCE
OPERATIONAL PEOPLE COMMITTEE

11. PURPOSE

The Operational People Committee is accountable to the Strategic People Committee and will maintain an operational overview of the Trusts human resources and organisational development arrangements with a view to ensuring that these are designed to provide a positive working environment for colleagues, and that the Trust has in place at all levels the right people systems and processes to deliver, from a patient perspective, safe high quality care.

The Operational People Committee will work to implement the People Strategy consistently across the Trust, and celebrate successes.

The Operational People Committee will act as a catalyst to inspire action and innovation to enable the trust to deliver our quality outcomes of providing:

- Clinical effectiveness
- A safe organisation
- Excellent patient experience

The Operational People Committee will provide assurance to the Strategic People Committee on the management of risks related to our people.

12. FREQUENCY OF MEETINGS

Meetings shall be held bi-monthly.

13. MEMBERSHIP

The following individuals, or their nominated Deputy, shall normally be in attendance at the meetings:

- Director of HR & OD (Chair)
- Deputy Director HR & OD (Deputy Chair)
- Deputy Chief Operating Officer
- Deputy Medical Director
- Deputy Chief Nurse
- Head of Transformation
- Head of Communications and Engagement
- Head of Education Development & Wellbeing
- Head of Strategic HR Projects
- Head of Medical Staffing and Education
- Head of HR Business Partners
- Head of Workforce Transformation
- Freedom to Speak Up Guardian
- Deputy Director Finance

Should the need arise, the Operational People Committee may approve a matter in writing by receiving written approval from all the members of the Operational People Committee, such written approval may be by email from the members Trust email account.

Directors including the Chief Executive or staff members may also be invited / expected to attend from time to time for appropriate agenda items; however, there is no requirement to attend the whole meeting.

14. QUORUM

Quorum shall be Director of HR & OD (Chair) or Deputy Director HR & OD (Deputy Chair) - plus 3 Committee Members (not within HR & OD Directorate) or their deputies and 2 Head of HR & OD services.

15. AUTHORITY

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

16. REPORTING

Governance

The Operational People Committee will have the following reporting responsibilities:

A Chairs Key Issues Report will be formally recorded and circulated to the Strategic People Committee of items discussed. The Chair of the Operational People Committee shall draw to the attention of the Strategic People Committee any issues that require disclosure to it, or require a decision or escalation.

The Operational People Committee will report to the Strategic People Committee annually on its work and performance in the preceding year.

17. DUTIES & RESPONSIBILITIES

Duties – decision making:

- To provide overview and scrutiny in areas of workforce performance referred to the Operational People Committee by the Strategic People Committee
- Receive and consider the workforce plans and make recommendations as appropriate to the Strategic People Committee.
- To provide overview and scrutiny to the development of the People Strategy
- To ensure the People Strategy is designed, developed, delivered, managed and monitored appropriately
- To ensure that appropriate clinical advice and involvement in the People Strategy is provided
- To receive, agree and monitor progress on the delivery and operationalisation of the People Strategy
- To attract and retain our workforce using the principles of Model Employer to become the employer of choice.

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- To ensure that appropriate consultation is undertaken with the relevant staff groups and representatives where appropriate
- To ratify employment policies and procedures on behalf of the Trust
- To receive the annual National Staff Opinion Survey Results and to provide a set of recommendations for action by the Trust
- To receive, agree and monitor the staff engagement activity in the Trust and employee reward in order to be assured of the effectiveness of these activities on improved morale; increased Staff FFT results and improved patient experience.

Duties – advisory:

- Consider any relevant 'people' risks within the Board Assurance Framework and corporate level risk register as they relate to the remit of the Operational People Committee, as part of the reporting requirements,
- To ensure that the framework for Education Governance is supporting the management of risks associated with our people and the quality of care provided to our patients.

Duties – monitoring:

- To monitor the Trust's performance against national standards so far as they relate to employment.
- To monitor the effectiveness of the Trust's workforce performance reporting systems ensuring that the Strategic People Committee and is assured of continued compliance through its annual reporting, reporting by exception where required.
- To review the performance indicators relevant to the remit of the Operational People Committee
- To report any areas of significant concern to the Strategic People Committee as appropriate via the Chair Key Issues Report.
- To receive and monitor progress on Employee Relations Cases and in particular those cases where suspension/exclusion is involved

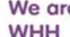
Duties of members:

Ensuring, through agreed communication strategies, that key decisions and requirements are appropriately disseminated and that appropriate responses are implemented

Sub-Committees (Groups):

- Joint Negotiating Consultative Committee
- Joint Local Negotiating Committee
- Staff Engagement and Wellbeing Group
- Electronic Staff Record & Systems Group
- Policy & Procedure Group
- Streamlining TIG
- Workforce Redesign Group
- Equality & Diversity Committee
- Educational Governance Committee

Each Sub-Committee / Group will submit a Chair Key Issues Report detailing any items of escalation or items requiring decision or action rather than minutes.



18. ATTENDANCE

A record of attendance will be kept, attendance of 75% per year is expected. Members unable to attend must send a deputy who is able to make decisions on their behalf.

19. ADMINISTRATIVE ARRANGEMENTS

The Operational People Committee will be supported by the admin team within the HR & OD Directorate.

- The ToR will be reviewed annually by Strategic People Committee
- A Cycle of Business (workplan) will be established

Papers to this Operational People Committee must be submitted for inclusion one week in advance of the meeting. Papers will be distributed by 5pm on the Wednesday preceding the Workforce Sub-Committee.

Papers are to be submitted in the following format:

7. Front sheet – with FOI exemptions duly applied if appropriate
8. Sub-Committees – Chairs key issues reports using the prescribed template
9. Members / HR & OD Service leads – reporting via the prescribed template
10. An Action Log will be maintained and distributed between meetings to enable members to respond.
11. Presentations must be sent to the Administrator ahead of the meeting
12. No tabled papers will be accepted unless in an emergency and with permission of the Director of HR & OD

20. REVIEW / EFFECTIVENESS

The Operational People Committee will undertake an annual review of its performance against its duties in order to evaluate its achievements. These terms of reference will be reviewed every 12 months by the Operational People Committee.

TERMS OF REFERENCE REVISION TRACKER

Name of Committee:	Operational People Committee
Version:	DRAFT V1
Implementation Date:	October 2018
Review Date:	April 2019 and annually thereafter
Approved by:	STRATEGIC PEOPLE COMMITTEE
Approval Date:	

REVISIONS			
Date	**Section**	**Reason on Change**	**Approved**

TERMS OF REFERENCE OBSOLETE		
Date	**Reason**	**Approved by:**

Operational People Committee

Dates: 2018/19

26 October 2018

19 December 2018

22 February 2019

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Work Plan 2018 - 2020

DRAFT OPERATIONAL PEOPLE COMMITTEE											
Topic	**Lead**	**October 2018**	**December 2018**	**February 2019**	**April 2019**	**June 2019**	**August 2019**	**October 2019**	**December 2019**	**February 2020**	**April 2020**
Apologies for Absence	Chair	√	√	√	√	√	√	√	√	√	√
Declarations of Interest	Chair	√	√	√	√	√	√	√	√	√	√
Minutes of the last meeting	Chair	√	√	√	√	√	√	√	√	√	√
Matters Arising	Chair	√	√	√	√	√	√	√	√	√	√
Action Log	Chair	√	√	√	√	√	√	√	√	√	√
Terms of Reference	Chair	√			√						√
Annual Cycle of Business	Chair	√			√						√
Committee Chairs Annual report to Trust Operational Board	Chair				√						√
MIAA Audit Reports – HR & OD & Action Plan Updates	Head of HR Strategic Projects	√			√			√			√
Integrated Performance Report – People KPIs	Deputy Chief Operating Office, Deputy Chief Nurse, Deputy Medical Director, Deputy Director HR & OD	√	√	√	√	√	√	√	√	√	√
Employee Relations Report (including MHPS)	Head of HR Business Partners	√	√	√	√	√	√	√	√	√	√
Medical Staffing and Medical Education Exception Report	Head of Medical Staffing & Education		√			√			√		
Education, Training & Wellbeing Exception Report	Head of Education Development & Wellbeing			√			√			√	
Workforce Redesign Activity Report	Deputy Director HR & OD	√			√			√			√
Policies and Procedures Report (as required)	Head of HR Strategic Projects	√	√	√	√	√	√	√	√	√	√
Staff Engagement Survey Reports – Staff FFT, Annual Report	Head of HR Business Partners	√			√			√			√
Leadership Development and OD Activity Report	OD Manager		√			√			√		
Equality and Diversity Exception Reports – to include (*as appropriate*): • WRES • Equality Delivery System 2 – Workforce (EDS) • Equality Duties Assurance (EDAR) • Workforce Equality Assurance (WDES) • Workforce Disability Equality Standards (WDES) • Draft Gender Pay Report • Gender Pay Action Plan Updates	Head of HR Business Partners	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC
Draft Facilities Time Off Annual Report	Head of HR Strategic Projects				√						√
Engagement and Recognition Report	Head of HR Business Partners / Head of Communications & Engagement			√			√			√	
Freedom to Speak Up	FTSU Guardian	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC
Joint Negotiating Consultative Committee (every 6 weeks) – as appropriate	Deputy Director HR & OD	√	√	√	√	√	√	√	√	√	√
Joint Local Negotiating Committee (every 6 weeks) – as appropriate	Head of Medical Staffing & Education	√	√	√	√	√	√	√	√	√	√
Policy and Procedures Group	Head of HR Strategic Projects	√	√	√	√	√	√	√	√	√	√
Electronic Staff Record Group	Head of Workforce Transformation	√	√	√	√	√	√	√	√	√	√
Streamlining TIG	Head of Workforce Transformation	√	√	√	√	√	√	√	√	√	√
Workforce Redesign Group	Deputy Director HR & OD	√	√	√	√	√	√	√	√	√	√
Education Governance Committee	Deputy Director HR & OD / Head of Education Development & Wellbeing	√	√	√	√	√	√	√	√	√	√
Equality & Diversity Committee	Deputy Director HR & OD / Head of HR Business Partners	√	√	√	√	√	√	√	√	√	√

Warrington and Halton Hospitals NHS
NHS Foundation Trust

DRAFT **TERMS OF REFERENCE**
STRATEGIC PEOPLE COMMITTEE

1. PURPOSE

The Strategic People Committee is accountable to the Trust Board and will maintain a strategic overview of the Trusts human resources and organisational development arrangements with a view to ensuring that these are designed to provide a positive working environment for colleagues, and that the Trust has in place at all levels the right people systems and processes to deliver, from a patient perspective, safe high quality care.

The Strategic People Committee will seek assurance on the:

- Trust's approach, plans and processes for the delivery of the People Strategy,
- Efficient and effective use of resources,
- CQC Well Led Domain specifically on culture, quality improvement and collaborative leadership development,
- Mechanisms in place to fully engage, listen and act on the feedback and suggestions from the workforce on its journey to CQQ Rating of Outstanding,
- Controls and systems in place to support line managers to make effective decisions in the deployment of staff,
- Redesign of the workforce so that it remains fit for the future, and
- Plans to recruit and retain staff at all levels and how this is reducing the reliance on temporary workers, and

The Committee will act as a catalyst to inspire action and innovation to enable the trust to deliver our quality outcomes of providing:

- Clinical effectiveness
- A safe organisation
- Excellent patient experience

The Committee will provide assurance to the Trust Board on the management of risks related to our people.

2. FREQUENCY OF MEETINGS

Meetings shall be held bi-monthly.

3. MEMBERSHIP

The following individuals, or their nominated Deputy, shall normally be in attendance at the meetings:

- Non-Executive Director (Chair)
- Non-Executive Director (Deputy Chair)
- Director of HR & OD
- Deputy Director HR & OD
- Chief Operating Officer
- Medical Director
- Chief Nurse
- Director of Transformation
- Director Finance & Commercial Development
- Director of Community Engagement

Date September 2018
Approved:
Review Date: March committee meeting each year

- Head of HR Strategic Projects

In attendance for specific agenda items scheduled in SPC annual workplan:
- Head of Education Development & Wellbeing
- Head of Medical Staffing and Education
- Head of HR Business Partners
- Head of Workforce Transformation

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

Other Directors including the Chief Executive or staff members may also be invited / expected to attend from time to time for appropriate agenda items; however, there is no requirement to attend the whole meeting.

4. QUORUM

Quorum shall be two NEDs, Director of HR & OD or Deputy Director HR & OD - plus 3 Executive Directors or their deputies.

5. AUTHORITY

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

6. REPORTING

Governance

The Strategic People Committee will have the following reporting responsibilities:

A Chairs Key Issues Report will be formally recorded and circulated to the Trust Board of items discussed. The Chair of the Strategic People Committee shall draw to the attention of the Trust Board any issues that require disclosure to it, or require a decision or escalation.

The Strategic People Committee will report to the Trust Board annually on its work and performance in the preceding year.

7. DUTIES & RESPONSIBILITIES

Duties – decision making:

- To provide overview and scrutiny in areas of workforce performance referred to the Strategic People Committee by the Trust Board
- Receive and consider the workforce plans and make recommendations as appropriate to the Trust Board.
- To provide overview and scrutiny to the development of the People Strategy

- To ensure the People Strategy is designed, developed, delivered, managed and monitored appropriately
- To ensure that appropriate clinical advice and involvement in the People Strategy is provided
- To receive, agree and monitor progress on the People Strategy through receipt of exception reports and updates
- To attract and retain our workforce using the principles of Model Employer to become the employer of choice.
- To ratify employment policies and procedures on behalf of the Trust
- To receive the annual National Staff Opinion Survey Results and to provide a set of recommendations for action by the Trust
- To receive, agree and monitor the staff engagement activity in the Trust and employee reward in order to be assured of the effectiveness of these activities on improved morale; increased Staff FFT results and improved patient experience.

Duties – advisory:

- Consider any relevant 'people' risks within the Board Assurance Framework and corporate level risk register as they relate to the remit of the Strategic People Committee, as part of the reporting requirements,
- To ensure that the framework for Education Governance is supporting the management of risks associated with our people and the quality of care provided to our patients.

Duties – monitoring:

- To monitor the Trust's performance against national standards so far as they relate to employment.
- To monitor the effectiveness of the Trust's workforce performance reporting systems ensuring that the Trust Board is assured of continued compliance through its annual reporting, reporting by exception where required.
- To review the performance indicators relevant to the remit of the Strategic People Committee
- To report any areas of significant concern to the Trust Board as appropriate via the Chair Key Issues Report.
- To receive and monitor progress on Employee Relations Cases and in particular those cases where suspension/exclusion is involved

Duties of members:

Ensuring, through agreed communication strategies, that key decisions and requirements are appropriately disseminated and that appropriate responses are implemented

Sub-Committees (Groups):

- Operational People Committee
- Premium Pay Spend and Review Group

Each Sub-Committee will submit a Chair Key Issues Report detailing any items of escalation or items requiring decision or action rather than minutes.

8. ATTENDANCE

A record of attendance will be kept, attendance of 75% per year is expected. Members unable to attend must send a deputy who is able to make decisions on their behalf.

Date September 2018
Approved:
Review Date: March committee meeting each year

Warrington and Halton Hospitals NHS
NHS Foundation Trust

9. ADMINISTRATIVE ARRANGEMENTS

The Strategic People Committee will be supported by the Secretary to the Trust Board.

- The ToR will be reviewed annually by Trust Board
- A Cycle of Business (workplan) will be established

Papers to this Strategic People Committee must be submitted for inclusion one week in advance of the meeting. Papers will be distributed by 5pm on the Wednesday preceding the Strategic People Committee.

Papers are to be submitted in the following format:

1. Front sheet – with FOI exemptions duly applied if appropriate
2. Sub-Committees – Chairs key issues reports using the prescribed template
3. Members / HR & OD Service leads – reporting via the prescribed template
4. An Action Log will be maintained and distributed between meetings to enable members to respond.
5. Presentations must be sent to the Administrator ahead of the meeting
6. No tabled papers will be accepted unless in an emergency and with permission of the Chair of the Committee.

10. REVIEW / EFFECTIVENESS

The Strategic People Committee will undertake an annual review of its performance against its duties in order to evaluate its achievements. These terms of reference will be reviewed every 12 months by the Strategic People Committee.

Date September 2018
Approved:
Review Date: March committee meeting each year

Appendix A

NHS
Warrington and Halton Hospitals
NHS Foundation Trust

DRAFT PROPOSAL: WHH Corporate Governance Structure
July 2018

Statutory Committees – all NED-chaired
Assurance Committee – NED-chaired, lead Execs in attendance
Sub committee/Groups to Assurance Committee – Exec Led
Operational delivery of the Board Strategy Exec-led
Constitutional Council and Board/Governor support

Council of Governors

Trust Board
Chair SMcG
Deputy Chair TA

FT Office

Audit Committee
Chair IJ SID

Quality Assurance Committee
Chair MB

- Patient Safety and Clinical Effectiveness
- Patient Experience
- Medicines Governance
- Complaints Quality Assurance
- Divisional Governance
- Infection Control
- Risk Review
- Information Governance and Corporate Records
- Health and Safety
- Safeguarding

NARC
Chair SMcG

Charitable Funds
Chair JNE

Finance and Sustainability Committee
Chair TA

- ICIC Chair DoT
- PPSRG Sub-cttee Chair DHR&OD
- CPG Chair SB
- OPD Transformation Sub-cttee Chair CE COO

Strategic People Committee
Chair AW

- Operational People Committee Chair DHR & OD
- PPSRG Sub-cttee Chair DHR&OD
- Triangulation Meeting Chair EMD/DCEO

Trust Operations Board
Chair MP CEO

- KPI Review Sub-Committee Chair: CE COO
- Patient Flow Sub-cttee Chair COO
- OPD Transformation Sub-cttee Chair CE COO
- ICIC Chair DoT
- Estates & Facilities Sub-cttee Chair: CE COO
- IM&T Sub-cttee Chair DIM&T
- Emergency Planning & Resilience (EPRR) Sub-cttee Chair CE COO
- Strategic Development & Delivery Sub-cttee Chair DoT

System Meetings: Contracting, Commissioners, ACPs, Health and Wellbeing Boards, STP/Alliance, Halton Healthy New Town and Health Campus, ED Delivery Board, IM&T Partnership, Clinical Networks, Health Watch

Date September 2018
Approved:
Review Date: March committee meeting each year

Warrington and Halton Hospitals NHS
NHS Foundation Trust

TERMS OF REFERENCE REVISION TRACKER

Name of Committee:	STRATEGIC PEOPLE COMMITTEE
Version:	DRAFT V3
Implementation Date:	September 2018
Review Date:	March 2019
Approved by:	TRUST BOARD
Approval Date:	

REVISIONS			
Date	**Section**	**Reason on Change**	**Approved**
May 2018	**Draft TORs v1**		Amendments – AW / MC
June 2018	**Draft TORs v2**		Amendments – AW / MC
July 2018	**Draft TORs v3 – to include Appendix A: Governance Flow Chart - for use to proceed to seek approval**		Amendments – AW / MC
July 2018	**Appendix A – Amendment to Key – Explanation of Sub Committee / Groups to Assurance Committees**		Amendments – AW / MC

TERMS OF REFERENCE OBSOLETE		
Date	**Reason**	**Approved by:**

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NHS
Warrington and
Halton Hospitals
NHS Foundation Trust

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/18/07/74**
SUBJECT:	**Board Assurance Framework and Strategic Risk Register report**
DATE OF MEETING:	25th July 2018
ACTION REQUIRED	**Review, Discuss and approve**
AUTHOR(S):	John Culshaw, Head of Corporate Affairs
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Medical Director & Deputy CEO
LINK TO STRATEGIC OBJECTIVES:	All
STRATEGIC CONTEXT	Risk Management is a mechanism for managing exposure to risk that enables the Trust to recognise the events that may result in harm and/or loss. The Trust has a legal and moral duty to patients, visitors and staff to ensure that their safety and wellbeing is not compromised as a result of hospital activities, processes or procedures, as well as regulatory implications.
EXECUTIVE SUMMARY (KEY ISSUES):	Since the last meeting, there have been no new risks added to the register Notable existing risk updates are given, with any impact of risk scores.
RECOMMENDATION:	Discuss and approve the changes and updates to the Board Assurance Framework and Strategic Risk Register
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None

BOARD OF DIRECTORS

SUBJECT	Board Assurance Framework	AGENDA REF:	BM/18/07/74

1. BACKGROUND/CONTEXT

This is an update of strategic risks on the Board Assurance Framework. It has been agreed that the Board receives a monthly update on all strategic risks and any changes that have been made to the strategic risk register, following review at Quality Assurance Committee.

The strategic risk register is outlined in Appendix 1 and the Board Assurance Framework. The following gives notable updates since the strategic risks were last presented to the Board of Directors.

2. KEY ELEMENTS

2.1 New Risks –Since the last meeting there have been no new risks added to the register; however, the Board should note that following escalation from the Workforce Committee that took place on 17th July 2018, the following risk will be submitted to the next Quality Assurance Committee to seek endorsement for inclusion on the BAF.

Risk	**Risk: Failure to attend mandatory resuscitation training caused by operational pressures resulting in low compliance rates and risk to patient and staff safety**
Controls and Assurances	▪ E-leaning was identified for staff to access specific courses. ▪ Review of compliance and staff competencies. ▪ Resuscitation group now meeting quarterly to review figures and TNA ▪ This will remain on the risk register until compliance figures are above 85%, monitored monthly through workforce committee and CQC group. ▪ 230 e mails sent out to Consultant staff requesting resuscitation compliance details. Deadline for response 13th May 2018. ▪ Additional training sessions provided in July and August (early and late to allow all staff to attend) ▪ Flyer produced to provide clarity of requirements for medical staff ▪ Individual correspondence to medical staff from Medical Director ▪ Changes to funding process to support medical staff to attend external courses
Gaps	▪ Low training compliance for specific staff groups
Initial Risk Rating	15 (3x5)
Residual Risk Rating	12 (3x4)

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2.2 Existing Risks – updates

Strategic Risk	Update since last Risk review	Impact of update on risk rating
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.	• The Trust accepted an offer from NHSi of a revised control total which moves the forecast for 2018/19 from £24.4m deficit to £16.9m deficit, which includes access to £4.9m PSF and an interest rate of 1.5% on corresponding loans. This also exempts the Trust from national fines and penalties. • The Trust now provides regular CIP updates/reports to NHSi • Awaiting guidance regarding revenue to support the national pay award and timing of cash. • Contacted NHSi for clarity regarding allocation of resources and cash relating to the national pay award and the Trust is awaiting imminent guidance.	No impact on risk rating
Failure to identify and manage patients' risk of sustaining a fall; caused by inadequate risk assessment and implementation of appropriate care plans. This may cause patient harm, has a negative effect on the patient's experience, may prolong their length of stay, and give rise to complaints and claims against the trust.	2 SI Falls occurred in May 2018. The financial impact associated with falls is great, the average cost of a no harm fall is approximately £2,600 for people over the age of 65 and for a severe harm fall £14,100. • Falls are discussed on a daily basis at the newly formed Trust Wide Safety Huddle and are first on the 'Hot Topics'; • The Trust has joined the NHSi Falls Collaborative Improvement Programme; • A Bed replacement programme has been put in place which will commence in July 2018; • Weekly harm free care meetings for falls commenced in May 2018; • Weekly MDT Falls walks to review clinical areas commenced May 2018; • Task and Finish group commenced May 2018; A Trust wide bathroom review has been commissioned with likely completion in September 2018	No impact on risk rating
Lack of assurance regarding the Trust's safeguarding agenda being implemented across the Trust due	Audit completed on the effectiveness of MCA training, MCA practice in the DNACPR process and the embeddedness of the	No impact on risk rating

Strategic Risk	Update since last Risk review	Impact of update on risk rating
to gaps highlighted during external review may impact on patient safety and cause the Trust to breach regulations.	practices. MIAA to conduct a review in September 2018, of the audit undertaken. Following this review, the residual risk rating will be reviewed.	

2.3 Risk Management Strategy Updates

The strategic risk register has now been transferred to Datix, enabling easier updates and monitoring The Risk review Group continues to meet monthly with the next meeting due to be held on 27th July 2018.

3 RECOMMENDATIONS

The Board of Directors are asked to note the updates to the strategic risks and the Board Assurance Framework.

Appendix 1- Strategic Risk Register

Risk	Residual Risk Rating (Impact x Likelihood) July 2017	Score at last review 21/09/17	Score at last review 14/11/17	Score at last review 17/01/18	Score at last review 15/02/18	Score at last review 13/03/18	Score at last review 18/04/18	Score at last review 08/05/18	Score at last review 13/06/2018	Score at last review 11/07/2018
Failure to provide adequate staffing levels in some specialities and wards caused by inability to fill vacancies, sickness which may result in pressure on ward staff , potential impact on patient care and impact on Trust access and financial targets.	20 (5x4)	20 (5x4)	20 (5x4)	20 (5x4)	20 (5x4)	20 (5x4)	20 (5x4)	20 (5x4)	20 (5x4)	20 (5x4)
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.	20 (5x4)	20 (5x4)	20 (5x4)	20 (5x4)	20 (5x4)	20 (5x4)	20 (5x4)	20 (5x4)	20 (5x4)	20 (5x4)
Failure to deliver national and local performance targets will impact on patient care, reputation and financial position.	20 (5x4)	20 (5x4)	20 (5x4)	20 (5x4)	20 (5x4)	20 (5x4)	20 (5x4)	20 (5x4)	20 (5x4)	20 (5x4)
Failure to provide a spinal service for the local population, caused by a voluntary suspension of the service amid potential governance	N/A	N/A	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)

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Risk	Residual Risk Rating (Impact x Likelihood) July 2017	Score at last review 21/09/17	Score at last review 14/11/17	Score at last review 17/01/18	Score at last review 15/02/18	Score at last review 13/03/18	Score at last review 18/04/18	Score at last review 08/05/18	Score at last review 13/06/2018	Score at last review 11/07/2018
concerns, resulting in poor patient experience, potential safety concerns for those patients with delayed procedures or follow ups, reputational damage and potential regulatory and contractual issues.										
Failure to provide adequate and timely IMT system implementations & systems optimisation caused by either increasing demands and enhanced system functionality which results in pressure on staff; potential in systems being poorly used resulting in poor data quality. Impact on patient access to services, quality of care provided, potential patient harm and financial & performance targets.	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4	16 (4x4	16 (4x4	16 (4x4	16 (4x4
Failure to identify and manage patients' risk of sustaining a fall;	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4	16 (4x4	16 (4x4	16 (4x4	16 (4x4

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Risk	Residual Risk Rating (Impact x Likelihood) July 2017	Score at last review 21/09/17	Score at last review 14/11/17	Score at last review 17/01/18	Score at last review 15/02/18	Score at last review 13/03/18	Score at last review 18/04/18	Score at last review 08/05/18	Score at last review 13/06/2018	Score at last review 11/07/2018
caused by inadequate risk assessment and implementation of appropriate care plans. This may cause patient harm, has a negative effect on the patient's experience, may prolong their length of stay, and give rise to complaints and claims against the trust.										
Failure to provide timely information caused by increasing internal and external demands for datasets, implementation of new systems and a lack of skilled staff with capacity to respond. This may cause financial impact, external reputation damage and poor management decision making due to lack of quality data.	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)
Lack of assurance regarding the Trust’s safeguarding agenda being implemented	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)

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Risk	Residual Risk Rating (Impact x Likelihood) July 2017	Score at last review 21/09/17	Score at last review 14/11/17	Score at last review 17/01/18	Score at last review 15/02/18	Score at last review 13/03/18	Score at last review 18/04/18	Score at last review 08/05/18	Score at last review 13/06/2018	Score at last review 11/07/2018
across the Trust due to gaps highlighted during external review may impact on patient safety and cause the Trust to breach regulations.										
Failure to influence sufficiently within the STP and LDS 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.	15 (5x3)	15 (5x3)	15 (5x3)	15 (5x3)	15 (5x3)	15 (5x3)	15 (5x3)	15 (5x3)	15 (5x3)	15 (5x3)
Failure to maintain an old estate could result in staff and patient safety issues, increased costs and unsuitable accommodation.	15 (5x3)	15 (5x3)	15 (5x3)	15 (5x3)	15 (5x3)	15 (5x3)	15 (5x3)	15 (5x3)	15 (5x3)	15 (5x3)
Lack of assurance regarding complaints handling within the Trust, caused by ineffective systems and processes, resulting in a poor experience for complainants, the Trust not meeting statutory and	16 (4x4)	16 (4x4)	12 (3x4)	12 (3x4)	12 (3x4)	12 (3x4)	12 (3x4)	12 (3x4)	12 (3x4)	12 (3x4)

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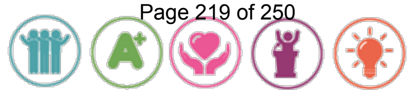
Risk	Residual Risk Rating (Impact x Likelihood) July 2017	Score at last review 21/09/17	Score at last review 14/11/17	Score at last review 17/01/18	Score at last review 15/02/18	Score at last review 13/03/18	Score at last review 18/04/18	Score at last review 08/05/18	Score at last review 13/06/2018	Score at last review 11/07/2018
contractual complaints targets and not having effective systems in place to learn lessons from complaints										
Failure to prevent harm to patients, caused by lack of timely and quality discharge summaries being sent to primary care, resulting in a lack of appropriate handover of care safety, operational, financial and reputational consequences.	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)
Failure to deliver essential services, caused by a Cyber Attack, resulting in loss of data and vital IT systems, resulting in potential patient harm, loss in productivity and Trust reputation	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)
Failure to comply with the Thromboprophylaxis procedure/policy caused by poor completion of thromboprophylaxis risk assessments and follow up	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)



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Risk	Residual Risk Rating (Impact x Likelihood) July 2017	Score at last review 21/09/17	Score at last review 14/11/17	Score at last review 17/01/18	Score at last review 15/02/18	Score at last review 13/03/18	Score at last review 18/04/18	Score at last review 08/05/18	Score at last review 13/06/2018	Score at last review 11/07/2018
investigation (Root Cause Analysis) of hospital associated VTE in some areas, resulting in the risk of patients not receiving the appropriate, preventative treatment for VTE in hospital.										
Clinical variation, caused by lack of systems/process or failure of systems/to follow process leading to lack of evidence based practice, potential patient harm and reputational impact.	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)
Failure to successfully engage the Workforce, causing the potential for a negative working environment and the consequential loss of discretionary effort and productivity, or loss of talented colleagues to other organisations, which would impact patient care, staff morale and delivery of the	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)

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Risk	Residual Risk Rating (Impact x Likelihood) July 2017	Score at last review 21/09/17	Score at last review 14/11/17	Score at last review 17/01/18	Score at last review 15/02/18	Score at last review 13/03/18	Score at last review 18/04/18	Score at last review 08/05/18	Score at last review 13/06/2018	Score at last review 11/07/2018
Trust's strategic objectives										
Failure to achieve the highest level of corporate governance, caused by the requirement to review and embed new structures, which may impact on statutory and regulatory requirements	12 (3x4)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)
Failure to implement best practice information governance and information security policies and procedures caused by lack of resources or ineffective communication of key information governance messages to WHH staff	N/A	N/A	N/A	N/A	N/A	N/A	N/A	12 (4x3)	12 (4x3)	12 (4x3)
Failure to ensure timely delivery of Getting to Good action plan, caused by potential lack of capacity and resource resulting in an organisational risk of not attaining a rating of 'Good'	N/A	N/A	N/A	N/A	N/A	N/A	N/A	12 (4x3)	12 (4x3)	12 (4x3)
Failure to have robust processes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	12 (4x3)	12 (4x3)	12 (4x3)

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Risk	Residual Risk Rating (Impact x Likelihood) July 2017	Score at last review 21/09/17	Score at last review 14/11/17	Score at last review 17/01/18	Score at last review 15/02/18	Score at last review 13/03/18	Score at last review 18/04/18	Score at last review 08/05/18	Score at last review 13/06/2018	Score at last review 11/07/2018
in place across the Trust relating to Medical devices, caused by inconsistency in applying policies and procedures and inability to provide assurance, resulting in potential for patient safety incidents, service disruption and non-compliance of regulatory standards.										
Failure to implement the requisite GDPR (General Data Protection Regulation) policies, procedures and processes caused by the lack of resources resulting in the areas of data protection non-compliance	N/A	N/A	N/A	N/A	N/A	N/A	N/A	12 (3x4)	12 (3x4)	12 (3x4)

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BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/18/07/75**	
SUBJECT:	Annual Report of the Quality Committee 2017-18	
DATE OF MEETING:	25 July 2018	
ACTION REQUIRED	**To approve**	
AUTHOR(S):	Margaret Bamforth, Non-Executive Chair Quality Committee	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon Jamieson, Chief Nurse Simon Constable – Medical Director	
LINK TO STRATEGIC OBJECTIVES:	SO1: To ensure that all care is rated amongst the top quartile in the North West of England for patient safety, clinical outcomes and patient experience	
EXECUTIVE SUMMARY (KEY ISSUES):	This report seeks to deliver assurance to the Board that the Quality Assurance Committee has met its Terms of Reference and has gained assurance throughout the reporting period of the Trust's performance.	
RECOMMENDATION:	The Board is asked to approve the document**.**	
PREVIOUSLY CONSIDERED BY:	**Meeting**	Quality Assurance Committee
	Date of meeting	1 May 2018
	Summary of Outcome	Approved
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

Board of Directors

SUBJECT	Annual Report of the Quality Committee 2017-18	AGENDA REF:	BM/18/07/75

The Quality Assurance Committee is required to report annually to the Board outlining the work it has undertaken during the year, and where necessary, highlighting any areas of concern. This paper presents the Quality Assurance Committee Annual Report which covers the reporting period 1st April 2017 to 31st March 2018.

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

The Quality Assurance Committee is accountable to the Board for ensuring that the integrated quality governance framework is implemented throughout the organisation and that organisational strategic risks are managed appropriately.

This report details the membership and role of the Committee and the work it has undertaken during the reporting period.

During the reporting period, the Committee has been composed of 2 Non-Executive Directors with a quorum of 2 (including the Chair). Any Non-Executive Director is able to attend the Committee to cover any absence.

During the reporting period, there were 10 meetings. The Quality Committee attendance record is attached in **Appendix 1**.

Terms of Reference

The Committee's Terms of Reference were reviewed during Quarter 4 of 2017/18, as was the business cycle, to ensure there was a focus on integrated systems of quality and assurance and also in line with the roll out of the revised Trust meetings structure. The terms of reference are attached in **Appendix 2.** From January 2018, the Quality Assurance Committee focused on assurance monitoring and revised its frequency to bi-monthly, with its reporting sub committees meeting on a more frequent basis to deliver the agenda. High level briefings are provided to the Quality Assurance Committee from the Executive Led Sub Committees for assurance purposes. In addition the Chair of the Quality Assurance Committee attends subcommittee meetings periodically for assurance purposes.

Frequency of Meetings and Summary of Activity

The Committee met 10 times during the year. The September meeting was cancelled. A summary of the activity covered at these meetings follows:

- **Strategy Development**

  The Committee has approved the Trust's Quality Priorities for the year as set out within the Quality Account. The Committee has had regular updates in relation to the strategic Quality Priorities for the Trust. In addition updates of enabling quality strategies have been provided e.g. Dementia strategy and Patient Experience strategy.

- **Risk Management**

  Following the revision of the Trust Risk Management Strategy, the Quality Assurance Committee has overseen the Trust strategic risks, as the designated Board Committee responsible for risk. The Committee has liaised closely with the Audit Committee to ensure the strategic risk register and Board Assurance Framework drives the internal audit plan and to provide the Audit Committee assurance regarding systems of internal control.

  In addition the Quality Assurance Committee convened the Risk Review Group, to ensure that there was scrutiny of departmental, speciality and Clinical Business Unit risk registers, and that appropriate escalation processes are in place to the Board.

  The Committee also put in place processes to oversee the impact of cost efficiencies, by ensuring updates of Quality Impact Assessments were given on at least a quarterly basis, with more updates in-between if warranted.

- **Quality Dashboard**

  The Committee has overseen an ongoing review of quality Key Performance Indicators, which are monitored in the corporate Integrated Performance Dashboard. A report is received at each meeting of the Quality Dashboard to review performance and to determine assurance of mitigating actions as appropriate.

- **Assurance**

  The business cycle for the Committee has been reviewed, with more focus on assurance monitoring. Reporting sub committees have also been under review, so that there is increased scrutiny.

  Key areas which have been monitored in year are complaints, Serious Incidents, falls prevention, infection prevention, information governance , safeguarding and VTE.

- **Investigations and Lessons Learned**

  The Committee receives a monthly update, to assure itself that investigations from Serious Incidents are being undertaken as per statutory and regulatory requirements. This also includes monitoring Duty of Candour, as the lack of a robust monitoring system was escalated to the Committee in year.

  The Committee has also approved a Lessons Learned Framework in year, and has received information regarding how this is being implemented, including having receipt and scrutiny of a Lessons Learned Audit, whereby actions and recommendations from Serious Incidents and Complaints are audited for assurance of completion.

In addition the Quality Assurance Committee convened the Complaints Quality Assurance Group, which is chaired by the Trust Chairman. This monitors the quality of the complaints responses in the Trust and also how we are implementing learning and change as a result of patient and public feedback.

- **Regulatory and statutory monitoring**

The Committee continued to monitor the statutory and regulatory requirements relating to quality governance throughout the year. This included monitoring of Care Quality Commission preparedness work, national audit activity, NICE guidance, national surveys, quality KPIs, complaints improvement etc.

In 2018/19, the Committee will oversee and monitor any follow on actions from the CQC report, which was received in November 2018.

Issues Carried Forward

There are a number of issues which the Committee will carry forward into 2018/19

Implementation of the Quality Priorities for the year

- Approval and implementation of the Trust revised Quality Strategy, which will focus on quality and continuous improvement.
- Safer Invasive procedures - Ensure that the Trust fully embraces the culture of safer surgery in theatres and in those areas that undertake invasive procedures.
- Falls – Reduction of injurious inpatient falls and increase the reporting of patient falls.
- Patient Experience Strategy implementation.
- Service provision and experience for patients with mental health and learning difficulties.
- VTE
- DNACPR
- Overview of the Getting to Good, Moving to Outstanding CQC Action Plan.

Delivery of other quality improvement areas e.g. CQUINS, quality improvement targets

Review of policy and document management systems within the Trust

Summary

The Committee has evolved in year, with a significant review of terms of reference and remit. I as Chair of the Quality Assurance Committee encourage honest and open discussion, so that areas of success can be celebrated and areas of improvement escalated and actioned.

I would like to thank all members of the Committee, along with Directors, staff, internal and external advisors for their responses, support and contributions during the year.

Margaret Bamforth
Chair of Quality Committee

QUALITY COMMITTEE ATTENDANCE RECORD April 2017-March 2018

	Apr	May	Jun	Jul	Aug	Sept XIId	Oct	Nov	Dec		Jan	Mar	% inc Dep Attendance	% exc Dep Attendance
Margaret Bamforth Non-Executive Director	√	√	√	√	√		√	√	√		√	√	100%	
Ian Jones Non-Executive Director	√	√	A	√	√		√	√	√				70%	
Jean-Noel Ezingeard, Non Executive Director *(from August 2017)*					√			A			√	√	50%	
Terry Atherton Non-Executive Director	A	A	√	A	A								10&	
Kimberley Salmon-Jamieson Chief Nurse	√	√	√	√	√		√	√	√		√	√	100%	
Simon Constable Medical Director/Deputy CEO	√	√	√	√	√		A/D	√	A			√	80%	70%
Ursula Martin, Deputy Director Quality + Integrated Governance	√	√	√	√	√		√	√	A		√	√	90%	
Alex Crowe, Deputy Medical Director	√	√	√	√	√		√	√	√		√	√	100%	
John Goodenough, Deputy Chief Nurse	√	√	√	√	√		√	√	√		√	A	90%	
Michelle Cloney Interim Director of HR	√	√	√	√	A		√	A	√		A/D	A/D	80%	60%
Mark Halliwell Chief of Service, SW+C	√	√	√	√	√		√	√	√		√	A	90%	
Kate Clark Chief of Service Acute	**A**	A	√	A	√		√					A	30%	
Diane Matthew Chief Pharmacist	√	√	√	A	√		√	A/D	√			√	80%	70%
Anne Robinson Associate MD Quality Improvement	√	√	√	√	√		A	√	√		√	√	90%	
Rachael Browning Associate Director Nursing	A	√	√	√	√		√	√	√		√		80%	
Carol Millington Head of Therapies	√	A	√	√	√		√					A	50%	
Lesley McKay Associate Director Infection Prevention and Control	√	√	√	√	√		A	√	√		A	√	80%	
Jan Ross Deputy Chief Operating Officer *Acting from June 2017 to Dec 2017)*	X/D	X/D	√	√	√		A	√						
Karen Foster Deputy DoIM&T *(wef May 2017)*			√	√	√		√	√	√		√	√	100%	
Lucy Gardner Director of Transformation	A/D	√	√	√	√		√	√	A/D		A	√	90%	70%
Tracey Cooper, Head of Midwifery	A/D	A/D	A	A	√		A/D	√	√		A	A	60%	30%
Alison Kennah Associate DoN Acute Care	√	√	√	√	√		A	A	√		√		70%	
John Culshaw, Head of Corp Affairs *(wef 11/17)*								√	√		√	√	100&	
Ann Goodwin, Risk & Governance Midwife	X/D													
Stephen Bennett	X/D								X/D					
Deborah Smith, Deputy HRD (*wef Jan 2017)*											√	A/D	100%	50%

Dawn Forrest, Assoc Direc of Ops SWC	A	A	A	A	A									
Neil Holland Ass Dir of Operations Acute				A	A									
Mel Pickup, Chief Executive					√									
Nicola Hayes, Deputy Chief Pharmacist							X/D							
Jennifer Crook-Vass (for specific item			√				√							
Jill Tomlinson (for specific item)							X/D							
James Wallace	√										√			
Louise Tucker	√													
Julie Burke Secretary Trust Board(Minutes)	√	√	√	√			√				√			
Sharon Gilligan, Chief Operating Officer (to April)	A/D													
Roger Wilson Director of HR & OD *(to Apr 17)*	A	A												

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

DRAFT TERMS OF REFERENCE

QUALITY ASSURANCE COMMITTEE

1. PURPOSE

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

The Quality Assurance Committee is accountable to the Board for ensuring that the integrated quality governance framework is implemented throughout the organisation and that organisational risks are managed appropriately in line with professional and regulatory standards..

2. FREQUENCY OF MEETINGS

Meetings shall be held bi-monthly

3. QUORUM

Quorum shall be seven members, of which at least two should be Non-Executive Directors.

4. MEMBERSHIP

The Committee shall be composed of three Non-Executive Directors, one of whom shall be appointed by the Board to be Chair of the Committee

Core Members

- Chief Nurse
- Medical Director
- Chief Operating Officer
- Director of Integrated Governance and Quality
- Deputy Chief Nurse
- Deputy Medical Director
- Director of Transformation
- Deputy Director of Workforce and Organisational Development
- Deputy Director of IM&T
- Head of Corporate Affairs
- Associate Medical Director – Quality + Safety
- Associate Medical Director – Clinical Effectiveness
- Associate Medical Director – Patient Experience
- Associate Nurse Director - Quality+Safety
- Associate Nurse Director – Clinical Effectiveness
- Associate Nurse Director – Patient Experience
- Audit and Governance Lead for Women's Health

Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute

presence in person at the meeting and count towards the quorum. Should the need arise, the Committee may approve a matter in writing by receiving written approval.

5. AUTHORITY

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

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

6. REPORTING

The Committee will have the following reporting responsibilities:

- The minutes of the Committee meetings will be formally recorded. The Chair of the Committee shall draw to the attention of the Board and Audit Committee any issues that require disclosure to it, or require executive action.
- The Chair of the Committee will provide a written key issues report to the Board monthly following each meeting providing assurance of the quality governance arrangements in place within the Trust and provide an annual report to be presented at the May Board meeting on its work and performance in the preceding year.

The sub committees listed below are required to submit high level briefing papers to the Committee:

- Patient Safety & Clinical Effectiveness Sub-Committee
- Patient Experience Sub-Committee
- Health, Safety & Welfare Sub-Committee
- Information Governance and Corporate Records Sub Committee
- Safeguarding Sub Committee
- Risk Review Group
- Complaints Quality Assurance Group
- Research and Development Sub Committee

7. DUTIES & RESPONSIBILITIES

The Committee will undertake the following duties:

- Oversee the development and implementation of the Trust's strategies aligned to integrated governance and quality, including the overarching Quality Strategy, Risk Management Strategy, Clinical Effectiveness Strategy, Patient Experience Strategy, Quality Improvement Strategy, with a clear focus on upholding the tenants of quality and integrated governance and avoiding harm, ensuring that all strategies and performance indicators are consistent with the Trust's Mission, Vision and strategic objectives;

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- Be the Trust Board of Directors delegated Committee responsible for risk management, ensuring that there is scrutiny and oversight of the strategic risk register and Board Assurance Framework, prior to approval at the Board of Directors and that there is appropriate liaison with the Audit Committee, to ensure internal audit resources within the Trust are aligned appropriately to risk;
- Overseeing 'Deep Dive Reviews' of identified risks to quality identified by the Board or the Committee, particularly "Serious Incidents Requiring Investigation" and how well any recommended actions have been implemented;
- The Committee may also initiate such reviews based on its own tracking and analysis of quality trends flagged up through the regular performance reporting to the Board;
- Review the quality dashboard and information presented to the Committee, with regard to ensuring assurance is received on all quality and safety of patient care matters, which fulfils the Trust's strategic goals regarding quality and assurance, as well as statutory, regulatory and contractual requirements;
- Ensure there is a process in place regarding assessing and monitoring the impact on quality from Trust transformation and efficiency plans;
- To consider all appropriate matters of clinical and non-clinical, quality governance including patient care, patient experience and patient and staff safety, via a planned integrated quality governance assurance system, giving assurance either directly to the Committee or indirectly via its reporting Sub Committees, and all risks are appropriately escalated;
- Ensure there is an appropriate investigations framework within the Trust i.e. ensure all incidents and complaints are appropriately investigated, ensure that the Trust's Mortality Review process aligns to the Royal College of Physicians Standard Judgment Review process, and that people have the skills and expertise to undertake these investigations;
- Ensure there is an appropriate policy development and review framework within the Trust, and that staff education strategy and organisational development is aligned to policy development within the Trust;
- Ensure there is an action planning framework in place within the Trust, so that actions from investigations, risk assessments and internal and external reviews are implemented, monitored appropriately and escalated when off track;
- Ensure that there is a learning framework in place within the Trust, so that aggregate learning from incidents, Serious Incidents, complaints, claims, audit and assessments are communicated appropriately and changes in practice are facilitated;
- Oversee the implementation of key national reports and inquiries recommendations and provide assurance to the Board on its delivery;
- Ensure all external accreditations are monitored within the Trust, so that the Board of Directors has assurance that the Trust is meeting external quality requirements, and where there is variance or risk, actions are put in place appropriately;
- Obtain assurance of the Trust's on-going compliance with the Care Quality Commission registration through appropriate systems of control.
- Ensure that the Trust has effective communication channels in place for ward to Board monitoring and that the Clinical Business Unit, directorate, speciality, ward and department governance and quality assurance structures are robust;
- Monitor the process for the production of the Trust's year end quality (Quality Accounts) and risk management (Annual Governance Statement) reports before they are presented to the Trust Audit Committee and Board for formal approval;
- Ensure all reporting Sub Committees have effective reporting structures in place and that planned assurance reports are scrutinised through a business and assurance cycle;

- To inform the Board where it has significant concerns about:
  - Standards of care in the Trust
  - Or where it considers any service (or part of) to be unsafe

8. ATTENDANCE

A record of attendance will be kept; attendance of 75% per year is expected
Members unable to attend must send a deputy who is able to make decisions on their behalf.
Other executive directors and officers of the Trust will be invited to attend the meeting as appropriate when an issue relating to their area of operation or responsibility is being discussed. Officers who are unable to attend a meeting of the Committee may appoint a deputy who will attend. It is the responsibility of the core member to inform the Chair of the Committee if they are unable to attend and who will attend as their deputy.

9. ADMINISTRATIVE ARRANGEMENTS

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

- The ToR will be reviewed annually by Trust Board
- A Cycle of Business will be established

Papers to this Committee must be submitted for inclusion one week in advance of the meeting. Papers will be distributed by 5pm on the Tuesday preceding the Quality and Assurance Committee.

Papers are to be submitted in the following format:

1. Front sheet – with FOI exemptions duly applied if appropriate
2. Sub-Committees – Chairs key issues reports using the prescribed template
3. Divisional leads/service leads – reporting via the prescribed template
4. An Action Log will be maintained and distributed, alongside the CEO report, by the Friday following the Executive Board.
5. Presentations must be sent to the Administrator ahead of the meeting
6. No tabled papers will be accepted unless in an emergency and with permission of the Chief Executive.

10. REVIEW / EFFECTIVENESS

The Committee will undertake an annual review of its performance against its duties in order to evaluate its achievements. These terms of reference will be reviewed every 12 months by the Committee.

TERMS OF REFERENCE REVISION TRACKER

Name of Committee:	Quality & Assurance Committee
Version:	V1
Implementation Date:	
Review Date:	6 December 2016, 0 January 2017, 7 February 2017, 2 January 2018
Approved by:	
Approval Date:	

REVISIONS			
Date	**Section**	**Reason on Change**	**Approved**
6 December 2016	5 - Membership	Revised to include Non-Executive Directors to be amended to read **two** Core Attendees – to read **Core Members** Delete Divisional Operational Directors from the Core Membership **ADD Transformation Director** **ADD - Co-Opted Members from the Workforce Sub Group.** The Quality Committee to receive minutes from the WSG and appropriate colleagues to be invited to the Quality Committee where assurance is required for specific matters in relation to staffing, quality and safety. Quorum – change from 10 **to maximum of 7, to include 1 Executive Director, 1 Non-Executive Director and 1 representative from**	

		each Division.	
	10 – Administrative Arrangements	The Committee will be supported by the Secretary to the Trust Board.	7.2.17
10 January 2017	5 - Membership	Membership further reviewed to include Head of Midwifery and Associate Director Infection Control + Prevention.	7.2.17
7 February 2017	5 – Membership	Delete Director of IM&T	7.2.17
02 January 2018	4 – Membership	Delete Chief Pharmacist, Chiefs of Service, Surgery, Women's & Children and Acute Care Services, Associate Directors of Nursing, Associate Director of Infection Control.	09.01.2018
02 January 2018	2 – Frequency of Meetings	Meetings to move from monthly to bi-monthly	09.01.2018
02 January 2018	6 – Reporting	Removal of Infection Control Committee, medicines management, Inclusion of Risk Review Group, Complaints Quality Assurance Group, Research and Development Sub Committee and Safeguarding Committee,	09.01.2018
04 May 2018	4 – Membership	Add Audit and Governance Lead for Women's Health	03.08.2018

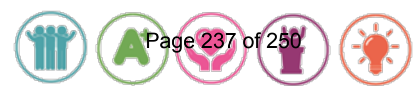
TERMS OF REFERENCE OBSOLETE		
Date	**Reason**	**Approved by:**

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/18/07/76**	
SUBJECT:	**Council of Governors Annual Cycle of Business 2018-19 and Terms of Reference**	
DATE OF MEETING:	25th July 2018	
ACTION REQUIRED	**Approval**	
AUTHOR(S):	John Culshaw, Head of Corporate Affairs	
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Deputy Chief Executive & Executive Medical Director	
LINK TO STRATEGIC OBJECTIVES:	All	
STRATEGIC CONTEXT	In accordance with the Foundation Trust's Constitution 'Board of Directors – Standing Orders' Committees of the Board are required to review their Terms of Reference and Cycles of Business on an annual basis.	
EXECUTIVE SUMMARY (KEY ISSUES):	The Council of Governors reviewed and approved the Cycle of Business and Terms of Reference. The Board is asked to review: • the Terms of Reference and note the proposed slight amendments to reflect changes to sections 9 and 10; • the Cycle of Business 2018-19	
RECOMMENDATION:	That the Board approves the Terms of Reference and the 2018-19 Cycle of Business as attached.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Council of Governors
	Agenda Ref.	COG/18/05/31
	Date of meeting	17 May 2018
	Summary of Outcome	Approved
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: *(if relevant)*	Choose an item.	

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/18/07/76 ii**	
SUBJECT:	**Establishment of the Financial Resources Group**	
DATE OF MEETING:	25th July 2018	
ACTION REQUIRED	**Noting**	
AUTHOR(S):	John Culshaw, Head of Corporate Affairs	
EXECUTIVE DIRECTOR SPONSOR:	Andrea McGee, Director of Finance and Commercial Development Lucy Gardner, Director of Transformation	
LINK TO STRATEGIC OBJECTIVES:	All	
EXECUTIVE SUMMARY (KEY ISSUES):	The Finance & Sustainability Committee reviewed and approved the proposed establishment of a Financial Resources Group (FRG) in the meeting held on 18th July 2018. The proposal requested that the existing Innovation and Cost Improvement Committee (ICIC) changed names to the Financial Resources Group and the remit of the group be extended to cover a wider range of financial performance to support the sustainability of Trust services. Included for the Board to note is the Group's Terms of Reference, example proposed agenda and accompanying cover report.	
RECOMMENDATION:	That the Board note the approval of the formation of the Financial Resources Group and agreed Terms of Reference approves the Terms of Reference.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Finance and Sustainability Committee
	Agenda Ref.	FSC/18/07/93
	Date of meeting	18th July 2018
	Summary of Outcome	Approved
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.	



FINANCE AND SUSTAINABILITY COMMITTEE

AGENDA REFERENCE	**FSC/18/07/93**
SUBJECT	**Establishment of the Financial Resources Group**
DATE OF MEETING	18 July 2018
ACTION REQUIRED	**For approval**
AUTHOR	Steve Barrow, Deputy Director of Finance
EXECUTIVE DIRECTOR	Andrea McGee, Director of Finance and Commercial Development Lucy Gardner, Director of Transformation
EXECUTIVE SUMMARY	The Innovation and Cost Improvement Committee (ICIC) was established a number of years ago to oversee the formulation, management and delivery of the Trust's annual cost improvement programme and the implementation of schemes to improve service delivery that improved productivity and efficiency. It is proposed that the name of the group is changed and the remit is extended to cover a wider range of financial performance to support the sustainability of Trust services.
RECOMMENDATIONS	The Committee is asked to approve the establishment of a Financial Resources Group.
FREEDOM OF INFORMATION STATUS (FOIA)	Partial FOIA Exempt
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Section 41 – confidentiality

FINANCIAL RESOURCES GROUP

1. PURPOSE

The purpose of this report is to update the Committee on the establishment of a Financial Resources Group.

2. EXECUTIVE SUMMARY

The Innovation and Cost Improvement Committee (ICIC) was established a number of years ago to oversee the formulation, management and delivery of the Trust's annual cost improvement programme and the implementation of schemes to improve service delivery that improved productivity and efficiency. These two functions are an important part of the Trust's financial performance but there are other factors that heavily influence delivery of the annual financial plan.

Therefore it is proposed that the name of the group is changed and the remit is extended to cover a wider range of financial performance to support the sustainability of Trust services.

A Terms of Reference and draft agenda is attached for information and includes

- Financial Performance
- Productivity and Efficiency
- Patient Level Costing
- Service Line Reporting

3. RECOMMENDATION

The Finance and Sustainability Committee is asked to approve the establishment of a Financial Resources Group.

Andrea McGee, Director of Finance and Commercial Development
Lucy Gardner, Director of Transformation

FSC/18/07/93

Financial Resources Group

Terms of Reference

1. Purpose

The Financial Resources Group (FRG) is accountable to the Finance and Sustainability Committee (FSC) and is responsible for monitoring and managing financial performance of all Clinical Business Units and Corporate Divisions to ensure the provision of high quality services within the resources available.

2. Authority

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

The FRG is authorised by the FSC to use professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for or expedient, to exercise its functions subject to compliance with delegated authorities.

The FRG is authorised by the FSC to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

The FRG has no executive powers other than those specifically delegated in these terms of reference.

3. Reporting Arrangements

The FRG will have the following reporting responsibilities

The minutes of the FRG meetings will be formally recorded and circulated to the FSC. The Chair of the FRG shall draw to the attention of the FSC any items that require disclosure or action.

The FRG will report to the FSC annually on its work and performance every year.

The Trust's Standing Orders and Standing Financial Instructions apply to the operation of the FRG.

4. Duties and Responsibilities

The FRG is responsible for providing information and assurances to the FSC that the Trust is monitoring and managing financial performance of all Clinical Business Units and Corporate Divisions to ensure the provision of high quality services within the resources available.

This will include the receipt and review of financial reports for each Clinical Business Unit and Corporate Division incorporating:

- Activity and Income Performance including key variances
- Expenditure Position including key variances
- CIP in year and recurrent
- Key risks

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- Mitigation Plans
- Forecast outturn

To ensure robust recovery plans are formulated and delivered.

To monitor performance against agreed cost improvement programmes.

To review and monitor productivity and efficiency to ensure maximisation of resources including use of Model Hospital information.

To review Commercial Development opportunities and to provide support and advice in the production of business cases.

To review the extent to which procurement opportunities and developments are being identified, supported and delivered.

To develop the extent to which Service Line Reporting and Patient Level Costing Information is being utilised to drive improved financial performance.

To review compliance with financial governance processes.

To monitor, review and update periodically these terms of reference as required.

5. Membership

The membership and attendees of the FRG is as follows:

- Director of Finance and Commercial Development (Chair)
- Deputy Director of Finance (Deputy Chair)
- Deputy Director of Finance (Strategy)
- Director of Transformation
- Head of Transformation
- Chief Operating Officer/ Deputy Chief Operating Officer
- CBU Managers
- CBU Clinical Director
- Deputy/Heads of Corporate Services
- Head of Financial Planning
- Head of Management Accounts
- Senior Business Accountants
- Senior Procurement Managers
- Head of Commercial Development

Each member shall be required to attend the meeting but shall send a deputy if appropriate to ensure that all Clinical Business Units and Corporate Divisions are represented (attendance from Clinical Business Units and Corporate Divisions required quarterly)

Other managers or staff members may also be invited to attend from time to time for appropriate agenda items however there is no requirement to attend the whole meeting.

An annual attendance report will be submitted to the FSC for information and action as required.

6. Quorum

The quorum be considered quorate with the attendance of

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- Chair or Deputy Chair
- Representative from Transformation Team
- Representative from each Clinical Business Unit Manager / Corporate Division (according to the quarterly rota).

7. Frequency of Meetings

The meetings will be held on a monthly basis. The chair may at any time convene additional meetings of the Group to consider business that requires urgent attention.

8. Administrative Arrangements

The FRG will be supported by a member of the Finance & Commercial Development Division.

9. Review / Effectiveness

The FRG will undertake an annual review of its performance against its duties in order to evaluate its effectiveness.

Date 29.06.18

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

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NHS
Warrington and Halton Hospitals
NHS Foundation Trust

FINANCIAL RESOURCES GROUP
Monday 17th September 2018, 3:00pm – 5:00pm
Trust Conference Room

AGENDA ITEM OFM/18/	AGENDA ITEM	OBJECTIVE/DESIRED OUTCOME	PROCESS	PRESENTER	Time
OFM/18/001	Welcome and Opening Comments • Apologies • Terms of Reference • Declarations of Interest			Chair	15:00
OFM/18/002	Notes of previous meeting	***For assurance***	***Minutes***		15:05
OFM/18/003	Action Log • Matters arising	***For assurance***	***Action Log***		15:10
OFM/18/004	Trustwide Financial Position • Income and Expenditure Position • CIP in year and recurrent • Forecast outturn	***For info/update***	***Report***		15:20
OFM/18/005	Clinical Business Unit / Divisional Review • Activity and Income Performance including key variances • Expenditure Position including key variances • CIP in year and recurrent • Key risks • Mitigation Plans • Forecast outturn	***For info/update***	***Report /Presentation***	CBU Management Teams with Finance Business Partners	15:30
OFM/18/006	Productivity & Efficiency • Model Hospital • Theatres • Outpatients • Beds • Other Clinical Metrics	***For info/update***	***Report /Presentation***	CBU Management Teams with Finance Business Partners	16:00
OFM/18/007	Commercial Development update	***For info/update***	***Report***	Commercial Development Team	16:20
OFM/18/008	Procurement update	***For info/update***	***Report***	Procurement Team	16:30
OFM/18/009	Service Line Reporting / Patient Level Costing update (quarterly when available)	***For info/update***	***Presentation***	SLR Team	16:40
OFM/18/010	Meeting review – what went well, what could be improved	***For assurance***	***Verbal***		16:50
OFM/18/011	Any Other Business	***For info/update***	***Verbal***		16:55

Date and time of next meeting:
TBC
Trust Conference Room

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

2018 Meeting Schedule

Date	Time
Mon 22nd Oct	3pm – 5pm
Mon 19th Nov	3pm – 5pm
Mon 17th Dec	3pm – 5pm

All meetings will take place in the Trust Conference Room.

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

COUNCIL OF GOVERNORS – CYCLE OF BUSINESS APRIL 2018 – MARCH 2019

	Lead	17.5.2018	16.8.2018	15.11.2018	2019	14.2.2019
Formal Business						
Chairman's Opening Remarks & Welcome	Chairman	X	X	X		X
Apologies & Declarations of Interest	Chairman	X	X	X		X
Minutes of Previous Meeting	Chairman	X	X	X		X
Action Log	Chairman	X	X	X		X
GOVERNOR BUSINESS						
Lead Governor Update	Lead Governor	X	X	X		X
Items Requested by Governors	Lead Governor	X	X	X		X
Annual Appraisal of Non-Executive Directors	Lead Governor	X				
Annual Appraisal of Trust Chairman	Lead Governor		X			
GNARC Ratification of NED Appointment (as required)	Lead Governor					
Chairs Report - Quality in Care Group	Chair QiC	X		X		X
Chairs Report - Governor Engagement Group	Chair GEG	X	X	X		
Governor Engagement Group Terms of Reference & Cycle of Business	Chair GEG	X	X			
Governor Quality in Care Group Terms of Reference & Cycle of Business	Chair QiC		X			
TRUST BUSINESS						
Chief Executives Report including Integrated Performance Report	CEO	X	X	X		X
Chairman's Briefing (report from work of NEDS)	Chairman	X	X	X		X
Trust Operational Plan	DoF	X				
Annual Reports + Accounts including Auditors Letter and Report on Quality Account	Auditors		X			
Quality Strategy	Dir Int Gov+Quality		X			
GOVERNANCE						
Council of Governors Cycle of Business + ToR	HCA	X				
Appointment of External Auditors (every three years next due October 2019)	HCA					
Compliance Trust Provider Licence (bi-annually)	HCA		X			
Elections Activity Bi-Annual Report : Vacancies & Governors Terms of Office (as required) June 2018	HCA		X			
Changes to the Constitution(as required)	HCA					
Governor Training & Development Programme (1) New Governor Induction Verbal report	HCA		X			
Governor Training & Development Programme (2) MIAA courses – as available	HCA					
Audit Committee Chairs Annual Report	Chair Audit Cte		X			
Workforce Race Equality Standard (WRES) Update (legislative requirement) bi-annual	WRES Lead	X		X		
Lead Governor role (every two years – next due January 2019)	HCA			X		
OTHER BUSINESS / CLOSING						
Annual Members Day + Annual Members Meeting: 13 September 2018 **(must be before December each year)**	**HCA**					

Date: DRAFT May 2018 V1.1

Approved: CoG 17 May 2018 Review Date: 12 months from approval date

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TERMS OF REFERENCE OF THE COUNCIL OF GOVERNORS

COUNCIL OF GOVERNORS (COG)

Approved by the Council of Governors on 17 May 2018

Council of Governors - Terms of Reference

1. PURPOSE

The role of the Council of Governors is derived from Schedule 7 and other sections of the National Health Service Act 2006 as amended by the Health & Social Care Act 2012. This document should be read in conjunction with the act.

2. GENERAL DUTIES

The general duties of the Council of Governors are:

- To hold the non-executive directors individually and collectively to account for the performance of the Board of Directors
- To represent the interests of the members of the Trust as a whole and the interests of the public

3. STANDING

The full meeting of the Council of Governors and its Nomination & Remuneration Committee are the bodies in which Governors have official standing. All other forums are advisory.

4. MEMBERSHIP

The composition of the membership of the Council of Governors is set out in the Constitution. The Chair of the Board of Directors is the Chair of the Council of Governors and presides over meetings of the Council of Governors. In the absence of the Chair, the Senior Independent Director will take the Chair.

5. **QUORUM**

The quorum for the Council of Governors is set out in the Constitution and states that 'No business shall be transacted at a meeting of the Council of Governors unless at least one third of all the members are present, at least five of which are elected Governors, are present.

If a Governor has been disqualified from participating in the discussion on any matter and from voting on any resolution by reason of a declaration of a conflict of interest she/he will no longer count towards quorum.

6. COUNCIL OF GOVERNORS COMMITTEES

The Council of Governors will establish the following committees:

- Nomination & Remuneration Committee
- Quality in Care and Governors' Engagement Group
- Such other committees as may be required from time to time
- Task & Finish Working Groups as necessary

7. THE ROLE OF THE COUNCIL OF GOVERNORS

Non-Executive Directors; Chief Executive and the Auditors

- Approve the policies and procedures for the appointment and where necessary for the removal of the Chair of the Board of Directors and non-executive directors of the Trust Board on the recommendation of the Council of Governor's Nomination & Remuneration Committee.
- Approve the appointment or removal of a Chair of the Board on the recommendation of the Council of Governor's Nomination & Remuneration Committee
- Approve the appointment or removal of a non-executive director on the recommendation of the Council of Governor's Nomination & Remuneration Committee
- Approve the policies and procedures for the annual appraisal of the Chair of the Board of Directors and non-executive directors of the Trust Board on the recommendation of the Council of Governor's Nomination & Remuneration Committee
- Approve changes to the remuneration, allowances and other terms of office for the Chair of the Board and other non-executive directors on the recommendation of the Council of Governor's Nomination & Remuneration Committee
- Approve or where appropriate, decline to approve the appointment of a proposed candidate as Chief Executive recommended by the non-executive directors
- Approve the criteria for appointing, re-appointing or removing the Auditor
- Approve the appointment or re-appointment and the terms of engagement of the Auditor on the recommendation of the Audit Committee

Constitution and Compliance

- Jointly approve with the Board of Directors amendments to the Constitution, subject to any changes in respect of the powers, duties or role of the Council of Governors being ratified at the next general meeting of members (at which a member of the Council of Governors needs to present the change.)
- Notify Monitor, via the Lead Governor, if the Council of Governors is concerned that the Trust is breaching its Licence if these concerns cannot be resolved at the local level.

Governors

- Approve the allocation of Governors to sub-groups of the Council of Governors, working groups and any joint working groups set up by the Board of Directors.
- Approve the appointment and the role of the Lead Governor.
- Receive quarterly reports from the Chairs of the Council of Governors sub-groups in the discharge of the sub-groups' duties
- Approve the removal from office of a Governor in accordance with procedure set out in the Constitution.
- Approve jointly with the Board of Directors the procedure for the resolution of disputes and concerns between the Board of Directors and the Council of Governors.

Strategy, Planning, Reorganisations

- Provide feedback on the development of the strategic direction of the Trust to the Board of Directors as appropriate.
- Contribute to the development of stakeholder strategies, including member engagement strategies.
- Act as a critical partner to the Board of Directors in the development of the forward plan.

- Where the forward plan contains a proposal that the Trust will carry on an activity other than the provision of goods and services for the purposes of the NHS in England, determine whether the proposal will interfere or not in the fulfilment by the Trust of its principal purpose (the provision of goods and services for the purposes of the health service in England). Notify the board of its determination.
  Approve or not approve increases to the proposed amount of income derived from the provision of goods and services other than for the purpose of the NHS in England where such an increase is greater than 5% of the total income of the trust.
- Approve or not approve proposals from the Board of Directors for mergers, acquisitions, separations and dissolutions. More than half of the total number of Governors needs to approve such a proposal.
- Approve or not approve proposals for significant transactions where defined in the Constitution or such other transactions as the Board may submit for the approval of Governors from time to time. Such transactions require the approval of more than half of Governors voting at a quorate meeting of the Council of Governors.

Representing Members and the Public

- Approve the membership engagement strategy.
- Contribute to members' and other stakeholders' understanding of the work of the trust in line with engagement and communication strategies.
- Seek the views of stakeholders, including members and the public and feedback relevant information to the Board of Directors or to individual managers within the Trust as appropriate.
- Act as ambassadors in order to raise the profile of the Trust's work with the public and other stakeholders.
- Promote membership of the Trust and contribute to opportunities to recruit members in accordance with the membership strategy.
- Attend events during the year that facilitate contact between members, the public and Governors to promote Governor accountability
- Report to members each year on the performance of the Council of Governors.

Holding the Non-Executive Directors to Account

- The Council of Governors must hold the non-executive directors individually and collectively to account for the performance of the board. It must agree a process and dialogue with the board that will enable them to fulfil this duty.
- As part of this a good working relationship between the Board of Directors and Council of Governors is critical; it can be fostered by meeting regularly and with sufficient frequency to establish appropriate channels of communication and constructive challenge.

Some of the following may support this process and dialogue:

- Receive the agenda of the meetings of the Board of Directors before the meeting takes place.

- Be equipped by the trust with the skills and knowledge they require in their capacity as governors.
- Receive the annual report of the audit committee on the work, fees and performance of the auditor.
- Receive the annual report and accounts (including quality accounts).
- Receive the quarterly report of the board of directors on the performance of the foundation trust against agreed key financial, operational, quality and regulatory compliance indicators and stated objectives.
- Participate in opportunities to review services and environments such as PLACE inspections/quality reviews/ local activities and evaluation of user/carer experience.
- Receive and review quarterly assurance reports.
- Receive reports from the board on important sectoral or strategic issues.
- Use information obtained through the above sources to monitor performance and progress against the key milestones in the strategic and annual plans and to hold the non-executive directors to account for the performance of the board of directors.
- If considered necessary (as a last resort), in the fulfilment of this duty, obtain information about the Trust's performance or the directors' performance by requiring one or more directors to attend a Council of Governor meeting

8. COLLECTIVE EVALUATION OF PERFORMANCE

The Council of Governors will carry out an annual review of its effectiveness and efficiency in the discharge of its responsibilities and achievement of its objectives.

9. FREQUENCY OF MEETINGS

The Council of Governors will meet 4 times per year. Members are expected to attend all meetings of the Council and of committees of which they are a member, or give timely apologies if absence is unavoidable.

10. MINUTES

The Council of Governors will be supported by the Head of Corporate Affairs and the Secretary to the Trust Board who will agree the agenda with the Chair and produce all necessary papers. Minutes will be circulated promptly to all members as soon as reasonably practical.

11. REVIEW

The Council of Governors will review these Terms of Reference annually.

TERMS OF REFERENCE REVISION TRACKER

Name of Committee	Council of Governors
Version	V3
Implementation Date	
Review Date	17 May 2018
Approved By	Council Of Governors

REVISION			
Date	**Section**	**Reason for Change**	**Approved By**
19.1.17	5	Changes to section 5 for clarity on quorum – item as described in the Trust's Constitution	CoG 19.1.2017
19.1.17	6	To include the named Committees established as Quality in Care and Governors Engagement Group	CoG 19.1.2017
19.1.17	10	The Council of Governors will be supported by the Secretary to the Trust Board.	CoG 19.1.2017
17.05.18	9	Changes to section 9 to provide clarity on the expectations relating to attendance.	CoG 17.5.2018
17.05.18	10	The Council of Governors will also be supported by the Head of Corporate Affairs.	CoG 17.5.2018

TERMS OF REFERENCE OBSOLETE		
Date	**Reason**	**Approved By**