We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

WHH Board of Directors Meeting Part 1

Wednesday 30 January 2019
9.30am-12.30pm
Trust Conference Room

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

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

Wednesday 30 January 2019 time 9.30am -12.30pm

Trust Conference Room, Warrington Hospital

REF BM/19	ITEM	PRESENTER	PURPOSE	TIME	
	Patient Story			**9.30**	
	Medicines Safety – Conclusion of Stanford University Project – Anne Robinson, Associate Medical Director Patient Safety		**Presentation**	**9.45**	**PPT**
BM/19/01/01	**Welcome, Apologies & Declarations of Interest**	**Steve McGuirk, Chairman**	**N/A**	**10.00**	**Verbal**
BM/19/01/02 PAGE 4	**Minutes of the previous meeting held on 28 November 2018**	**Steve McGuirk, Chairman**	**Decision**	**10:02**	**Encl**
BM/19/1/03 PAGE 14	**Actions & Matters Arising**	**Steve McGuirk, Chairman**	**Assurance**	**10:05**	**Encl**
BM/19/01/04 PAGE 28	**Chief Executive's Report** **- NHS Provider Chair and CEO correspondence** **- Summary of NHS Providers Board papers**	**Mel Pickup, Chief Executive**	**Assurance**	**10:10**	**Verbal**
BM/19/01/05	**Chairman's Report**	**Steve McGuirk, Chairman**	**Information**	**10:25**	**Verbal**

Quality People Sustainability

BM/19/01/06 PAGE 34	**Integrated Performance Dashboard M9 (to follow) and Assurance Committee Reports**	**All Executive Directors**	**Assurance**	**10.30**	**Enc**
(a) PAGE 75	**Quality Dashboard incl:** **- Monthly Nurse Staffing report (November, December)**				**Enc**
(b) PAGE 92	**- Key Issues report Quality and Assurance Committee (8.01.2019)**	**Margaret Bamforth, Committee Chair**			**Enc**
(c) PAGE 95	**People Dashboard** **- Key Issues Strategic People Committee 23.01.2019 (to follow)**	**Anita Wainwright Committee Chair**			**Enc**
(d) PAGE 98	**Sustainability Dashboard** **- Key Issues Finance and Sustainability Committee (19.12.2018 + 17.01.2019)**	**Terry Atherton, Committee Chair**			**Enc**
(e) PAGE 101	**- Key Issues Audit Committee (22.11.2018)**	**Ian Jones, Committee Chair**			**Enc**

Quality

BM/19/01 07 PAGE 105	**CQC Action Plan Report**	**Kimberley Salmon-Jamieson Chief Nurse**	**Assurance**	**11.05**	**Enc**

Sustainability

BM/19/01/08 PAGE 112	Quarterly Progress on Carter Recommendtions + Use of Resources Assessment	Andrea McGee Director of Finance + Commercial Development	Assurance	11.15	Enc
BM/19/01/09 PAGE 154	EPRR confirmation of compliance across all areas	Chris Evans Chief Operating Officer	Assurance	11.25	Enc

People

BM/19/01/10 PAGE 162	FTSU Bi-Annual Report	Kimberley Salmon-Jamieson Chief Nurse	Assurance	11.30	Enc
BM/19/01/11 PAGE 167	Guardian of Safe Working Q3 Report	Alex Crowe Medical Director	Assurance	11.35	Enc

GOVERNANCE

BM/19/01/12 PAGE 181	Board Assurance Framework Update	John Culshaw Head of Corporate Affairs	Assurance	11.45	Enc
BM/19/01/13 PAGE 191	Clinical Strategy	Alex Crowe Medical Director Lucy Gardner Director of Strategy	Approval	11.55	Enc
BM/19/01/14	NHS 10 Year Plan	Lucy Gardner Director of Strategy	Assurance	12.00	PPT
BM/19/01/15 PAGE 220	SORD/SFIs – approval following full revision	Simon Constable Executive Medical Director/ Deputy Chief Executive	Approval	12.05	Enc
BM/19/01/16 PAGE 224	EU Exit Readiness Guidance	Chris Evans Chief Operating Officer	Assurance	12.15	Enc

BM/19/01/17	Any Other Business	Steve McGuirk, Chairman	N/A	12.20	Verbal
	Date of next meeting: 27 March 2019				

Warrington and Halton Hospitals NHS Foundation Trust
Minutes of the Board of Directors meeting held in Public (Part 1) on Wednesday 28 November 2018
Trust Conference Room, Warrington Hospital

Present	
Steve McGuirk (SMcG)	Chairman
Mel Pickup (MP)	Chief Executive
Terry Atherton (TA)	Deputy Chair, Non-Executive Director
Margaret Bamforth (MB)	Non-Executive Director
Simon Constable (SC)	Executive Medical Director/ Deputy Chief Executive
Chris Evans (CE)	Chief Operating Officer
Jean-Noel Ezingeard (JNE)	Non-Executive Director
Ian Jones (IJ)	Non-Executive Director / Senior Independent Director
Andrea McGee (AMcG)	Director of Finance and Commercial Development
Kimberley Salmon-Jamieson (KSJ)	Chief Nurse
Anita Wainwright (AW)	Non-Executive Director
In Attendance	
Michelle Cloney (MC)	Director of HR + OD
Alex Crowe (AC)	Medical Director and Chief Clinical Information Officer
John Culshaw (JC)	Head of Corporate Affairs
Lucy Gardner	Director of Strategy
Pat McLaren (PMcL)	Director of Community Engagement
Julie Burke (JB)	Secretary to Trust Board (Minutes)
Rachael Browning (RB)	Associate Chief Nurse Clinical Effectiveness (Ward Accreditation presentation)
Beverley Caine (BC)	Ward Manager B4 Halton (Ward Accreditation presentation)
Carol McEvoy (CMcE)	Ward Manager A4 Warrington (Ward Accreditation presentation)
Ursula Martin (UM)	Director of Integrated Governance and Quality
Observing	
Norman Holding	Public Governor
Alison Kinross	Public Governor
Kenneth Roberts	
Phillip James	WH Joint Chief Information Officer (to commence 3.12.2018)

BM/18/11/	**Presentation** Rachael Browning gave an overview of the Ward Accreditation Programme which had commenced in May 2018 led by the Senior Nursing Team. Sixteen wards out of 30 had been accredited to date, 8 achieving Silver Status, 7 Bronze Status and one Ward to be reassess today. AW asked if CQC action plan is aligned with the Programme. KSJ explained that the metrics are aligned with each domain of the CQC action plan providing a framework for Wards to feedback to CBUs. IJ asked regarding the process to move from Silver to Gold. CMcE explained Wards review their action plan, identifying requirements to achieve the next standard. 12 month's data is required to support achievement Gold Accreditation. SMcG commented the Programme provides a consistent framework to drive quality, safety and transformational change with evidence of correlation and triangulation of information from Governor Observational Visits and the Complaints Quality Assurance Group Following concerns raised during a Governor visit, a follow-up visit demonstrated an improvement

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	across a range of areas. SMcG asked if the level of variation on Wards was comparable to other Trusts with a similar Programme. KSJ explained variation is 30-40% and Mid-Cheshire are using WHH version of the Programme.
BM/18/11/102	**Welcome, Apologies & Declarations of Interest** The Chair opened the meeting, and introductions were made. Declarations of Interest: None were noted
BM/18/11/103	**Minutes of the meeting held 26 September 2018** Pg 3 Falls – 2nd point to read …. Some patients do require this level of enhanced care … Pg 5 FSC Chairs report, 2nd point to read, .. change in portfolio responsibility for CIP reporting to the DoF. Pg 5 RCS Spinal Services Report – amend to read the RCS summary of the RCS report had been shared at the Annual Members meeting. Pg 6 CQC Report – amend action to read. Some elements of CQC will link to LiA to address part of CQC recommendations, ie engagement element. With these amendments, Minutes of 26 September 2018 were agreed as an accurate record.
BM/18/11/104	**Actions and Matters Arising** Action log and rolling actions were noted.
BM/18/11/105	**Chief Executive's report** CEO provided an update on matters for the Board to note since the last meeting. NHSI – feedback had been received following the Trust QRM meeting on 15 October, since the meeting the Trust second highest in the country for take up on the flu vaccination. Brexit – led by the COO the Trust continue to put processes and preparedness plans in place, work is progressing by Procurement and Pharmacy team as the 2 areas of principle risk. In relation to Settled Status no concerns highlighted relating to staff leaving the Trust as a result. Regarding the proposal to include a risk related to Brexit on the Risk Register, SMcG asked if the rating of 16 was adequate. JC explained risk will be reviewed by the Risk Review Group in December followed by a proposal to Quality Assurance Committee and Trust Board in January for approval, TA added FSC had also requested this be included on the Risk Register. NHS Provider Board Papers – Summary of Board papers noted A third formal meeting had taken place to further discuss the ambition for a new fit for purpose hospital, led by Director of Strategy with Commissioners and local authority colleagues and councillors, supporting the ambition which is now part of the local borough plan consultation, to be published in the Spring. A joint funded post with partners supported to progress an outline business case over the next 12-18 months. Any proposal or process regarding a decision and location will be subject to public consultation. Regular updates are provided to the Health Scrutiny Committee and Health and WellBeing Board. Work continues with Warrington Together Board to define new models of care to inform how the Trust can become an integrated care provider and a design event for stakeholders is to be held early in the New Year. In relation to Halton Healthy New Town and the Health and WellBeing Campus, the CEO explained that the outcome of the latest Wave 4 for DoH capital funding to support a move from planning to design stage, is now anticipated to be early-mid December.

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	The Chair and CEO had attended a meeting with counter-parts from Clatterbridge Cancer Centre (CCC) to explore future potential collaborative relationships. The Trust had delivered a presentation to Commissioners and Clatterbridge Hospital Trust colleagues regarding collaborative working as part of the Eastern Sector Cancer Hub to meet the needs of local patients, seeing some facilities consolidated to one location while still providing some less complex services locally, ie Halton for Chemotherapy services. A formal process for consultation in Spring 2019 will be shared when finalised. The Trust presented a strong strategic case to support provision of such services at Halton Health Campus. The CEO will report progress to the Board and Council of Governors. TA asked if and how changes would affect current patient flow ie from Chester to the Christie. MP assured the Board there will be opportunity for Providers to challenge any proposed changes as the Chief Officer of Knowsley CCG at the System Management Board on 27.11.2018 had shared that all patient flows will be modelled. MP referred to the impending winter period and A&E challenges. Winter plans are in place to support patients for speedy discharge to home. CEO was pleased to report that the newly opened Discharge Lounge has created a permanent facility supporting patient flow. In addition, the Frailty Assessment Unit will support improved patient flow with additional funds to support growth. The Trust is exploring outreach of some services to identify patients who may be able to be accepted earlier in the pathway, avoiding admissions and ensure treatment in the correct care setting. CEO referred to a Capacity and Demand exercise that had been undertaken looking at bed base required, headline figures indicate a shortfall of 100 beds on any given day, impacting on elective capacity and WHH patients if beds are not provided elsewhere, correlating with growth required as part of the NHS long term plan of 34,000 additional beds in the system. SMcG challenged refurbishment of estate and MP and KSJ commented a fine balance is required as current estate needs to be maintained at a standard to maintain delivery of safe care until a new hospital is approved. In relation to nursing care, KSJ added requirements are not just a refurbishment exercise as there are limits to stock/estate available, particularly in provision of side rooms.
BM/18/11/106	**Chairman's Report** The Chairman explained that future minutes will highlight instances of challenge/resolution.
BM/18/11/107 (a)	**IPR Dashboard** Quality measures. The Chief Nurse provided an overview of Quality KPIs in month drawing particular attention to areas of variation in performance relating to Incidents, Safety Thermometer, Infection Control, Healthcare Acquired Infections (CDif), VTE, Falls, SEPSIS, Friends and Family Test and MSA. In relation to the Falls Collaborative, AW asked how soon outcomes will be known, how many Trusts are involved and how improvements will be shared. KSJ explained there are 3 Collaboratives to be set up including reduction in pressure ulcers and reduction of GNBSI safety collaborative, these are small tests of change using Quality Improvement metric to pilot areas, what has worked well and where improvements have worked and scaling up, ie shift patterns, environmental issues. Sharing of improvements will be through a formal

framework, a 90 day cycle culminating in March.

KSJ provided reassurance on weekly monitoring by advising the Board that a weekly Infection Control meeting had now been established, Chaired by KSJ to oversee RCAs related to Infection Control.
MP noted suggestion of weekly meetings due to infection control issues and asked as room issue cannot be fixed is an alternative strategy in place, noting 2 emerging risks on the risk register relating to infection control.
KSJ explained some environmental issues and some issues related to the taking of samples too late, however reassured the Board that she will have direct oversight at weekly meetings to expedite change and improvement.

KSJ advised that there has been a slight rise in Gram Negative Blood Stream infection when MB expressed disappointment referring to increase in CDif hospital acquired infections and if this is reflected with community acquired infections.

KSJ explained a number of environmental issues relating to hygiene, sinks and floors had been identified through Ward and Estate walkround, correlating with the rise in infections on specific wards. KSJ reassured the Board that a prioritised list of works has been agreed with herself and the COO. SMcG and NH both commented that these issues correlate with information received from Governor Observational visits

Referring to MSA, MB referred to the new pathway for escalation and how CQC will review the process is being followed. KSJ explained there needs to be a fine balance, with Silver Command being aware of which patients who can be stepped down from ICU through a clear escalation process with any issues escalated directly to herself and/or the COO. In relation to Discharge Lounge, KSJ reassured MB there is no risk of exacerbating occurrences of MSA.

Monthly Safe-staffing report. There were no matters to escalate to the Board. The Board were asked to note the increase in care hours per patient day in July/Aug/Sept to 7.1, overall change to 6.9. Improvement triangulates with care hour per patient day.

MP referred to consequence of increase in agency spend, understanding difficulty to recruit to RNs but carrying HCA vacancies which are being filled on a temporary basis.
KSJ explained of the 70 HCSW posts identified in the recent establishment case, 40 appointed and 40 applications received following a recent recruitment and exploring opportunities to retrain other staff groups to support future workforce planning.

In relation to complaints JNE asked if trends continue in the right direction and if improvement is fast enough. KSJ explained there has been significant improvement in the last 12 months, with a reduction in the number of complaints being received by the Trust and a low number of PHSO complaints. SMcG echoed the improvement and comparable position when compared with similar Trusts.

JNE asked how safe staffing is monitored and mitigating actions to address gaps. KSJ explained that staffing is managed operationally, reviewed hourly, recruitment and retention is managed through the Recruitment and Retention Group to inform workforce planning.

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BM/18/11/107 (b)	Quality Assurance Committee (QAC) Chair Key Issues Report 6 November The Key Issues Report was taken as read. One matter escalated from the Chair related to End of Life Steering Group to report to QAC for oversight of progress against improvement plans. QAC aware of some issues relating to accurate reporting of DNACPR, however improved documented evidence in place of where conversations had taken place. Appointment of additional Consultant support and 24/7 advice to provide further support for other staff who look after this cohort of patients. An External Review Panel concurred with the Trust grading of 18 of 20 cases following an internal peri-natal review into 20 cases over an 18 month period. QAC to receive a detailed action plan in January. • **The Board noted the Quality update and Safe Staffing report.** Access and Performance measures. The Chief Operating Officer provided an overview of KPIs in month including A&E, RTT, Cancer, Stranded and Superstranded patients, Diagnostics, Ambulance Handovers, Discharge Summaries within 24 hours, Cancelled Operations. The Trust had achieved all performance standards with the exception of the emergency access standard. In response to query raised by MB relating to ways to improve timely discharge summaries being completed, CE explained the SOP had been reviewed which will ensure CBU direct ownership coupled with enhanced performance reporting to support monitoring of this standard and continued improvement. AC explained that discharge letters are now available electronically to support timely population of letters. In response to question raised by SMcG relating to spike in cancelled operations in month, CE explained that all cancellations had had an RCA undertaken to understand root causes, early indications being overrunning of theatre and priority for trauma patients. SMcG further queried if CE was confirming that the review would help resolve increasing trend, which was confirmed. Workforce measures. The Director of HR & OD provided an overview of KPIs in month: Pay spend monitoring continues at FSC, with continued reporting of bank utilisation to NHSI. Sickness absence – pilot launched with direct individual Senior Nurse support for staff reporting absence. Evaluation underway, outcomes to be reported to Strategic People Committee. Robust monitoring of absence will support improvement in agency spend. Early indications, 2 key areas of absence are mental health and MSK issues. Improvement in these areas will be supported by LiA and Mental Health First Aid Programme. Flu campaign - 2nd highest Trust in C&M and 9th nationally for up-take of the vaccine. National Staff Survey – underway, overall response rate 47%. SMcG challenged the data indicating WHH consistently above the NW average for absence and what processes are in place to reduce Trust agency spend, why the sickness absence is only a Pilot. MC explained this is comparable within C&M. The Pilot within Nursing and LiA initiatives will support a decrease in agency spend but a full infrastructure would need to be developed to establish an individualised sickness absence support mechanism.

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	KSJ added that the pilot has been extended as anticipated benefits had not been realised and had only included Wards from a Nursing perspective. MP referred to the correlation of absence with holiday periods and any direct link with impact on activity due to the number of staff working during these periods. • **MP proposed a deep dive into working patterns related to agency expenditure and holiday periods, this was supported by AW and SMcG.** <u>Strategic People Committee Key Issues Report 21 November 2018.</u> Key Issues report was taken as read. Chair of SPC explained the Committee had received a comprehensive update relating to the success of Preceptorship Scheme. The Chair escalated one matter relating to the HENW/GMC visit in June and subsequent enhanced monitoring for the Trust. However a 'trigger' visit in November reported significant improvement and progression in a number of areas. AC added that as progress had been made, HENW will not be re-visiting for 12 months. SPC had asked for the risk to be reviewed by the Risk Review Group for any impact on a CQC follow-up visit.
BM/18/09/84 (d)	SMcG and AW asked if enhanced monitoring status would adversely impact on CQC follow-up inspection rating. SC advised there had been no change since the last CQC visit and that some Trusts in enhanced monitoring have achieved 'Good' CQC rating. <u>Finance and Sustainability measures</u>. The Director of Finance + Commercial Development provided an overview of KPIs highlighting variation in performance, including deficit position, performance, CIP, and on-going financial challenges.
BM/18/09/84 (d)	• AMcG highlighted the proposed changes to the Capital Programme to meet additional requirements informed by the CQC action plan, PLACE inspections and the Ward Accreditation Programme. The Chief Nurse and COO had undertaken a prioritisation exercise. Further review of the Capital Programme identified some slippage which with the remaining CQC allocation of £490k has meant that costs can be accommodated in this financial year. This approach was supported by FSC on 21.11.2018 for approval. • Cash remains a challenge, the Trust had received a holding statement in October from the DoH extending loan period of a 2015-16 loan of £14.2m from a repayment date in May 2018 to 19.11.2018. Final confirmation for further extension is still awaited. SMcG asked if the current position had been reported at the QRM meeting in October. AMcG explained that whilst the current position was not available for that meeting, the Trust is in line with other C&M providers and that NHSI continue to be kept informed of the Trust financial position. • **The Board noted the report and approved changes to the 2018-19 Capital Programme.** <u>Finance and Sustainability Chairs Key Issues Report - 24.10.2018 + 21.11.2018</u> Chair of FSC explained that key issues had been discussed in detail earlier today, echoing the significant progress to achieve the mandatory performance standards. - Financial position discussed at length, in particular the increase in agency spend, progress to close the shortfall in the CIP plan noted; the Committee had received a comprehensive Estates presentation, highlighting £16m backlog maintenance across both sites. - Significant progress to develop the SLR reporting system, now informing future

	opportunities for strategic/service reviews, investment and procurement opportunities. - One matter to be escalated to Part 2 of the Board relating to a Debtor position. • **The Board noted the October and November Key Issues Report.** Audit Committee Key Issues report from 22.11.2018 to be deferred to January.
BM/18/11/108	**RCS Spinal Services Update** The Executive Medical reported that Spinal Services remain suspended at WHH. He and the CEO had attended C&M Spinal Services Network continuing discussions for the vision and future strategy for a single spinal surgery service for the region, with the intention of keeping access for patients as local as possible with 2 work-streams, one for specialist spinal trauma and one for complex deformity and cancer work. We are working with the Royal Liverpool University Hospital on honorary contractual relationships for our two remaining spinal surgeons, working at RLBUHT to work within the NHS maintaining their expertise. Four Index cases had been identified in the Spinal Services Suspension in 2017. Three additional SIs were declared relating to historical cases back as far as 2014. These had now been concluded, resulting in 7 SIs in total. Full dialogue and engagement continues with the affect patients and/or families. • **The Board noted the report.**
BM/18/11/109	**Learning from Experience Summary Report** The report had been discussed in detail at the Quality Assurance Committee on 6 November, the Chief Nurse asked to note the actions relating to escalated matters. SMcG noted the improvement in customer care and correlation with feedback from Governor Observation Visits and Ward Accreditation Programme. • **The Board noted the update report.**
BM/18/11/110	**DIPC Quarterly Report** The report had been discussed in detail at the Quality Assurance Committee on 6 November and earlier in the Board, the Chief Nurse highlighted work with finance and IT colleagues to ensure correct software in place for the surveillance system to track patients. • **The Board noted the update report.**
BM/18/11/111	**CQC Update Progress Report** The Chief Nurse highlighted key points for the Board to note on progress: - 80% of the action plan had been delivered and is compliant. 72% of all Must Do and Should Do actions are compliant. - All training actions (16) have been merged into 1 action – which is all areas to be compliant with mandatory and core skill training. - Second round of auditing being undertaken by MIAA, auditing actions the Trust had deemed to be compliant. Final report to be reported to Executives, Getting to Good Steering Group and Audit Committee when completed in December. - Significant progress in the 5 Amber fundamental breaches with audits underway to assesses effectiveness of actions before full sign off. - Work progressing in relating to the 2 Red Regulatory breaches (Reg 12 and Reg 18). - AMcG asked for caution and accuracy when providing narrative on action plans/risk registers relating to 'lack of resources' and for a reinforced communication to staff that finances are not a barrier to improvement. DCE added the second phase of CQC communication plan will be to build and deploy a new Communication Strategy to

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	become 'outstanding'. • **The Board noted and approved the report and the assurance of progress made to date.**
BM/18/11/112	**Safeguarding Adult's Annual Report** The Annual Report had been reviewed and supported at the Quality Assurance Committee on 6 November 2018, declaring compliance with section 11 of the Children's Act. • **The Board noted and approved the Report and objectives set for 2018-19.**
BM/18/11/113	**Ward Accreditation** - Referring to the earlier presentation, the Chief Nurse explained that 25 assessments had been completed. Reassessment of the 'White' Ward taking place today, the issues identified relating to environment had already been completed. The Ward Manager Development programme continues to support staff. - SMcG recognised the work achieved to date supporting the correct culture to support staff to improve quality which will see a direct correlation with KPIs, ie Falls. • **Ward Accreditation reports to be circulated to Board members.**
BM/18/11/114	**Quality Academy** UM provided an overview of the role of the Quality Academy, its development and its implementation plan which will support effective clinical audit, development of quality improvement skills for staff to analyse data, empower staff to make change and provide opportunities with leaders in the Trust to support improvement from RI to G. The Quality Academy has 2 PAs through redesign and reinvestment within the Governance Team, 1 in Innovation and 1 in Research. The Quality Academy will provide an opportunity for income growth as well as support Well Led KLOEs. Successes included development of links with the Innovation Agency for a physical hub either off site or at WHH, the establishment of the Quality Board; working with AQuA as a partner to support implementation; tentative meetings with Manchester Metropolitan University and Chester for partnership working. Further support required includes funding for 'branded' premises and developing the Trust Library service to link with external organisations as a potential 'host'. Bids submitted for external capital funding and working with Finance Team for investment opportunities. UM explained that formal partnerships and governance arrangements will need to be sanctioned when formalised. **JNE declared an interest in Item BM/18/11/114 in his role as Deputy Vice chancellor of Manchester Metropolitan University and potential future joint working with the Trust** JNE asked that the Strategy clearly stipulates the Trust do not become a research organisation, acknowledging and supporting the positive direction to further the Trust position in R&D, particularly link with CoCH libraries and move to a shared service. • **The Board supported the direction of travel and approved the Strategy and Implementation Plan**
BM/18/11/15	**Quarterly Mortality Review Report** The report had been reviewed and recommendations approved at the November Quality Assurance Committee. The CEO challenged the relatively high number of 'Excellent' categorisation with respect to care delivered from the Structured Judgement Reviews, and if there is appropriate challenge from within the clinicians in the Mortality Review Group, proposing a deep dive on a sample of the 'Excellent' reviews.

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	The Executive Medical Director explained reviews are subjective but undertaken by trained reviewers, with all reviews peer reviewed at the Mortality Review Group which includes some external stakeholders. From Quality Assurance perspective MB commented that the process has been embraced by the Trust and data triangulates with SI and inquest data. • **The Board noted reviewed, discussed and noted the Report.** • **The Board requested an internal and external Peer Review of SJRs to be undertaken.**
BM/18/11/116	**Quarterly Progress on Carter Report, recommendations and Use of Resources Assessment** The Director of Finance + Commercial Development highlighted key points for the Board to note indicating progress in the last quarter against Carter recommendations, underpinned by Use of Resources workstream with Governance support to review data to support improvements. SMcG welcomed review of increase in red indicators with continued reporting of specific indicators to the appropriate Assurance Committee for monitoring non-compliance • **The Board noted the report. Reporting of non-compliance and assurance to be progressed via the appropriate Board Sub Committees.**
BM/18/11/117	**EPRR Assurance Report** The Chief Operating Officer highlighted key points for the Board following self-assessment against 64 core standards, achieving compliance with 54 standards and partial compliance with 10 standards. The COO reassured the Board an action plan is in place to support full compliance by the end of December. Internal business continuity plans continue to be developed for completion by the end of December. • **The Board noted the Report, noting low risk due to areas of non-compliance.** • **The Board to receive a further report providing assurance of compliance in all areas.**
BM/18/11/118	**Guardian of Safe Working Q2 Report** The Medical Director highlighted key points for the Board to note within the report- - 35 exception reports were completed, covering 58 incidents (July to September 2018) from foundation doctors, CT and ST Doctors. The previous quarter reported 27 exception reports and 33 incidents. Most exception reporting related to working past allocated hours. There were 4 immediate safety concerns (related to gaps from sickness/rota) which were dealt with promptly by CBUs. Exception reporting is being used more for time in lieu (69%). - AC acknowledged there is improvement relating to educational supervision sign off for exception reporting but still work to improve. Support had been given to Educational Supervisors from the Guardian of Safe Working (3 induction tutorials) and was a topic for Grand Round. The Junior Doctors Forum is Chaired by the Medical Director and works well. Shifts/Vacancy cover had reduced (2650 to 1300). Physician Associates, International Training Fellows have been appointed and medical rotas continue to be scrutinised in order to improve substantive trainee posts. - There were no fines imposed on the Trust. Concerted effort continues to manage rota to ensure that training and teaching is included within the rota to allow trainees to attend. MP referred to the number of vacancies for FY1 and FY2 and high number of shift requests for small level of vacancies reported. MB stressed the importance of ensuring that 'opt out' forms are in place where doctors are on bank shift so that staff are not working excess hours. • **The Board noted the Report and assurance provided and will continue to report any**

	concerns to the Guardian. • **The Board requested deep dive of shift/agency and out opt issues to be reported to SPC and FSC to provide assurance regarding financial and people elements.**
BM/18/11/120	**Strategic Risk Update** The Head of Corporate Affairs highlighted key points for the Board to note within the report - 4 new risks added relating to HCAI surveillance data, continuity of Palliative Care, adequate level of Consultant Microbiology cover, failure to attend mandatory resuscitation training. - Following review by the Risk Review Group and QAC of the Complaint risk, all actions being completed, the Board was asked to approve the removal of this risk. Risk updates noted relating to, Microbiology, Staff recruitment, Medical Devices, Brexit risk. All risks continued to be reviewed at the monthly Risk Review Group. • **The Board noted the Report and approved the updates.**
BM/18/11/121	**Changes to Scheme of Reservation and Delegation (SORD)/SFIs** The Director of Finance + Commercial Development highlighted key points for the Board following a review of Table B of the SORD to ensure it is comprehensive clear and robust. The Board was asked to support the proposed amendments and revisions made. - AMcG assured the Board that no limits had been changed, the only addition being the addition of approval level up to £5k. A comprehensive exercise to review the full SORD will be undertaken by the Board on 14.12.2018. - AMcG assured the Chairman due process is followed at all times relating to Quotations and Tenders. • **The Board noted the Report, and approved the changes to Table B, with the amendment of reference to NHS Recovery to NHS Resolution.**
BM/18/11/122	**WHH Charitable Funds Annual Report and Accounts year ending 21.3.2018** The DoF informed the Board that draft accounts and Audited accounts had been endorsed by the Charitable Funds Committee for formal approval to the Trust Board. PMcL clarified the reference in the Executive Summary should read expenditure included disbursement of funds for direct patient benefit. • **The Board approved the Charitable Funds Annual Report and Accounts.**
BM/18/11/123	**Any Other Business** The CEO confirmed the Trust had received a letter of support from University of Chester to enable to the Trust to progress with NHSI to the next phase to change the Trust name to University Hospital of Warrington and Halton.
	Next meeting to be held: Wednesday 30 January 2019

Highlighted text reflects challenge

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NHS Warrington and Halton Hospitals NHS Foundation Trust

BOARD OF DIRECTORS ACTION LOG

AGENDA REFERENCE:	BM/19/01/03	SUBJECT:	TRUST BOARD ACTION LOG	DATE OF MEETING	30 January 2019

1. ACTIONS ON AGENDA

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
BM/18/11/117	28.11.2018	EPRR	Update report to confirm compliance across all elements	**Chief Operating Officer**	30.01.0219		Paper circulated with today's papers. PB/19/01/09	
BM/18/11/107	28.11.2018	IPR Dashboard – People element	Deep dive into working patterns related to agency expenditure and holiday periods.	**Director of HR + OD**	30.01.2019		Paper circulated with today's paper. BM/19/01/03	

2. ROLLING TRACKER OF OUTSTANDING ACTIONS

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
BM/18/09/84c	26.09.2018	IPR	Forward looking actions / proposal to be taken to Executives on 8.11.2018 to incorporate a summary of mitigation actions being taken as part of the IPR from Exec Leads	**All**	28.11.2018		28.11.2018 discussed in Part 2, further changes to be made to the IPR.	
BM/18/11/118	28.11.2018	Guardian of Safe Working	Deep dive into agency usage, shift requests and opt issues to be reported to SPC and FSC to provide assurance regarding financial and people elements with update to March Board.	**Medical Director**	27.03.2019			
BM/18/11/115	28.11.2018	Mortality Review Report	Internal and External Peer review of SJRs to be undertaken	**Medical Director**	27.03.2019			
BM/18/05/34 ii	24.05.2018	HEE visit 29 June	Report following the visit on 29 June	**Medical Director**	27.03.2019		Report not yet received from HEE 26.9.2018. Report still awaited. Defer to November. 12.11.2018. Defer to January 14.01.2019 . Report not received, defer to March.	
BM/18/07/57		Junior Doctor Update/Trainee Engagement (Trello)	6 mth progress/update presentation.	**Medical Director**	27.03.2019		14.01.2019. Deferred to March	

3. ACTIONS COMPLETED AND CLOSED SINCE LAST MEETING

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

RAG Key

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

We are WHH

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/19/01/03 I (Action BM18/11/107)**
SUBJECT:	**Sickness Absence**
DATE OF MEETING:	30 January 2019
ACTION REQUIRED	Trust Board are asked to note the findings of the deep dive review and to support the proposed actions.
AUTHOR(S):	Deborah Smith, Deputy Director of HR and OD
EXECUTIVE DIRECTOR SPONSOR:	Choose an item. Choose an item.
LINK TO STRATEGIC OBJECTIVES:	All
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	BAF2.5: Right People, Right Skills in Workforce
	Choose an item.
	Choose an item.
STRATEGIC CONTEXT	
EXECUTIVE SUMMARY (KEY ISSUES):	In November 2018 Trust Board requested a 'deep dive review', to consider what immediate operational actions can be taken to improve attendance. The HR and OD Directorate have undertaken this review in December 2018 and the finding and associated actions are presented in this paper. The review has focused on operational controls and management of sickness absence rather than our strategic approach to the Health and Wellbeing of our workforce, which is detailed in People Strategy and monitored via Operational People Committee and Strategic People Committee. As part of the deep dive review the HR and OD team have undertaken analysis and benchmarking of the Trust sickness absence data, a best practice review and a review of absence rates, processes and initiatives in Peer Group organisations. This exercise was undertaken in December 2018 therefore the information in this paper is based on November 2018 data. The information collated throughout this review has been analysed and an action plan produced to

	support increased control and management of sickness absence across the Trust. This action plan is in addition to the current operational processes in place. Appendix 1.	
RECOMMENDATION:	Trust Board are asked to note the findings of the deep dive review and to support the proposed actions.	
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	

We are WHH

SUBJECT	Sickness Absence	AGENDA REF:	BM/19/01/03i (ActionBM18/11/107)

1. BACKGROUND/CONTEXT

Trust sickness absence rates in October 2018 were 4.93% against a target of 4.2%. Sickness absence has been above target for the past 12 months.

This data was presented to Trust Board in November 2018. Trust Board requested a 'deep dive review', to consider what immediate operational actions can be taken to improve attendance. The HR and OD Directorate have undertaken this review in December 2018 and the finding and associated actions are presented in this paper.

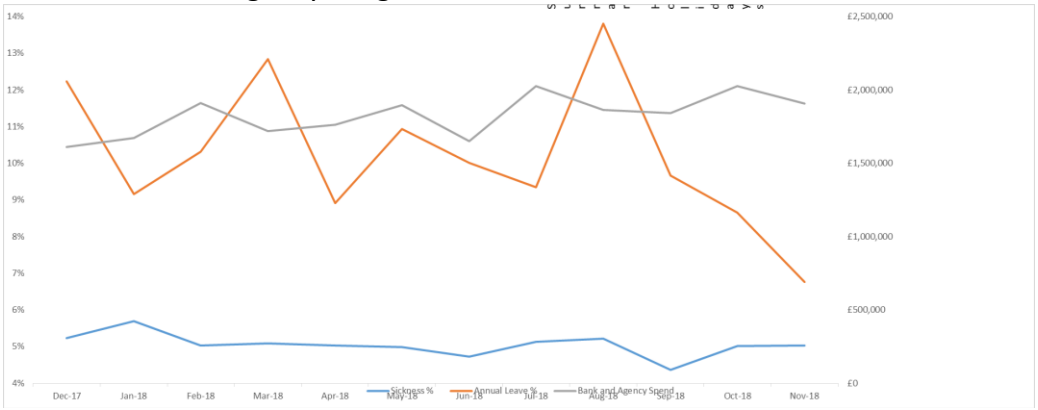
The review has focused on operational controls and management of sickness absence rather than our strategic approach to the Health and Wellbeing of our workforce, which is detailed in People Strategy and monitored via Operational People Committee and Strategic People Committee.

As part of the deep dive review the HR and OD team have undertaken analysis and benchmarking of the Trust sickness absence data, a best practice review and a review of absence rates, processes and initiatives in Peer Group organisations. This exercise was undertaken in December 2018 therefore the information in this paper includes sickness absence data up to November 2018 data.

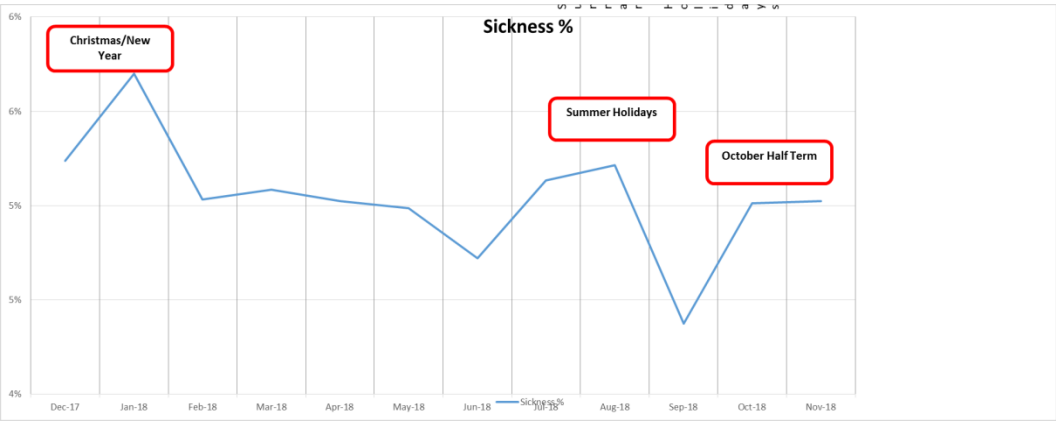
2. TRUST SICKNESS ABSENCE RATES

2.1. Sickness Absence, Annual Leave and Bank/Agency Usage

There is no obvious correlation between monthly sickness absence rates, annual leave and bank/agency usage.



There is however some correlation between sickness absence rates and school holiday periods.

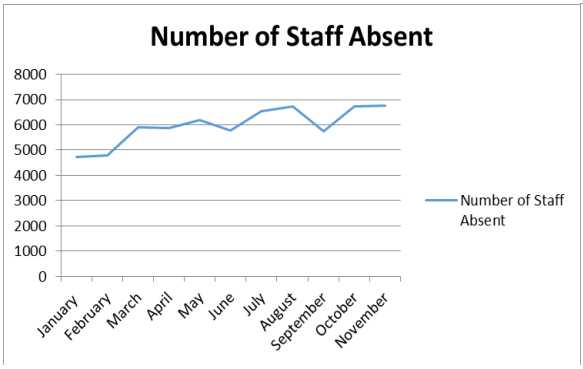


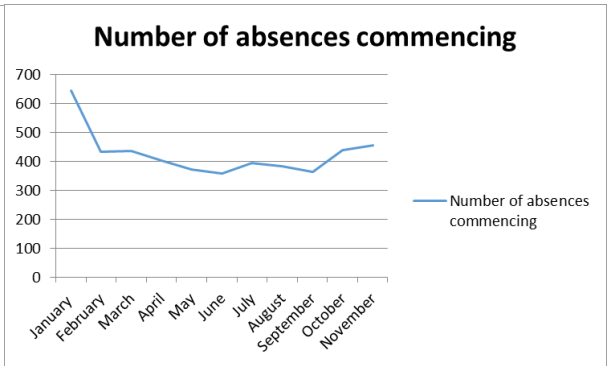
2.2. Analysis of Monthly and Daily Absences

- Friday is the most common day of the week for a member of staff to commence a period of sickness absence.
- Sunday is the second most common day of the week for an absence to commence and sickness absences commencing on a Sunday are more likely to be longer.

Day	Number of absences commencing	Avg Lenth of Absence (days)
Monday	607	17.5
Tuesday	650	11.4
Wednesday	659	11.0
Thursday	634	9.4
Friday	1133	9.2
Saturday	214	5.0
Sunday	787	27.6

- January is the most common month for a member of staff to commence a period of sickness absence.
- More staff are off work due to sickness on any one day in October and November than any other month.





2.3. Analysis by Staff Group

- The staff groups with the highest rate of sickness absence are Additional Clinical Services, Estates and Ancillary and Nursing and Midwifery.
- The most common sickness absence reason for each of these staff groups is 'anxiety/stress/depression/other psychiatric illnesses'.
- The second most common reason for Additional Clinical Services and Estates and Ancillary staff is musculoskeletal related illness.
- 'Other known cause' is the second most common reason for Nursing and Midwifery. 'Unknown cause' is the third most common reason for both Additional Clinical and Nursing and Midwifery staff groups.

Staff Group	Sickness Absence	Long Term	Short Term	Highest Reason	Second Reason	Third Reason
Additional Clinical Services	7.4%	5.9%	1.5%	Anxiety/stress/depression/other psychiatric illnesses'	Other musculoskeletal	Unknown causes
Estates and Ancillary	7.3%	5.7%	1.5%	Anxiety/stress/depression/other psychiatric illnesses'	Back problems	Other musculoskeletal
Nursing and Midwifery	5.7%	4.3%	1.4%	Anxiety/stress/depression/other psychiatric illnesses'	Other known causes	Unknown causes
Trust	**4.9%**	**3.7%**	**1.3%**	**Anxiety/stress/depression/other psychiatric illnesses'**	**Other musculoskeletal**	**Other known causes**

2.4. Analysis by CBU/Department

- 6 CBUs/Departments sickness absence rates are higher than the Trust rate. (CBUs/Departments with fewer than 13 staff have been excluded).
- The most common sickness absence reason for each of these CBU/Departments is 'anxiety/stress/depression/other psychiatric illnesses'.

- Long term sickness absence rates for each of these CBU/Departments are notably higher than the Trust rate.

CBU/Department	Sickness Absence	Long Term	Short Term	Highest Reason	Second Reason	Third Reason
Estates & Facilities	7.1%	5.7%	1.4%	Anxiety/stress/depression/other psychiatric illnesses	Back Problems	Other musculoskeletal problems
Integrated Medicine and Community	6.4%	5.0%	1.4%	Anxiety/stress/depression/other psychiatric illnesses	Unknown causes / Not specified	Other known causes - not elsewhere classified
Medical Care RWW357	6.3%	5.1%	1.2%	Anxiety/stress/depression/other psychiatric illnesses	Other musculoskeletal problems	Genitourinary & gynaecological disorders
Urgent & Emergency Care RWW355	6.3%	4.7%	1.6%	Anxiety/stress/depression/other psychiatric illnesses	Other known causes - not elsewhere classified	Unknown causes / Not specified
Digestive Diseases RWW350	5.5%	4.0%	1.5%	Anxiety/stress/depression/other psychiatric illnesses	Other musculoskeletal problems	Back Problems
Womens & Childrens Health RWW352	5.4%	4.0%	1.3%	Anxiety/stress/depression/other psychiatric illnesses	Other known causes - not elsewhere classified	Other musculoskeletal problems

3. CURRENT TRUST PRACTICES AND PROCESSES

The Trust has an Attendance Management Policy in place which sets out the Trust's approach to managing attendance in the workplace. The policy creates a clear and transparent framework within which managers are able to address the issues of attendance and sickness absence with a consistent, supportive and fair approach. Line managers have responsibility to manage their staff within the remit of the policy with guidance from the HR Business Partnering team where required. Line managers are required to monitor the attendance of all employees for whom they have responsibility and ensure that any period of absence is dealt with appropriately. This includes recording the absence in a timely way on ESR or E-rostering, completing a return to work interview and recording that this has taken place, monitoring whether employees have hit a trigger for action within the policy and then ensuring the appropriate action takes place and making timely and comprehensive referrals to the Health and Well-Being service.

Monthly reports are provided by the workforce information team. These reports include trigger reports which detail all employee absences over the last 12 months and highlights where triggers have been met. People measures are also provided monthly at CBU level so that hotspots and compliance against Trust targets can be monitored. Further reports provided to managers on a monthly basis include return to work interview compliance reports and sick pay reports.

The HR team provide support in a number of ways, although the responsibility for managing attendance remains with the line manager. HR representative attend all formal meeting above stage two of the short term process and they support managers at all welfare meetings under the long term process, advising managers on policy and procedure and providing expert advice on issues such as reasonable adjustments under the Equality Act 2010. HR Business Partners attend CBU SMT meetings and will advise and help the CBU teams to identify trends and patterns which can lead to interventions or further support in certain hot spot areas. Senior HR Advisors meet with line managers on a monthly basis to support manager in ensuring that all appropriate policy actions are taken in a timely way. In line with the HR Consultancy model which is in place, the HR team prioritise this support

depending on the complexity of cases and the level of absence in each area as there is insufficient capacity to meet all managers every month. The HR team provide coaching and support to managers with the writing of letters to employees and producing management reports to be considered at hearings, however the ownership of the management of cases remains a line management responsibility. The HR team also provide training on Attendance Management as part of the Essential Managers programme.

The Trust has an attendance target of 4.2% and the policy triggers for action at an individual level are as follow:-

- 3 episodes in any 12 month rolling period
- 10 working days in any 12 month rolling period
- 2 episodes in two months
- Any pattern of sickness absence

Long term absences are classed as any absence where employees are absent from work for 4 weeks or more. The policy requires managers to undertake welfare meetings every four weeks throughout the period of long term absence and referral to the Health and Wellbeing service should take place after 4 weeks. Managers are required to keep in regular contact with staff during long term absence and provide any reasonable support to assist a return to work, with advice from the Health and Wellbeing team. If a return to work date cannot be agreed and /or suitable redeployment cannot be found a final review will take place to consider whether the employee should be terminated on the grounds of ill health.

Under the Equality Act 2010, an employer must consider making 'reasonable adjustments' for a disabled employee if:-

- It becomes aware of their disability and/or
- They ask for adjustments to be made and/or
- A disable employee is having difficulty with any part of their job and/or
- Either an employee's sickness record, or delay in returning to work, is linked to their disability.

The provision of the Equality Act 2010 is covered in the Trust policy.

4. ATTENDANCE MANAGEMENT BEST PRACTICE REVIEW

A best practice review has been undertaken, reviewing guidance from the following organisations:

- ACAS
- Unison
- Kings Fund
- NHS Employers
- CIPD

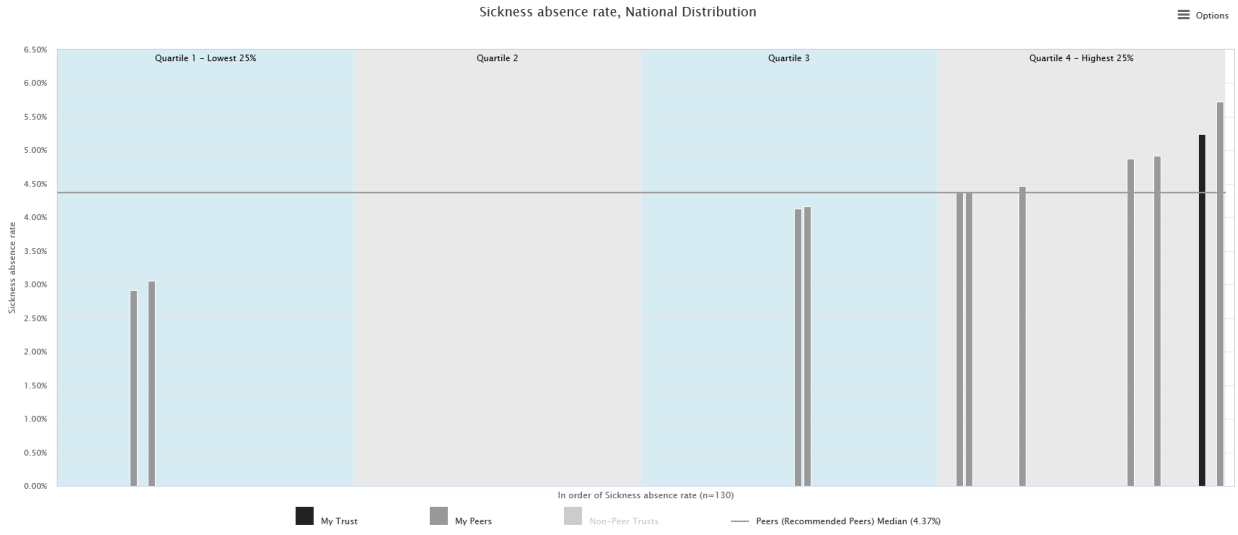
All documentation recommends a combination of strategic approaches to workforce health and wellbeing, and robust operational management of sickness

absence. This paper is focusing on the recommendations relating to operational management of sickness absence, which are summarised below.

- The role of the line manager is key in terms of managing and monitoring attendance. Line manager accountability and 'ownership' is vital.
- Timely local management of any sickness absence is important.
- The role of senior management is also important in terms of leadership and setting expectation.
- There is a strong emphasis on training and clarity of responsibility for Line Managers.
- Clarity for managers and staff on policy expectations improves attendance.
- Sharing cost of sickness absence with line managers promotes more robust management of attendance.
- Co-operation and team work between Line Manager, Senior Manager, HR and OH is essential.
- Providing support to managers around handling difficult conversations with staff.
- Managers who know how to deal with mental health and musculoskeletal related illnesses.
- Early intervention and a focus on rehabilitation is important to promoting attendance.

5. PEER GROUP BENCHMARKING

The graph below is taken from NHSI Model Hospital and shows the Trust sickness absence rate benchmarked against organisations in our recommended peer group.



The HR and OD Directorate have made contact with all peer group organisations to request further information about their current sickness absence rates, their attendance management processes and any key initiatives they have implemented in relation to reducing absence.

Responses were received from the following organisations:

- Aintree University Hospital
- Burton Hospitals NHS Foundation Trust
- Royal Liverpool and Boardgreen University Hospitals Foundation Trust
- St Helens and Knowsley Hospitals
- West Herts NHS Trust
- Wrightington, Wigan and Leigh NHS Foundation Trust

Please note that STHK have confirmed that their sickness absence rate is skewed by the Lead Employer data. Their current absence rate is 4.7%

Key findings from the benchmarking review are summarised below:

- Policy triggers are broadly similar across all organisations.
- Not all respondents provided long term sickness rates but those who did were notably lower than the Trust current rate.
- Anxiety/stress/depression/other psychiatric illnesses and musculoskeletal related illnesses were the two most common reasons for absence rates.
- Not all respondents provided numbers of dismissals relating to sickness absence but those who did reported slightly higher numbers that the Trust.
- Only 2 respondents provided waiting times for Counselling Services; they were 5-8 working days and 10 weeks. The Trust current wait is 12 – 15 weeks.
- Only 2 respondents provided waiting times for Physiotherapy Services; they were 11 days and 4 weeks. The Trust average wait is 10 days
- When asked what has made the biggest impact to your sickness absence rates 4 respondents replied line manager action and 2 mentioned close monitoring/management of absences.
- When asked what other action they have taken in relation to reducing sickness absence the following were mentioned:
    - Monthly sickness absence review meetings
    - Sickness absence escalation meetings
    - Close monitoring of long term sickness cases through specific stages

6. ACTION REQUIRED

The information collated throughout this review has been analysed and an action plan produced to support increased control and management of sickness absence across the Trust. This action plan is in addition to the current operational processes in place. Appendix 1.

7. MONITORING/REPORTING ROUTES

The progress against the actions identified will be monitored via Operational People Committee.

8. ASSURANCE COMMITTEE

Assurance will be provided to Trust Board via the Workforce section of the Integrated Performance Report.

9. RECOMMENDATIONS

Trust Board are asked to note the findings of the deep dive review and to support the proposed actions.

Appendix 1
Sickness Absence Action Plan

Theme	Action	Date	Progress
Line Management Role	Refresh Essential Managers training to emphasise importance of timely and robust attendance management	Complete	Training content refreshed and ready for roll out in April 2019
Line Management Role	Include training on handling difficult conversations in Essential Managers training	Complete	Training content refreshed and ready for roll out in April 2019
Line Management Role	Roll out 1:1 refresher training for line managers	February 2019	
Line Management Role	Write to all managers to clarify roles and responsibilities	January 2019	
Absence Over Holiday Periods	Implement a programme of reviewing individual staff absences patterns related to key holiday periods and support line managers with 1:1 conversations with staff	June 2019	This exercise will commence ahead of July/August holiday period
Absence Over Weekends	Undertake additional analysis of patterns of absence commencing on Fridays at individual employee level. Support line managers with 1:1 conversations with staff	March 2019	
Mental Health Related Absence	Target Mental Health First Aid training to staff in high absence areas/staff groups	February 2019	
Musculoskeletal Related Absence	Provide targeted physio and moving and handling interventions /support to high absence areas/staff groups	February 2019	
Recording of Absence	Remove the option to select 'other' or 'unknown' as reason for absence on E-Rostering	February 2019	
Occupational Health Support	Audit OH referrals for high absence areas to ensure all staff have been identified and supported	Complete	
Senior Manager Role	Introduce an escalation process of absences over 9 months, to include a review of management process by senior CBU/Department manager and HR Business Partner	February 2019	
Occupational Health and HR Support	Introduce an automatic case review meeting with employee, line manager, Occupational Health and HR for all absences over 9 months (where appropriate)	February 2019	
Line Manager Role	Highlight the financial cost of sickness absence to line managers as part of monthly workforce information	Complete	
Policy Application/Compliance	Undertake an audit of outcomes of attendance management hearings	March 2019	
Policy Application/Compliance	Refresh the Trust Attendance Management Policy, utilising the policies shared by Peer organisations	August 2019	Due date in line with policy review date
Policy Application/Compliance	Refresh the Trust Attendance Management Toolkit	August 2019	Due date in line with policy review date

13 December 2018

TO ALL NHS PROVIDER CHAIRS AND CEOs

Dear Colleague

THE RELATIONSHIP BETWEEN PROVIDERS AND THE NEW NHS ENGLAND / IMPROVEMENT (NHSE/I) JOINT STRUCTURE

You may have seen the recent article in *Health Service Journal* which suggested that NHS Improvement (NHSI) may be seeking strengthened powers over the provider sector. Those of you who attended last week's NHS Providers chairs and chief executives network meeting will also have noted how frequently the relationship between NHSE/I and the provider sector came up in discussion.

We want to create a new work programme in this space and are therefore keen to seek your feedback and involvement as we develop this work.

Context

In terms of the context, there are five intertwined developments here:

- The next stages in the move from individual institutions to local system working
- The future shape of the provider landscape including provider sector consolidation
- How the new NHSE/I structure will work in practice
- Two workstreams in the long-term plan on future system architecture and potential legislative changes and
- How all of the above interacts with current provider governance and the 2012 Act, within the context of the best way to oversee and assure delivery of local healthcare services.

Taken together, we think these developments could result in far-reaching changes to the strategic environment in which providers operate.

First principles

Our starting point is that local unitary provider boards are accountable for everything delivered by their organisation for good reason, recognising that foundation trust and trust boards have different statutory bases and different powers.

Local provider boards are best placed to oversee and assure the delivery of complex local healthcare services and manage the large levels of risk inherent in this task, given the operational expertise of their executives, and the level of challenge and strategic impetus provided by their chairs and non-executives. As an employer, they are also best placed to support, develop, manage and empower local staff, a key enabler of high-quality care. Appropriate local board autonomy also underpins the strong local leadership and

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innovation we need in the NHS and ensures a clear line of accountability to patients, staff and local communities.

We believe that if provider boards are to be held to account for delivery, it is important for them to have the appropriate powers to discharge that accountability effectively. These include the powers to appoint their own directors, decide who to acquire or merge with, create their own annual operational and financial plan and determine the required level of capital expenditure. These are fundamental decisions, central to an organisation's success, recognising, again, that trusts and foundation trusts operate in different ways.

However, we are also clear that defence of local board autonomy is not a protectionist defence of providers working in isolation – we all acknowledge the need to move to local system working in which local organisations collaborate to make best use of collective resource and develop more integrated services for patients. Defending provider boards is a defence of the principle that local unitary boards are the best governance mechanism to oversee local health service delivery.

Over time, following legislative change, we may move to local system boards, not local foundation trust/trust boards. But, either way, local unitary board autonomy and the clarity of their full accountability for all that goes on inside their organisation needs to be carefully guarded. Any proposals to curtail board powers, to cut across them or to extend arm's-length body/government powers over boards, needs to be carefully scrutinised.

There is, of course, plenty of nuance here. There is a world of difference between, on the one hand, a targeted and limited power, used on an exception basis, to require a provider who refuses to recognise it is no longer viable to seek a merger partner and, on the other, a general power to direct all providers to undertake any merger or acquisition the government or an arm's-length body thinks fit.

Our new work programme

Our new work programme will address a number of issues.

Long-term plan – system architecture and potential legislative change

We have, as you would expect, already been inputting heavily into the long-term plan workstreams on system architecture and potential legislative change and will continue to do so. We will, for example, continue to contribute provider views on how the NHS should move to more consistent local system working.

The way NHSE and I operate in their new structure

Although there are formal proposals for legislative changes being developed for consultation, the way that the new NHSE/I structure actually operates will be just as important. NHSI's chair and chief executive have both said they want to create a new, more collaborative, relationship with the NHS frontline that works for both NHSE/I and providers – one based more on support and improvement and less on regulation and performance management.

We believe there are a number of things NHSE/I could do to deliver this new relationship, many of them set out in the recent report led by Sir Ron Kerr, including:

- Collaborative agreement of the behaviours and processes governing how the new NHSE/I regional directors and frontline trust, CCG and STP leaders will work together
- New approaches to reduce the volume of ALB requests and 'all trust' communications, for example, through setting up a formal gateway with frontline input

- A formal, collaboratively agreed, protocol setting out how NHSI will intervene in chair and CEO appointments so everyone knows where they stand when providers start a new appointment process
- Development of a new "strategic support not tactical performance management" approach to special measures, based on trust feedback on what works and doesn't
- A genuinely collaborative planning process covering all elements of planning, not just the tariff where formal consultation is required by law
- A collaborative approach to designing the new financial architecture including what will replace control totals and the Provider Sustainability Fund and a much needed new capital regime
- A return to genuine and full consultation on all major new policy developments, for example, the development of system working.

Our work programme will continue to push for the importance of developing this type of collaborative approach and in ensuring that provider views are fully represented if and when this work is undertaken.

Provider consolidation and provider landscape
We also think there is a need for an informed debate about the future provider landscape and what extent and form of consolidation may, or may not, be required. There is a range of different member views here but one unifying theme will be the need to ensure that any redrawing of the landscape is driven locally.

As part of our work I have already had two long conversations with Ian Dalton to understand his perspective. He reassured me that he personally, and NHSI as an organisation, remain committed to the importance of strong, appropriately autonomous local boards leading local providers. He did, however, point to the need to ensure the regulatory framework and NHSI's powers remain relevant in a fast-moving environment including, for example, the move to system working and the need to look at the provider landscape.

I stressed the importance of NHSE/I leading a full, collaborative, debate with the sector around these issues and have offered NHS Providers' help in helping facilitate such a debate.

Your views

It would be very helpful to get your views, in particular on the following:

- Are we right to identify this as a major set of potential changes that we should seek to strongly influence?
- Do you agree with our articulation of the key principles set out above?
- Are there any areas you particularly want us to focus on or are particularly concerned about or where you have strong views?
- Is there anything major missing?

We would also like to establish a formal reference group of members to support this work so please also let us know if you would like to be part of this group.

Long-term plan and planning guidance

We know that you will be anticipating the publication of the long-term plan and the planning guidance that will follow. My PowerPoint slides from last week's chairs and chief

executives network meeting included new material on each of these areas and can be accessed via this link.

We will keep you up to date on our work and encourage you to join the reference group or send any thoughts and feedback via ella.jackson@nhsproviders.org.

Yours sincerely

Chris Hopson
Chief Executive

Summary of board papers – statutory bodies

NHS Improvement board meeting – 12 December 2018

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

Improvement report

- The Outpatient Improvement programme has identified an opportunity to improve the way outpatient services are delivered with potential savings of £700m. A clinic level dashboard, accessible via the model hospital tool, enables analysis and benchmarking of outpatients across 110 trusts.
- NHS Improvement (NHSI) and NHS England (NHSE) regional teams have established an improvement collaborative that will support the reduction and eventual elimination of mental health out of area placements over a period of eight months.
- The model hospital tool has been updated with a more intuitive design that features bespoke productivity opportunities, articles, videos, tips, a new metric search and comprehensive metric pages.
- The Mental Health Intensive Support Team is working with systems to improve data quality for the mental health services data set. This system will help providers better understand process, benchmark and identify gaps to improve delivery.

Chair's report

- NHS Improvement chair Dido Harding has recently sent out the first of a potential regular quarterly bulletin to NHS trust and foundation trust chairs to keep them updated on NHSI thinking. This is planned to be a joint communication with David Prior, chair of NHS England NHSE, going forward.
- The joint committees in common between NHSI and NHSE are expected to kick off from January. Draft terms of reference are currently under discussion with both boards and are expected to be confirmed by the committees in common at the first meeting in the New Year.
- Dido has also spent time with David Behan, newly appointed chair of Health Education England (HEE), to look at how NHSI and HEE can work better together on the 'people development agenda'.

Quality Dashboard

- Patient experience is generally positive with the rate of written complaints running statistically below average. Additionally, for community services, the percentage of patients who would recommend the trust that treated them is at a high of 96.5%. Mental health patient experience is also at a high of 90%.

Corporate report

- Issues flagged as a priority for winter preparations this year was the need to avoid corridor waits and to speed up ambulance turnaround times.

Health Education England board meeting – 18 December 2018

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

Chief executive update and finance report

- HEE will work jointly with NHSI to ensure that workforce plans are more closely aligned with NHS service plans.
- From 1 April 2019 the NHS Leadership Academy will transfer from HEE to the new people function that will be hosted by NHSI. A cross-organisational governance structure has already been established to drive forward the transfer of the Leadership Academy.
- Opportunities will be identified for HEE's regional teams to align with the seven integrated regional teams of NHSI and NHSE, to continue building on the strong collaborative working that already exists across the country in support of local health systems.
- A growing proportion of the HEE budget is coming from NHSE. As a result, additional time is required to agree and get appropriate approvals through NHSE's governance arrangements.
- There has been a delay in some areas for paying and recharging the cost of GP trainees pay.

Performance report

- The Cancer Workforce Plan has raised the profile of work planning with Cancer Alliance Partners and now forms the basis of the workforce plans to 2021.
- The HEE Mental Health programme has made good progress on a number of areas. Cross-system work is under way to refine the definitions of the mental health workforce.
- HEE is investing in implementing a range of workforce initiatives to support the primary care workforce transformation, including physician associates, general practice nurses and clinical pharmacists.
- HEE is working with ambulance trusts, the College of Paramedics, NHSE, NHSI and staff-side groups to enable paramedic workforce development.
- The Public Health and Prevention programme continues to work across the system to provide leadership in training and educating the core and wider public health workforce.
- HEE is leading considerable work to develop the nursing associate role and to support providers to introduce and expand this workforce.

Medical Education Reform programme

- HEE's Medical Education Reform Programme will aim to make a radical change in how medical education is delivered.
- HEE has produced a joint report with NHSI, the General Medical Council, The Academy of Medical Royal Colleges, NHS Employers, provider organisations and the British Medical Association 'Maximising the potential – A system wide strategy to support and progress careers of SAS doctors'. This report makes recommendations on how best to support staff grade, associate specialist and speciality (SAS) doctors.

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/19/01/06**			
SUBJECT:	**Integrated Performance Dashboard**			
DATE OF MEETING:	30th January 2019			
AUTHOR(S):	Marie Garnett – Head of Contracts and Performance			
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse Michelle Cloney – Director of Human Resources & Organisational Development Andrea McGee - Director of Finance & Commercial Development Chris Evans - Chief Operating Officer			
LINK TO STRATEGIC OBJECTIVES:	All			
EXECUTIVE SUMMARY (KEY ISSUES):	The Trust has 71 IPR indicators which have been RAG rated as follows: **Red: 24 (decreased from 26 in November)** **Amber: 11 (decreased from 12 in November)** **Green: 31 (increased from 30 in November)** **Non RAG Rated: 5 (increased from 3 in November)** The performance against the Control Total excluding Provider Sustainability Funding is £19.4m which is line with plan.			
PURPOSE: (please select as appropriate)	Information	Approval X	To note X	Decision
RECOMMENDATION:	The Trust Board is asked to: **1.** Note the contents of this report. **2.** Approve amendments to the Capital programme.			
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.			

SUBJECT	Integrated Performance Dashboard	AGENDA REF:	BM/19/01/06

1. BACKGROUND/CONTEXT

The RAG rating for all 71 indicators from January 2018 to December 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 - 24 in December, decreased from 26 in November.
- Amber – 11 in December, decreased from 12 in November.
- Green – 31 in December, increased from 30 in November.
- Not RAG rated – 5 in December, increased from 3 in November.

Due to validation and review timescales for Cancer, VTE, Pressure Ulcers and Sepsis, the RAG rating on the dashboard for these indicators is based on November's validated position.

Quality

Quality KPIs

There are 6 Red indicators in December, a decrease from 9 in November.

The 6 indicators which were Red in November and remain Red in December are as follows:

- Incidents – the Trust had 38 open incidents which were over 40 days old in December, a reduction from 103 in November, against a target of 0.
- Healthcare Acquired Infections (MRSA) – there was 1 case of MRSA reported in December 2018 in addition to the case reported in April 2018, against a national threshold of zero tolerance; this indicator will be Red for the remainder of the year.
- Total Falls & Harm Levels – there were 71 falls in December, an increase from 78 in November.
- Medication Safety – there was 1 incident of harm in December, (1 in November), there is zero tolerance for this indicator.

- Friends & Family Test (A&E and UCC) – the Trust achieved 81% in December, an improvement from November's position of 78% against a target of 87%.
- Mixed Sex Accommodation Breaches (MSA) – there were 6 Mixed Sex Accommodation Breaches in December (6 in November), against a target of 0.

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

- Healthcare Acquired Infections (CDif) – there were 0 reported cases of CDif in December, a decrease from 2 in November against a threshold of less than 2.
- Friends & Family Test (Inpatients) – the Trust achieved 96% in December, an improvement from November's position of 94%, against a target of 95%.

There are 2 Sepsis indicators and 1 VTE indicator which cannot be RAG rated this month, due to validation timescales.

Access and Performance

Access and Performance KPIs

There are 8 Access and Performance indicators rated Red in December, an increase of 1 in month.

The 7 indicators which were Red in November and remain Red in December are as follows:

- A&E Waiting Times 4 hour national target – the Trust achieved 79.93% including walk ins and 76.38% excluding walk ins in December, which is an decrease from November's performance of 83.22% and 80.26% respectively, against the target of 95%.
- A&E Waiting Times Improvement Trajectory – the Trust's improvement trajectory for December was 90%; therefore the Trust did not achieve this in month.
- Ambulance Handovers 30>60 minutes – there were 273 patients who experienced a delayed handover in December, an increase from 156 in November.
- Ambulance Handover at 60 minutes or more – there were 167 patients who experienced a delayed handover in December, an increase from 72 in November. This directly correlates with the A&E position and is challenging, particularly with peak hour attendances; however the CBU team has focused on this standard into January and has seen significant improvement.
- Discharge Summaries % sent within 24 hours – the Trust achieved 84.73% in December, a decrease from November's position of 87.20% against a target of 95%.
- Cancelled operations on the day (for non-clinical reasons) – there were 20 cancelled operations in December, an increase from 18 in November against a target of 0.
- Super Stranded Patients – the Trust had 124 super stranded patients at the end of September and was set a trajectory to reduce this to 86 patients by the end of December. This target was achieved prior to the festive period with significant work taking place around Impact 5; however as at the end of December the Trust had 119 super stranded patients.

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

- Cancer 62 Days Screening – the Trust achieved 87.5% for November's validated position, a decrease from October's validated position of 100% against a target of 93%.

PEOPLE

Workforce KPIs

There are 5 indicators rated Red in December, the same number as November.

The 5 Red indicators are as follows:

- Sickness Absence – the Trust's achieved 5.17% in December, a decrease from November's performance of 5.1% against a target of less than 4.2%.
- Non-Contracted Pay – remains above budget at 14.16% of total pay in December 2018, a decrease from November's position of 14.19%
- Agency Nurse Spend – this has decreased to £0.23m in December, however this exceeds expenditure for the same period last year of £0.18m.
- Agency AHP Spend – this has decreased to £0.12m in December; however this exceeds expenditure for the same period last year of £0.07m.
- Average Length of Service (Top 10 agency workers) – was 28 months in December, the same as November's position.

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

- Turnover – the Trust achieved 12.82% in December, an improvement from November's position of 13.19% against a target of less than 13%.

SUSTAINABILITY

Finance and Sustainability KPIs

There are 5 Red rated Finance and Sustainability indicators in December, the same number as November.

The 5 red indicators are as follows:

- Operating Surplus/Deficit – the actual deficit is £17.1m which is £0.7m above the planned deficit of £16.4m. PSF funding of £1.0m has not been achieved in relation to the A&E performance target. The Trust has signed up to a control total of £16.9m deficit which includes Provider Sustainability Funding (PSF) of £4.9m. Performance against the year to date control total (excluding PSF) is £19.4m deficit which is in line with plan. The current position assumes £1.3m income from insurers in respect of the capital costs associated with the Kendrick Wing Fire.

The current variance on clinical income is £0.4m above plan. After excluding the £2.3m additional income from the Department of Health for the additional costs of the Agenda for Change pay award, the variance is £1.9m below plan.

- Capital Spend – the actual spend is £5.0m which is £2.5m below the planned spend of £7.5m. The cancellation and delay in a number of schemes has resulted in the current underspend.
- Better Payment Practice Code (BPPC) – the challenging cash position results in a year to date performance of 53% which is 42% below the national standard of 95%.
- Agency Spending – the actual year to date spend is £8.3m which is £1.8m above the year to date ceiling of £6.5m.
- Cost Improvement Programme Recurrent – recurrent CIP has been assessed at £3.1m which is £3.9m below the £7.0m CIP target.

The Income, Activity Summary and Use of Resources Rating Statement as presented to the Finance and Sustainability Committee is attached in **Appendix 3**.

The current forecast delivery of in-year CIP poses a significant risk to the Trust's ability to deliver against the planned £16.9m deficit. Any variance from plan will have an adverse impact on cash and may lead to the need for further loans.

Workshops have been held with CBUs and Corporate Divisions to focus on CIP opportunities and forecast outturn. An additional £1m CIP has been identified from the workshops moving CIP to £3.9in year (£3.1m behind plan).

The forecast outturn calculations have been updated to reflect the position at Month 9. The updated calculations show a potential deterioration in the financial performance that would move the position off plan by £6.1m off plan (excluding PSF). The main reasons for this are shortfall in CIP, unfunded cost pressures, underachievement of clinical income and reduction in contribution towards financial position. A number of mitigations totalling £4.7m have been identified which include elements of risk, a gap of £1.4m still remains. Further mitigations are required and will be explored externally with commissioners and internally with budget holders.

Capital Programme

The 2018/19 capital programme approved by the Board in February 2018 was £7.5m. This has increased to £10.2m to reflect a high level estimate of £2.4m for the Kendrick Wing restructure and £0.3m for externally funded schemes.

There are some proposed changes to the capital programme as summarised in the table below.

Table: proposed changes to the 2018/19 capital programme.

Scheme	Value £000
Additional Funding Requirements	
Children's Outdoor Play Area (1)	45
Cooling Blanket (1)	19
Bladder Scanners (1)	18
Bladder Scanners	8
Ultrasound Machine (2)	29
Mobile X Ray Detector (2)	43
Defibrillators (2)	266
Estates Safety Work (Frailty Assessment Unit) (2)	5
Sub Total	**433**
Funded by	
External Funding	(82)
Contingency	(351)
Sub Total	**(433)**
Total	**0**

(1) Externally Funded
(2) Emergency Approval by Director of Finance and Commercial Development and Deputy Chief Executive.

The annual capital programme has increased to £10.3m and the actual spend for the year is £5.0m (£1.8m relates to the fire expenditure) which is £2.5m below the plan. The main reasons for the under spend is due to scheme slippage. This includes a number of IM&T and Estates schemes, together with the removal of the MRI scanner scheme and delays on the fire related schemes pending the outcome of discussions with insurers.

The opening 2018/19 capital programme included a contingency of £0.6m. After the changes resulting from the CQC, ward accreditation and PLACE inspection work, offset by scheme slippage the balance of the contingency is £0.9m. It is likely that there will be an under spend on this year's capital programme which will be carried forward to support next year's capital requirements. A detailed forecast is currently being prepared.

An updated capital programme is attached in **Appendix 4**.

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
- Strategic Peoples Committee
- KPI Sub-Committee

5. RECOMMENDATIONS

The Trust Board is asked to:

1. Note the contents of this report.
2. Approve amendments to the Capital programme.

Appendix 1 – KPI RAG Rating January 2018 – December 2018

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

Appendix 1 – KPI RAG Rating January 2018 – December 2018

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

Appendix 1 – KPI RAG Rating January 2018 – December 2018

	KPI	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18
	WORKFORCE												
50	Sickness Absence	↑↓	↓	↑	↓	↓	↓	↑	↑	↓	↓	↑	↑
51	Return to Work	↓	↑	↓	↑	↑	↓	↓	↓	↓	↓	↓	↓
52	Recruitment											↓	↔
53	Turnover	↓	↓	↑	↓	↓	↑	↑	↑	↑	↓	↑	↓
54	Non Contracted Pay	↑	↓	↑	↔	↑	↓	↑	↓	↑	↔	↓	↑
55	Agency Nurse Spend	↑↓	↓	↑↓	↑↓	↓	↑	↑	↑	↓	↑	↑	↑
56	Agency Medical Spend	↓	↑	↓	↓	↑	↓	↓	↓	↑	↑	↑	↑
57	Agency AHP Spend	↑	↓	↑	↑	↓	↓	↑	↓	↓	↑	↑	↓
58	Core/Mandatory Training						↑	↑	↑	↑	↑	↑	↑
59	PDR	↓	↓	↑	↑	↑	↑	↑	↓	↓	↓	↑	↓
60	Average cost of the top 10 highest cost Agency Workers	↑	↓	↓	↓	↑	↑	↓	↓	↑	↓	↓	↓
61	Average length of service of the top 10 longest serving agency workers	↑	↑	↓	↑	↓	↑	↑	↓	↔	↓	↑	↔
	FINANCE												
62	Financial Position	↑	↑	↑	↑	↑	↑	↑	↑	↓	↑	↑	↓
63	Cash Balance	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
64	Capital Programme				↑	↑	↓	↑	↑	↓	↓	↓	↓
65	Better Payment Practice Code				↑	↑	↓	↑	↑	↓	↓	↓	↔
66	Use of Resources Rating	↔	↔	↔	↔	↓	↔	↔	↔	↔	↔	↔	↔
67	Fines and Penalties					↓	↔	↔	↔	↔	↔	↔	↔
68	Agency Spending				↓	↑	↓	↑	↓	↓	↑	↓	↓
69	Cost Improvement Programme – Performance to date					↑	↑	↓	↓	↑	↓	↑	↑
70	Cost Improvement Programme – Plans in Progress (In Year)						↑	↑	↑	↑	↑	↑	↑
71	Cost Improvement Programme – Plans in Progress (Recurrent)												

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

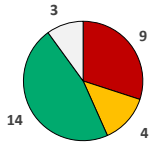
Warrington and Halton Hospitals NHS
NHS Foundation Trust

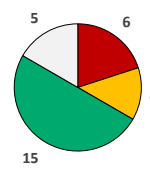
Integrated Dashboard - December 2018

Appendix 2

Key Points/Actions

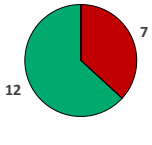
Quality Improvement

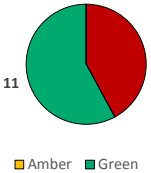




As of 31st December 2018, there were 368 open incidents that require review and sign off. Whilst this continues to reduce in line with the improvement trajectory, work is ongoing to ensure that this remains a focus for staff. Compliance in month in relation to Duty of Candour remains 100%. MRSA bacteraemia - 1 hospital onset case reported from ward A4 in December 2018. The post infection review is in progress. Gram negative bloodstream infections in December: E. coli 2 hospital onset cases; Klebsiella - 0 hospital onset cases and 1 case of Pseudomonas aeruginosa. There has been 0 Serious Incident falls reported during December. The overall number of reported falls has increased from 55 to 71 which is a 29.1% increase on the previous month. 96% of our patients recommend our inpatient and day case services which exceeds a target of 95%. The response rate has decreased slightly to 25.5%. Positive themes about staff attitude increased from 392 in November 2018 to 481 in December 2018, praising the kindness, politeness and friendliness of the staff for inpatients.

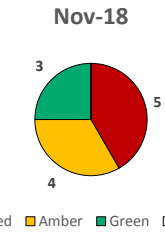
Access & Performance

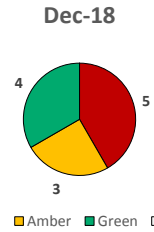




In December 2018, 11 out of the 19 indicators were RAG rated as Green. The Diagnostic target continues to remain compliant. The Trust has achieved the RTT standard in month. The Trust did not meet the 4 hour A&E standard or improvement trajectory in month; a number of actions are being implemented to improve the position. With the exception of Cancer 62 day screening, the Trust achieved all Cancer standards. The 62 day screening position was impacted by another Trust clearing its backlog and subsequent breach allocations. Ambulance handovers remains challenging in direct correlation with A&E pressures. The Trust continues to drive improvement around discharge summaries. There was a slight increase in cancelled operations, however all patients were re-admitted within the 28 days. The Trust did reduce the number of super stranded patients prior to the festive period and continues to focus on the discharge process.

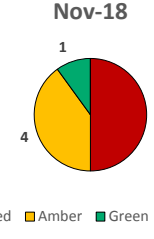
Workforce

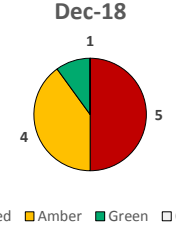




The Trust has seen an increase in sickness absence in month to 5.17%. Return to work compliance has reduced to 75.53%. Recruitment timeframes has increased to at an average of 65.7 days. Turnover has decreased in month to 12.82%. Pay spend was £0.4m above budget and temporary staffing expenditure is above the same period last year. Core Skills Training compliance continues to be positive at 88.25%. PDR compliance is below the target in month at 82.11%. The average cost of the Top 10 agency workers has reduced from last month.

Finance





In month, the Trust recorded a deficit of £1.7m which increases the cumulative deficit to £17.1m which is £0.8m above plan. The year to date control total (excluding Provider Sustainability Funding) is a £19.4m deficit which is in line with plan. Capital spend is £5.0m which is £2.5m below the planned capital spend of £7.5m. Due to the historic and current operating position 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 53% which is 42% lower than the 95% target. The Trust has recorded a Use of Resources Rating of 3 which is on plan.

Quality Improvement - Trust Position

Description	Aggregate Position	Trend	Variation

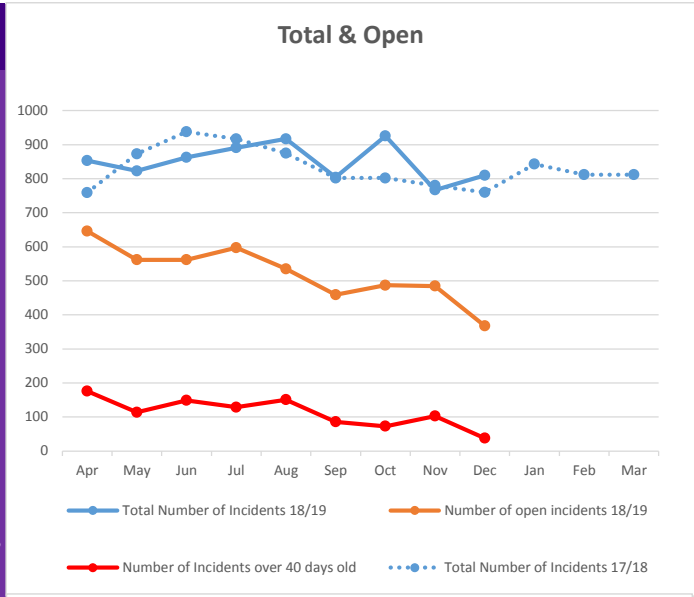
Patient Safety

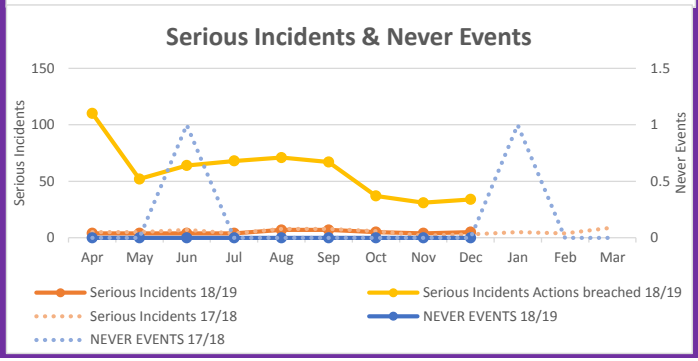
Incidents

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. As part of the 2018 - 2021 Trust Quality Strategy, the Trust has pledged to Increase Incident Reporting to ensure that we don't miss opportunities to learn from our mistakes and make changes to protect patients from harm.

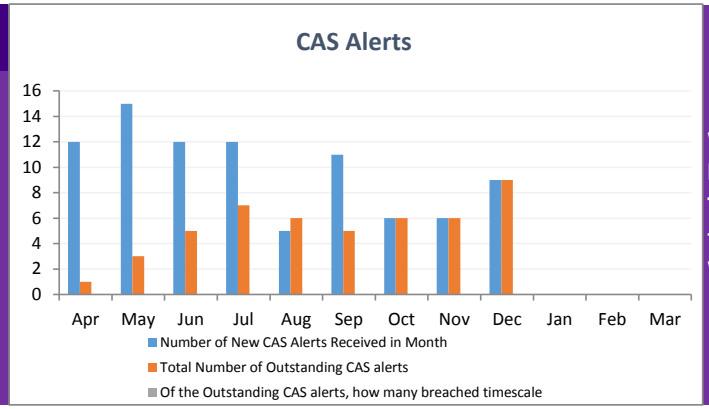
The target for Never Events is a zero tolerance. Green: open incidents within timeframe (within 20 working days) Amber: open incidents outside of timeframe (within 40 working days) Red: open incidents outside of timeframe (over 40 working days old).





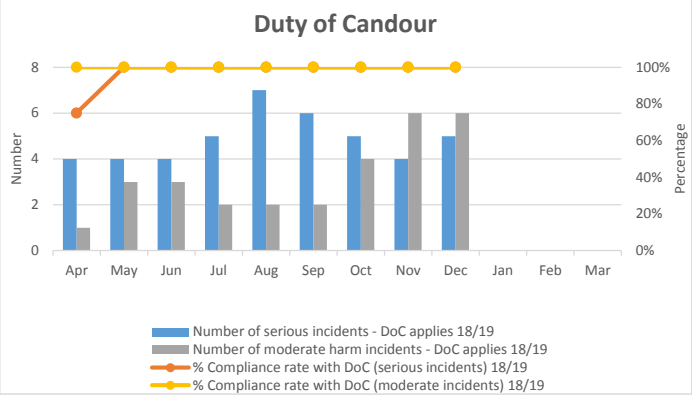
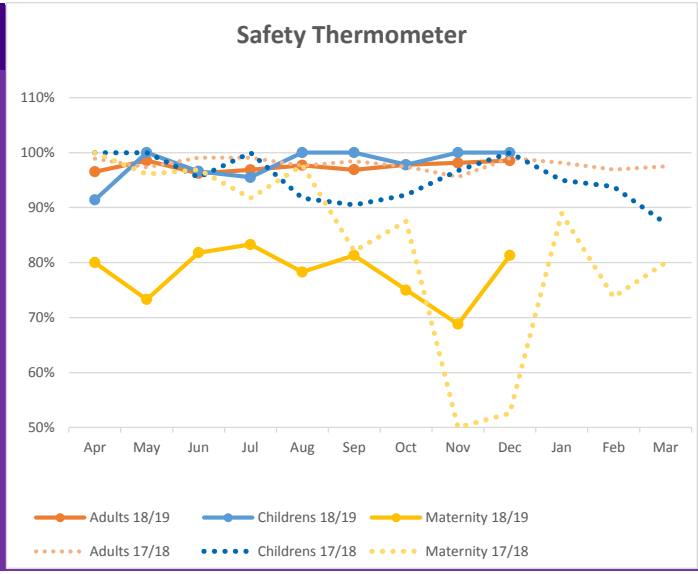
As of 31st December 2018, there are 368 open incidents require review and sign off. 293 relate to CBUs with the remaining incidents for Corporate or External Organisations. This represents a further decrease in open incidents. Work will continue to ensure progress is in line with the CQC action to close all backlog incidents. The Trust launched the 'Reporting to Improve' campaign at the Safety Summit held in October and work continues across the Trust to support this campaign into 2019.

Quality Improvement - Trust Position

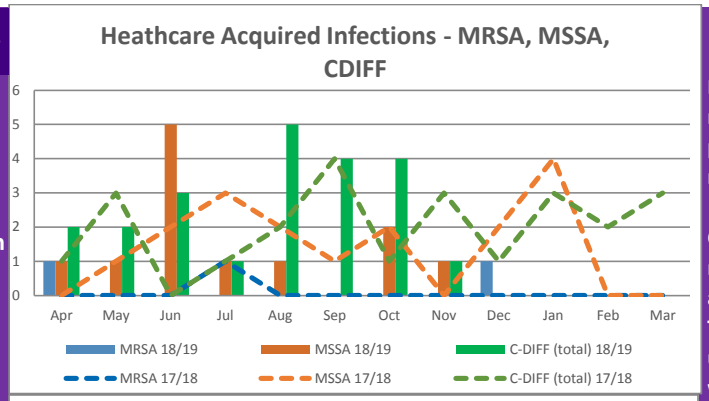
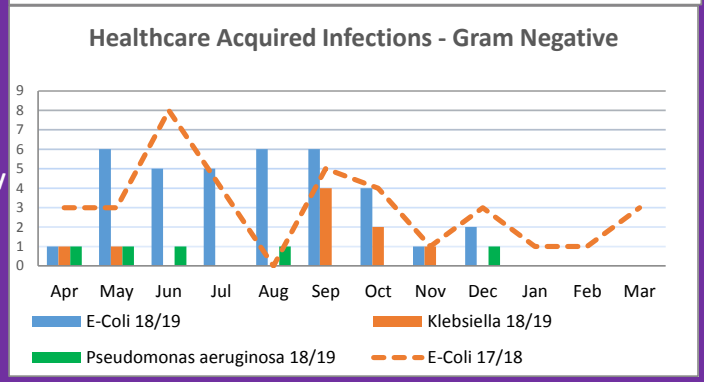
Description	Aggregate Position	Trend	Variation
The Central Alerting System (CAS) is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and others, including independent providers of health and 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 9 alerts in December, of which 6 have been closed. There are 9 open alerts within the CAS system for the Trust. We have no alerts past the close by date.

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

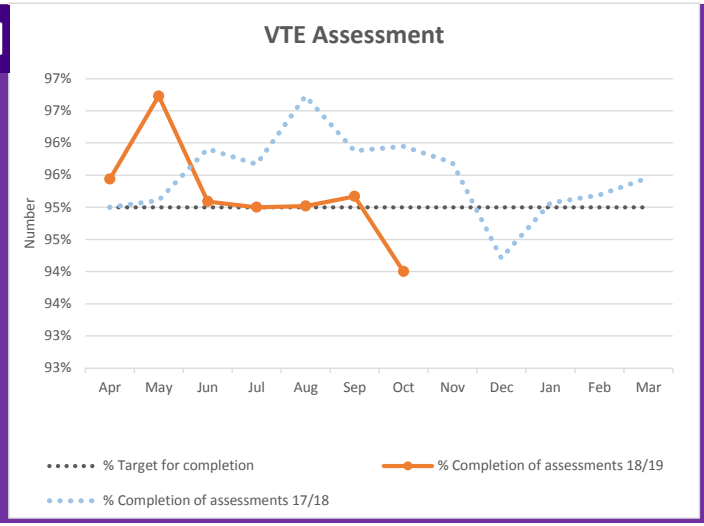
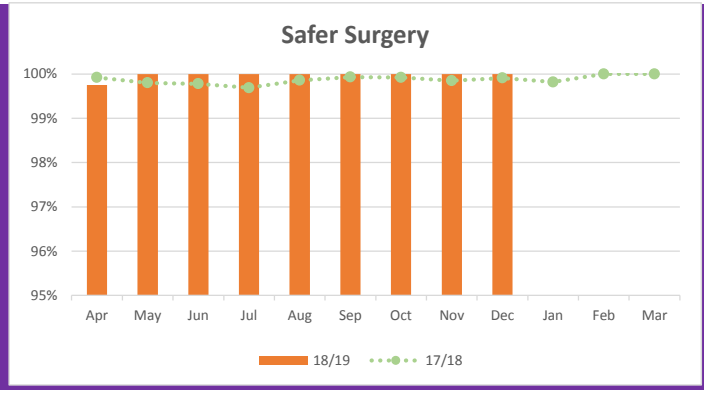
Quality Improvement - Trust Position

	Description	Aggregate Position	Trend	Variation
Duty of Candour Red: <100% Green: 100%	Every healthcare professional must be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress. Duty of Candour is where we contact the patient or their family to advise of the incident; this has to be done within 10 working days.	Duty of Candour has to be completed within 10 working days.		As previously reported, there have been 2 breaches in relation to Duty of Candour year to date, where there was a delay in completing Duty of Candour within 10 working days; this was subsequently completed. These breaches occurred in May 2018. As of December 2018, there have been no further breaches and the Datix system in now fully updated for all moderate harm and above incidents currently under investigation.
Adult Safety Thermometer Red: Less than 90% Amber: 90% to 94% Green: 95% or more **Childrens Safety Thermometer** Red: Less than 80% Amber: 81% to 84% Green: 85% or more **Maternity Safety Thermometer** Red: Less than 70% Amber: 70% to 73% Green: 74% or more	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.	The target for all areas is to achieve over 95%.		In December 2018, the Adult Safety Thermometer shows 3 new Pressure Ulcers, 2 Falls with Harm, 1 Catheter Associated UTIs & 1 VTE, with no individual ward being of concern. Overall the Trust is showing harm free percentage of 98.56%. The number of women and babies who received physical harm free care was 81.3%. An improvement from 68.8%, in November 2018. In December 2018, 2 women sustained physical harm including 1 woman who had a ventouse birth and required an iron infusion and was diagnosed with a perineal wound infection. A second woman was diagnosed with a urinary tract infection. The womens perception of safety was 100% which has been sustained since October 2018. The Children's Safety Thermometer was 100% harm free.

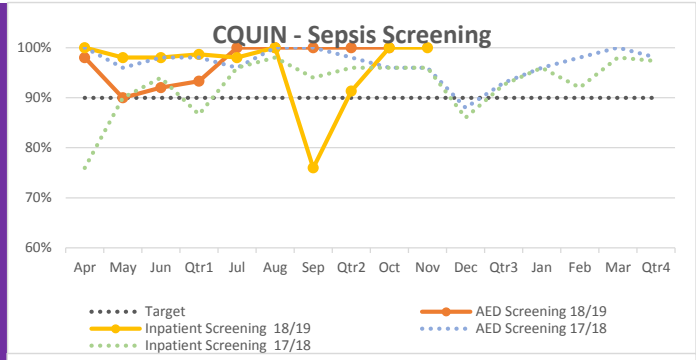
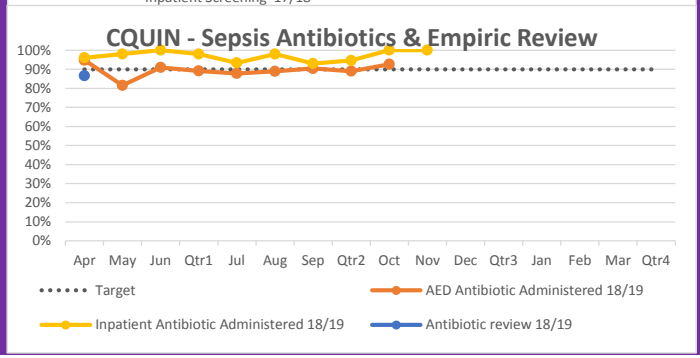
Quality Improvement - Trust Position

	Description	Aggregate Position	Trend	Variation
Healthcare Acquired Infections **MRSA** **Red: 1 or more**	Methicillin-resistant Staphylococcus aureus (MRSA) is a bacterium responsible for several difficult-to-treat infections in humans. Those that are sensitive to methicillin are termed methicillin susceptible Staphylococcus aureus (MSSA). Clostridium difficile, also known as C. difficile or C. diff, is a bacterium that can infect the bowel. Escherichia coli (E-Coli) bacteraemia which is one of the largest gram negative bloodstream infections.	MRSA - National objective is zero tolerance of avoidable MRSA bacteraemia. If breached a £10,000 penalty in respect of each incidence in the relevant month. MSSA - Has no National objective set by public health. Clostridium Difficule (c-diff) due to lapses in care; agreed threshold is <=27 cases per year. E-Coli, Klebsiella, Pseudomonas aeruginosa - A national objective has been set to reduce gram negative bloodstream infections (GNBSI) by 50% by March 2021.		MRSA bacteraemia - 1 hospital onset case reported from ward A4 in December 2018. The post infection review is in progress. The Trust has reported 2 hospital onset cases this financial year. Clostridium difficile - no hospital onset case were reported in December 2018. 5 cases from Q3 were assessed by the CCG review panel in January 2019. The panel concluded 2 case were avoidable, 1 case undetermined but likely unavoidable and 2 cases were unavoidable. Action plans are in place to support learning from these incidents. MSSA - 0 hospital onset case in December. Gram negative bloodstream infections in December: E. coli 2 hospital onset cases; Klebsiella - 0 hospital onset case and 1 case of Pseudomonas aeruginosa. The GNBSI action group is meeting monthly to review key themes from surveillance data and identify preventative action.
Healthcare Acquired Infections **C-Difficile** **Red: More than 2** **Amber: 1 to 2** **Green: 0**				
Healthcare Acquired Infections - Gram Negative **E-Coli** **Red: More than 2** **Amber: 1 to 2** **Green: 0 OR** **Klebsiella/Pseudomonas** **Red: More than 1** **Amber: 1**				

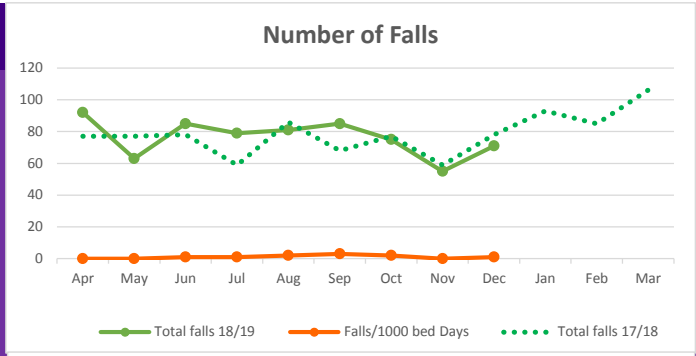
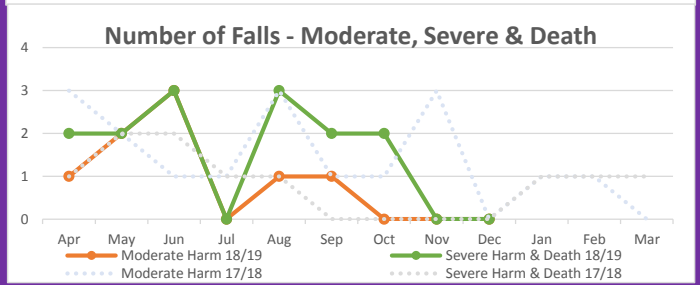
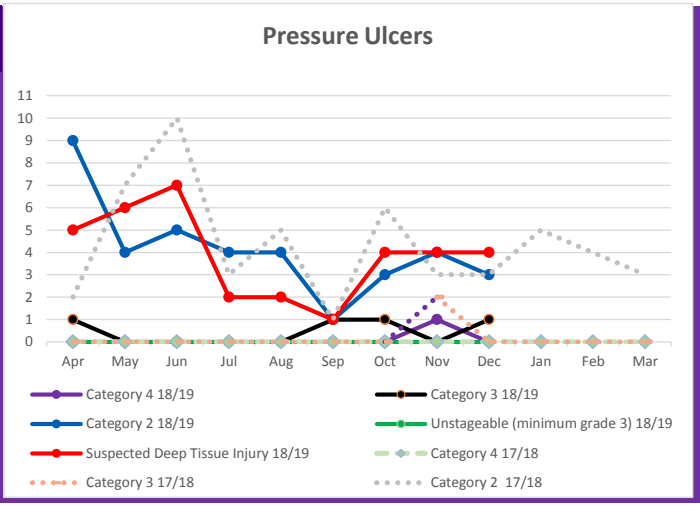
Quality Improvement - Trust Position

	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).		Due to the time required for data validation, VTE will be reported quarterly.
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%.		We have reviewed ALL surgical procedures conducted since April 2017 as to whether a checklist was completed. In December 2018, 100% of check lists were reviewed and the overall score was 100% compliant.

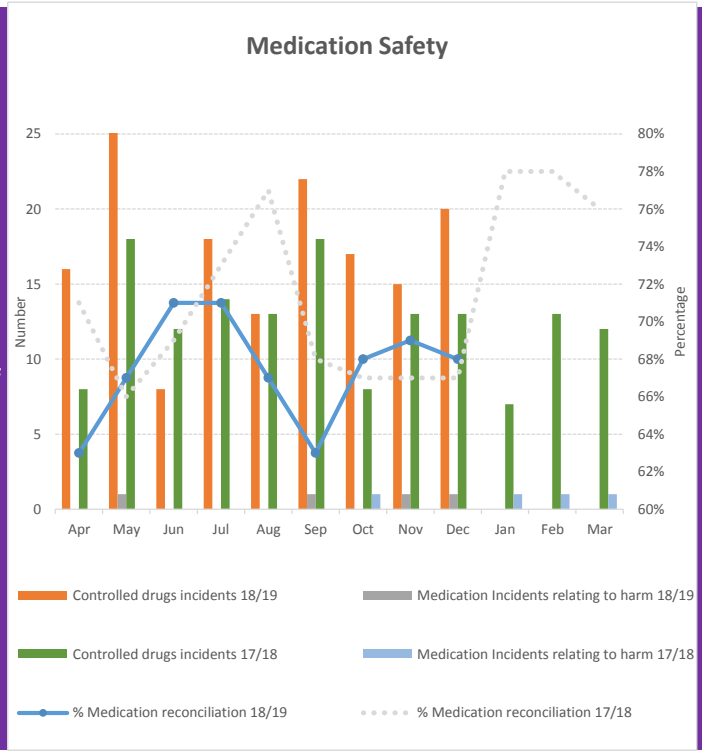
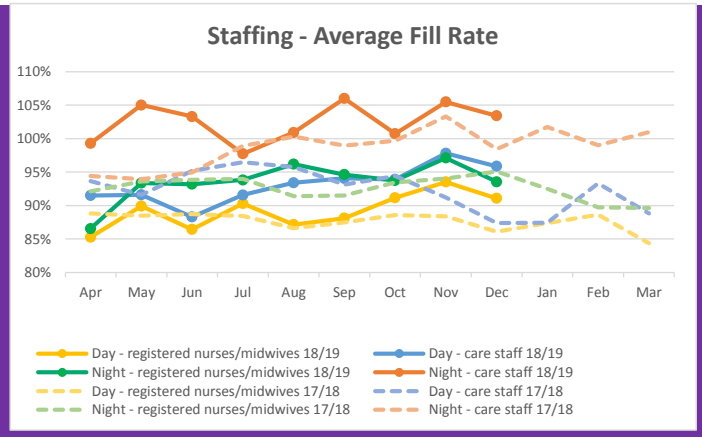
Quality Improvement - Trust Position

	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%	 	Inpatient Sepsis assessment and antibiotic administration continues to be maintained at 100% for November. ED - November figures are currently being validated, it has been confirmed that there Trust achieved 100% for screening for ED in October. The patient safety improvement nurse is visiting the wards with pathways to keep the awareness of Sepsis heightened, ED awareness work continues. Plan in place to upload the paper based pathway onto Lorenzo. We are currently awaiting completion of the validation of the December data.

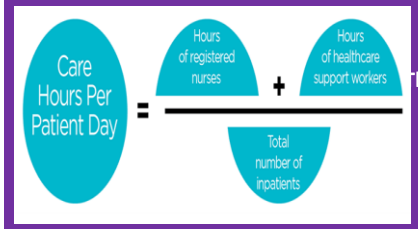
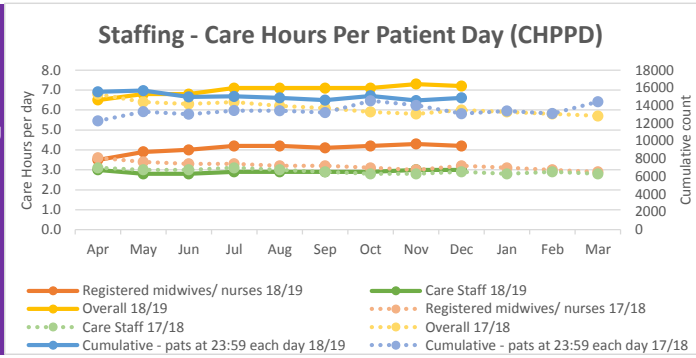
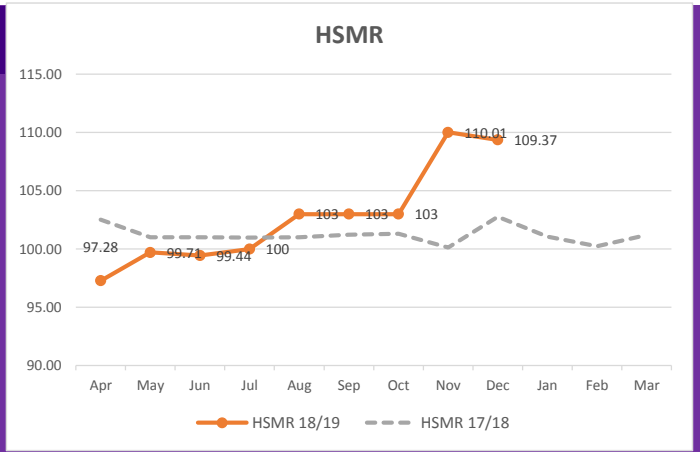
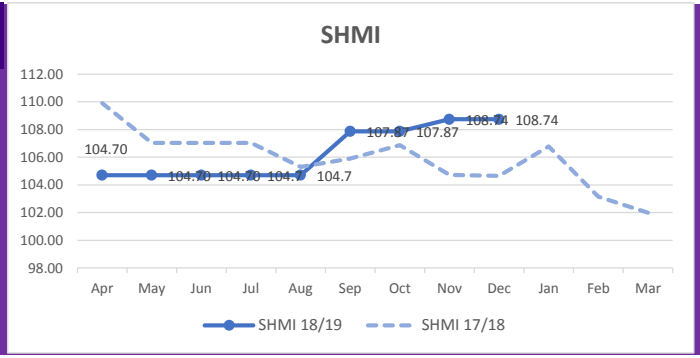
Quality Improvement - Trust Position

	Description	Aggregate Position	Trend	Variation
Total number of Falls & harm levels Red: <20% decrease from 17/18 Green >20% decrease from 17/18	Total number of falls per month and their relevant harm levels.	20% reduction in falls in 2018/19 using 2017/18 data as a baseline.	 	There were 0 Serious Incident falls reported during December. The overall number of reported falls has increased from 55 to 71 which is a 29.1% increase on the previous month. So far this financial year there has been 686 falls (including staff & visitor falls). This time last year for the same period there had been 659 falls which is a 4.1% increase. Following completion of the NHSI falls collaborative, improvement work will continue with support from the Trust Quality Academy. Weekly falls review meetings continue and falls walks in clinical areas. Themes are shared at TWSB. Inpatient falls increased from 38 in November, to 56 in December - A 47.4% increase on the previous month. However, the total number of inpatient falls in December was the 3rd lowest so far in 2018/19 - November (n=38), May (n=54) & December (n=56).
Pressure Ulcers Category 4 Red: 1 or more Category 3 Red: More than 3 Green: 3 or less Category 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.	Category 4 hospital acquired Category 3 hospital acquired Category 2 hospital acquired		3 category 2 and 1 category 3 PU recorded for December. Our performance for category 2 PU's currently is demonstrating a 7.5% reduction against the same time last year with common themes highlighted as: timely and accurate risk assessment, delay in obtaining equipment and failure to recognise risk factors. A role specific training programme has been developed and commenced in January 2019 with a TNA completed. Targeted training to be undertaken with the areas with a higher incidence, and reinforced senior nurse oversight. Category 2 PU's RCA meeting arranged for January 17th. Lessons learned document to be shared following support from Trust quality academy. The unstageable PU from ward A8 in November has now been confirmed as a category 4 PU- and a category 3 PU noted from B18 both have improvement plans in place.

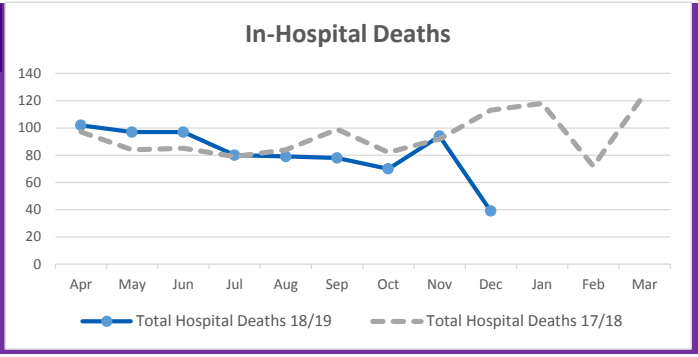
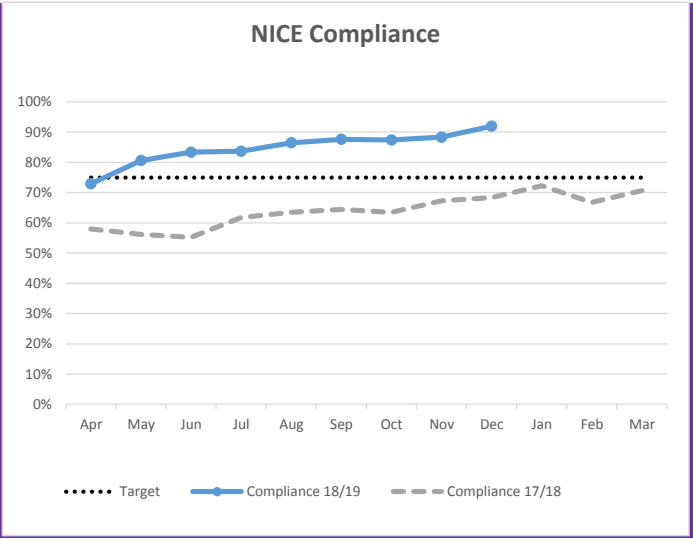
Quality Improvement - Trust Position

	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.		The percentage of Medicine Reconciliations completed within 24 hours of admission has increased year to date from 20% to 26% and within 48 hours from 38% to 46% but is still falling short of the target of 80% within 24 hours. The overall percentage medicines reconciliation has increased from 63% to 67%. The number and percentage achieved are affected by admission day, length of stay, Pharmacy staffing capacity particularly at admission points and the absence of a weekend on ward Pharmacy service for admissions. A business case has been submitted to support medicines reconciliation within 24 hours, Phase 1 funding has been approved. The number of Controlled Drug incidents reported in December (20) is higher than the previous month (15): There were 7 in Urgent & Emergency Care↑, 2 in Digestive Diseases↔, 3 in Integrated Care & Medicine↔, 3 in Medical Care↔, 1 in MSK↑ & 1 in Women's &Children's Health↔. Learning is being identified for dissemination to individuals and collectively. There have been 4 moderate medication harm incidents YTD, 3 are attributed to Medical Care, 1 to Integrated Medicines & Community. 3 have been reviewed and learning identified for dissemination, 1 is under review. The percentage of medication harm incidents graded 2 or above is on a downward trend. Recruitment of a full time MSO and additional ITU pharmacist resource is underway to support the safe use of medicines.
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.		The majority of areas are above the 90% target YTD, and those that are below the target mitigation and responsive plans are in place to ensure that the safe delivery of patient care. Staffing is discussed at every bed meeting and escalated as appropriate. Shift fill rates have increased in recent months, which further supports safe staffing levels on the wards. Bank incentives and escalated rates for critical areas are in use to support additional beds over the winter months.

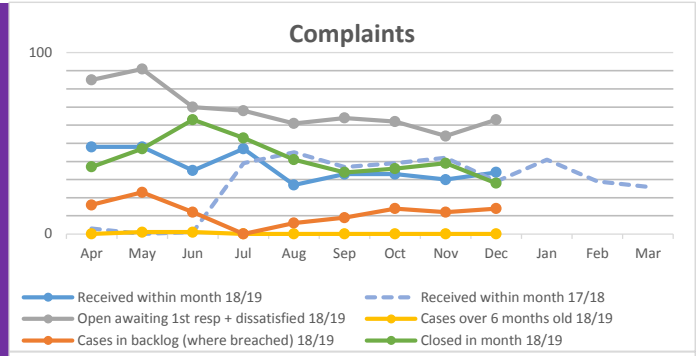
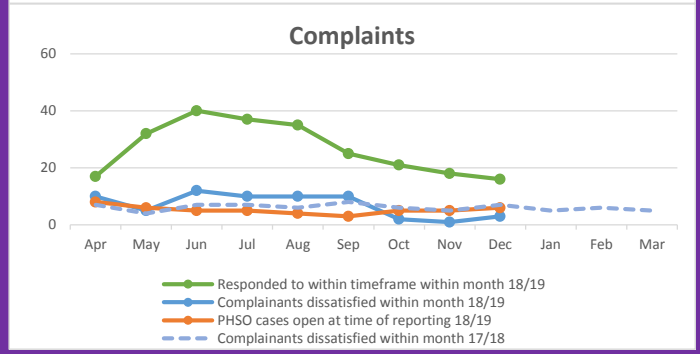
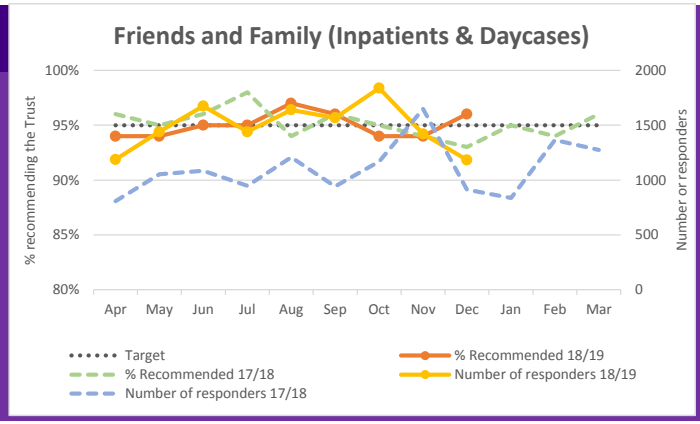
Quality Improvement - Trust Position

	Description	Aggregate Position	Trend	Variation
Staffing - Care Hours Per Patient Day (CHPPD)		The data produced excludes CCU, ITU and Paediatrics and does not have an associated target.		CHPPD is recorded at 7.2 in December which is maintaining the current improvements since July 2018. Recruitment to all vacant nursing posts remains a priority for the senior nursing team, which will support the further improvements in staffing and CHPPD going forwards.
Mortality ratio - HSMR Red: Greater than expected Green: As or under expected	CQC 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.		Both HSMR and SHMI are within expected range, however this will be closely monitored by the mortality review group.
Mortality ratio - SHMI Red: Greater than expected Green: As or under expected	SOF CQC 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 has risen to 108.74 from 107.87. This is in part to a number of deaths in the Diagnostic Groups: Congestive Heart Failure (11) and Pleurisy; Pneumothorax. The Mortality Review Group will review all deaths to understand if there are any care issues on which we need to take action. In addition, the Quality Committee has also asked for a coding report to be presented to the next meeting to understand the impact of coding on the increased mortality indices.

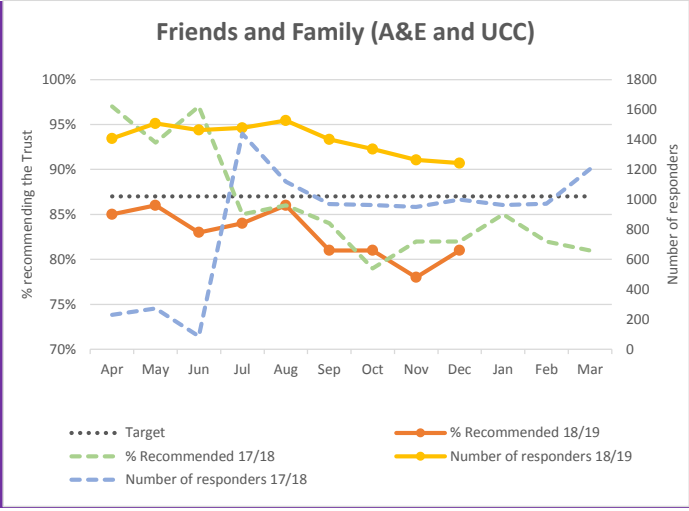
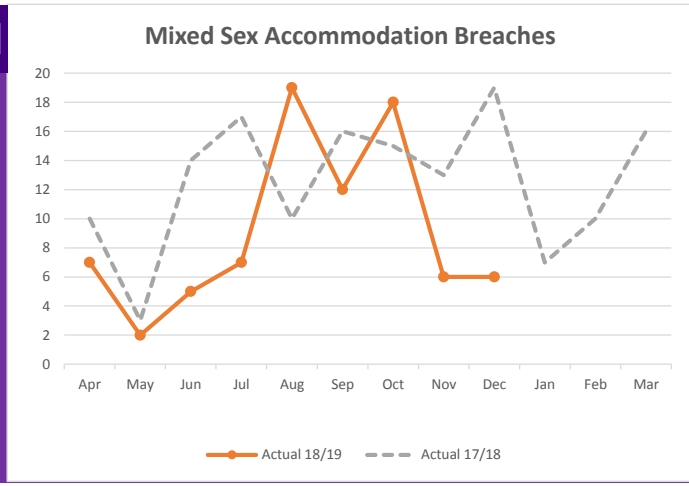
Quality Improvement - Trust Position

	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.		All Standard Judgment Reviews (SJRs) are being tracked through Mortality Review Group, reporting to Patient Safety & Effectiveness Sub-Committee. The Trust will report avoidable mortality in the Quality Account, which is currently being prepared. Any review conducted where there 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.		There is 1 piece of NICE Guidance outside the 90 day assessment period: NG89 - VTEs in over 16's - work has commenced on this regarding completion of baseline assessment.

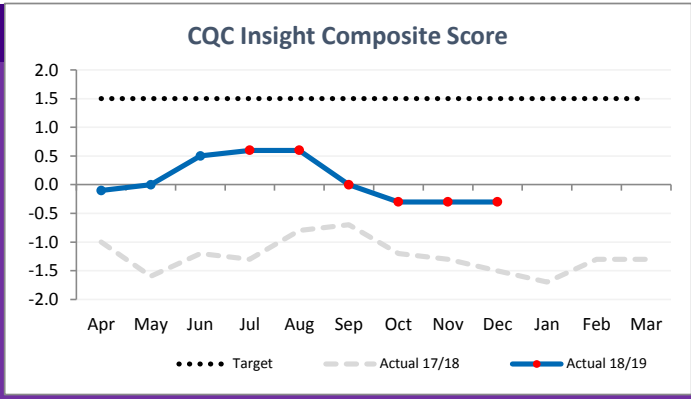
Quality Improvement - Trust Position

	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.	 	The Trust now holds no complaints over 6 months and has 14 complaints that have breached their deadline, which is an increase on last month. Timeliness in responding has increased (November 45.7%, December 56.3%). The Trust has received a below average number of complaints in month, based on the number received over the past year. The Trust has seen an increase in the amount of dissatisfied complaints from the previous month, with 3 cases being recorded. The Trust has closed 2 complaints in December which have been deemed to be serious incidents.
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%.		96% of our patients recommend our inpatient and day case services which exceeds a target of 95%. The response rate has decreased slightly to 25.5%. Positive themes about staff attitude increased from 392 in Nov 2018 to 481 in Dec 2018, praising the kindness, politeness and friendliness of the staff for inpatients.

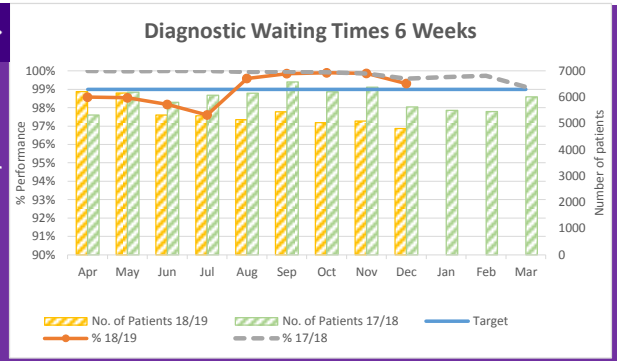
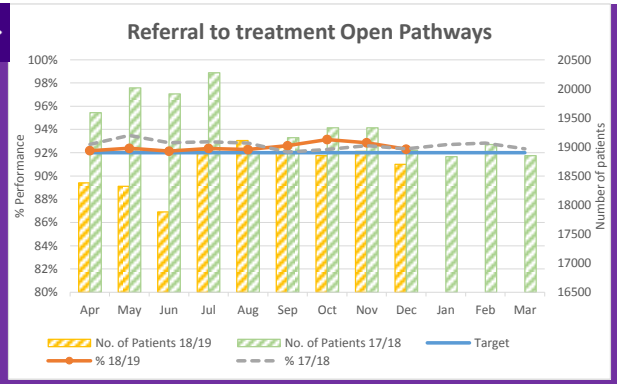
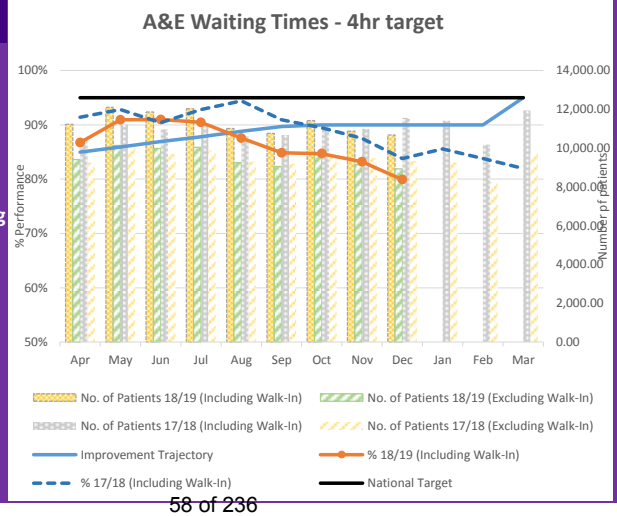
Quality Improvement - Trust Position

	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%.		The target for the Trust for patients attending A&E and/or UCC and providing a positive feedback has increased to 81% from 78% last month, from a target of 87%. The response rate has improved from 16.5% to 17.8%. Halton UCC (paediatric element) has significantly improved from the November 2018 position, with 80% of patients attending, recommending the service in comparison to 65.2% in November 2018. The Lead Nurse responded to the data and patients comments in the November 2018 feedback and addressed the issues, which supports the improvement.
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.		MSA breaches, in totality, have not increased since Nov 2018 (n=6). Coronary Care Unit had no reported MSA breaches and ICU reported six breaches in Dec 2018. The ICU breaches occurred as a result of the trust "Red" status and one was delayed as a result of infection prevention issues on a ward, resulting in reduced capacity to move the patient out of the unit. Further work is being progressed with the planned implementation of 3 cubicles within the critical care unit.

Quality Improvement - Trust Position

	Description	Aggregate Position	Trend	Variation
CQC Insight Composite Score Red (inadequate): <-3 Amber (req improvement): >-2.9 - 1.5 Green (good/outstanding): >1.5	**CQC** 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"		The Trust composite is a pilot indicator created from 12 specific indicators within Insight. The composite indicator score helps to assess a trust's overall performance but it is not a rating or a judgement. As a Trust we are aiming at achieving 1.5. As of November 2018 we are currently at -0.2 which has dropped since our summer score of 0.6. The reason for the lower score relates to a decrease in performance for the following indicators; Patients spending less than 4 hours on major A&E and NRLS – Proportion of reported patient safety incidents that are harmful.

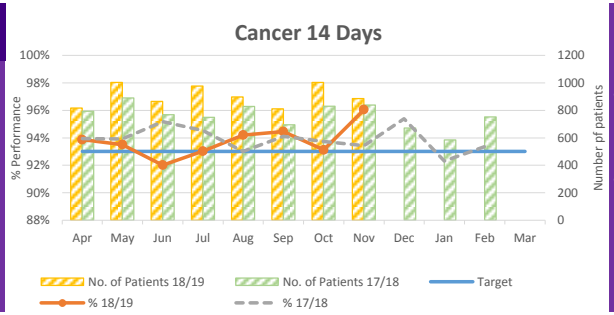
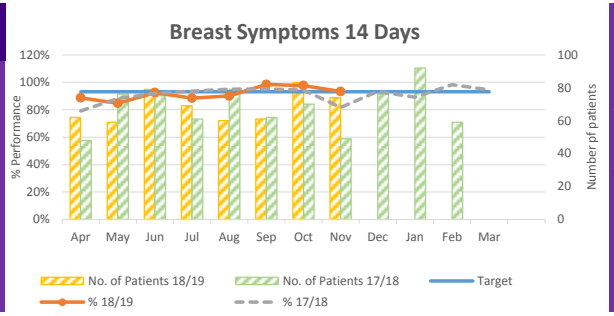
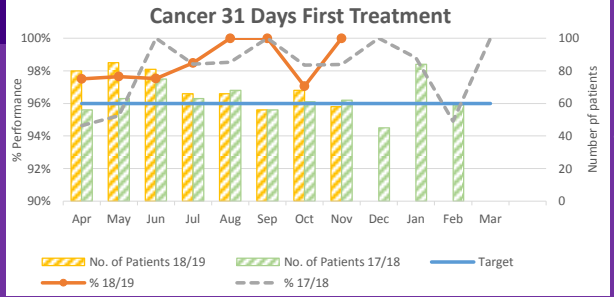
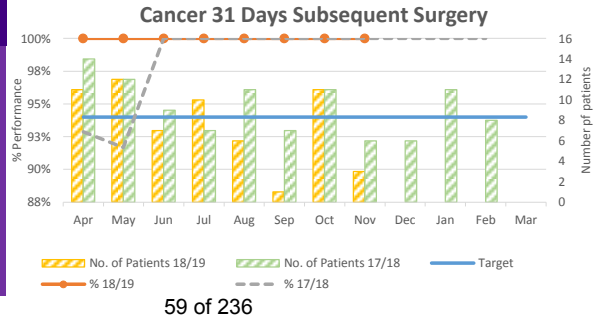
Mandatory Standards - Access & Performance - Trust Position

	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 99.31% in December 2018.		The Trust achieved the diagnostic standard in December 2018, achieving 99.31% against a target of 99%.
Referral to treatment Open Pathways Red: Less than 92% Green: 92% or above 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 92.31% in December 2018.		The Trust achieved the 18 week referral to treatment target, achieving 92.31% against a target of 92%.
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 79.93% (including walk in) and 76.38% (excluding walk in) in December 2018.		The Trust achieved 79.93% (including Widnes UCC) which fell below the agreed NHSI performance improvement trajectory of 90.0%. There are a number of actions in place to support improvement against this standard which have included, the ward reconfiguration of A3, C21 and CCU, opening of a dedicated Discharge Lounge, FAU operationalisation 5 days per week, IMPACT 5 focusing on stranded and super stranded patients and a review of ward rounds. In addition, the Urgent & Emergency Care CBU have opened a new ED Ambulatory Care Unit in the vacant CCU space form January 2019 and have plans to open a GP Assessment Unit (GPAU) as soon as the original ambulatory care unit has been de-escalated.

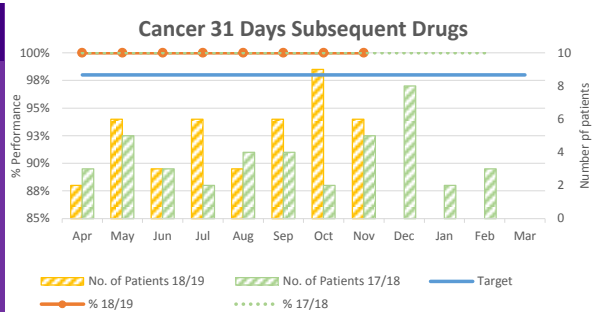
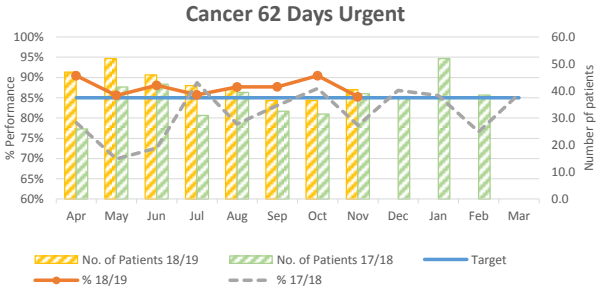
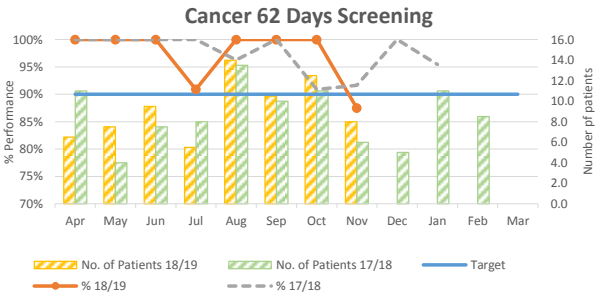
Integrated Dashboard - December 2018

Key:
Single Oversight Framework
Care Quality Commission

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 96.05% in November 2018 - please note cancer validation is not completed until 8 weeks after the end of the reporting period.		The Trust achieved the Cancer 14 day target in November 2018. The December data is in draft format and will only be released once fully validated and uploaded.
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 93.24% in November 2018 - please note cancer validation is not completed until 8 weeks after the end of the reporting period.		The 2 week wait for Breast Symptomatic has achieved 93.24% in November 2018. This continues to improve the number of people who are able to access appointments within 7 days.
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 100% in November 2018 - please note cancer validation is not completed until 8 weeks after the end of the reporting period.		The Trust achieved this target in November 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 November 2018 - please note cancer validation is not completed until 8 weeks after the end of the reporting period.		The Trust achieved this target in November 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 November 2018 - please note cancer validation is not completed until 8 weeks after the end of the reporting period.		The Trust achieved this target in November 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 85.19% in November 2018 - please note cancer validation is not completed until 8 weeks after the end of the reporting period.		The Trust achieved this target in November 2018.
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 87.50% in November 2018 - please note cancer validation is not completed until 8 weeks after the end of the reporting period.		The Trust achieved 87.5% in November 2018 against a standard of 90%. Unfortunately, this was due to another Trust clearing their backlog which had a negative impact upon us due to breach allocations.

Integrated Dashboard - December 2018

Key:
Single Oversight Framework
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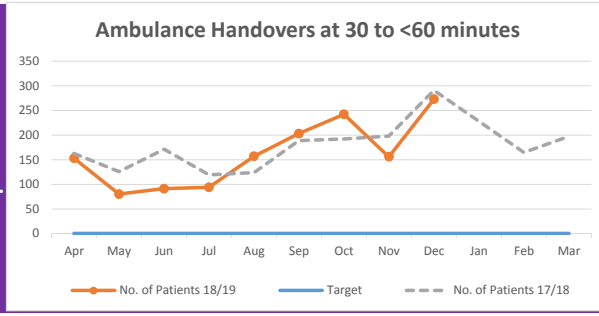
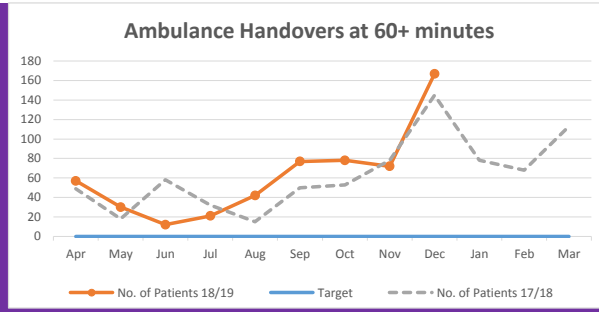
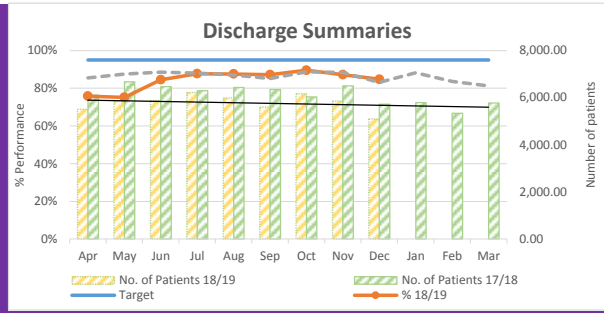
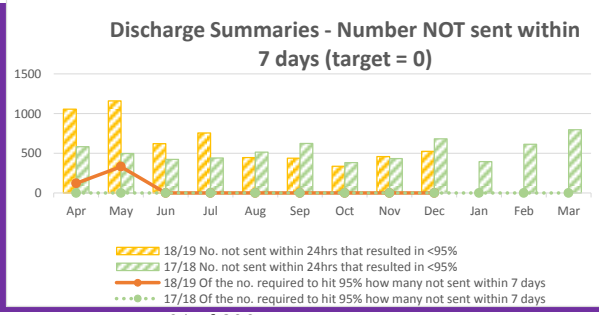
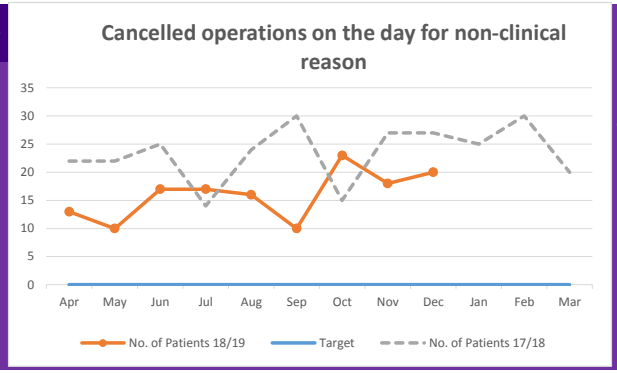
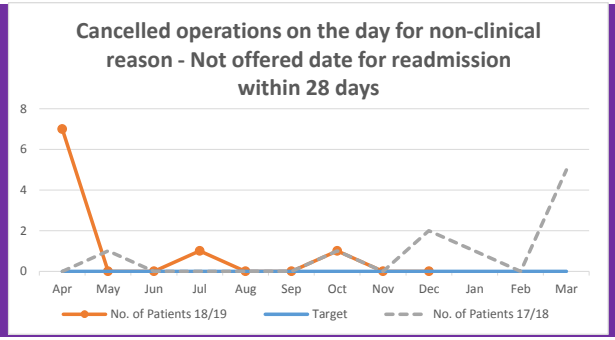
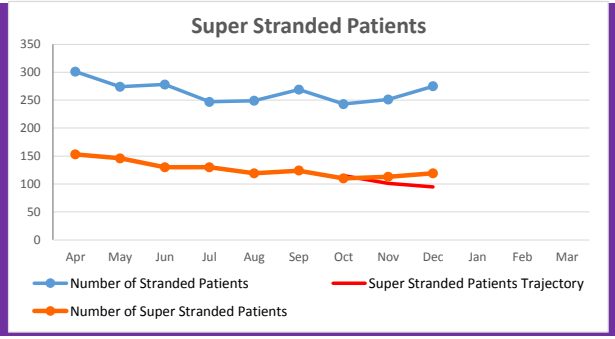
Mandatory Standards - Access & Performance - Trust Position

	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 273 patients where the ambulance handover was between 30 and 60 minutes in December 2018.		Ambulance handovers remain a challenge particularly when we have peaks in attendances within an hour, in line with the under achievement in performance against the NHSI trajectory this position has deteriorated in December.
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 167 patients where the ambulance handover was more 60 minutes in December 2018.		Directly correlating to the emergency access standard, ambulance handovers remain have continued to be challenging particularly when we have peaks in attendances within an hour. Performance in December 2018 peaked for the number handover within the 30 to 60 mins timeframe. Positively, the HAS compliance score has improved. The UEC CBU team have focused on this standard into January 2019 which has seen significant improvement and allowed timely handovers to take place.
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 84.73% in December 2018.		The Trust continues to drive compliance improvement across all CBUs. This is monitored via the weekly & monthly KPI meetings. There is an SoP in place to support compliance against this standard.
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 in order to meet the 95% threshold were sent in December 2018.		The Trust achieved this target in December 2018.

Mandatory Standards - Access & Performance - Trust Position

	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 20 operations cancelled on the day due to non-clinical reasons in December 2018.		There was a slight increase in the number of cancelled operations on the day in December and all were readmitted within the specified time and no breeches recorded. The cancellations are being actively monitored weekly to ensure lessons are learnt.
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 were no patients whose operation was cancelled on the day for non-clinical reasons whom was not readmitted within 28 days in December 2018.		The Trust achieved this standard in December 2018.
Super Stranded Patients Green: Meeting Trajectory Red: Missing Trajectory	Stranded Patients are patients with a length of stay of 7 days or more. Super Stranded patients are patients with a length of stay of 21 days or more.	There were 275 stranded patients and 119 super stranded patients at the end of October 2018.		Impact 5 (perfect week methodology) was undertaken proactively during week commencing 17th December 2018 and directly following the New Year from 2nd January 2019. This did achieve a reduction of super stranded patients to supersede the Trust objective of 86 patients with a LoS of 21 days or greater prior to the festive period. Teams continue to focus on individual wards to expedite the discharge process sustaining learning from the IMPACT 5 weeks.

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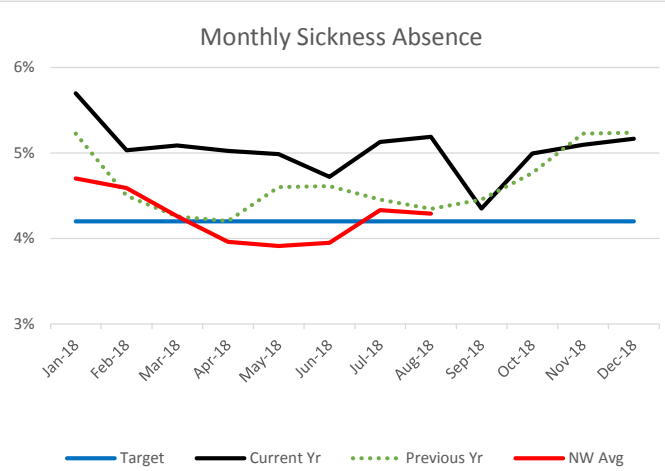
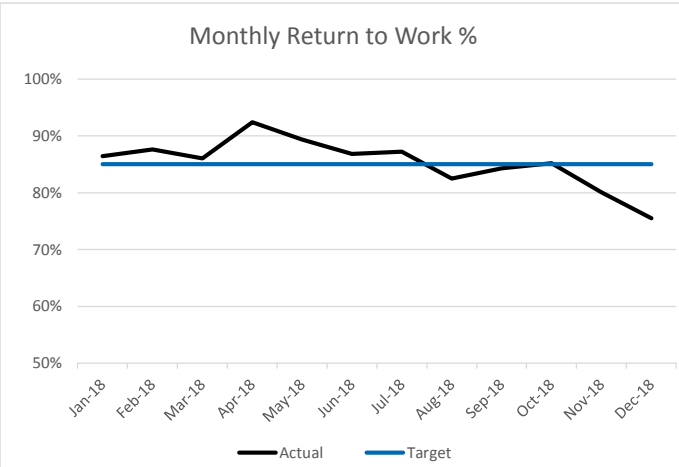
	Description	Aggregate Position	Trend	Variation
Sickness Absence Red: Above 4.5% Amber: 4.2% to 4.5% Green: Below 4.2%	Comparing the monthly sickness absence % with the Trust Target (4.2%) previous year, and North West average	Sickness absence in December 2018 was 5.17%.		Sickness absence is closely managed by line managers across the Trust, in line with the Attendance Management Policy and supported by the HR Team. The HR and OD Directorate are have undertaken a piece of work to review attendance management approaches, initiatives and processes within our peer Trust to make recommendations for application at WHH. This piece of work will be presented to Trust Board in January 2019. The Nursing Sickness Absence Reporting Pilot has been extended and an evaluation will take place in March 2019. Mental Health and Musculoskeletal related absence continue to be key causes of absence. A review of provision of mental health services and physiotherapy services to staff within Occupation Health is in progress. Engagement with the workforce has been undertaken to gather feedback on how the Trust supports staff and this will form part of the reviews. A refreshed service delivery plan will be complete for implementation in Q1 2019/2020.
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 December 2018 is currently reported at 75%.		To be noted is the pattern of low reporting of RTW compliance followed by an increase in compliance the following month. 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 to either E-Rostering or ESR. The HRBP team continue to work with the CBU/Departments to raise this importance of this aspect of the attendance policy. An exercise to check RTWI paperwork compliance in selected areas was undertaken in December 2018 and showed that 85% were completed.

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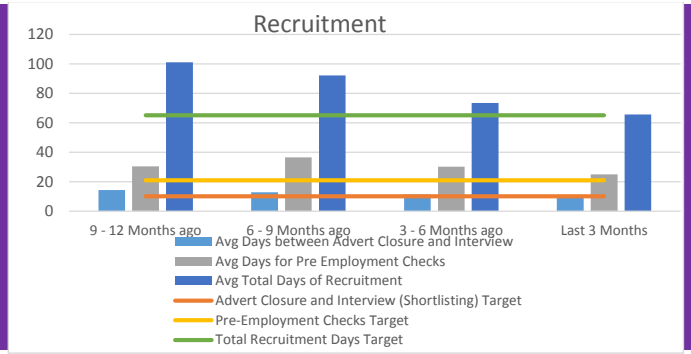
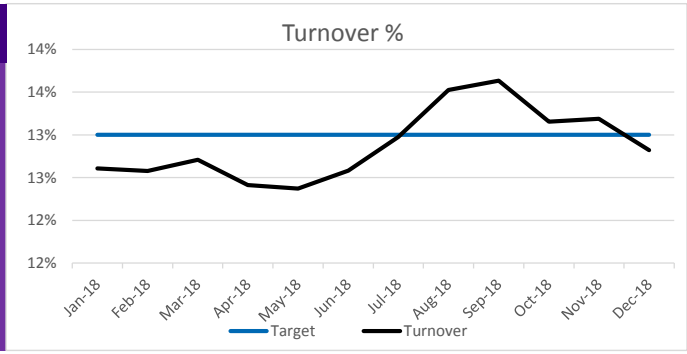
	Description	Aggregate Position	Trend	Variation
Recruitment Red: 76 days or above Amber: 66 to 76 days Green: 65 days or	A measurement of the average number of days it is taking to recruit into posts. It also shows the average number of days between the advert closing and the interview (target 10) to 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 reduced to 65.7 days over the last 3 months.		Average time to recruit over the last 3 months has been within target. The Recruitment Team continue to work with the Regional Streamlining Group to identify opportunities to further reduce timescales.
Turnover Red: Above 15% Amber: 13% to 15% Green: Below 13%	A review of the turnover percentage over the last 12 months	Turnover has reduced in month to 12.82%, against a target of 13%.		Turnover has reduced in month and is now 0.15% below the target. The refreshed People Strategy includes a focus on how we retain talent within the organisation, including reviewing data collection at exit, retention initiatives and building career pathways.

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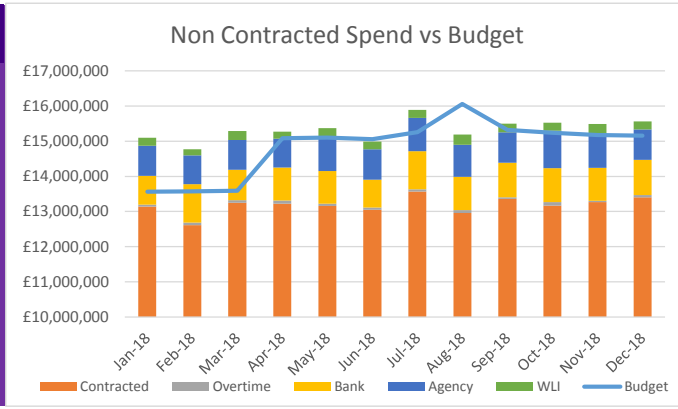
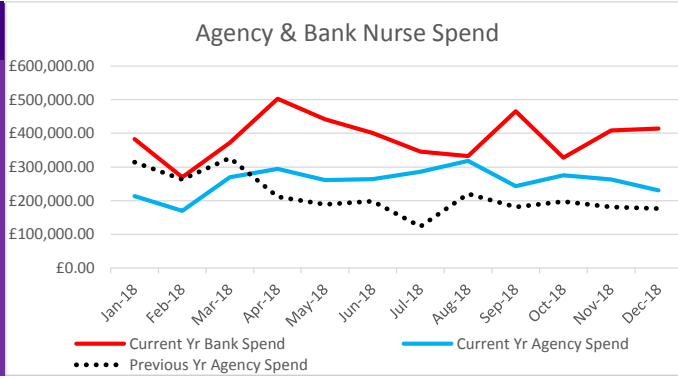
	Description	Aggregate Position	Trend	Variation
Non Contracted Pay Red: Greater than Budget Green: Less than Budget	A review of the Non-Contacted pay as a percentage of the overall pay bill year to date	Total pay spend in December 2018 was £15.6m against a budget of £15.2m. Non-contracted pay spend was £2.2m.		Temporary staffing usage in December 2018 was 13.9%. A number of work streams to address temporary staffing spend are on going and are managed via the Premium Pay Spend Review Group. These include a review of plans in areas with high temporary staffing usage, a centralised temporary staffing model and collaborative work across Cheshire and Mersey Region.
Agency Nurse Spend Red: Greater than Previous Yr Green: Less then	A review of the monthly spend on Agency Nurses	Agency Nurse Spend was £231k and Bank Nurse Spend £391k in December 2018.		Throughout December 2018 there were 7,418 hours of agency work undertaken at a cost of £231k. Temporary staffing usage in Nursing and Midwifery in December 2018 equated to approximately 115 FTE. There were 10,892 hours of bank work undertaken at a cost of £391k. Temporary staffing usage in Nursing and Midwifery in December 2018 equated to approximately 115 FTE.

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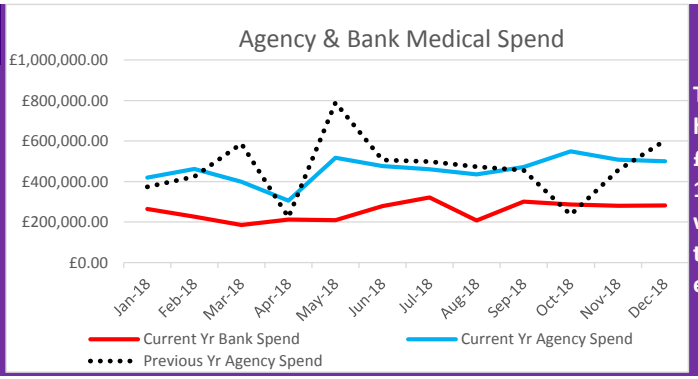
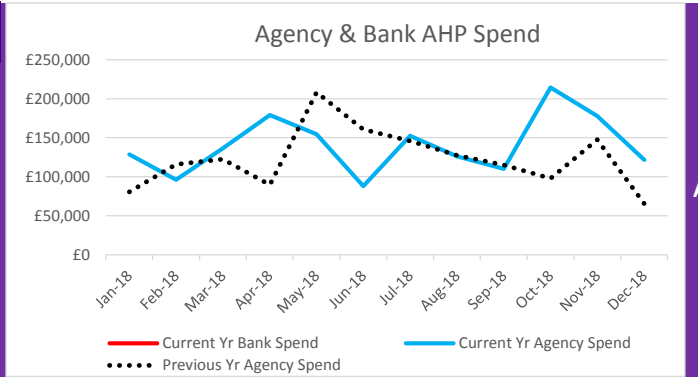
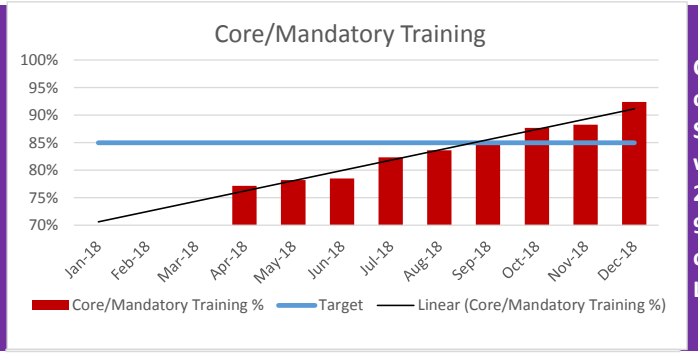
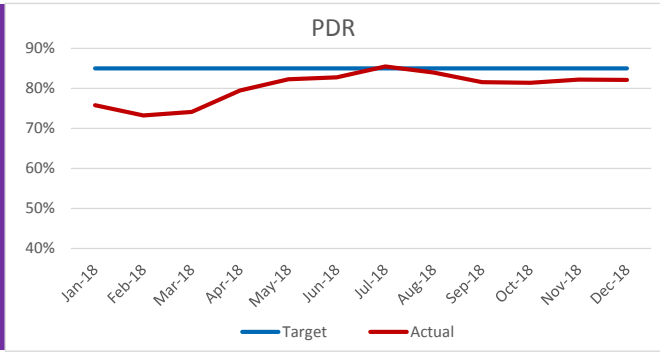
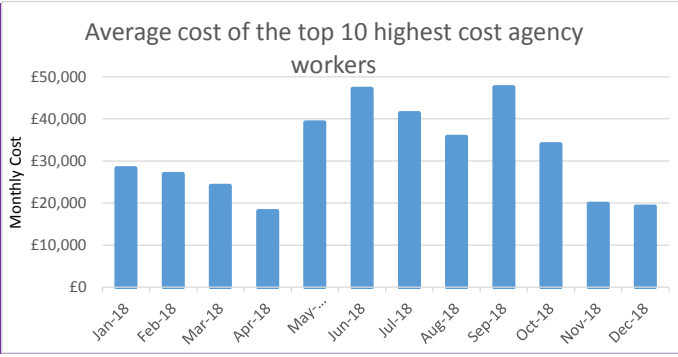
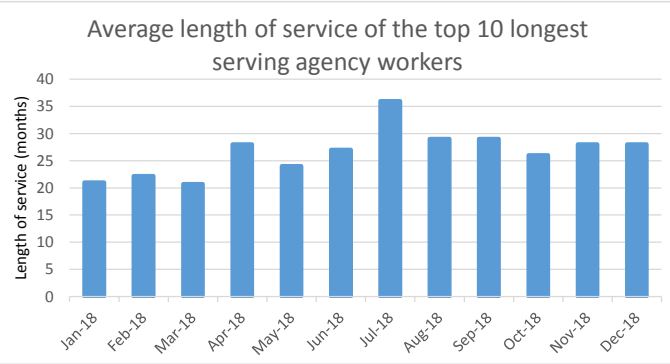
	Description	Aggregate Position	Trend	Variation
Agency Medical Spend Red: Greater than Previous Yr Green: Less then	A review of the monthly spend on Agency Locums	Medical Agency Spend was £500k and Bank Medical Spend was £344k in December 2018.		Throughout December 2018 there were 5,067 hours of agency work undertaken at a cost of £500k. Breech cap form compliance was 100%. Medical bank spend in December 2018 was £334k. Temporary staffing usage across the Medical workforce in December 2018 equated to approximately 51 FTE.
Agency AHP Spend Red: Greater than Previous Yr Green: Less then Previous Yr	A review of the monthly spend on AHP Locums	AHP Agency Spend was £122k in December 2018.		AHP Agency Spend has reduced in month.
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 Safeguarding.	Core Skills Mandatory Training Compliance was 92% in December 2018.		Core Skills Training remains above target overall. A session took place to support Subject Matter Experts in reviewing all topics which were not 85% compliant in November 2018. As at December 2018 compliance was 92% and all mandatory topics were over 85% compliant with the exception of Resuscitation Level 2 which was 82%.

Workforce

	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 82% in December 2018.		Compliance remains below target. A more detailed breakdown of compliance at CBU / Departmental level in December 2018 is presented to and scrutinised by Operational People Committee and Getting to Good Steering Group.
Average cost of the top 10 highest cost Agency Workers Red: Greater than previous month Green: Less than previous month	Monthly costs for the top 10 highest cost Agency Workers	The monthly cost for the top earning agency workers ranged from £14k to £33k, with the average cost being £19k.		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 Green: Less 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 18 months to 36 months with the average length of service being 28 months.		The length of service for agency workers is reported on a weekly basis to NHSI.

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Key:
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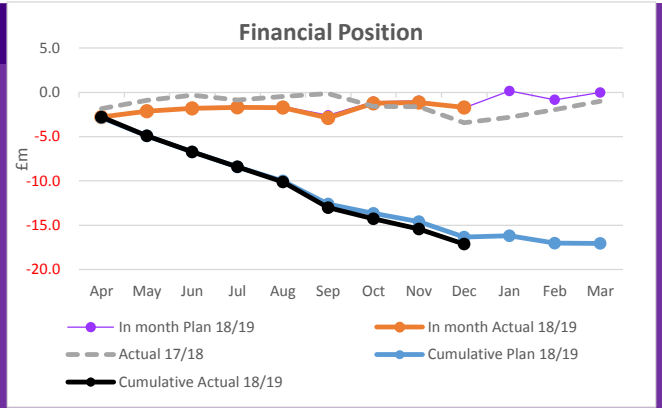
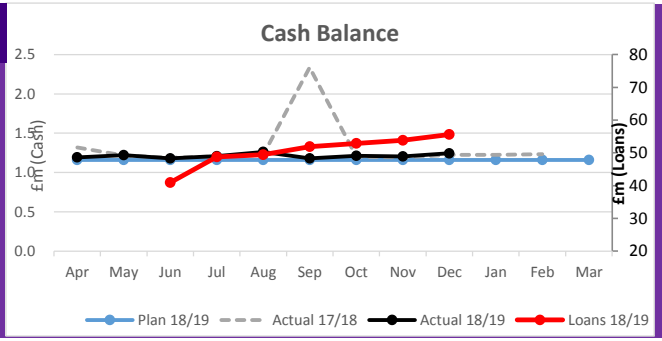
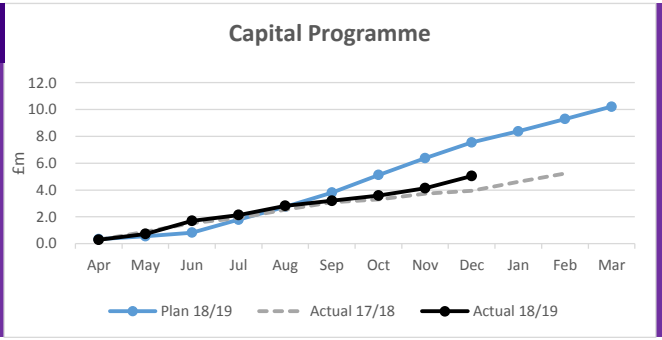
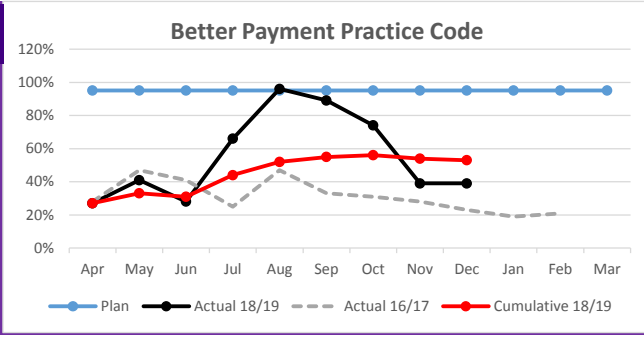
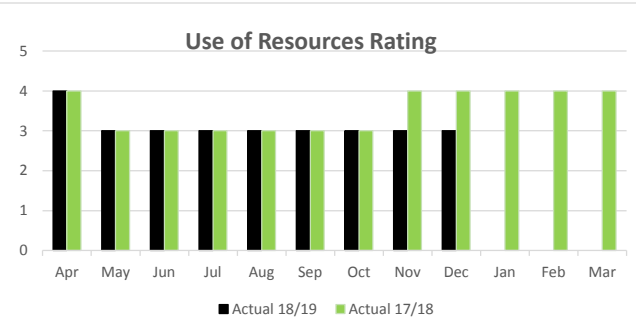
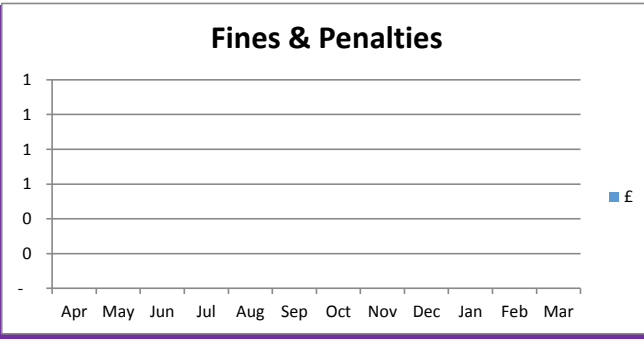
Sustainability & Mandatory Standards - Finance

	Description	Aggregate Position	Trend	Variation
Financial Position Red: Deficit Position Amber: Actual on or better than planned but still in deficit Green: Surplus	Operating surplus or deficit compared to plan.	The actual deficit in the month is £1.7m which increases the cumulative deficit to £17.1m.		The cumulative deficit of £17.1m is £0.8m below plan. The year to date control total (excluding Provider Sustainability Funding) is a £19.4m deficit which 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	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.		The current cash balance of £1.2m is in line with plan.
Capital Programme Red: Off plan <80% - >110% Amber: Off plan 80-90% or 101 - 110% Green: On plan 90%-100%	Capital expenditure compared to plan (The capital plan has been increased to £10.2m as a result of additional funding from the Department of Health, Health Education England for equipment and building enhancements).	The actual capital spend in the month is £0.9m which increases the cumulative spend to £5.0m.		The cumulative capital spend of £5.0m is £2.5m below the planned capital spend of £7.5m. The phasing of the capital expenditure relating to the Kendrick Wing fire and scheme slippage is the main reason for the current position.

Integrated Dashboard - December 2018

Key:
Single Oversight Framework
Care Quality Commission
Use of Resources Assessment

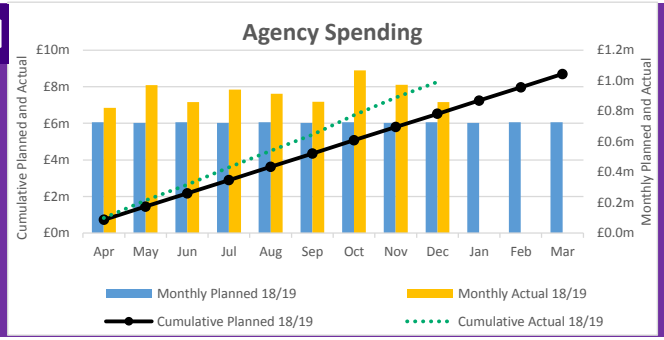
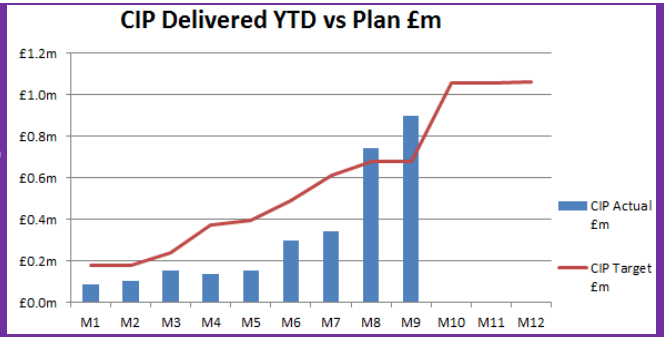
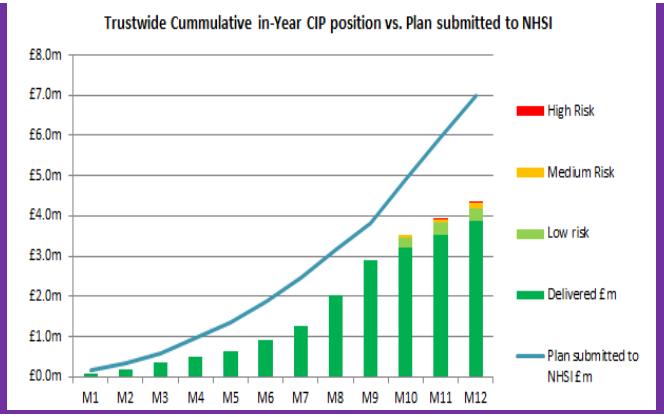
Sustainability & Mandatory Standards - Finance

	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	Payment of non NHS trade invoices within 30 days of invoice date compared to target.	In month the Trust has paid 39% of suppliers within 30 days which results in a year to date performance of 53%.		The cumulative performance of 53% is 42% below the national standard of 95%, this is due to the low cash balance and the need to manage cash very closely.
Use of Resources Rating Red: Use of Resource Rating 4 Amber: Use of Resource Rating 3 Green: Use of Resource Rating 1 and 2	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, Agency Ceiling is scored at 3 and performance against control total is scored at 2.		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.		The Trust has not been notified by commissioners of any fines or penalties as of month 8. A previous penalty levied by NHS England for the non-achievement of CQUIN has been withdrawn as the Trust was able to demonstrate compliance. The Trust has agreed with commissioners in Warrington & Halton to reinvest any fines and penalties as part of the sustainability contract.

Integrated Dashboard - December 2018

Key:
Single Oversight Framework
Care Quality Commission
Use of Resources Assessment

Sustainability & Mandatory Standards - Finance

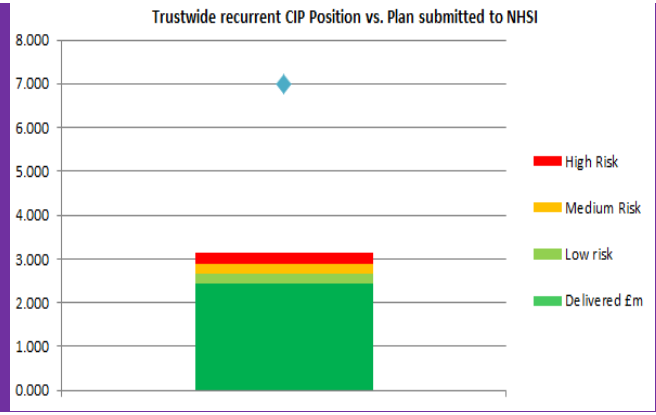
	Description	Aggregate Position	Trend	Variation
Agency Spending Red: More than 105% of ceiling Amber: Over 100% but below 105% of ceiling Green: Equal to or less than agency ceiling.	Agency spend compared to agency ceiling	The actual agency spend in the month is £0.9m which increases the cumulative spend to £8.3m.		The cumulative agency spend of £8.3m is £1.8m (27%) above the cumulative agency ceiling of £6.5m.
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 schemes deliver Year to Date (YTD) compared to plan	M9 YTD CIP £2.91m delivered vs YTD target £3.83m (76% of target).		YTD M9 the Trust is £0.92m behind plan.
Cost Improvement Programme - Plans in Progress - In Year Red: Forecast is less than 50% of annual target Amber: Forecast is between 50% and 90% of the annual target Green: Forecast is more than 90% of the annual target	Cost savings schemes in-year compared to plan.	Best case In-year forecast for CIP is £4.36m (62% of target).		Best case In-Year forecast for CIP is £4.36m - £2.64m below £7m target.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - December 2018

Key:
Single Oversight Framework
Care Quality Commission
Use of Resources Assessment

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	**Cost savings schemes recurrent compared to plan.** **Best case Recurrent forecast for CIP is £3.14m (45% of target).**		**Best case Recurrent forecast for CIP is £3.14m - £3.86m below £7m target.**

Appendix 3

Income Statement, Activity Summary and Use of Resources Ratings as at 31st December 2018

Income Statement	Month			Year to date		
	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Operating Income						
NHS Clinical Income						
Elective Spells	2,545	2,210	-335	25,454	22,635	-2,819
Elective Excess Bed Days	8	2	-5	76	80	5
Non Elective Spells	5,005	4,747	-258	43,883	44,125	242
Non Elective Excess Bed Days	171	94	-77	1,496	1,822	326
Outpatient Attendances	2,517	2,459	-59	25,175	25,234	60
Accident & Emergency Attendances	1,171	1,167	-4	9,997	10,865	868
Other Activity	5,722	6,017	295	50,973	52,679	1,707
Sub total	**17,139**	**16,696**	**-443**	**157,053**	**157,441**	**388**
Non NHS Clinical Income						
Private Patients	20	2	-18	91	98	7
Non NHS Overseas Patients	4	11	7	33	54	21
Other non protected	95	78	-17	855	765	-90
Sub total	**119**	**92**	**-27**	**979**	**917**	**-62**
Other Operating Income						
Training & Education	641	642	0	5,770	5,926	156
Donations and Grants	0	79	79	0	177	177
Provider Sustainability Fund (PSF)	494	49	-445	3,212	2,246	-966
Miscellaneous Income	1,575	3,183	1,608	14,172	17,700	3,528
Sub total	**2,710**	**3,952**	**1,242**	**23,154**	**26,049**	**2,895**
Total Operating Income	**19,968**	**20,740**	**772**	**181,187**	**184,408**	**3,221**
Operating Expenses						
Employee Benefit Expenses	-14,794	-15,562	-768	-134,610	-138,802	-4,193
Drugs	-1,419	-1,248	172	-12,794	-12,207	588
Clinical Supplies and Services	-1,716	-1,840	-124	-15,554	-16,279	-725
Non Clinical Supplies	-3,034	-2,986	48	-27,796	-27,497	299
Depreciation and Amortisation	-501	-503	-2	-4,505	-4,444	62
Restructuring Costs	0	0	0	0	0	0
Total Operating Expenses	**-21,463**	**-22,138**	**-674**	**-195,260**	**-199,229**	**-3,969**
Operating Surplus / (Deficit)	**-1,495**	**-1,398**	**98**	**-14,073**	**-14,821**	**-748**
Non Operating Income and Expenses						
Profit / (Loss) on disposal of assets	0	-23	-23	0	-23	-23
Interest Income	3	7	4	27	63	36
Interest Expenses	-64	-66	-3	-652	-656	-5
PDC Dividends	-181	-181	0	-1,632	-1,632	0
Net Impairments	0	0	0	0	0	0
Total Non Operating Income and Expenses	**-242**	**-264**	**-22**	**-2,257**	**-2,248**	**8**
Surplus / (Deficit)	**-1,737**	**-1,661**	**76**	**-16,330**	**-17,069**	**-739**
Donations & Grants Income	0	-79	-79	0	-177	-177
Depreciation on Donated & Granted Assets	13	14	1	117	123	6
Performance against Control Total inc PSF	**-1,724**	**-1,726**	**-2**	**-16,213**	**-17,124**	**-911**
Less PSF	-494	-49	445	-3,212	-2,246	966
Performance against Control Total exc PSF	**-2,219**	**-1,775**	**443**	**-19,425**	**-19,370**	**55**
Activity Summary	**Planned**	**Actual**	**Variance**	**Planned**	**Actual**	**Variance**
Elective Spells	2,714	2,422	-292	27,137	25,314	-1,823
Elective Excess Bed Days	31	10	-21	312	333	21
Non Elective Spells	3,144	2,527	-617	27,578	25,193	-2,385
Non Elective Excess Bed Days	702	397	-305	6,158	7,592	1,434
Outpatient Attendances	23,468	23,441	-26	234,676	234,175	-502
Accident & Emergency Attendances	9,998	8,934	-1,064	85,376	85,639	263
Use of Resources Ratings	**Planned Metric**	**Actual Metric**	**Variance Metric**	**Planned Metric**	**Actual Metric**	**Variance Metric**
Metrics						
Capital Servicing Capacity (Times)				-4.08	-3.90	0.19
Liquidity Ratio (Days)				-9.1	-32.3	-23.1
I&E Margin (%)				-8.95%	-9.29%	-0.35%
Performance against control total (%)				0.00%	-0.35%	-0.35%
Agency Ceiling (%)				0.00%	26.77%	26.77%
Ratings						
Capital Servicing Capacity (Times)				4	4	0
Liquidity Ratio (Days)				3	4	1
I&E Margin (%)				4	4	0
Performance against control total (%)				1	2	1
Agency Ceiling (%)				1	3	2
Use of Resources Rating				**3**	**3**	**0**

Appendix 4

2018/19 Capital Programme

Proposed Amendments

Description	Approved Programme 2018/19	Approved Amendments M1 - M8 2018/19	Proposed Amendments M9 2018/19	Total Revised Programme 2018/19
	£000	£000	£000	£000
Estates				
Backlog - Replace emergency back-up generators	400	7	0	407
Staffing	177	0	0	177
Fire - Appleton Wing, Fire Damper Second Phase, Installation	0	16	0	16
Backlog - All areas, fixed installation wiring test	50	0	0	50
Backlog - footpath, road and car park surface repairs	0	2	0	2
Six Facet Survey (annual rolling programme) to include dementia & disability	60	0	0	60
Backlog - Asbestos re-inspection & removals	30	0	0	30
Halton Endoscopy Essential power supply to rooms 1 & 2	20	0	0	20
Backlog - Air Con/ Cooling Sys upgrade. Ph1-Survey	12	0	0	12
Automatic sliding / entrance doors across all sites	20	0	0	20
External Fire Escapes Replace (Kendrick & Appleton)	40	3	0	43
Estates Minor Works	50	3	0	53
High Voltage Maintenance	40	0	0	40
Substation C air circuit breakers	404	(202)	0	202
Electrical Infrastructure Upgrade	200	0	0	200
North Lodge fire compartmentation	150	0	0	150
Appleton Wing fire doors	100	0	0	100
Thelwall House emergency escape lighting	100	0	0	100
North Lodge & Kendrick lightening protection works	100	0	0	100
Cheshire House fire doors	25	0	0	25
CCU relocation to Ward A3	703	0	0	703
B4 Enabling Works Re A3 Conversion	25	0	0	25
Removal of redundant chillers - Croft Wing	30	0	0	30
Replacement Combi Oven (Halton Kitchems)	0	9	0	9
Ophthalmic Flat Roof Replacement	0	23	0	23
Delamere Centre (Can Treat) Enhancements (Externally Funded)	0	84	0	84
Discharge Lounge/Bereavement Office	0	208	0	208
Essential Power Supply - Halton Pharmacy	0	6	0	6
Bathroom A9	0	28	0	28
N20 Exposure	0	100	0	100
Urology - Minor Refurb	0	7	0	7
B3 Door	0	5	0	5
Catering EHO Works	0	35	0	35
CQC (Environmental Improvements)	0	566	0	566
CQC (MLU)	0	600	0	600
Outdoor Play Area (Phase 1) (Externally Funded)	0	0	45	45
Kendrick Wing Fire - Estates	0	987	169	1,156
Kendrick Wing Fire - F & F	0	50	1	51
Kendrick Wing Fire - Miscellaneous	0	169	29	198
Pharmacy Clinical Trials Room (Externally Funded)	0	16	0	16
	2,736	**2,722**	**244**	**5,702**
Medical Equipment				
AER Machines (4 W 2 H)	700	(350)	0	350
Warrington MRI Scanner (replacement)	1,200	(1,200)	0	0
ICU Ventilators	250	(11)	0	239
NICU Incubators	108	(108)	0	0
Spectrophotometer	0	10	0	10
Oral Surgery Dental Chair x1	158	(91)	0	67
Ultrasound Machine	0	58	0	58
Training Simulation Equipment (HEE) (Externally Funded)	0	77	0	77
Obstretrics Simulation Monitors (HEE) (Externally Funded)	0	7	0	7
Anaerobic Cabinet	0	20	0	20
Transducer - Baby Hips	0	7	0	7
Ultrasound Machines LOGIQER7 x 2	0	56	0	56
DR Mobile X-Ray Detector	0	0	43	43
Door Lock (FAU)	0	0	5	5
Bladder Scanner (FAU)	0	0	8	8
Defibs	0	0	266	266
Ultrasound Rheumatology	0	0	29	29
Kendrick Wing Fire -Medical Equipment	0	437	8	445
Neonatal Monitors	0	35	0	35
CMAC Video Laryngoscope	0	9	0	9
Techotherm Cooling Blanket	0	0	19	19

Bladder Scanner B14 (LOF)	0	0	9	9
Bladder Scanner AMU (LOF)	0	0	9	9
	2,416	**(1,044)**	**396**	**1,768**
IM&T				
Technology & Devices refresh and developments	500	12	0	512
SAM	30	0	0	30
Security (Stonesoft firewall replacement/renewal)	200	0	0	200
Server refresh	100	0	0	100
VDI Roll Out	150	0	0	150
SIP Setup Costs	15	0	0	15
BI Tool	27	0	0	27
IPPMA/ePrescribing/ePMA	250	(59)	0	191
ePMA Lorenzo Digital Exemplar (LDE)	0	59	0	59
Video MDT (PDC) (Externally Funded)	0	100	0	100
Meditech Restoration	0	22	0	22
Deontics Care Pathway	0	8	0	8
Kendrick Wing Fire - IT	0	226	2	228
	1,272	**368**	**2**	**1,642**
CQC Reserve	**500**	(500)	0	**0**
Kendrick Wing Fire Balance	**0**	531	(209)	**322**
Contingency	**624**	611	(351)	**884**
Totals	**7,548**	**2,688**	**82**	**10,318**

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/19/01/06**			
SUBJECT:	**Safe Staffing Assurance Report**			
DATE OF MEETING:	30 January 2019			
AUTHOR(S):	**Rachael Browning – Associate Chief Nurse**			
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse			
LINK TO STRATEGIC OBJECTIVES:	All			
	Choose an item.			
	Choose an item.			
EXECUTIVE SUMMARY (KEY ISSUES):	Ward staffing data continues to be systematically reviewed to ensure we safely staff our wards and provide mitigation and action when a ward falls below 90% of planned staffing levels. It is a recommendation of the National Quality Board (NQB 2018) that the Board of Directors receives a monthly Safe Staffing report, which includes the measure of Care Hours Per Patient Day (CHPPD) and 'planned' versus 'actual' staffing levels, highlighting areas where average fill rates fall below 90%, along with mitigation to ensure safe, high quality care is consistently delivered for those areas.			
PURPOSE: (please select as appropriate)			To note	
RECOMMENDATION:	It is recommended that the Board of Directors note the monthly Safe Staffing Assurance Report.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Strategic People Committee		
	Agenda Ref.	SPC/19/01/11		
	Date of meeting	23 January 2019		
	Summary of Outcome	Noted		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.			

NAME OF COMMITTEE

SUBJECT	Safe Staffing Assurance Report	AGENDA REF:	BM/19/01/06

1. BACKGROUND/CONTEXT

Safe Staffing Assurance Report

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

2. KEY ELEMENTS

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

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

Care Hours Per patient Day

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

Chart 1 illustrates this data to December 2018, which continues to show a sustained improvement. Since July 2018 we have seen an improvement in the CHPPD which is an increase on the overall time spend on direct patient care by our staff. This will continue to be monitored via the Trust monthly Safer Staffing Report.

Chart 1 – CHPPDD over 2018 – month by month

Fin year	Month	Cumulative count over the month of patients at 23:59 each day	CHPPD - Registered	CHPPD - Care Staff	CHPPD All
2018/19	Apr	15539.5	3.5	3.0	6.5
	May	15689	3.9	2.8	6.8
	Jun	14983	4.0	2.8	6.8
	Jul	15037	4.2	2.9	7.1
	Aug	14879	4.2	2.9	7.1
	Sep	14608	4.1	2.9	7.1
	Oct	15093.97	4.2	2.9	7.1
	Nov	14558	4.3	3.0	7.3
	Dec	14861	4.2	3.0	7.2

NHSI have recently produced standards in their document "E-rostering the clinical workforce: levels of attainment and meaningful use standards (Nov 2018)". This has been reviewed for e-rostering use in nursing by the Informatics Matron. The Trust has scored green on the RAG rating for all the standards except one, standard 2.3 *final roster publications occurs at least six weeks before the roster start date* which is amber. The progress for improvement against this standard will be monitored at the Operational Staffing group and reported at the Trust Recruitment and Retention Group.

We have a number of trainee nurse associates in the Trust who are due to register in March 2019. We have reviewed the guidance from NHS Improvement (NHSI), Safe, Sustainable and Productive Staffing an Improvement Resource for the deployment of Nursing Associates in Secondary Care (NHSI 2019) and have undertaken a Quality Impact Assessment process to ensure that we have all the workforce safeguards in place for this new role in our organisation.

Key Messages

Although some areas are above the 90% target year to date, it is acknowledged that the percentage of registered nurses/midwives on some wards 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 continue to improve month on month.

Recruitment remains a priority for the senior nursing team. Further recruitment events planned for both registered nurses and health care assistants including an external RCN event in February 2019.

Additional bed capacity was opened at the end of December 2018 to support the operational pressures in the Trust, Ward C21 (24 beds) and Ambulatory Care (16 beds) are currently being used and require nurse staffing. Both areas are reviewed daily to determine the additional staffing required to ensure patient safety as part of the daily operational staffing plans.

Patient Harm by Ward

In December 2018 we reported a total of 4 pressure ulcers. These comprised of 3 grade 2 pressure ulcers on wards B14, B18 (2) and 1 grade 3 pressure ulcer on ward B18. Each of these cases are currently being reviewed

by the Tissue Viability nurse and the Associate Chief Nurse, Patient Safety to identify themes and shared learning. There have been 0 patient falls with moderate or major harm falls reported this month.

Infection Incidents

We had 1 case of MRSA bacteraemia in December on ward A4; this case is currently being investigated in line with Trust process

No cases of MRSA have been reported in December.

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

Monthly Safe Staffing Report – December 2018

		Day	Day	Day	Day	Day	Day	Night	Night	Night	Night	Night	Night	CHPPD			
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	Cumulative count over the month of patients at 23:59 each day	RN	HCA	Overall
		= above 100%		= above 90%			= above 80%			= below 80%							
SWC	SAU	930	922.569	697.5	660	99.2%	94.6%	-	-	-	-	-	-	-	-	-	-
SWC	Ward A5	1782.5	1460.5	1302	1265	81.9%	97.2%	1069.5	1023.5	724.5	1012	97.2%	95.7%	1023	2.4	2.2	4.7
SWC	Ward A6	1782.5	1345.5	1302	1374.25	75.5%	105.5%	1069.5	1046.5	1069.5	1046.5	97.8%	97.8%	992	2.4	2.4	4.9
SWC	Ward CMTC	977.5	973.5	644	614	99.6%	95.3%	529	529	345	345	100%	100%	224	6.7	4.3	11.0
SWC	Ward B4	692.5	723	470	447	104.4%	95.1%	195.5	195.5	195.5	195.5	100%	100%	62	14.8	10.4	25.2
SWC	Ward A9	1782.5	1640	1426	1299.5	92%	91.1%	1069.5	1069.5	1426	1449	100%	101.6%	966	2.8	2.8	5.7
SWC	Ward B11	2610.3	2528.1	775	775	96.9%	100%	1649.2	1649.4	322.4	312	100%	96.8%	372	11.2	2.9	14.2
SWC	NCU	1782.5	1622.7	356.5	299	91%	83.9%	1782.5	1587	356.5	345	89%	96.8%	387	8.3	1.7	10.0
SWC	Ward C20	922	985.5	690	662	106.9%	95.9%	713	701.5	0	23	98.4%	-	398	4.2	1.7	6.0
SWC	Ward C23	1426	1024	713	617	71.8%	86.5%	759	724.5	713	686.5	95.5%	96.3%	273	6.4	4.8	11.2
SWC	Delivery Suite	2495.5	2282.5	356.5	322	91.5%	90.3%	2495.5	2079.5	356.5	287.5	83.3%	80.6%	246	17.7	2.5	20.2
ACS	Ward A1	2325	1962.5	1937.5	2137.5	84.4%	110.3%	1627.5	1438.5	651	924	88.4%	141.9%	1116	3.0	2.7	5.8
ACS	Ward A2	1426	1225	1426	1361	85.9%	95.4%	1069.5	943	1069.5	1023.5	95.4%	88.2%	868	2.5	2.7	5.2
ACS	Ward C22	1182	1170.5	1069.5	1155	99%	108%	713	713	713	1051.5	100%	147.5%	651	2.9	3.4	6.3
ACS	Ward A4	1667.5	1532	1426	1203.5	91.9%	84.4%	1069.5	931.5	1069.5	1069	87.1%	100%	1023	2.4	2.2	4.6
ACS	Ward A8	1426	1311	1426	1532	91.9%	107.4%	1426	1276.5	1069.5	1127	89.5%	105.4%	1054	2.5	2.5	5.0
ACS	Ward B12	1069.5	1070.5	2495.5	2172.25	100.1%	87%	713	713	1782.5	1736.5	100%	97.4%	651	2.7	6.0	8.7
ACS	Ward B14	1426	1311.5	1426	1325	92%	92.9%	713	713	1069.5	1069.5	100%	100%	720	2.8	3.3	6.1
ACS	Ward B18	1426	1223.5	1426	1246.5	85.8%	87.4%	1069	1069.5	816.5	816.5	100%	100%	744	3.1	2.8	5.9
ACS	Ward B19	1069.5	1087.5	1426	1476.5	101.7%	103.5%	713	713	1069.5	1190.5	100%	111.3%	744	2.4	3.6	6.0
ACS	Ward A7	1782.5	1658	1426	1450.5	93%	101.7%	1426	1351.5	1069.5	1242	94.8%	116.1%	1023	2.9	2.6	5.6
ACS	Ward C21	1069.5	1041	1069.5	1122.5	97.3%	105%	747.5	713	1069.5	1069.5	95.4%	100%	602	2.9	3.6	6.6
ACS	CCU	1426	1278	356.5	313.5	89.6%	87.9%	1069.5	1035	0	0	96.8%	-	229	10.1	1.4	11.5
ACS	ICU	4991	4571.25	1069.5	776.25	91.6%	72.6%	4991	4611.5	1069.5	621	92.4%	58.1%	493	18.6	2.8	21.5

Appendix 2

December 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	99.2%	94.6%	-	-	**Vacancy rate:** - RN 1.15wte band 5, 1 wte band 4 Sickness rate 6.65% ytd **Action taken:** - recruitment process in place. Attendance management policy followed
Ward A5	81.9%	97.2%	97.2%	95.7%	**Vacancy rate:** HCA – 3.55wte, 2.6RN vacancy remains. Sickness rate 7.28% ytd **Action taken:** Daily review by the matron to review staffing levels and acuity, staff moved from other areas to support. Attendance management policy followed, monthly meeting with HR and welfare meetings arranged
Ward A6	75.5%	105.5%	97.8%	97.8%	**Vacancy rate:** - RN 6.15wte vacancies HCA-1.9wte vacancies Sickness rate – 7.11% **Action taken:** Daily review by the matron to review staffing levels and acuity, staff moved from other areas to support. Attendance management policy followed, monthly meeting with HR and welfare meetings arranged
CMTC	99.6%	95.3%	100%	100%	**Vacancy rate**: 2.3wte HCA vacancies **Sickness rate** – 10.99% **Action taken:** Daily staffing review against acuity and activity. Posts advertised. Sickness absence reduced in month and being managed in line with Trust policy.
B4	104.4%	95.1%	100%	100%	**Vacancy rate:** - HCA 2.72wte. 2.52 RN 2 Associate Nurses commencing in Jan 19 when qualified. Sickness rate – 6.65% ytd **Action taken:** Staffing and activity reviewed daily. recruitment programme in place. Attendance management policy followed, Sickness absence being managed in line with the Trust policy.
Ward A9	92%	91.1%	100%	101.6%	**Vacancy rate:** ward fully established **Sickness rate -** 5.69% **Action taken**: All vacancies filled and awaiting start dates. Sickness absence being managed in line with the Trust policy.
Ward B11	96.9%	100%	100%	96.8%	**Vacancy Rate:** HCA 1.6wte.band 5 1.2wte **Sickness rate** – 4.56wte long term sick **Action taken:** Staffing reviewed daily and support provided if necessary. Sickness absence being managed in line with the Trust policy.
NCU	91%	83.9%	89%	96.8%	**Vacancy rate:** 1.0wte Band 5. **Action taken:** - recruitment process in place. Staffing reviewed daily and

					support provided if necessary.
Ward C20	106.9%	95.9%	98.4%	-	**Vacancy rate:** -ward fully established **Action taken:** Staffing reviewed daily and support provided if necessary.
Ward C23	71.8%	86.5%	95.5%	96.3%	**Vacancy Rate: :** ward fully established Sickness rate – 5.64% **Action taken:** Staffing reviewed daily by the matron and staff moved to support if required and additional shifts request via NHSP. Sickness is being managed in line with Trust policy.
Delivery Suite	91.5%	90.3%	83.3%	80.6%	**Vacancy Rate:** ward fully established **Sickness rate** – 3.29% **Action taken:** Daily review of staffing and staffed moved from other areas depending on acuity and occupancy. Sickness is being managed in line with Trust policy.
Ward A1 - AMU	84.4%	110.3%	88.4%	141.9%	**Vacancy rate:** - vacancies at 1.0wte Band 6 and 10.87.0wte Band 5. This is predominantly due to a funded increase in the bed base on the ward **Sickness rate** – 7.33% **Action taken:** – Recruitment ongoing Daily review of staffing and acuity, staff moved from other areas to support and additional staff access via NHSP. Sickness being managed in line with Trust policies.
Ward A2	85.9%	95.4%	95.4%	88.2%	**Vacancy rate:** - 4.0wte Band 5, 5 WTE HCA **Action taken:** Recruitment ongoing. Daily review of staffing and acuity, staff moved from other areas to support and additional staff access via NHSP.
Ward C22	99%	108%	100%	147.5%	Daily review of staffing and acuity, staff moved from other areas to support and additional staff access via NHSP. Sickness being managed in line with Trust policies.
Ward A4	91.9%	84.4%	87.1%	100%	**Vacancy rate:-** RN 1.4wte band 5 HCA 0.63wte Sickness Rate: 3.72% **Action taken:** - Daily review of staffing and acuity, staff moved from other areas to support and additional staff access via NHSP.
Ward A8	91.9%	107.4%	89.5%	105.4%	**Vacancy rate:** - RN 4wte band 5 Sickness rate - 3.0wte LTS minimal ST sickness throughout the month of November 2018 **Action taken:** Recruitment process in place. Ward support by the continued use of NHSP and agency to ensure safe staffing levels. Pharmacy Technician support morning and lunchtime supports nursing staff.
Ward B12 (Forget-me-not)	100.1%	87%	100%	97.4%	**Vacancy rate:** - 9wte HCA vacancies following the nurse staffing business case. Recently recruited 6 HCAs currently going through pre-employment checks **Action taken**: - Recruitment plan in place, with a number of staff recently recruited to the vacancies. Daily review by the matron to review staffing levels and acuity, staff moved from other areas to support.
Ward B14	92%	92.9%	100%	100%	**Vacancy rate:-** 2.5wte Band 5 and 2.05wte HCA **Action taken:** - following recent recruitment HCA vacancies are now all filled with applicants going through pre-employment checks. Staffing reviewed daily against acuity and activity.

Ward B18	85.8%	87.4%	100%	100%	**Vacancy rate:** -3.63wte RN vacancies **Action taken:** - Recruitment ongoing, staffing reviewed on daily basis by matron and ward manager
Ward B19	101.7%	103.5%	100%	111.3%	**Vacancy rate:** -1.19wte RN and 1.32 wte HCA **Action taken:** - band 5 post filled with a February start date. Ward reviewed daily for acuity and staffing.
Ward A7	93%	101.7%	94.8%	116.1%	**Vacancy rate: -** RN 3.22wte band 6. **Action taken:** - Staffing reviewed daily against acuity and activity. Recruitment process underway.
Ward C21	97.3%	105%	95.4%	100%	**Vacancy rate: -** RN 3wte band 5 **Sickness Rate:** 8.13% **Action taken:** Recruitment process in place. Staffing reviewed daily against acuity and activity. Sickness being managed appropriately in line with trust policies.
Coronary Care Unit	89.6%	87.9%	96.8%	-	**Vacancy rate: -** RN Band 5 2.8wte, HCA 1.57. **Action taken:** Staffing reviewed daily against acuity and activity, staff support accessed from other areas when required.
Intensive Care Unit	91.6%	72.6%	92.4%	58.1%	**Vacancy rate:** – RN 4.0wte band 5, 3.7wte HCA interview dates in place. **Sickness rate** –2.5% **Action taken:** - recruitment process underway. Sickness absence managed robustly in line with Trust Attendance Management Policy. Rota shortfall managed with temporary staffing, mainly own staff via NHSP.

Rachael Browning
Associate Chief Nurse
December 2018

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

To note the contents of the report

4. ASSURANCE COMMITTEE

5. RECOMMENDATIONS

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/19/01/06**	
SUBJECT:	**Safe Staffing Assurance Report**	
DATE OF MEETING:	30 January 2019	
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 a ward falls below 90% of planned staffing levels. It is a recommendation of the National Quality Board (NQB) that the Board of Directors receives a monthly Safe Staffing report, which includes the measure of Care Hours Per Patient Day (CHPPD) and 'planned' versus 'actual' staffing levels, highlighting areas where average fill rates fall below 90%, along with mitigation to ensure safe, high quality care is consistently delivered for those areas .	
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 report is to provide transparency with regard to the nursing and midwifery ward staffing levels during November 2018. 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 are reviewed and addressed, with action to ensure safe staffing levels being taken at the daily staffing meeting. It is well documented that nurse staffing levels make a difference to patient outcomes (mortality and adverse events, including levels of harm), patient experience, quality of care and the efficiency of care delivery.

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

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

Care Hours Per patient Day

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

Chart 1 illustrates this data to November 2018, which continues to show a sustained improvement. Since July 2018 we have seen an improvement in the CHPPD which is an increase on the overall time spend on direct patient care by our staff. This will continue to be monitored via the Trust monthly Safer Staffing Report.

Chart 1 – CHPPDD over 2018 – month by month

Fin year	Month	Cumulative count over the month of patients at 23:59 each day	CHPPD - Registered	CHPPD - Care Staff	CHPPD All
2018/19	Apr	15539.5	3.5	3.0	6.5
	May	15689	3.9	2.8	6.8
	Jun	14983	4.0	2.8	6.8
	Jul	15037	4.2	2.9	7.1
	Aug	14879	4.2	2.9	7.1
	Sep	14608	4.1	2.9	7.1
	Oct	15093.97	4.2	2.9	7.1
	Nov	14558	4.3	3.0	7.3
2018/19 Total		120387.47	4.0	2.9	7.0

Key Messages

Although some areas are above the 90% target year to date, it is acknowledged that the percentage of registered nurses/midwives on some wards 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 continue to improve month on month.

Recruitment remains a priority for the senior nursing team; we have recruited 14 Health Care Assistants and 14 Registered nurses in November who are currently going through pre-employment checks. Further recruitment and 'Keep in Touch' events planned for the year ahead.

The reduction in the number of additional beds open across the Trust has been sustained in November. The additional beds on AMU (8) have been funded and are part of the overall nurse recruitment programme and A5 has one additional bed which is used in times of operational pressure. Both areas are reviewed daily to determine the additional staffing required to ensure patient safety.

Patient Harm by Ward

In November 2018 we reported a total of 5 pressure ulcers. These comprised of 4 grade 2 pressure ulcers on wards B1, A2 (2) , A7 and 1 grade 3 pressure ulcer on ward A5. Each of these cases are currently being reviewed by the Tissue Viability nurse and the Associate Chief Nurse, Patient Safety to identify themes and shared learning. There have been 0 patient falls with moderate or major harm falls reported this month.

Infection Incidents

We had 1 cases of CDT in the month of November on ward A2; this case is currently being investigated in line with Trust process

No cases of MRSA have been reported in November.

Monthly Safe Staffing Report – November 2018

		Day	Day	Day	Day	Day	Day	Night	Night	Night	Night	Night	Night	CHPPD			
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	Cumulative count over the month of patients at 23:59 each day	RN	HCA	Overall
		= above 100%		= above 90%			= above 80%			= below 80%							
SWC	SAU	900	925.5	675	650	102.8%	96.3%	0	0	0	0	-	-	-	-	-	-
SWC	Ward A5	1725	1345.5	1260	1259.25	78%	99%	1035	1035	690	1092.5	100%	158.3%	960	2.5	2.4	4.9
SWC	Ward A6	1725	1397.3	1260	1265	81%	100.4%	1035	1035	1035	989	100%	95.6%	1020	2.4	2.2	4.6
SWC	Ward CMTC	1242	1237.5	747.5	709.5	99.6%	94.9%	690	690	437	425.5	100%	97.4%	284	6.8	4.0	10.8
SWC	Ward B4	815	815	493	481.5	100%	97.7%	241.5	253	241.5	253	104.8%	104.8%	68	15.7	10.8	26.5
SWC	Ward A9	1725	1559.5	1380	1370	90.4%	99.3%	1035	1035	1380	1345.5	100%	97.5%	954	2.7	2.8	5.6
SWC	Ward B11	2130	2084.4	750	750	97.9%	100%	1596	1704	239.2	208.4	106.8%	87.1%	497	7.6	1.9	9.6
SWC	NCU	1725	1670	345	253	96.8%	73.3%	1725	1518	345	264.5	88%	76.7%	310	10.3	1.7	12.0
SWC	Ward C20	932	957	690	667	102.7%	96.7%	690	644	0	0	93.3%	-	380	4.2	1.8	6.0
SWC	Ward C23	1380	1098	690	667	79.6%	96.7%	736	724.5	690	644	98.4%	93.3%	331	5.5	4.0	9.5
SWC	Delivery Suite	2415	2385.5	345	413.5	98.8%	119.9%	2415	2079.5	345	322	86.1%	93.3%	246	18.2	3.0	21.1
ACS	Ward A1	1875	2034.5	1875	2023.5	108.5%	107.9%	1575	1522.5	651	766.5	96.7%	117.7%	847	4.2	3.3	7.5
ACS	Ward A2	1380	1224	1380	1269.5	88.7%	92%	1035	1069.5	1035	1035	103.3%	100%	840	2.7	2.7	5.5
ACS	Ward C22	1158.5	1092.5	1035	1094	94.3%	105.7%	690	690	690	1064.5	100%	154.3%	630	2.8	3.4	6.3
ACS	Ward A4	1633	1345.5	1380	1286.5	82.4%	93.2%	1035	1012	1035	1114.5	97.8%	107.7%	990	2.4	2.4	4.8
ACS	Ward A8	1380	1250	1380	1468	90.6%	106.4%	1380	1311	1035	1173	95%	113.3%	1020	2.5	2.6	5.1
ACS	Ward B12	1035	969.5	2415	2244.5	93.7%	92.9%	690	690	1725	1736.5	100%	100.7%	630	2.6	6.3	9.0
ACS	Ward B14	1380	1298.5	1380	1399.5	94.1%	101.4%	690	690	1025	1023	100%	99.8%	720	2.8	3.4	6.1
ACS	Ward B18	1426	1190	1426	1384	83.5%	97.1%	1069	908	1069	1276	84.9%	119.4%	720	2.9	3.7	6.6
ACS	Ward B19	1035	1040.5	1380	1383	100.5%	100.2%	690	701.5	1035	1201.5	101.7%	116.1%	720	2.4	3.6	6.0
ACS	Ward A7	1725	1544	1380	1223	89.5%	88.6%	1380	1437.5	1035	1180.5	104.2%	114.1%	980	3.0	2.5	5.5
ACS	Ward C21	1035	1035.5	1035	1081.5	100%	104.5%	690	690	1035	1035	100%	100%	720	2.4	2.9	5.3
ACS	CCU	1380	1304.5	345	272.5	94.5%	79%	1035	1035	0	0	100%	-	228	10.3	1.2	11.5
ACS	ICU	4830	4720.75	1035	891.25	97.7%	86.1%	4830	4703.5	1035	632.5	97.4%	61.1%	463	20.4	3.3	23.6

Appendix 2

November 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	102.8%	96.3%	-	-	**Vacancy rate:** - RN 1.15wte band 5, 1 wte band 4 Sickness rate – 0.8% **Action taken:** - ECF completed and posts advertised. Attendance management policy followed
Ward A5	78%	99%	100%	158.3%	**Vacancy rate:** HCA - 4.35wte recruited 2 awaiting start dates, 4.6wte vacancy remains. Sickness rate – 5.75% **Action taken:** Daily review by the matron to review staffing levels and acuity, staff moved from other areas to support. Attendance management policy followed, monthly meeting with HR and welfare meetings arranged
Ward A6	81%	100.4%	100%	95.6%	**Vacancy rate:** - RN 8.15wte vacancies HCA-3.9wte vacancies Sickness rate – 7.11% **Action taken:** Daily review by the matron to review staffing levels and acuity, staff moved from other areas to support. Attendance management policy followed, monthly meeting with HR and welfare meetings arranged
CMTC	99.6%	94.9%	100%	97.4%	**Vacancy rate**: 2.3wte HCA vacancies **Sickness rate** – 6.83% **Action taken:** Daily staffing review against acuity and activity. Posts advertised. Sickness absence reduced in month and being managed in line with Trust policy.
B4	100%	97.7%	104.8%	104.8%	**Vacancy rate:** - HCA 2.72wte. 2 Associate Nurses commencing in Jan 19 when qualified. Sickness rate – 5.11% **Action taken:** Staffing and activity reviewed daily. Posts advertised. Attendance management policy followed, Sickness absence being managed in line with the Trust policy.
Ward A9	90.4%	99.3%	100%	97.5%	**Vacancy rate:** ward fully established **Sickness rate -** 4.80% **Action taken**: All vacancies filled and awaiting start dates. Sickness absence being managed in line with the Trust policy.
Ward B11	97.9%	100%	106.8%	87.1%	**Vacancy Rate:** HCA 1.6wte.band 5 1.2wte **Sickness rate** – 4.56wte long term sick **Action taken:** Staffing reviewed daily and support provided if necessary. Sickness absence being managed in line with the Trust policy.
NCU	96.8%	73.3%	88%	76.7%	**Vacancy rate:** 1.0wte Band 5. **Action taken:** - recruitment process in place. Staffing reviewed daily and

					support provided if necessary.
Ward C20	102.7%	96.7%	93.3%	-	**Vacancy rate:** -ward fully established **Action taken:** Staffing reviewed daily and support provided if necessary.
Ward C23	79.6%	96.7%	98.4%	93.3%	**Vacancy Rate: :** ward fully established Sickness rate – 1.14% **Action taken:** Staffing reviewed daily by the matron and staff moved to support if required and additional shifts request via NHSP. Sickness is being managed in line with Trust policy.
Delivery Suite	98.8%	119.9%	86.1%	93.3%	**Vacancy Rate:** ward fully established Sickness rate – 1.14% **Action taken:** Daily review of staffing and staffed moved from other areas depending on acuity and occupancy. Sickness is being managed in line with Trust policy.
Ward A1 - AMU	108.5%	107.9%	96.7%	117.7%	**Vacancy rate:** - vacancies at 1.0wte Band 6 and 10.87.0wte Band 5. This is predominantly due to a funded increase in the bed base on the ward **Sickness rate** – 4.20% **Action taken:** – Recruitment ongoing Daily review of staffing and acuity, staff moved from other areas to support and additional staff access via NHSP. Sickness being managed in line with Trust policies.
Ward A2	88.7%	92%	103.3%	100%	**Vacancy rate:** - 4.0wte Band 5, 5 WTE HCA **Action taken:** Recruitment ongoing. Daily review of staffing and acuity, staff moved from other areas to support and additional staff access via NHSP.
Ward C22	94.3%	105.7%	100%	154.3%	**Sickness rate-** 2% **Action taken**: - Sickness being managed in line with Trust policies.
Ward A4	82.4%	93.2%	97.8%	107.7%	**Vacancy rate:-** RN 2.4wte band 5 HCA 0.63wte **Action taken:** - Daily review of staffing and acuity, staff moved from other areas to support and additional staff access via NHSP.
Ward A8	90.6%	106.4%	95%	113.3%	**Vacancy rate:** - RN 4wte band 5 Sickness rate - 3.0wte LTS minimal ST sickness throughout the month of November 2018 **Action taken:** Recruitment process in place. Ward support by the continued use of NHSP and agency to ensure safe staffing levels. Pharmacy Technician support morning and lunchtime supports nursing staff.
Ward B12 (Forget-me-not)	93.7%	92.9%	100%	100.7%	**Vacancy rate:** - 9wte HCA vacancies following the nurse staffing business case. Recently recruited 6 HCAs currently going through pre-employment checks **Action taken**: - Recruitment plan in place, with a number of staff recently recruited to the vacancies. Daily review by the matron to review staffing levels and acuity, staff moved from other areas to support.
Ward B14	94.1%	101.4%	100%	99.8%	**Vacancy rate:-** 2.5wte Band 5 and 2.05wte HCA **Action taken:** - following recent recruitment HCA vacancies are now all filled with applicants going through pre-employment checks. Staffing reviewed daily against acuity and activity.

Ward B18	83.5%	97.1%	84.9%	119.4%	**Vacancy rate:** -3.63wte RN vacancies **Action taken:** - Recruitment ongoing, staffing reviewed on daily basis by matron and ward manager
Ward B19	100.5%	100.2%	101.7%	116.1%	**Vacancy rate:** -1.19wte RN and 4.2wte HCA **Action taken:** - HCA vacancies recruited to and start dates in place for Oct 18, band 5 post filled with a February start date. Ward reviewed daily for acuity and staffing.
Ward A7	89.5%	88.6%	104.2%	114.1%	**Vacancy rate: -** RN 1wte band 6. **Action taken:** - Staffing reviewed daily against acuity and activity. Recruitment process underway.
Ward C21	100%	104.5%	100%	100%	**Vacancy rate: -** RN 3wte band 5 **Sickness Rate:** 8.13% **Action taken:** Recruitment process in place. Staffing reviewed daily against acuity and activity. Sickness being managed appropriately in line with trust policies.
Coronary Care Unit	94.5%	79%	100%	-	**Vacancy rate: -** RN Band 5 2.8wte, HCA 1.57. **Action taken:** Staffing reviewed daily against acuity and activity, staff support accessed from other areas when required.
Intensive Care Unit	97.7%	86.1%	97.4%	61.1%	**Vacancy rate:** – RN 4.0wte band 5, 3.7wte HCA interview dates in place. **Sickness rate** –3.56% **Action taken:** - recruitment process underway. Sickness absence managed robustly in line with Trust Attendance Management Policy. Rota shortfall managed with temporary staffing, mainly own staff via NHSP.

Rachael Browning
Associate Chief Nurse
November 2018

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

BOARD OF DIRECTORS CHAIR'S KEY ISSUES REPORT

AGENDA REFERENCE:	BM 19 01 06 b	COMMITTEE OR GROUP:	Trust Board	DATE OF MEETING	30th January 2019

Date of Meeting	8th January 2019
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/19/01/05	Getting to Good (G2G) Steering Group update	• 94% of 366 actions closed down • Outstanding actions have plans to achieve work required, ie, MLU and Out Patients, C21 winter ward to move in March which will allow MLU work to commence in March • PIR data submitted had indicate a significant improvement in quality	n/a	**QAC March 2019**
QAC/19/01/07	Maternity Update/Maternity Safety Champion update	• AQuA Safety report relating to Maternity Safety highlighted that the Trust is within national variation but outlier for maternal/neonatal non-elective readmissions in Quarter 1	Internal data to be reviewed and discussed within professional networks. Update to be provided at the next Committee	**QAC March 2019**
QAC/19/01/10	Ward Quality Metrics 4 month	• Ward audits had been undertaken aligned with domains of CQC showing compliance against metrics	Future reports to include clarity in relation to where discussions and	**QAC March 2019**

	report	and ward and department level, underpinning Ward Accreditation visits. • Significant improvement and assurance provided since the last dashboard report, current ward compliance 92% compliance (Green) against 72% in the previous report. • Programme to be implemented in Outpatients and Theatres and Therapies with full roll out to other departments in April 2019.	progress of actions has taken place.	
QAC/19/01/14	IG + Corporate Records High Level Briefing inc GDPR action plan	• Annual IG Gap analysis underway by MIAA, findings expected in January 2019 • 86% compliance reported in the baseline assessment against the Data Protection and Security Toolkit that was completed in October 2018 • Areas where full compliance will not be achieved by 31.3.2019 will be documented within supporting action plans and dates agreed for compliance. • MIAA to undertake audit • Current trajectory indicated 95% IG training compliance. NHSi expect 100%	IG ward/department audit findings to be reported to the next meeting	**QAC March 2019**
QAC/19/01/15	BAF	The Committee approved the following: • four new risks added to the BAF; • 11 risks removed from the BAF; • ratings for three risks on the BAF reduced; • rating for one risk on the BAF increased; • descriptions of two risks on the BAF amended.	Further update to be presented at next meeting	**QAC March 2019**

QAC/19/01/22	High Level Briefing Health and Safety Sub Committee - November 2018.	Sharps incidents – There have been a number of incidents reported on the Halton site when the lids on a Sharps Bin had detached during transportation by the Porters	Requested the Sharps Audit findings to be included in March report.	**QAC March 2019**

Strategic People Committee Chair's Report

Agenda Ref	BM 19/01/06 c	COMMITTEE OR GROUP:	Strategic People Committee	DATE OF MEETING	23 January 2019	CHAIR:	Anita Wainwright, Non-Executive Director

Attendance

Anita Wainwright	Non-Executive Director (Chair)
Ian Jones	Non-Executive Director
Michelle Cloney	Director of HR and OD
Deborah Smith	Deputy Director of HR and OD
Dan Moor	Deputy Chief Operating Officer
Andrea McGee	Director of Finance
Simon Constable	Executive Medical Director
Lucy Gardner	Director of Strategy
Alex Crowe	Medical Director

Apologies

Kimberley Salmon-Jamison	Chief Nurse
Chris Evans	Chief Operating Officer
Mick Curwen	Head of Strategic HR Projects

In attendance

Julie Burke	Secretary to the Trust Board

AGENDA ITEM	LEAD OFFICER	Issue / Exception Report	Recommendation / Assurance/ Action/Decision
SPC/19/01/05	Deputy Director of HR and OD	BAF and Risk Register	Two additional workforce risks have been identified in OPC to be added to the Risk Register: **Equality and Diversity**

			Failure to deliver an effect Equality, Diversity and Inclusion service caused by a lack of specialist staff within the Trust and other staff's capacity to support the service resulting in failure to deliver statutory and regulating reporting requirements in relation to Equality and Diversity and delivery of the Equality, Diversity and Inclusion Strategy **Apprenticeship Levy** *Failure to fully utilise the apprenticeship levy caused by a lack apprenticeship opportunities and inability to fund backfill, resulting in loss of levy funds.*
SPC/19/01	Deputy Director of HR and OD	Employee Relations Report	**Action** There has been an increase in Employee Relations activity overall. The Committee have requested further information to understand reasons for increase and actions to mitigate. **Action** There has also been an increase in Employment Tribunal claims due to the removal of Employment Tribunal fees. The Committee were assured that lessons learned from tribunal cases are collated, distributed and actioned organisationally. The Committee requested that going forward this process includes a specific lessons learned to be shared with Trust Board members, to increase awareness and take learning forward in future Appeal Hearings. The Committee also requested that the Disciplinary Policy is changed so that Appeal Hearings are not chaired by Non-Executive Directors.

SPC/19/01/1O	Deputy Director of HR and OD	Equality Duty Assurance Report	The Committee approved this document for publication.
		Workforce Equality Assurance Report	The Committee approved this document for publication.
		Equality, Diversity and Inclusion Strategy	**Action** The Committee requested an engagement session on the draft strategy at the February 2019 Board Development Day.
SPC/19/01/11	Chief Nurse	Trust Board Monthly Staffing Report	**Action** The Committee approved a proposal for E-Rostering to be included in PPSRG as a work stream as this work is key to the appropriate allocation of staff and therefore controls around premium spend.
SPC/19/01/15	Medical Director	HENW/GMC Progress Report	**Action** Continue with robust action plan to address Enhanced Monitoring status and monitor progress. Review risk score on risk register. A Royal College of Physician visit is scheduled for 15 March 2019 The next GMC Survey is scheduled to open on 17 March 2019
SPC/19/01/17	Director of HR and OD	Operational People Committee Chair's Log: Apprenticeship Levy Transfer	**Action** The Committee supported in principle the proposal to sign up to the transfer of 10% of the apprenticeship levy via the Warrington Together programme of work. The Committee requested that the proposal is submitted to the Executive Team for approval.

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NHS Warrington and Halton Hospitals NHS Foundation Trust

CHAIR'S KEY ISSUES REPORT

AGENDA REFERENCE:	BM/19/01/06 d	COMMITTEE OR GROUP:	Trust Board of Directors	DATE OF MEETING	30 January 2019

Date of Meeting	19th December 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/18/12/154	Rolling Tracker	• 129 CQC stocktake will be discussed at Exec on 20/12/18 • 145 Additional controls included in paper		
FSC/18/12/156	Pay Assurance Dashboard Monthly Report	• Agency ceiling remains a concern and high reliance on temporary and premium rate continues, this is being reviewed through SPC. Ceiling is lower than last year but still 28% above. • FRG is looking at enhanced expenditure controls for Admin and Clerical, Non Pay and WLIs without impact on safety. An audit of overtime is taking place and a review of booking out of hours • Need to understand more units of agency or higher cost • Longer term full medical review under way what do we really need looking at recruitment, skill mix and process	The Committee reviewed, discussed and noted the report.	FSC January 2019
FSC/18/12/157	Risk Register	• The new Brexit risk which has been drafted with a score of 16 which is going through the process • Further work is being done to show movement on risk scores	The Committee reviewed, discussed and noted the report.	FSC January 2019

FSC/18/12/158	Corporate Performance Report	• November A&E performance is 83.16% • Diagnostics, RTT and Cancer targets for November met • Super stranded in November was reduced lowest it has been and got below 100 • FAU is now 5 days and AMU and NWAS pathways into FAU are being developed	The Committee reviewed, discussed and noted the report.	FSC January 2019
FSC/18/12/159	Monthly Finance report	• The year to date deficit is £15.4m which is £0.9m off control total (£0.4m excluding PSF). • Month 8 CIP achieved • All PSF included except Q1 A&E and Q2 A&E • FRG minutes noted 1 items to escalate to FSC which would be picked up in item 160 under the forecast position	The Committee reviewed, discussed and noted the report and the financial challenges faced.	FSC January 2019
FSC/18/12/160	Financial forecast	• Potential for financial forecast to be £5m off plan • Reviewed actual Income and expenditure rather than budget variance • Noted unfunded pressures, CIP and activity issues • Potential mitigations of £4m plus further un-costed CIP	The Committee discussed and noted the presentation.	FSC January 2019
FSC/18/12/161	Operational plan 2019/20	• Guidance has been delayed from NHSI and the January submission will now focus on activity only, additional suggested for the 10th January prior to submission on the 14th	The Committee noted the presentation and agreed additional meeting to sign off in January	FSC January 2019
	Key issues for escalation	• Agency spend • Moving off plan / mitigation plan and an eye on cash • Improvement in CIP achievement and ongoing work		

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NHS Warrington and Halton Hospitals NHS Foundation Trust

CHAIR'S KEY ISSUES REPORT

AGENDA REFERENCE:	BM/19/01/06 d	COMMITTEE OR GROUP:	Trust Board of Directors	DATE OF MEETING	30 January 2019

Date of Meeting	10th January 2019
Name of Meeting + Chair	Finance & Sustainability Committee - Terry Atherton
Was the meeting quorate?	Yes

REF	AGENDA ITEM	ISSUE	Recommendation / Assurance/ mandate to receiving body	Follow up/ Review date
FSC/18/12/161	Operational plan 2019/20	• Due to delay in guidance from NHSI the January submission focuses on activity only. It is due to be submitted on the 14th January 2019 • The plan does not include any financial information. • The Committee received a presentation on the process and the detail behind the figures • The Committee noted that the timetable may change as it is dependent on guidance and templates being released from NHSE/I. • Discussion took place on the ability to revise the figures in the next submission and the detailed work required from Finance and Operational Teams. • The Committee reviewed the CCG draft return against the Trusts and this was agreed as acceptable at this point in the process.	The Committee agreed sign off of the initial activity plan. It will be presented to Private Board to note on the 30th January 2019	FSC February 2019
	Key issues for escalation	• Advise Board initial activity plan approved by FSC on 10th January 2019 • Acknowledged initial plan is very high level and further work will be required for the Draft plan to be submitted in February 2019		

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Warrington and Halton Hospitals NHS
NHS Foundation Trust

CHAIRS KEY ISSUES REPORT

AGENDA REF	BM 19 01 06 e	COMMITTEE OR GROUP:	Trust Board	DATE OF MEETING	30th January 2019

Date of Meeting	**Thursday 22 November 2018**
Name of Meeting + Chair	**Audit Committee – Ian Jones, Chair**
Was the meeting quorate?	**Yes**

REF	AGENDA ITEM	ISSUE	Recommendation / Assurance/ Action/Decision	Follow up/ Review date
AC/18/ 11/86	Welcome, apologies and declarations of interest - Chairs Action	The Chair explained that he had raised concerns with Grant Thornton in relation penalties imposed on Grant Thornton and some senior members of staff about their role as external auditors with another organisation. The Chair explained that he had been provided with the necessary assurance	The Audit Committee noted the update	**n/a**
AC/18/11/ 91	Changes or updates to the BAF	• Four new risks had been added to the BAF since the last meeting • One risk had been removed from the BAF • Committee were advised that there was a forthcoming proposal to include a risk relation to Brexit on the BAF.	Further update to be presented at next meeting	**Audit Committee February 2019**

AC/18/ 11/93	Risk Management Annual Report	The Committee received the Annual Report and noted the considerable amount of work that had taken place in the development of the new Risk Management Process, including the roll-out of Datix and the establishment of Risk Registers at all speciality and CBUs.	The Audit Committee noted the update	**Ongoing review of risk management at the Audit Committee**
AC/18/ 11/94	Commission and receive ANY additional scrutiny projects as required	It was explained that a review of the recommendations following the concerns raised about Gosport War Memorial Hospital was taking place to ensure there were no concerns for the Trust	Further update to be presented at next Quality Assurance Committee	**Quality Assurance Committee – Jan 2019**
AC/18/ 11/96	Review of Quotation + Tender Waivers for period 1.07.2018 to 30.09.2018	• There has been a significant reduction in the value and number of waivers raised, together with the number raised retrospectively • In response to query raised relating to Financial Skills Development (FSD) Waiver, SB advised that WHH is the host organisation and the FSD team comply with WHH SFIs and SORD. AMc stated that MIAA is to undertake governance review of current arrangements and remit of the FSD Board.	The Audit Committee noted the update	**TBC**
AC/18/ 11/98	Internal Audit Progress Report	Four reports had been issued and two issued as final draft report and are in the process of being discussed/reviewed for a Management response and fieldwork in progress for five reviews. • Temporary Staffing – Limited Assurance ○ Different approached have been taken with regards to the initial request and authorisation of the use of temporary staff. • Server Management Review - Limited	The Audit Committee approved changes to the Audit plan to change Out of Hospital review to CQC Action Plan Phase 2 and change Extra duties Payment Review to Overtime Payments audit.	**Audit Committee ongoing**

		Assurance ○ Register was out of date / inaccurate • Safer Surgery – Moderate assurance • Patching Regime - compliance in the mid 90% with 2 instances where servers associated with • Lorenzo system being 64% and 74% compliantly to currently available patch levels		
AC/18/ 11/100	Internal Audit Progress Report on follow-up actions	• Extended deadlines had been requested for 6 reviews • A total 9 reviews were followed up (24 recommendations) from 2014-15 and 2017-18. • At 8 November, 3 reviews (3 recommendations) have been fully implemented. The remaining 6 contain recommendations that are now overdue, 11 recommendations remain partially implemented and 1 recommendation has not been implemented.	The Audit Committee reviewed, discussed and noted the report and supported the revised deadlines for the outstanding recommendations.	**Audit Committee ongoing**
AC/18/ 11/105	GDPR - Cyber Security progress report	**GDPR Action Plan** The Committee received a comprehensive overview of the challenges to achieve compliance with NHS Digital Cyber Security Policy and to comply with mandatory standards contained within the NHS Digital Data Security and Protection Toolkit.	MIAA to complete a further review of IG Toolkit compliance and report findings to the next Audit Committee.	**Audit Committee - Feb 2018**

		Data Security & Protection Toolkit (IG Toolkit) • Baseline assessment on new toolkit submitted at the end of October 2018 • Staff had been regularly reminded of the need to remove Smartcards and lock PC screens		

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Warrington and Halton Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/19/01/07**	
SUBJECT:	**CQC Update report**	
DATE OF MEETING:	30 January 2019	
AUTHOR(S):	Ursula Martin, Director Integrated Governance + Quality	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse	
LINK TO STRATEGIC OBJECTIVES:	All	
EXECUTIVE SUMMARY (KEY ISSUES):	The following report gives an update on - Performance against the CQC action plan – all actions have been marked as compliant except 1 relating to paediatric staffing. The CBU are providing an update to the Chief Nurse regarding what further action is required. - An update of the latest MIAA report, auditing compliance is outlined. - An update on the fundamental breaches is also provided, with demonstrates considerable improvement across 8 of the 9 areas. Further work required on information governance, following Mock CQC. - Preparation for CQC assessment, and also an update on the Use of Resources return.	
PURPOSE: (please select as appropriate)	For Information	
RECOMMENDATION:	The Board of Directors are asked to note the report.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality + Assurance Committee
	Agenda Ref.	
	Date of meeting	8th January 2019
	Summary of Outcome	Position noted
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.	

REPORT TO BOARD OF DIRECTORS

SUBJECT	CQC Update Report	AGENDA REF:	

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 preparation for the forthcoming inspection.

2. KEY ELEMENTS

a. CQC action plan performance

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

- 99% of the action plan has been delivered and is marked as compliant, based on the evidence provided.
- At the time of writing this report – there is one action outstanding, which is outlined below along with an update.

CY04c	**Warrington Report Children & Young People P166**	**Children and Young People**	Staffing within the children's unit did not follow Royal College of Nursing (RCN) standards (August 2013) and neonatal nurse staffing did not meet standards of staffing recommended by the British Association of Perinatal Medicine (BAPM).	Ensure an update is given of the Paediatric Ward staffing and ED/Paediatric handover processes	A review of ward staffing has been completed following the transfer of the paediatric ED. This has identified that additional resources may be required to bring the staffing in line with the RCN guidelines. A check and challenge process will take place and dependent upon the outcome of this then a business case may be required. Therefore the initial action has been complete and the work in relation to the exercise will be taken forward as required by the Clinical Business Unit (CBU).

- 100% of all Must Do and Should Do actions are marked as compliant based on the evidence provided.

Row Labels	Report completed - Compliant	Amended date agreed	Action closed-merged with another	Grand Total
However	151	1	9	161
Must	50		3	53
Should	58		5	63
Grand Total	**259**	**1**	**17**	**277**

- MIAA have concluded their second round of auditing the actions that we have deemed to be compliant. This involved observing the actions in practice. This report was presented to the Trust Getting to Good Steering Group 17th January 2019 and showed the following compliance. The results of the audit are shown below.

Action Type	Compliant	Partially Compliant	Not Compliant	Not possible to assess*	Total
Must	7	2		1	**10**
Should	3	2			**5**
However	2	2	1		**5**
Total	**12**	**6**	**1**	**1**	**20**

- MIAA found evidence to support full compliance in 63% of the actions that they audited.
- Areas which showed partial/non compliance were are follows

Areas of partial/non compliance	Details
Critical care Fridge checks	Overall, 10% of the sample had details that were not fully completed as follows;
Critical care ward round and twice daily review by a Consultant	Overall, for 10% of the testing, there was no evidence in the case notes, to demonstrate whether the round had been completed;
Medicine Handover	For the sample of days selected, 46% did not have a form to evidence the meeting taking place: There was no evidence of a 16.30 meeting taking

Areas of partial/non compliance	Details
	place. In addition there were also some missing 21.00 meetings.
AMU/Endoscopy resus trolley checks	11% of the sample tested had missing information e.g signatures, tag number and missing check
Enhanced Recovery Pathway maternity	Not evident that this was embedded in practice 100%
Radiation Protection and regulations	Overall, the checks had not been fully evidenced as complete for 6% of the sample. This included, missing signatures, missing limits, and evidence of action, when out of limits.
Radiology Discrepancy meetings	No meetings held in March, May, June, July or Oct.

Feedback has been given to all areas. Action was taken immediately to address some of the actions (fridge checks, board rounds, resus trolleys and discussion regarding discrepancy meetings) and there are some follow on actions which have been agreed which include further auditing and monitoring (medical handover and radiology).

b. Fundamental breach Analysis

Within the Trust's CQC report, there were a number of fundamental breaches listed. 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 Steering Group.

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
GREEN	**5** ↑ *Previously 2*	a) Regulation 12 – equipment and checks in radiology b) Regulation 12 – checks of equipment trollies and anaesthetics machines c) Regulation 12- checks intheatre Halton to prevent Never Events	a) Since the last Board report in June, the Trust has moved to Green with regard to the 6 breaches highlighted by the CQC. Further checks of all regulations are

RAG status of breaches	Number	Details	To note
		d) Regulation 11- Consent and Mental Capacity e) Regulation 13- Safeguarding training	underway. b) Checks of equipment trollies and anaesthetic machines are continuously made. c) All Serious Incident actions regarding Never Events in Halton have been implemented. Monthly audits of safer surgery in place. d) MIAA have undertaken Safeguarding and Mental Capacity audits – Moderate Assurance was given for both audits e) Regarding Safeguarding training all safeguarding training at a Trust level is above Trust target of 85%. To note New training requirements aligned to collegiate document being scoped out.
AMBER	**3** ↓ *Previously 5*	a) Regulation 15 – premises (radiology, gynae, maternity) b) Regulation 12 – medical devices training c) Regulation 18 – a) staffing b) APLS training for staff	a) Work regarding environment for radiology, gynae an maternity has been reviewed and business cases/risk assessments in place b) Assessment of competencies for medical devices has commenced across the Trust with medical devices folders being distributed across the Trust. Maternity/Paediatrics 100% (Must Do/Should Do

RAG status of breaches	Number	Details	To note
			actions). Weekly report in place to Executive Directors regarding roll out across the Trust c) A full assessment of risk for Regulation 18 is being undertaken, given the work we have implemented with regard to investment, recruitment, staffing escalation processes and resuscitation training.
RED	**1** ↓ *Previously 2*	a) Regulation 17 – Governance a) Risk Management b) record keeping c) IG and records being maintained securely	a) Information Governance audit and Mock CQC shows areas of non compliance. We have purchased notes trollies for the wards and raised auditing/scrutiny. Further Executive led work will be undertaken, focusing on improvement.

c. CQC Preparation

The Trust has undertaken the following actions to support the preparation for CQC

- Held a CQC Mock assessment. This was held on 21st January 2019 across the Warrington and Halton sites, with review teams made up of Executive/Non Executive Directors, senior clinical and non clinical staff, external experts, students, junior doctors, CCG colleagues and governors. Feedback was given to the Board of Directors on the day of the assessment and individual ward/department feedback will be given to all areas visited, and a report presented to Getting to Good and Trust Quality Committee.

- We have developed a communications plan, to that all key staff will know what to expect from the forthcoming CQC inspection and ensure that we are able to respond effectively. Part of this has been the development of a handbook for staff and we will be holding interviews and drop in sessions for key members of staff.
- Submitted the Provider Information Request (PIR) on 9th January 2019 to the CQC.
- The Trust has been given the date for the Use of Resources Inspection which is 2nd April 2019. The information required on the Key Lines of Enquiry (KLoE) for the Use of Resources assessment is due to be submitted on 22nd February 2019- this will be reviewed at getting to Good Steering Group on 14th February 2019.

3. RECOMMENDATIONS

Trust Board are asked to discuss and note the:

- CQC action plan progress and update,
- The update on fundamental breaches,
- The update on CQC preparation.

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Warrington and Halton Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/19/01/08**			
SUBJECT:	**Progress on Lord Carter Report Recommendations & Use of Resource Assessment (UoRA)**			
DATE OF MEETING:	30th January 2019			
AUTHOR(S):	Marie Garnett, Head of Contracts & Performance			
EXECUTIVE DIRECTOR SPONSOR:	Andrea McGee, Director of Finance + Commercial Development			
LINK TO STRATEGIC OBJECTIVES:	All			
EXECUTIVE SUMMARY (KEY ISSUES):	The Trust continues with the delivery of the Lord Carter Recommendations and is progressing preparation for the Trust's Use of Resource Assessment by the CQC and NHSI. The Trust has been notified by NHSI that the Use of Resources Assessment day will take place on 2nd April 2019 supported by an information submission on 22nd February 2019.			
PURPOSE: (please select as appropriate)	Information	Approval	To note X	Decision
RECOMMENDATION:	The Board of Directors is requested to note the contents of the report.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.		
	Agenda Ref.			
	Date of meeting			
	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. BACKGROUND/CONTEXT

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.

In February 2016 the Lord Carter 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 is designed to improve understanding of how effectively and efficiently the Trust uses its resources. The UoRA is based on 5 key lines of enquiry (KLOEs) these are; clinical services, people, clinical support services, corporate services and finance. The UoRA workstream has prepared a narrative for each KLOE and has developed a dashboard. This forms the basis from which to review and improve each KLOE indicator.

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

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 is based on NHSI's peer finder tool.

Chapter 2 of The NHS long term plan, published in January 2019, sets out objectives to achieve cash releasing productivity growth by at least 1.1% per year which relate to the Lord Carter/Use of Resources aims. These include:

- **Improving the availability of clinical workforce**, further reducing bank and agency costs: By 2021, all clinical staff working in the NHS will be deployed using an electronic roster or e-job plan. By 2023, all providers will be able to use evidence-based approaches to determine how many staff they need on wards and in other care settings
- **Procurement:** By 2022, the volume of products bought through Supply Chain Coordination Limited (SCCL) will double to 80%, the number of nationally contracted products will be extended and the way local and regional procurement teams operate will be consolidated.
- **Pathology and imaging networks:** By 2021, all pathology services across England will be part of a pathology network and, by 2023 diagnostic imaging networks will be introduced.
- **Medicines:** Over the next five years, all providers will be expected to implement electronic prescribing systems to reduce errors by up to 30%.
- **NHS administrative costs:** Further efficiencies will save over £700 million by 2023/24, comprising £290 million from commissioners and over £400 million from providers.
- **Land, buildings and equipment:** National work with providers will reduce the amount of non-clinical space by a further 5% and by 2020, the aim is to reduce the NHS carbon footprint by a third from 2007 levels.
- **Non-clinically effective interventions:** The NHS needs to ensure that the least effective interventions are not routinely performed, or only performed in more clearly defined circumstances; freeing up scarce professional time and allowing resources to be reinvested into patient care.
- **Improving patient safety:** Measures include a new patient safety incident management system by 2020; a shared and consistent patient safety curriculum; and the development of a network of senior patient safety specialists.
- **Patient, contractor, payroll, or procurement fraud:** The NHS Counter Fraud Authority will continue to tackle this including large scale patient eligibility checking services.

2. KEY ELEMENTS

This paper presents the quarterly update report for Quarter 3. 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. The Trust is monitoring and actioning improvements for each indicator and is gathering evidence which demonstrate the Trust's effective Use of Resources.

Use of Resources Assessment Day

Final preparations are underway for the Use of Resources Assessment day which NHSI have confirmed will be on 2nd April 2019 with an information submission on 22nd February 2019.

A plan is currently being developed to ensure that the senior team involved in the assessment is fully prepared and has the information and evidence they need for the day. The following senior staff will be attending the day on behalf of the Trust:

- Trust Chair
- Chief Executive
- Deputy Chief Executive & Executive Medical Director
- Director of Finance & Commercial Development
- Chief Nurse
- Chief Operating Officer
- Medical Director
- Director of HR & OD
- Chief Pharmacist
- Associate Director of Estates
- Associate Director of Procurement
- Head of Therapies (AHP Lead)

CONCLUSION

The Trust continues to make progress against the Lord Carter recommendations. It is vital that the Operational and Executive leads for each KLOE fully understand their performance and identify and monitor actions for improvement and have an overview of the Trust's performance for all KLOEs.

3. RECOMMENDATIONS

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

Andrea McGee
Director of Finance and Commercial Development
23rd January 2019

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

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

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Use of Resource Graph Key
Trust Position
National Median
Peer Median

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

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 3 2018/19

Recommendation 1 - NHS Improvement (NHSI) should develop a national people strategy and implementation plan by October 2016 that sets a timetable for simplifying system structures, raising people management capacity, building greater engagement and creates an engaged and inclusive environment for all colleagues by significantly improving leadership capability from "ward to board", so that transformational change can be planned more effectively, managed and sustained in all Trusts.

Lead Director: Director of Human Resources & Organisational Development

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Development and Approval of People Strategy and Dashboard	• The refreshed People Strategy was signed off by the Trust board in Q2 2018/19. Quarterly reports will be presented to the Strategic People Committee.	• Ongoing monitoring and management of the dashboard. • The Strategic People Committee will provide oversite of the refreshed people Strategy.	Trust Board, TOB, Strategic People Committee	Complete
Restructure of HR Directorate	• The HR department restructure is complete and key posts in the Senior Management Team have been recruited to.		Trust Board, Strategic People Committee	Complete
HR Polices reviewed to ensure they are clear, simple and transparent	• The Human Resources (HR) & Organisations Development (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.	• The Trust is undertaking a programme to review and where required simplify HR policies which will be monitored by the Strategic People Committee. Policies to be reviewed and ratified in Q4 include Disciplinary Policy, Relationships at Work Policy, and Special Leave Policy.	Strategic People Committee	Ongoing Monitoring

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UoR Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 3 2018/19

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
"Fit to Care" Heath & Wellbeing Programme	• 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 implemented. • The Trust has piloted a weight management clinic. • Health topics have focused on the different effects of stress both physically and mentally. • Drop in sessions have been held for staff on healthy hearts and stress management. • The Trust 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. • Heath topics on exercise and movement at work and hydration have been in focus around the Trust. • Q1 2018/19 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 for staff has been held.	• Wellbeing initiatives will continue to be offered and monitored for effectiveness. • During Q3 the Health and Wellbeing Team have consulted with the workforce to seek their feedback on the Fit to Care programme, suggestions for improvement and overall input with regards to supporting staff wellbeing. This will be incorporated into the revised delivery plans to be completed in Q4.	Strategic People Committee	Rolling Programme
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 continues to work through the agreed milestones for year 3 for the following workstreams (Training, Occupational Health, PREP, Recruitment, Medical Staffing and Systems). Updates are provided to the Operational People Committee by the Internal Implementation Group and externally to regional groups. • Key priorities for Q4 are benefits realisation and identifying sustainable working processes following the closure of the Streamlining Programme after March 2019.	Operational People Committee	Ongoing

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Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 3 2018/19

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Staff Opinion Survey	• The 2017/18 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 and outputs are linked to Listening In To Action (LIA) • Themes from the 2017/18 staff survey were used to develop the refreshed People Strategy.	• The 2018 Staff Opinion Survey 2018 has now closed. The Trust achieved a very positive response rate of 50.6%, a 4.6% improvement on the previous year. The Trust is awaiting results from the survey which will be developed into a new action plan.	Trust Board, TOB, Strategic People 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 SOS 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. • The Trust has reviewed the SOS results against other employee relations metrics around bullying and harassment and has analysed the areas where we are doing well to look how learning can be shared across other areas. This 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. • Work has been undertaken with the Trust's communications team to ensure staff know who to raise concerns with and how they would go about this.	• An Equality, Diversity and Inclusion Strategy is being produced, the first draft was presented to the Equality and Diversity sub-committee in Q3. Additional engagement will take place in January 2019 and the Strategy will be submitted to Trust Board for ratification in March 2019.	Strategic People Committee	Ongoing Monitoring

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Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 3 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% (November 2018) against a target of 85%. • HR Business Partners have worked with CBUs to develop a recovery plans, 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. • As part of the new NHS pay award, from April 2019 the Trust will be required to further strengthen the link between performance and pay progression. The HR team will be working with colleagues from other Trusts to ensure this is implemented regionally in a consistent way.	Trust Board, TOB, Strategic People Committee	Ongoing Monitoring
Improving Sickness Absence	• Sickness absence was 5.02% in November 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. • A new clinical supervision framework has been rolled out which will help to address some of the stress/anxiety related absences. •An ongoing programme of Mental Health first aid training is being rolled out across the Trust.	• A piece of work is underway to review sickness absence management processes and initiatives in comparator Trusts, to learn from best practice. Results will be submitted to Trust Board in March 2019.	Trust Board, TOB, Strategic People Committee	Ongoing Monitoring

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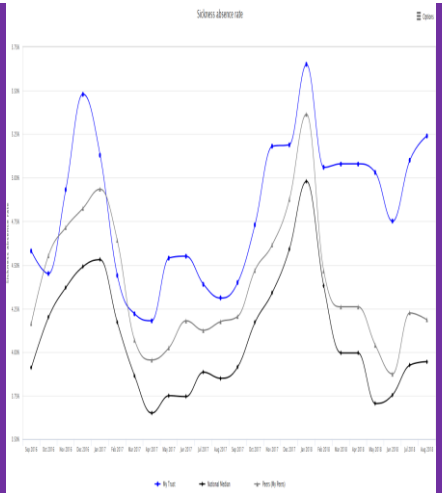
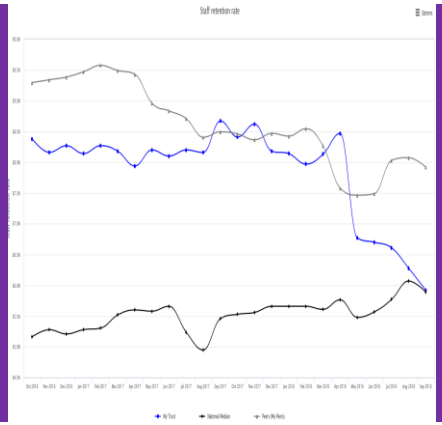
UoR Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 3 2018/19

KLOE 2 - People

	Progress/Performance			Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Sickness Absence Rate	UoR Percentage of staff FTE sick days.	**National Median = 3.95%** Peer Median = 4.19% 1. STHK 2.92% 2. Sunderland 3.82% 3. Gateshead 4.01% 4. North Tees 4.13% 5. Mid Cheshire 4.16% 6. N Lincolnshire 4.21%	**August 2018** 7. Bournemouth 4.34% 8. Chester 4.37% 9. Wirral 4.92% 10. WHH 5.24% 11. Southport 5.72%	 Source: HSCIC - NHS Digital iView Stability Index Monitoring - Trust Board, TOB, SPC (from March 2019)	Absence remains above the Trust target; November 5.02%, 4.94% ytd. The main reasons for absence is Mental Health and MSK related illnesses.	> Increased focus on workforce KPIs (sickness and RTW) with the CBUs. HR business partners are working with CBU managers to look at what additional support is available. > HR team delivering bespoke actions, training and coaching with hotspot areas. > Development of guidance on RTW for managers. > Evaluate the success of Mental Health First Aider programme. > Benchmarking against similar neighbouring Trust is take place to understand and implement best practice in relation to stress.	
Staff Retention Rate	UoR The percentage of staff that remained stable over 12 months period.	**National Median = 85.9%** Peer Median = 87.9% 1. Wirral 88.9% 2. N Lincolnshire 88.9% 3. Southport 88.5% 4. Gateshead 88.4% 5. Sunderland 88.0% 7. STHK 87.9%	**Sept 2018** 8. Mid Cheshire 87.1% 9. Bournemouth 87.0% 10. North Tees 86.7% 11. Chester 86.0% 12. WHH 85.9%	 Source: HSCIC - NHS Digital iView Stability Index Monitoring - SPC (from March 2019)	The Trust retention rate remains above national median but below our peers. October 2018 retention is 86.5%. There has been decrease from 88.5% in April to 859% in October. The Trust Recruitment and Retention group has met and developed an action plan. The Trust is part of the NHSI cohort of Nursing retention and will share ideas for retention across staff groups.	Key actions include: > Reviewing best practice across the NHS as an aid to developing our action plan. > Improving our understanding of reasons for leaving and analysis of current data to inform priorities. > Improve the promotion of development opportunities and benefits of working at WHH. > Establish a method for employees to discuss their options before seeking alternative employment.	

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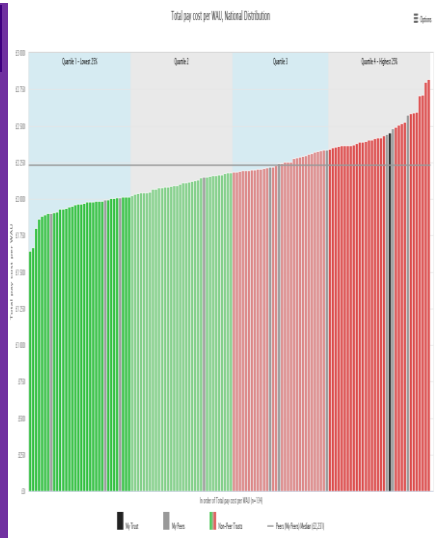
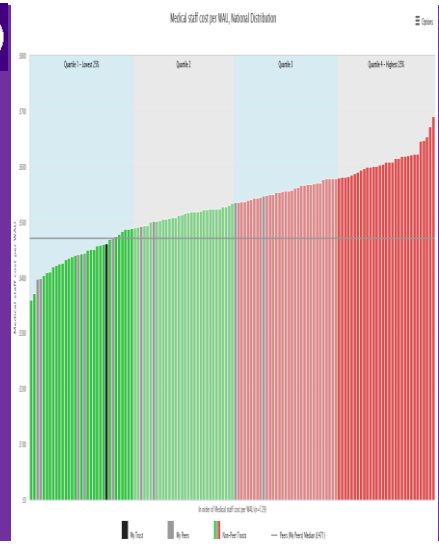
UoR Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 3 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 = £2180** **2017/18** Peer Median = £2231 1. Sunderland £1904 2. STHK £1995 3. Bournemouth £2010 4. Gateshead £2151 5. Wirral £2219 6. North Tees £2242 7. Chester £2336 8. Mid Cheshire £2442 9. WHH £2455 10. N Lincolnshire £2482 11. Southport £2577 **Source: Trust consolidated annual accounts and reference cost data.** **Monitoring - Trust Board, SPC (From March 2019), FSC, TOB.**	 Pay Costs per WAU exceeds the Peer and National Medians. The below shows the WAU Staff Costs per staff group and the percentage difference compared to our peers: Staff Group / Trust / Peer % Medical £465 -4.5% Nursing £764 -6.2% AHP £188 19.1% Scientists £192 9.4% Corp Supp £413 -3.1% Agency £169 32.0% Non-Sub £183 8.2% This data shows that the Trust is utilising more agency staffing than our peers.	The key actions focus on reducing reliance and improving value for money for temporary staff (AHP explained below). > The temporary staffing team continue to support the CBUs to improve locum fill and pay rates. > Launch of new Medical Bank system to manage the medical bank to go live on 31/03/2019. > Process medical bank bookings through the Brookson system, improving fill rate and compliance. > Working with C&M, challenge agencies to improve their pay rates. Phase 1 complete, Phase 2 in progress - to be complete in Q4. > Process all other agency work through the Brookson system. Admin staff to go live on 31/03/2019.	
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 = £533** **2017/18** Peer Median = £471 1. Gateshead £398 2. Mid Cheshire £399 3. Sunderland £442 4. North Tees £444 5. WHH £461 6. Wirral £471 7. Bournemouth £493 8. Chester £502 9. Southport £536 10. N Lincolnshire £548 **Source: ESR, Trust consolidated annual accounts and reference cost.** **Monitoring - SPC**	 The Trust is below the national and peer median which is excellent news, however the large number of vacancies within this workforce will have contributed to this. As we seek to recruit to these vacant posts we could see costs per WAU increase. To mitigate this, we're currently completing a Medical Establishment Review, using the RCP Medical Safe Staffing Methods as our guide this will continue until the end of Q4.	The key actions relate to the Medical Establishment Review. > Agree the baseline Medical Establishment by Ward - complete. > Complete a time and motion study to understand activity - complete. > Analyse the established medical model and the proposed effective establishment, within the context of RCP Safe Medical Staffing Guide. > Identify the gaps within the Medical Workforce based on the analysis, developing innovative solutions to fill the gaps. > Working with WWL to recruit Drs Internationally.	

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UoR Use of Resource Assessment Indicator

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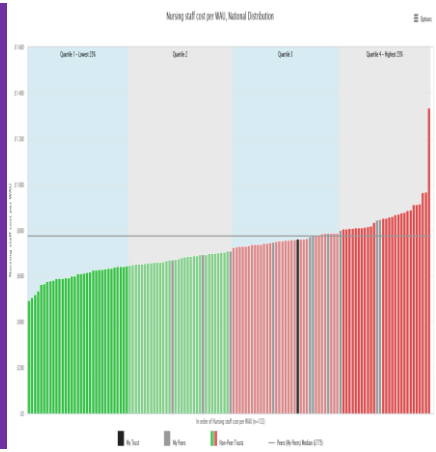
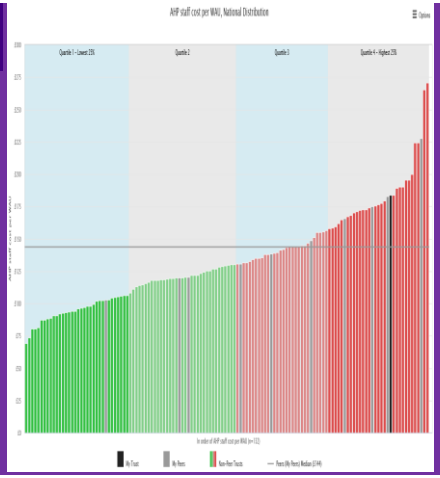
Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 3 2018/19

	Progress/Performance				Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Nurses Cost Per WAU	UoR Total pay costs for nursing staff, adjusted for the % of Trust expenditure reported in reference costs, the MFF, and the % of pay costs that are capitalised, divided by Cost Weighted Output in WAUs.	**National Median = £710** Peer Median = £775 1. Bournemouth £671 2. Sunderland £694 3. STHK £711 4. Gateshead £750 5. WHH £761 6. Wirral £772	**2017/18** 7. Chester £778 8. N Lincolnshire £789 9. North Tees £801 10. Southport £845 11. Mid Cheshire £848	**Source: ESR, Trust consolidated annual accounts and reference cost.** **Monitoring - SPC (from March 2019)**		The Trust is below the peer median for our Nursing Costs per WAU which is positive, however again the large number of vacancies will have contributed to this. The Trust seeks to reduce reliance on temporary staffing by offering alternative retention and recruitment solutions with the expansion of the Band 6 nursing workforce, advanced practice and specialist interest roles.	The key actions are: > Working alongside the WHH Recruitment and Retention group, develop retention strategy and NHSI. > Continue the successful Staff Nurse recruitment open days. > Improve the promotion of the Band 6 nursing roles, as both a retention and attraction tool.
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 = £130** Peer Median = £144 1. STHK £103 2. Wirral £120 3. Bournemouth £121 4. Chester £131 5. Sunderland £138 6. Gateshead £149	**2017/18** 7. N Lincolnshire £166 8. Southport £175 9. Mid Cheshire £183 10. WHH £184 11. North Tees £228	UoR **Source: ESR, Trust consolidated annual accounts and reference cost.** **Monitoring - SPC (from March 2019)**		WHH employ a number of AHPs that do not contribute to the clinical care of WHH patients (they are contracted out to other organisations via SLA) and therefore AHP Costs per WAU will be distorted. The Trust is reviewing possible solutions to increase it's AHP workforce to support the Nursing vacancies.	The key actions are: > Validate the data with local intelligence, producing and accurate cost per WAU. We are looking to re-calculate the WAU to look at staff contributing to WHH activity only. > Continue to support Workforce Redesign projects to offer alternative solutions where appropriate. > Mirror the Nursing recruitment campaigns and attend University job fairs and recruitment open days to fill vacancies and reduce vacancy gaps.

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UoR Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 3 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 Integrated Performance Report (IPR). • Data is submitted monthly to NHSI via the Trust Information 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-Rostering team is co-located with the operational management team in a centralised location. • Capacity and demand meetings are held after the bed meetings and the staffing template updated in real time. • The interface between e-roster and NHS(P) is now in place and temporary staff must now be booked via e-roster. • Safe Care acuity is now embedded and the information is used for 6 monthly safe staffing review. • The Trust has shared its achievements with Safe Care and Health Roster products with 4 Trusts in the region and continues to be seen as an exemplar by Allocate for Nurse Rostering & SafeCare.	• Continue to support the Matron daily safe staffing meetings, allows for early identification of hotspots/issues. • Future rollouts for Outpatient Nursing, Administration Staff, Medical Staff and Corporate Functions.	Trust Board	Ongoing development and daily monitoring with Senior Nurse Oversight

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Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 3 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	• The Trust uses Allocate Software for e-Job planning. • The Consultant Job planning policy has been reviewed and a revised policy was agreed for implementation in June 2018. • Terminology within Allocate has been streamlined for easier input. • Proposal for reducing sign off levels from 3 to 2 has been accepted. • The project involving Programmed Activity (PA) corporate budgets for Medical Leadership, Education & Training, Quality & Governance and Appraisal & Revalidation has been completed. The Trust is in the process of providing an SOP to detail the revised process for the financial management of PAs. • 2019/20 Job planning round has been launched and the first cohort of consistency panels has been held for each of the eight Clinical Business Units. Of 202 clinicians (both Consultant & SAS doctors) 162 job plans have been released for review as at 31st December 2018. • The project involving Programmed Activity (PA) corporate budgets for Medical Leadership, Education & Training, Quality & Governance and Appraisal & Revalidation has been completed. The Trust has provided an SOP to detail the revised process for the financial management of PAs.	• Job planning progress will continue to be monitored on a regular basis. • Job planning compliance is scrutinised at a fortnightly HR meeting when data is presented to the Head of Medical Staffing & Education. • Updates are provided regarding progress to the Trust Joint Local Negotiating Committee. • Mediation meetings have been convened for 2 of the residual 2017/18 job plans and conclusions have almost been reached. • A second round of consistency panels are in the process of being arranged to consider 2019/20 job plans.	Operational People Committee	Ongoing development and daily monitoring

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Use of Resource Graph Key
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Peer Median

Key
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Progress off track - plans in place to get back on track/Amber on the Model Hospital
Progress significantly off track/Red on Model Hospital
Not started/Awaiting further information/New actions parameters to be established

UoR Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 3 2018/19

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
	Recommendation 3 - Trusts should, through a Hospital Pharmacy Transformation Programme (HPTP), develop plans by April 2017 to ensure hospital pharmacies achieve their benchmarks such as increasing pharmacist prescribers, e-prescribing and administration, accurate cost, coding of medicines and consolidating stockholding by April 2020, in agreement with NHS Improvement and NHS England so that their pharmacists and clinical pharmacy technicians spend more time on patient facing medicines optimisation activities.			
	Lead Director(s): Medical Director & Chief Nurse			
Hospital Pharmacy Transformation Programme - developing HPTP plans at a local level	• Developed and approved HPTP Plan, nominated Directors, Board sign off and submission of final plan to NHS Improvement. • The HPTP was completed in May 2017.	• Model hospital metrics are monitored at the Trust's Medicines Governance Committee.	Trust Board	Complete
Moving prescribing and administration from traditional drug cards to Electronic Prescribing and Medicines Administration systems (EPMA)	• Electronic prescribing and medicines administration (ePMA) business case and PID signed off by Trust Board and NHS Digital – the outline business case was approved by the Trust board in October 2017, NHS Digital approved the business case in principle in November 2017. • The ePMA rollout plan was signed off by the Digital Operational Group and the IM&T Committee in Q1 2018/19 • The ePMA pilot commenced on CDU on 5th March 2018. Positive feedback from staff/system users has been received. 2nd ePMA pilot at Halton UCC – the pilot was a success and operation of the system has continued post pilot. • The 2nd pilot on B1 in Halton commenced in July. An evaluation of the risks has been undertaken post pilot and it has been agreed by the project team to continue rollout once the developments have been implemented in the system. • A "market place" event took place for staff to evaluation the potential equipment that will be used on the wards and in pharmacy as part of the ePMA rollout. Recommendation are to be reported to the IM&T Committee. • ePMA was successfully implemented on the surgical pathway on Ward B4 in December 2018.	• The Trust is working with the supplier on further developments to ensure flow between A&E and non-elective wards is robust. Lorenzo is due to be upgraded to version 2.17 in 2019. When v2.17 is available the required system improvements will be in place to enable to Trust to implement ePMA across the emergency admissions pathways. • It is anticipated that the system will be implemented at the CMTC in Q4, this will complete the Halton site. • Planning for rollout at Warrington Hospital will take place during Q4.	Trust Board/IM&T Committee	Project expected completion – March 2020

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UoR Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 3 2018/19

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Ensuing that coding of medicines are accurately recorded	• The Trust continues to work on improving data quality with workshops held to identify gaps, issues and areas for improvement with plans to address. • PHE SACT data has been reviewed, based on this the Trust is achieving current data quality targets. • A Blueteq drop in presentation day to be held in January 2018 to demonstrate the system and inform clinicians about the contractual requirements to obtain prior approval for the patient pathway before commencing treatment – commencing 1st April 2018. Implementation of Blueteq was paused due to technical issues with the system, which are being resolved by the CSU. • Q1 2018/19 – Blueteq was implemented for endocrinology drugs.	• The Trust continues to monitor the contents of the Schedule 6 schema reports to address any data quality issues. Workshops to take place with Finance, Pharmacy and Information colleagues during Q4 to address outstanding issues. • A new rollout plan for Blueteq has been agreed with the CCG. Rheumatology have commenced using the system and this implementation will continue into Q4. It is anticipated Ophthalmology will rollout in Q1 2018/19. • A conference call has been scheduled by NHSE to address the collective concerns of the pharmacy teams across the region to look at how processes can be streamlined to avoid duplication.	Medicines Governance Committee	Ongoing Work Programme
80% of trusts' pharmacist resource utilised for direct medicines optimisation activities, medicines governance and safety remits	• 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. • 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. Funding has been agreed for the wider rollout, however, the role of the nursing associates is being considered in relation to this project to ensure that wider rollout will be effective. • A draft business case for a 7 day emergency admissions Pharmacy service has been developed and was partially agreed including the MSO and ITU area. A updated business case for the remaining areas will be submitted during Q4 with pilot to commence subject to recruitment.	Quality & Assurance Committee	Ongoing Monitoring

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UoR Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 3 2018/19

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Reduce stockholding days from 20 to 15, deliveries to less than 5 per day and ensure 90% orders and invoices are sent and processed electronically	• The Trust's current stockholding days are 18, which is below the national and peer median. • Average number of deliveries to the Trust per day is 14 which is below the national median. • 97% orders are carried out electronically.	• Reducing stockholding days or number of deliveries to the Trust per day any further would carry an unacceptable level of risk. The Trust continues to monitor performance against our peers.	Medicines Governance	Ongoing Monitoring

KLOE 3 - Clinical Support Services

Top 10 Medicines - Percentage Delivery of Savings

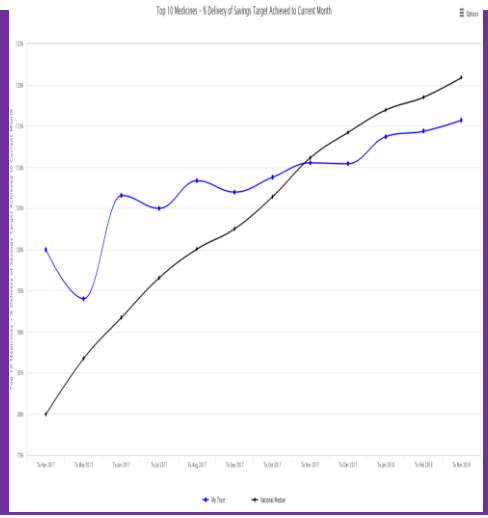
UoR

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

National Median = 100% **March 2018**
Peer Median = 127%

1. Southport 173%
2. N Lincolnshire 166%
3. Gateshead 129%
4. Wirral 127%
5. STHK 126%
6. Mid-Cheshire 119%

7. WHH 116%



Maximal savings achieved for:
1. Infiximab & 2. Imatinib
Savings targets for:
3. Etanercept - £124.9K, achieved 18/19
4. Rituximab - £307.07K, aiming to achieve in year
5. Caspofungin - £55k, max. achieved 17/18 & 18/19
6. Linezolid - 10.69K, max. achieved 17/18 & 18/19
7. Prednisolone Soluble - £3.7K, achieved 18/19
8. Voriconazole – £1.7K, max. achieved 17/18 & 18/19
9. Trastuzumab – N/A
10. Valganciclovir – N/A
11. Adalimumab (from 12/18) - £1.01m in progress

No target saving set for:
1. infliximab & 2. imatinib
3. Etanercept – patient switching completed in Q3 17/18, achieving maximal savings 18/19
4. Rituximab – switching remaining haematology patients who require maintenance with MabThera subcut., from Q3 18/19
5,6,8,10. All patients on generics 100% of savings achieved in 17/18 & 18/19. Target due to lower use in 17/18 vs 16/17 benchmark
7. Switch to alternative steroid preparations completed 18/19
9. Not commissioned
11. Switching commenced

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

Monitoring - Medicines Governance Committee

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UoR Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 3 2018/19

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
	Recommendation 4 - Trusts should ensure their pathology and imaging departments achieve their benchmarks as agreed with NHS Improvement by April 2017, so that there is a consistent approach to the quality and cost of diagnostic services across the NHS. If benchmarks for pathology are unlikely to be achieved, trusts should have agreed plans for consolidation with, or outsourcing to, other providers by January 2017. **Lead Director(s):** Chief Operating Officer & Director of Strategy			
Establishment of a shared pathology across the local economy	• NHSI has proposed 29 Pathology Networks across the country, with Cheshire & Merseyside being "North 4". An STP wide Pathology Board has been created with a Clinical Director and Pathology Manager from each of the Trusts in the region. • Three main working groups have been established (Blood Sciences, Microbiology & Cellular Pathology). • STP Cheshire & Mersey Pathology Board met in Q1– the CEO of Aintree Hospital NHS Trust has been named Executive lead for the relaunched group. • A Transition Management Team has been established (Wirral Chester, Aintree, Liverpool and Southport & Ormskirk). A project manager has been appointed by the STP. • Branch work stream meeting established to look at equipment with a view to joint procurement opportunities and contract alignments. • Several drafts of the strategic outline case have been developed. The final case was approved by the Executive Oversight Group on 20th December 2018.	• The outline business case will be developed and signed off during Q4. • The project will appoint a Clinical Director and Director of Operations during Q4. • The project will begin to scope transition and implementation initiatives. • Development of specification for the procurement of Managed Equipment Services (MES). • The project will begin to explore options around IT interoperability.	Strategic Development and Delivery Committee	Project – expected completion 2021
Development of pathology service specification	• The original plan called for a new specification to be developed, however this has now been superseded by the STP wide pathology board.	N/A	N/A	N/A
Introduce the Pathology Quality Assurance Dashboard	• A Pathology Quality Assurance Dashboard (PQAD) has been developed. • PQAD implemented from November 2016.	• Monthly data indicators continue to be submitted. • PQAD data is reviewed monthly at the KPI sub-committee. • The Trust continues to review quarterly and bi-annual indicators, however we understand that the indicators are under review and a new dashboard is under development.	KPI Sub-Committee	Rolling Programme

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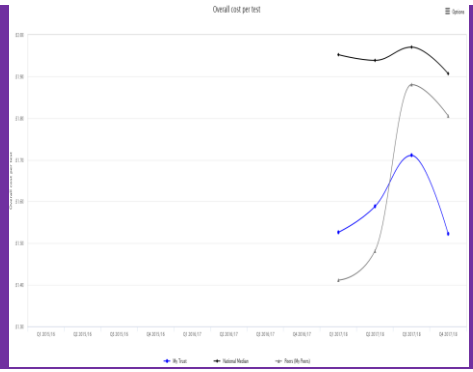
Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 3 2018/19

	Progress/Performance		Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Pathology - Cost Per Test	**KLOE 3 - Clinical Support Services** UoR The cost per test is the average cost of undertaking one pathology test across all disciplines, taking into account all pay and non-pay cost items.	**National Median = £1.91** **Q4 2017/18** Peer Median = £1.81 1. Chester £1.21 2. WHH £1.52 3. North Tees £1.81 4. Bournemouth £6.96 **Source: NHSI Q Pathology Data Collection 17/18** **Monitoring - Pathology Business Meeting**		The Trust benchmarks well against peer and the national median and also against Trusts within our STP footprint. Overall the Trust's pathology service is efficient with the use of streamlined processes, technology and procurement opportunities.	The Trust is working with STP partners as part of the Lord Carter recommendations to look at how further efficiencies can be made across the footprint. > The strategic outline case has been developed which includes 3 options. The outline business case is to be developed in Q3/Q4. > Specifications to be developed for the procurement of Managed Equipment Services. > IT interoperability options to be explored.	

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Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 3 2018/19

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
	Recommendation 5 - All trusts should report their procurement information monthly to NHS Improvement to create an NHS Purchasing Price Index commencing April 2016, collaborate with other trusts and NHS Supply Chain with immediate effect, and commit to the Department of Health's NHS Procurement Transformation Programme (PTP), so that there is an increase in transparency and a reduction of at least 10% in non-pay costs is delivered across the NHS by April 2018. **Lead Director(s):** Chief Operating Officer & Director of Finance & Commercial Development			
Provide data to NHSi for the NHS purchasing price index benchmarking tool (PPIB)	• The procurement team continues to provide the 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 & Knowles and Southport and Ormskirk NHS Trusts for a collaborative approach to be taken in reviewing and securing lower prices. • The Trust has agreed to run PPIB data on behalf of the Group Purchasing Organisation (GPO) run by HealthTrust Europe which will inform their work plans for driving down costs. • A report of the Top 25 variances has been produced which compares the Trust nationally and against peers. Actions will be produced to address variance where it is possible to do so. This will be run and reviewed on a monthly basis.	• Where is has been identified that the Trust can obtain a better price for a product or service as a result of the comparison with peers, this will be actioned by the procurement team on an ongoing basis. • The Trust is reviewing data for Trusts at a comparable size to look at areas around the Top 100 products for commonality of spend with view to renegotiating on our prices with suppliers.	Finance & Sustainability Committee	Rolling Programme

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UoR Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 3 2018/19

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
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 will be refreshed during Q4 using the new NHSI format which contains additional requirements. • The Trust continues to measure progress against the PTP. The Trust is actively working with the new NHS Supply Chain Operating Model (formerly known as the Future Operating Model (FOM)) as follows: • A review of all direct spend i.e. that not with NHS SC is under review to determine which products can be transferred to NHS SC to further support the operating model. This will be completed by the end of January 2019. • A review of optimum pack sizes as supplied under the Operating Model is being undertaken to determine the impact upon the Trust. • All savings identified by Supply Chain Coordination Ltd (SCCL) will be incorporated in the Trust's 2019/20 CIP Plans. In addition to the above the Trust's Associate Director of Procurement has been selected to sit on a Procurement Target Operating Model Reference Group jointly managed and facilitated by NHS Improvement and Deloittes. This is part of the overall Procurement Transformation Plan within the NHS to input into how procurement should look in the future. Reference Group meeting are being held in January and February to develop a blueprint for Trust procurement.	Finance & Sustainability Committee	Project Implementation

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UoR Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 3 2018/19

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
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 in post the Supply Chain Manager to lead on the Scan4Safety project from a procurement prospective. • The Deputy Head of Procurement has presented Scan4Safety to the Finance & Sustainability Committee and Trust Operational Boards. • A presentation on the benefits of implementing Scan4Safety has been given at the Trust's 'Grand Round' • A briefing paper was presented to the Trust Board, Trust Operational Board and Finance and Sustainability Committee during Q2. • A draft PID has been developed and will need further development once the project team has been established. • The Trust has had 2d GS1 and ISB-1077 compliant wristbands at the Trust since 2015. • The Procurement Team has, for several years, proactively managed both content and price on over 300 masked catalogues containing over 90,000 of the products required to provide patient care.	The Trust has made progress in a number of areas: • been allocated our 10,000 GLN's by GS1 has agreed a way to assign a GLN to all of the locations within the Trust. This will be complete within Q4. • agreed in principle that the issue relating to GSRN will be dealt with by replacing all staff ID Badges with a badge which as well as a photograph will contain a barcode linked to the member of staffs payroll number. • had a number of discussions with potential PEPPOL access providers and are currently waiting on an announcement from NHS SBS relating to their PEPPOL access provider to assist and provide direction in our own decision making. • The inventory management systems offered by the main providers in this area have been evaluated. This area along with the associated hardware and software represents the biggest cost to the Trust, so care is required to ensure that the solution we select meets our requirements not only currently but also into the future. This is proving particularly difficult given the changing landscape. This work is ongoing and represents a significant part of the feasibility study outlined below. In Addition • Most of our main suppliers display GTIN's on their packaging. • A project group is in the process of being established to review the requirements and will be instrumental in developing a feasibility study to be considered by the Trust Board. The Deputy Head of Procurement is meeting with individuals who will make up the project group to discuss objectives and roles and responsibilities. Part of the remit of the group will be to view various systems, explore options including pricing, and to undertake site visits. This will culminate in a Statement of Need, Feasibility Study and Outline Business Case. If this is approved the next step would be the procurement that would result in a full business case to be signed off. • A Senior Project Lead with an Executive Sponsor will be identified discussions will take place with the COO.	Trust Board	Project Implementation

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Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 3 2018/19

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
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 procurement team has identified and collated evidence in order to meet the criteria for Level 2 accreditation. • The Trust submitted the evidence to the Procurement Skills Development Network (FSD) in October.	• The Trust is waiting for PSD to identify assessors for the pre and full assessment. It is anticipated that the Trust will achieve Level 2 based on the evidence provided.	Finance & Sustainability Committee	Project Implementation
Benchmarking – Model Hospital Procurement	• The Trust is currently ranked 50/136 Trusts – placing the Trust in the middle of upper quartile. • Data has been 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 procurement team has produced a strategy to look at the feasibility of the Trust reaching the upper quartile for each metric and actions needed to get there.	• The procurement team will continue to work through actions to improve its position against the Model Hospital metrics as part of a rolling programme. • The procurement team has developed a tracker to review progress against the key metrics.	Finance & Sustainability Committee	Ongoing
Key Procurement Metrics	• Target of 80% addressable spend transaction volume on catalogue - Trust currently is at 90% (Q3 2018/19). • Target of 90% addressable spend transaction volume with a purchase order - Trust currently at 95% (Q3 2018/19). • 90% addressable spend by value under contract - Trust currently at 81% (Q3 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.	Finance & Sustainability Committee	Ongoing Monitoring

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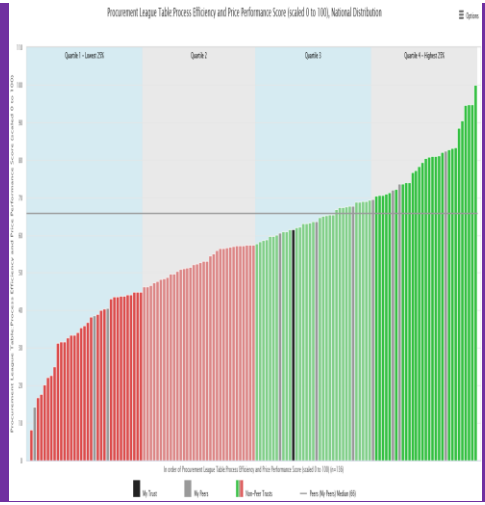
Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 3 2018/19

Procurement Process Efficiency and Price Performance Score Clinics

Progress/Performance			Actions to Improve Position/Actions for Next Quarter	Assurance	Status
KLOE 4 - Corporate Services					
UoR This measure provides an overall view of how efficient and how effective an NHS Provider is in it's procurement process and price performance, respectively, when compared to other NHS providers.	**National Median = 57** Peer Median = 66 1. Bournemouth 82 2. Wirral 74 3. STHK 72 4. N Lincolnshire 70 5. North Tees 68 6. Southport 64	**Q4 2017/18** 7. WHH 62 8. Chester 61 9. Mid Cheshire 41 10. Gateshead 39 11. Sunderland 14		The Trust is below the National Median but above the Peer Median In terms of the Procurement League Table the Trust is as follows: Overall Procurement Process – Meets Expectations Procurement Process Efficiency – Exceeds Expectations Price Performance – Meets Expectations The Procurement Team has in place a strategy for improving performance that is reviewed on a monthly basis.	The Trust has undertaken a review of all procurement metrics and track this on a monthly basis. The key actions are as follows: > Undertake a monthly review of a rolling top 25 by spend to identify and implement any areas of opportunity producing a monthly summary report. > Undertake an analysis of all non-pay spend to understand what is not applicable to PPIB and why. > Submitted for Level 2 of the Procurement Standards by the due date of October 2018 (pending assessment).
Source: Purchase Price Index and Benchmark (PPIB) tool **Monitoring: Senior Procurement Meeting**					

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Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 3 2018/19

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
	Recommendation 6 - All trusts estates and facilities departments should operate at or above the benchmarks for the operational management of their estates and facilities functions by April 2017 (as set by NHS Improvement by April 2016); with all trusts (where appropriate) having a plan to operate with a maximum of 35% of nonclinical floor space and 2.5% of unoccupied or under-used space by April 2017 and delivering this benchmark by April 2020, so that estates and facilities resources are used in a cost effective manner. **Lead Director:** Chief Operating Officer			
Strategic estates strategy inc cost reduction for 16/17 based on benchmarks and in the longer term plan for investment/reconfiguration	• The Trust has an estates strategy in place to meet the overall Trust strategy. The strategy is phased 1, 2, and 3. Phase 1 is to explore immediate options for delivering savings by rationalising part of the estate. Phase 2 is to explore the potential for external and/or better utilised 'on site' accommodation for current service provision and phase 3 is to explore opportunities for wider STP collaborative initiatives. • Phase 1 is being delivered and monitored through Strategic Development and Delivery Committee. The strategy has been refreshed to reflect local clinical strategy and the STP estates strategy. • A draft estates and facilities strategy aligned with the Trusts clinical strategy has been developed and submitted to the Director of Strategy for review. • The Associate Director of Estates and Facilities has been nominated as co-chair for the One Halton estates enabler sub-group.	• The Trust continues to explore internal and partnership collaboration opportunities for relocation of back office and clinical support functions. • A final estates and facilities strategy will be submitted to the Trust board during Q4. • A 12 month estates and facilities workforce plan is in development.	Estates and Facilities sub-Committee, TOB, Strategic Development and Delivery Committee	Ongoing management and monitoring of the plan
Investing in energy saving schemes such as LED lighting, combined heat and power units, and smart energy management systems	• The Trust has procured an energy infrastructure upgrade (CHP) which will save carbon, energy, money and future investment, upgrading their facilities using private sector capital repaid through guaranteed savings. • Estates have accessed funding from Carbon Energy Fund (CEF) replacing 4000 halogen bulbs with more cost effective LED. Trust has invested in Combined Heat. • The Trust has realised saving of £140k from the CHP contract which has been used for the departments CIP target.	• There is a survey being carried out around fans and controls within all our air handling units which should provide some additional energy efficiency and reduce our Carbon Footprint.	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

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Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 3 2018/19

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
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. • 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, Moving to Outstanding programme. • A business case outlining the resources required to meet the CQC recommendations was approved during Q3 to carry out action against 2018 PLACE assessment and CQC environmental requirements.	• A PLACE assessment took place in June 2018; results have been developed into an action plan which is monitored by the estates and facilities operational board and the quality assurance committee. • The new model hospital data for 2017/18 shows the Trust favourable when benchmarking against peer and national medians.	Estates and Facilities Sub-Committee/TOB/ Quality Assurance Committee	Ongoing Monitoring
All trusts (where appropriate) have a plan to operate with a maximum of 35% of 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 2018/19 reports the Trust utilises 38.7% of its estate for non-clinical use and has 0.9% of empty space. Whilst efforts to minimise the use of trust accommodation for non-clinical purposes has been made, it is difficult given the complexities of the numerous corporate functions. • The current estate strategy aims to address the under-utilised space by rationalising the estate. Better use of under-utilised estate will result in a reduction in the size of the estate and the amount of estate used by non-clinical functions.	• The estates and facilities function is fully involved in the Halton Healthy New Towns and New Hospital for Warrington initiatives to ensure changes to estates centre around patient care.	Strategic Development and Delivery Committee	Ongoing Monitoring

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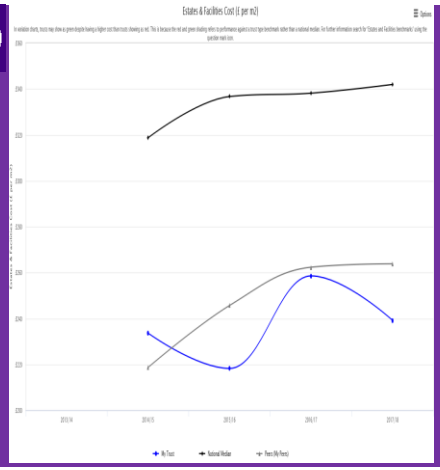
Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 3 2018/19

	Progress/Performance			Actions to Improve Position/Actions for Next Quarter	Assurance	Status
KLOE 4 - Corporate Services						
Estates & Facilities Costs (£ per m2)	The total estates and facilities running costs is the total cost of running the estate in an NHS trust including, staff and overhead costs. In-house and out-sourced costs, including PFI costs, will be included.	**National Median = £342** Peer Median = £264 1. North Tees £186 2. Sunderland £200 3. Wirral £211 4. Mid Cheshire £221 5. WHH £239 6. N Lincolnshire £253	**2017/18** 7. Chester £275 8. Bournemouth £304 9. Southport £321 10. Gateshead £336 11. STHK £432	The Trust benchmarks well against national and peer median for hard facilities costs even with the challenges of maintaining an aging estate. We have invested 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 and will continue to have an adverse effect on overall estates and facilities costs.	Estates and facilities costs are continually monitored. Where efficiencies can be made, proposals/business cases produced for consideration from the Trusts Executive Team.	

Source: ERIC 2017-18 Total Estates and Facilities Running Costs
Monitoring - Estates and Facilities Operational Group



Warrington and Halton Hospitals NHS
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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 8.7% of income based on planned income as of Q3 2018/19. It is unclear if Nursing & Governance should be included as a corporate service, this is being looked into. If we exclude this function, the Trust's costs would be 7.2% based on planned income. • 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. • 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. • 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. • NHSI operational productivity team visited the Trust on 16th August 2018 to look at the whole of the model hospital and identify opportunities. • As a follow up to the NHSI productivity session, a specific corporate service session is arranged for 17th October 2018 which will focus on IM&T, Finance and HR.	• This requirement will be taken forward internally by the Deputy Directors forum with each Deputy Director responsible for developing a plan. • Corporate Services are utilising NHSI Corporate Service Productivity Programme to review opportunities around Chart of Accounts, Journal Policy, Budget Holder Support, Accounts Payable Automation, Sharing Ledger Costs, Policies and Procedures and Financial Reporting. The Trust is working with Mid-Cheshire Hospitals NHS Trust to review structures as part of a wider benchmarking exercise. • The Trust is reviewing WTE costs and benchmarking against Model Hospital data.	Strategic Development and Delivery Committee	Rolling Programme
Corporate CIP Targets	• All corporate divisions have been assigned costs savings targets in 2018/19. 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. • CIP targets for 2018/19 are set against specific programmes of work linked to the organisation's agreed portfolio of strategic projects. The main project impacting on corporate functions is the Corporate Services review.	• Corporate CIP Performance as at M9 end - £0.65m year to date against a target of £0.61m, the full year target is £1.1m.	Finance & Sustainability Committee	Rolling Programme

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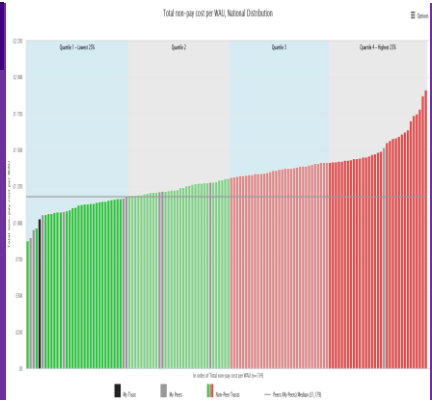
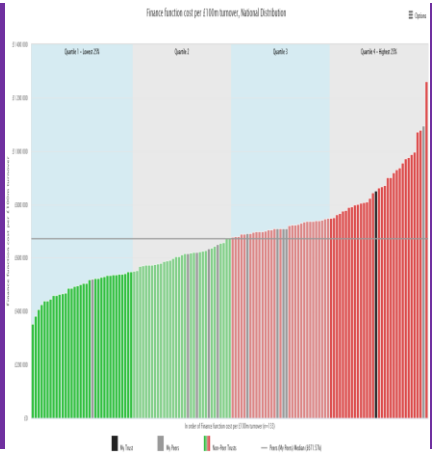
KLOE 4 - Corporate Services

	Progress/Performance		Actions to Improve Position/Actions for Next Quarter	Assurance	Status
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 = £1307** **Peer Median = £1179** **2017/18** 1. Chester £898 2. Mid Cheshire £954 3. WHH £1027 4. Gateshead £1058 5. Wirral £1078 6. Southport £1172 7. N Lincolnshire £1187 8. Bournemouth £1213 9. STHK £1218 10. North Tees £1280 11. Sunderland £1518 **Source: HSCIC - NHS Digital iView Stability Index**		The Trust is below the national and peer medians. However the Trust continues to review opportunities to reduce non-pay costs whilst maintaining quality.	All departments across the Trust are continuously looking at ways to reduce costs as part of day to day business as well as via CIP.
Finance Costs per £100m Turnover	Total finance cost divided by trust turnover multiplied by a £100m	**National Median = £676k** **Peer Median = £672k** **2017/18** 1. Sunderland £522k 2. Chester £617k 3. STHK £621k 4. N Lincolnshire £636k 5. Mid-Cheshire £651k 6. Wirral £692k 7. Bournemouth £710k 8. Gateshead £711k 9. North Tees £711k 10. WHH £852k 11. Southport £1.1m **Source: Trust consolidated annual accounts and NHSI improvement 17/18 data collection template.**		For 2017/18 the Trust actual position £852k – work is ongoing to identify why the Trust benchmarks higher than the national and peer medians. The Trust is awaiting the final 2017/18 benchmarking report to be issued by NHSI.	As part of the Lord Carter recommendations, each Corporate service will carry out a review to look at potential opportunities as identified within the model hospital and the national benchmarking exercise.

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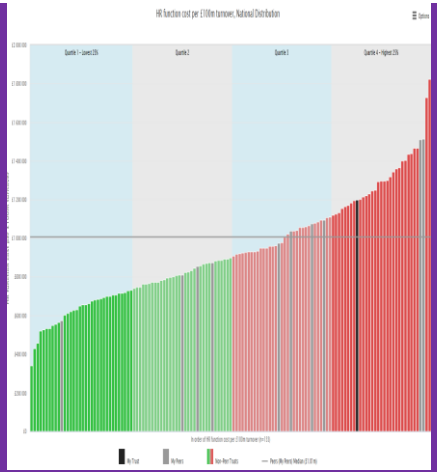
	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Human Resource Costs per £100m Turnover	UoR HR is made up of a number of sub compartments taken into consideration when considering total HR costs per £100m turnover. **National Median = £898k** **Peer Median = £1.01m** **2017/18** 1. Sunderland £575k 2. STHK £812k 3. Chester £854k 4. Bournemouth £875k 5. Wirral £974k 6. Mid Cheshire £1.04m 7. Gateshead £1.07m 8. North Tees £1.09m 9. WHH £1.2m 10. Southport £1.5m 11. N Lincolnshire £1.5m **Source: Trust consolidated annual accounts and NHSI improvement 16/17 data collection template.**	 Model hospital data is from 2017/18 data, work is ongoing to identify why the Trust benchmarks higher than the national and peer medians. The Trust is awaiting the final 2017/18 benchmarking report to be issued by NHSI.	As part of the Lord Carter recommendations, each Corporate service will carry out a review to look at potential opportunities as identified within the model hospital and the national benchmarking exercise.	

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Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 3 2018/19

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
	Recommendation 8 - NHS Improvement and NHS England should establish joint clinical governance by April 2016 to set standards of best practice for all specialties, which will analyse and produce assessments of clinical variation, so that unwarranted variation is reduced, quality outcomes improve, the performance of specialist medical teams is assessed according to how well they meet the needs of patients and efficiency and productivity increase along the entire care pathway. **Lead Director(s):** Chief Operating Officer and Director of Strategy			
Variation in Theatres and Outpatients	• 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 was launched in November 2017 and 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 was 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. • From 1st October 2018, the specialties have been re-aligned against the CBUs. As part of this, Theatres and Anaesthetics now come under the same CBU (Digestive Diseases), this is expected to improve pathways and coordination of activity. 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. • A 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.	• A programme of work around improving Theatre Utilisation and Late Starts has commenced. Full analysis and benchmarking with peers has been undertaken regarding late starts and improvements have been made. A proposal to amend the indicator to reflect national guidance has been made to allow for further improvements. An external review of theatre utilisation has been undertaken with positive feedback noted. • The Theatre productivity group has been established with a sub-group focusing specifically on cancellations with a view to address the number of cancelled sessions. • The Associate Director of Elective Care Performance has established a project around pre-operations and will present findings during Q4. • A review of CMTC capacity and utilisation of sessions is to be undertaken in Q4.	Strategic Development and Delivery Committee	Ongoing

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Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 3 2018/19

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
	• 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 new rota master system has been implemented with the aim of improving anaesthetic scheduling. This has assisted with future forecasting. • The KPI Sub-Committee continue to monitor Theatre utilisation, Late starts and Cancellations. • A Theatre Transformation Board to be chaired by the CBU Manager for Digestive Diseases has been established. • The Transformation Team have developed a capacity and demand summary which CBU managers will monitor.			

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Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 3 2018/19

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Emergency Care Improvement Programme	• An Improvement Programme around improvements in patient 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. • 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. • The refreshed Patient Flow Steering Group will now move to govern a more strategic programme of work. • The FAU pilot was completed, 86% of patients were discharged back to their own home during the pilot. The Trust will work with commissioners to continually monitor outcomes. • 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 FAU has been extended to 5 days per week utilising agency staff with the plan to have substantive staff in post during Q4. • The new discharge lounge is now operational. • As a result on the system wide capacity and demand review carried out by the Venn Group, the Trust has agreed with partners to approve capacity and flow in the short	• Estate has been identified for the Integrated Discharge Team, with a business case submitted to the BCF for enhanced support. • The Trust will continue to work with One Halton and Warrington Together to ensure proposals are developed consistently with an integrated approach. • The Trust is working with NHSI around Safer Collaboration. • ED Ambulatory Care is to open in January 2019. The GP Assessment Unit will be relaunched in the old Ambulatory care area thereafter. • During Q4, the Trust will continue to focus on Super Stranded Patients with system partners (having met the agreed trajectory). • In Q4, there will also be a focus on Ambulance Handovers in order to maintain the timely handover of patients to free up Ambulance staff and improve the patient experience.	A&E Delivery Board Flow Board	Ongoing

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Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 3 2018/19

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Specialty level reviews across local delivery system	• The Trust is participating in a series of specialty level reviews across the Local Delivery System (LDS). • Implementation of plans to reduce variation within pathways across the LDS. • 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 was launched early in 2018/19. This will support delivery of the Trusts objectives by the clinical teams. • Work to re-invigorate the DTOC process to include daily validation with weekly reviews and a weekly corporate flow meeting has commenced.	• A new clinical model around the Stroke Pathway has been agreed, the Trust with system partners is currently working to agree the financial model. • GIRFT reviews continue to take place within a number of specialities across the Cheshire & Mersey footprint. • The Trust is working with Cheshire and Mersey Cancer Alliance to develop optimal pathways beginning with Colorectal, the Trust is supported by Aqua. A one stop show has been launched. • The Trust has signed up with NHSI to carry out a length of stay evaluation programme, this is included in the SAFER collaboration. • Work to re-invigorate the DTOC process to include daily validation with weekly reviews and a weekly corporate flow meeting.	Strategic Development and Delivery Committee	Ongoing

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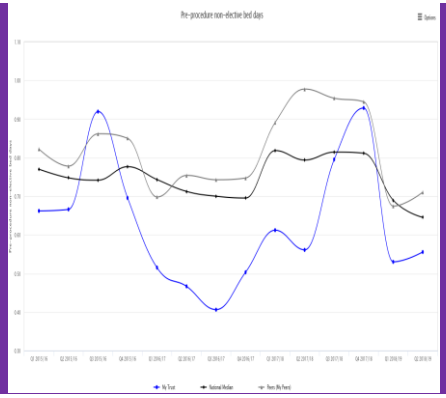
KLOE 1 - Clinical

	Progress/Performance				Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Pre Procedure Elective Bed Days	UoR The number of bed days between the elective admission date and the date that the procedure taken place.	**National Median = 0.12** Peer Median = 0.13 1. North Tees 0.01 2. Bournemouth 0.05 3. Mid-Cheshire 0.05 4. Wirral 0.05 5. WHH 0.07 6. Sunderland 0.12 **Monitoring : KPI Sub-Committee** **Source: Hospital Episode Statistics**	**Q2 2018/19** 7. Southport 0.14 8. Chester 0.18 9. STHK 0.20 10. N Lincolnshire 0.21 11. Gateshead 0.38		The Trust continually reviews opportunities to provide same day admission. The surgical transformation programme is supporting the reduction in theatre cancellations and improving productivity and efficiency.	Theatre productivity and efficiency remains a focus for the surgical theatre transformation in 2019/20. Performance against this metric is further monitored via the Theatre Performance Dashboard.	
Pre Procedure Non Elective Bed Days	UoR The number of bed days between an emergency admission date and the date the procedure taken place.	**National Median = 0.65** Peer Median = 0.71 1. Bournemouth 0.31 2. North Tees 0.47 3. WHH 0.56 4. Sunderland 0.59 5. Wirral 0.69 6. Mid Cheshire 0.71 **Monitoring: KPI Sub-Committee** **Source: Hospital Episode Statistics**	**Q2 2018/19** 7. Chester 0.72 8. STHK 0.89 9. N Lincolnshire 0.93 10. Gateshead 1.00 11. Southport 1.21		The Trust continually reviews opportunities to improve efficiency around emergency and non elective procedures. The surgical transformation programme is supporting the reduction in theatre cancellations and improving productivity and efficiency.	Theatre productivity and efficiency remains a focus for the surgical theatre transformation in 2019/20. Performance against this metric is further monitored via the Theatre Performance Dashboard.	

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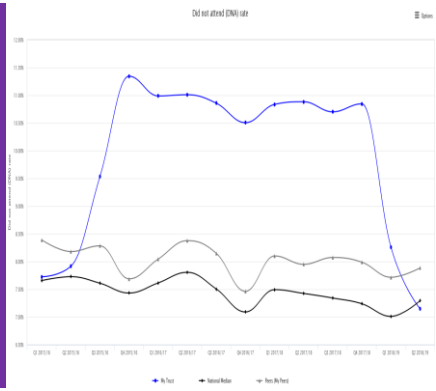
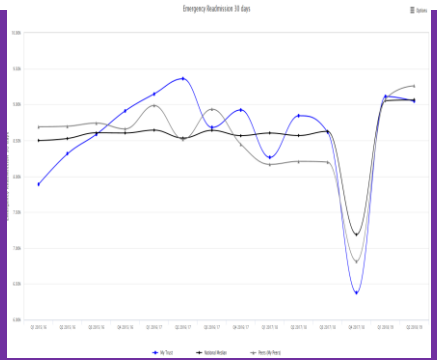
	Progress/Performance			Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Did Not Attend (DNA) Rate	UoR Rate of patients not attending their outpatient appointment.	**National Median = 7.29%** Peer Median = 7.89% 1. Chester 5.70% 2. Mid-Cheshire 5.96% 3. Bournemouth 6.77% 4. WHH 7.15% 5. Southport 7.39% 6. N Lincolnshire 7.41% **Monitoring: KPI Sub-Committee** **Source: Hospital Episode Statistics**	**Q2 2018/19** 7. North Tees 8.37% 8. Gateshead 8.54% 9. Wirral 8.83% 10. Sunderland 9.14% 11. STHK 11.35%		In May 2018, the Trust reintroduced a text reminder service which has resulted in a significant improvement in the DNA rate. The DNA rate for Q2 is at 7.15% almost a 4% improvement on the Q1 position.	The Trust has continued to implement improvements in the interface with patients. Further improvements in the interface are being implemented via the Outpatient Steering group, which is intended to improve the position further.	
Emergency Readmission (30 Days)	This indicator measures the percentage of admissions of people who returned to hospital as an emergency within 30 days of the last time they left hospital after a stay. Admissions for cancer and obstetrics are excluded as they may be part of the patient's care plan.	**National Median = 9.06%** Peer Median = 9.26% 1. Chester 7.02% 2. N Lincolnshire 7.89% 3. Bournemouth 8.41% 4. Sunderland 8.89% 5. WHH 9.04% 6. Wirral 9.12% **Monitoring: KPI Sub-Committee** **Source: Hospital Episode Statistics**	**Q2 2018/19** UoR 7. Southport 9.40% 8. Gateshead 9.67% 9. Mid-Cheshire 9.75% 10. STHK 10.49% 11. North Tees 11.65%		Every effort is made when discharging patients to ensure that the discharge is appropriate. Readmissions are reviewed by the clinical directors to review any inappropriate discharges and ensure lessons are learned.	The Trust will continue to review the improvement through the Trust clinical governance processes to ascertain if there is a need to review discharge procedures.	

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Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 3 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 2017/18 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 2018/19. • 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. • 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. Following testing it is now anticipated this functionality will be available during Q4 2018/19. • The Trust's business case has been submitted to NHS Digital as part of the Digital Exemplar programme. The business case has been approved and PID has been signed off.	• The Trust in collaboration with the CCG and other stakeholders is working with PKB (Patient Knows Best), scoping sessions have commenced. Funding has been agreed by the CCG to commence from April 2019. • Lorenzo Digital Exemplar - Head Trauma and Diabetes current state mapping is progressing. Stage 1 on track for completion for end of Q1.	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. • 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 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 a paperless Trust by 2020.	IM&T Sub-Committee	Project Implementation – Initiation

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Progress significantly off track/Red on Model Hospital
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UoR Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 3 2018/19

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
ePMA	• Electronic prescribing and medicines administration (EPMA) Business case and PID signed off by Trust Board and NHS Digital – 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. • Successful implementation of ePMA on B4 and Theatres in December 2018.	• The Trust is working with the supplier on further developments to ensure flow between A&E and non-elective wards is robust. Lorenzo is due to be upgraded to version 2.17 in 2019. When v2.17 is available the required system improvements will be in place to enable to Trust to implement ePMA across the emergency admissions pathways. • It is anticipated that the system will be implemented at the CMTC in Q4.	IM&T Sub-Committee	Project Implementation

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Use of Resource Graph Key
Trust Position
National Median
Peer Median

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

UoR Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 3 2018/19

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

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Use of Resource Graph Key
Trust Position
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Peer Median

Key
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Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 3 2018/19

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

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Use of Resource Graph Key
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Peer Median

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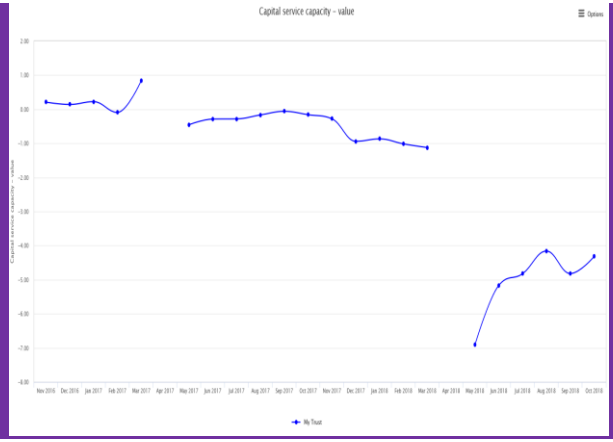
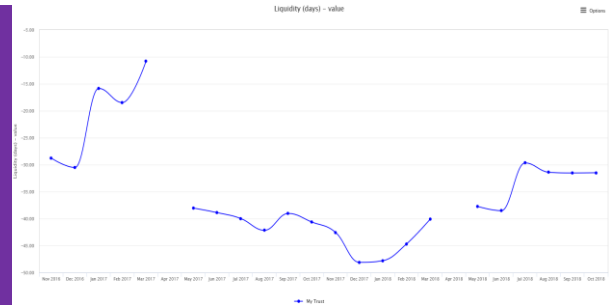
On track for completion
Progress off track - plans in place to get back on track/Amber on the Model Hospital
Progress significantly off track/Red on Model Hospital
Not started/Awaiting further information/New actions parameters to be established

UoR Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 3 2018/19

KLOE 5 - Finance

	Progress/Performance		Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Capital Services Capacity	UoR **WHH Model = -4.32 (Oct 2018)** **WHH Current = -3.9 (Nov 2018)** The degree to which the provider's generated income covers its financial obligations **Monitoring: FSC/Trust Board**		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.	> CBU Workshops have been held to workshops to identify opportunities to close the shortfall, these schemes will be taken forward. > The Trust continues to work with commissioners on the current and future sustainability of services. > The new Trust Financial Resource Group (FRG) continues to review performance though SLR, Benchmarking and the Model Hospital.	
Liquidity (Days)	UoR Days of operating costs held in cash or cash-equivalent forms, including wholly committed lines of credit available for drawdown. **WHH Model = -31.48 days (Oct 2018)** **WHH Current = -31.6 days (Nov 2018)** **Monitoring: FSC/Trust Board** **Source: Provider returns**		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.	The Trust is working to improve Liquidity in the number of ways including; Strengthening of treasury management, Focus on aged debt, Creditor stretch, Management of capital programme and Access to working capital loans.	

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Use of Resource Graph Key
Trust Position
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Peer Median

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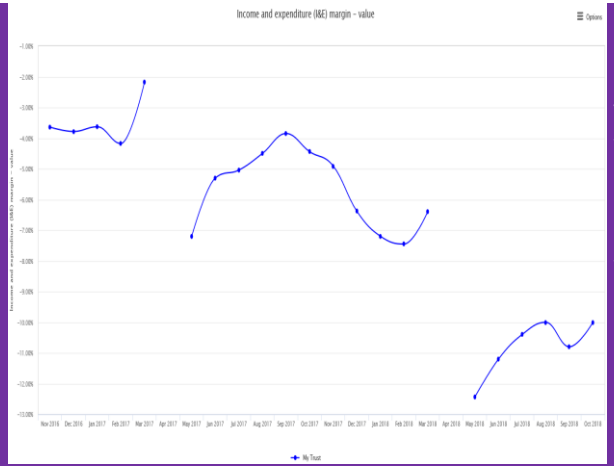
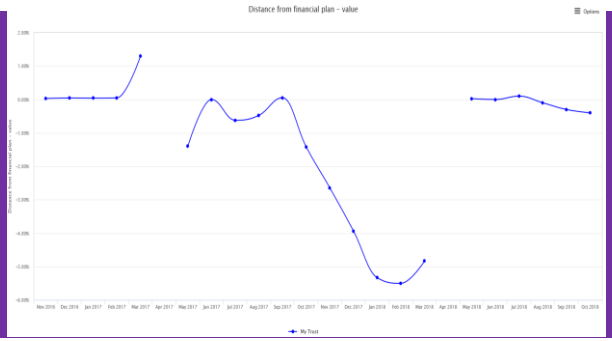
UoR Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 3 2018/19

	Progress/Performance		Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Income & Expenditure Margin	UoR The income and expenditure surplus or deficit, divided by total revenue.	**WHH Model = -10.00% (Oct 2018)** **WHH Current = - 9.41% (Nov 2018)** **Monitoring: FSC/Trust Board** **Source: Provider returns**		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.	> CBU Workshops have been held to workshops to identify opportunities to close the shortfall, these schemes will be taken forward. > The Trust continues to work with commissioners on the current and future sustainability of services. > The new Trust Financial Resource Group (FRG) continues to review performance though SLR, Benchmarking and the Model Hospital.
Distance from Financial Plan	UoR Year-to-date actual I&E margin in comparison to year-to-date plan I&E margin. I&E margin calculated on a control total basis. Measure is in percentage points.	**WHH Model = -0.40% (Oct 2018)** **WHH Current = -0.43% (Nov 2018)** **Monitoring: FSC/Trust Board** **Source: Provider returns**		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.	The Trust is currently forecasting achievement of financial plan and continues to monitor and manage the plan.
Agency Spend - Cap Value	UoR The extent to which the trust is meeting the target for the amount spend on agency workers for the financial year.	**WHH Model = 26.28% (Oct 2018)** **WHH Current = 27.83% (Nov 2018)** **Monitoring: FSC/Trust Board** **Source: Provider returns**		The Trust is ahead of the allocated agency ceiling due to the continued reliance of agency staff to cover gaps from vacancies.	The Trust continues do everything in its power to reduce its reliance on agency by recruiting to substantive roles, focusing on retention, innovative workforce models and international recruitment.

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/19/01/09**			
SUBJECT:	**Emergency Preparedness, Resilience and Response (EPRR) Core Standards Assurance – update Jan 19**			
DATE OF MEETING:	January 2019			
AUTHOR(S):	Emma Blackwell, Resilience Manager			
EXECUTIVE DIRECTOR SPONSOR:	Chris Evans, Chief Operating Officer			
LINK TO STRATEGIC OBJECTIVES:	SO1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience			
	Choose an item.			
	Choose an item.			
EXECUTIVE SUMMARY (KEY ISSUES):	The Board was informed in November 2018 that the Trust achieved a 'Partial' compliance against the NHS England EPRR Core standards. An improvement plan was produced to address the 10 partially compliant standards and work has been undertaken in the last 3 months to improve the Trust position. A further self-assessment has taken place in January 2019 and the Trust has now achieved a 'Substantial' compliance level. The Board asked to be updated in the new year of the progress that has been made.			
PURPOSE: (please select as appropriate)	Information √	Approval	To note √	Decision
RECOMMENDATION:	The Board is asked to note the 'Substantial' compliance rating that has now been achieved.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Event Planning Group		
	Agenda Ref.	EPG/220119/06		
	Date of meeting	22.01.19		
	Summary of Outcome	For information		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Emergency Preparedness, Resilience and Response (EPRR) Assurance 2018/19 – update January 19	AGENDA REF:	BM/19/01/09

1. BACKGROUND/CONTEXT

All providers of NHS funded care are required to undertake an annual self-assessment against the Emergency Preparedness Resilience and Response (EPRR) Core Standards and rate their level of compliance. Once this has been completed organisations must report to their Board.

In November 2018 the Board were informed that the Trust had achieved a 'Partial' compliance against the EPRR Core Standards. Due to a number of factors, the Trust compliance level had dropped from previous year's level of 'Substantial'. An improvement plan was produced and actions identified to ensure the Trust achieved a 'Substantial' compliance level by the end of the calendar year.

A further self-assessment has taken place in January 2019 which demonstrated a 'Substantial' compliance level against the EPRR Core Standards.

2. KEY ELEMENTS

The Trust was rated against 64 applicable standards, and reported full compliance with 59 standards. 5 standards were rated as partially compliant but with evidence of progress towards full compliance. No standards were rated as non-compliant.

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	6	0	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	14	14	0	0
Command and control	2	2	0	0
Training and exercising	3	3	0	0
Response	7	7	0	0
Warning and informing	3	3	0	0
Cooperation	4	4	0	0
Business Continuity	9	8	1	0
CBRN	14	10	4	0
Total	64	59	5	0

Overall assessment:	Substantially compliant

Improvements undertaken to achieve compliance

- ✓ **Core standard 33 – the organisation has 24 hour access to a trained Loggist**
  Administration staff attended in house Loggist training on the 6th December 2018. The Trust now has 8 trained Loggist and further training is scheduled for later in the year. A process has been implemented so that Loggists can be contacted 24/7.

- ✓ **Core standard 55 – the organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers.**
  The Supplies business continuity plan was reviewed and updated in November 2018. In October 2018, the Supplies department undertook a comprehensive self-assessment of suppliers contingency plans as part of preparedness for a no deal Brexit.

- ✓ **Core standard 61 – the organisation has the expected number of Powered Respirator Protective Suits (PRPS) available for immediate deployment.**
  The Trust had a total of 9 in date PRPS which was below the minimum level of 12 needed to mount a response. 6 new PRPS were delivered to the Trust in November 2018 bringing the current total to 15 in date PRPS available for deployment.

- ✓ **Core standard 64 – There are effective disposal arrangements in place for PPE no longer required.**
  The Trust had 14 expired PRPS which have now been disposed of by an external company.

- ✓ **Core standard 68 – Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient.**
  Within the CBRN plan the Reception action card has been updated and circulated to reception staff. Briefing sessions have taken place within ED and an information leaflet produced and circulated.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

Work is ongoing with the 5 partially compliant standards. The improvement plan has been updated (appendix 1) to reflect the progress to date and this is being monitored via the monthly Event Planning Group.

The partially compliant standards are:-

- **Core standard 51 – Business Continuity**
  The Trust wide Business Continuity Plan has been updated and approved at the Event Planning Group in November. The majority of corporate and service levels plans have now been reviewed however, a small number are due to be completed by the end of January.

- **Core standards 59, 65, 66, 67 - CBRN**

The remaining standards are all linked to CBRN training. NWAS failed to provide the necessary and scheduled CBRN train the trainer courses in 2018, however new dates have now been issued for January to April 2019. A total of 8 ED staff have been booked onto these courses and will become training leads for the department.

4. IMPACT ON QPS?

The risk of failure to provide adequate decontamination capability is on the Trust risk register.

5. MEASUREMENTS/EVALUATIONS

The Trust has now achieved a 'Substantial' compliance against the EPRR Core Standards.

6. TRAJECTORIES/OBJECTIVES AGREED

The Trust EPRR Improvement Plan is detailed in appendix 1.

7. MONITORING/REPORTING ROUTES

Progress on the Trust EPRR Improvement Plan will be monitored via the monthly Event Planning Group.

8. TIMELINES

Timelines for action are detailed in the EPRR Improvement Plan.

9. ASSURANCE COMMITTEE

Trust Event Planning Group and the Local Health Resilience Partnership

10. RECOMMENDATIONS

The Board is asked to note the contents of this paper and be assured that the Trust is now substantially compliant in the EPRR Core Standards for 2018/19. Progress against the Improvement Plan will be reported via the monthly Event Planning Group.

Appendix 1 – EPRR Improvement Plan

2018-19 EPRR Improvement Plan upc

Core Standard reference	Core Standard description	Current Trust Position	Improvement required to achieve compliance	Action to deliver improvement	Deadline	Progress to date
Response 33	The organisation has 24 hour access to a trained Loggist(s) to ensure decisions are recorded during business continuity incidents, critical incidents and major incidents.	The small group of Loggist that were trained in the Trust are either no longer employed by the Trust or are out of date with their training. 3 members of staff (including the Resilience Manager) would currently be able to fulfil the role.	A cadre of administration staff to undertake an internal Loggist training course. A documented process of how to access and utilise a loggist in the event of a major incident.	A group of administration staff to be identified who would be willing and able to undertake the Loggist role as part of the Incident Co-ordination Team in the event of a Major Incident.	December 2018	Training took place on the 06.12.18 to train new loggists. The Trust now has 8 members of staff trained as Loggist and a further training date will be scheduled for later this year.
Business Continuity 51	The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure These plans will be updated regularly (at a minimum annually), or following organisational change.	The Trust Business Continuity Plan was due for review in February 2018. Clinical Business Unit and Service level plans were developed early in 2017 for some but not all areas. 2 CBU's do not have BCP's in place. The remaining service level plans are overdue their annual review.	Review and updates to the Trust Business Continuity Plan. Review of CBU and Service level BCPs. Development of BCP's for Musculoskeletal Care and Airways, Breathing and Circulation. Corporate service plans to be reviewed.	Resilience Manager to update Trust Business Continuity Plan and table at the November Event Planning Group. BCP's to be sent to CBU's for review and updates. Resilience Manager to work with the 2 CBU's to ensure BCP's in place. Resilience Manager to link in with HR, Finance and Estates for	January 2019	November 2018 Trust BCP has been updated and approved at EPG. The majority of CBU's now have service level BCP's in place. Work is ongoing in MSK, and Medical Care on their BCP's. All corporate areas except HR now have up to date BCP's. The HR BCP is in progress.
Business Continuity 55	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers;	The Business Continuity Plan for Supplies is out of date.	Supplies BCP to be updated to incorporate requirements of the core standard.	BCP to be updated by the Deputy Head of Procurement.	November 2018	November 2018 Supplies Manager confirmed BCP updated.

	and are assured that these providers arrangements work with their own.					
CBRN 59	The organisation has adequate and appropriate decontamination capability to manage self-presenting patients (minimum four per hour), 24 hours a day, 7 days a week.	There are CBRN leads on both the Warrington and Halton site. However, not all ED staff have received decontamination training. Some staff require an update and refresher training. NWAS have failed to provide the necessary and scheduled Decontamination/CBRN Train the Trainer courses. The last was cancelled at short notice. Unable to obtain training records from previous ED Practice Educator.	8 ED staff have been identified to attend the NWAS train the trainer course once the dates are released. Training will then be rolled out in the department.	Identified CBRN Leads to attend NWAS Decontamination/CBRN Train the Trainer course. Training to be rolled out within the ED department.	April 2019	8 members of ED staff have been booked on the NWAS CBRN train the trainer course scheduled to take place in Jan-April 2019.
CBRN 61	The organisation has the expected number of PRPS (sealed and in date) available for immediate deployment. There is a plan and finance in place to revalidate (extend) or replace suits that are	The Trust has a total of 9 in date PRPS suits which below the minimum level of 12 needed to mount a response. All of these suits are on loan from Central Store pending national role out of new suits. A further 6 suits were mislaid in delivery and never arrived.	A further 3 PRPS suits need to be provided from the Central store.	NHS England to liaise with DH Central Store	January 2019	31.10.18 – 6 new PRPS suits have been delivered to ED. The Trust currently has 15 PRPS available for deployment.

	reaching their expiration date.	Despite efforts of Trust and NHSE they have not been located . Out of date suits are scheduled to be disposed of in accordance with national guidance.				
CBRN 64	There are effective disposal arrangements in place for PPE no longer required, as indicated by manufacturer / supplier guidance.	The Trust currently has 14 expired PRPS suits that need to be disposed of.	14 suits to be destroyed.	Funding to be identified for external company Respirex to collect suits.	October 2018	September 2018 – Funding has been authorised by ED. Purchase order has been raised and suits to be collect w/c 12/12/18.
CBRN 65	The current HAZMAT / CBRN Decontamination training lead is appropriately trained to deliver HAZMAT / CBRN training.	Late 2017 NWAS cancelled at short notice all 8 places the Trust had booked for Training of Trainers for decontamination/ Hazmat . This has led to a hold on training for staff. The Current training leads on both sites need a refresher/update.	CBRN Leads to attend NWAS training as soon as dates are released.	Staff to be released from department to attend training once dates are released	April 2019	8 members of ED staff have been booked on the NWAS CBRN train the trainer course scheduled to take place in Jan-April 2019.
CBRN 66	Internal training is based upon current good practice and uses material that has been supplied as appropriate. Training programme should include training for PPE and decontamination.	Previously, Decontamination Leads who attended the NWAS CBRN Train the trainer courses have trained staff within the department using the material given. Current staff are in need of refresher training.	8 ED staff have been identified to attend the NWAS train the trainer course once the dates are released. Training plans will then be developed using the materials they have been provided.	Staff to be released from department to attend training once dates are released.	April 2019	A CBRN awareness leaflet has been circulated to staff within the ED department on both sites. The Resilience Manager has also provided briefings at the safety handovers.

CBRN 67	The organisation has a sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.	Previously, Decontamination Leads who attended the NWAS CBRN Train the trainer courses have trained staff within the department using the material given. Current staff are in need of refresher training.	8 ED staff to attend the NWAS train the trainer course once the dates are released. The trainers will then provider CBRN/Decontamination training sessions within the department.	Staff to be released from department to attend training once dates are released.	April 2019	8 members of ED staff have been booked on the NWAS CBRN train the trainer course scheduled to take place in Jan-April 2019.
CBRN 68	Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	The Trust CBRN plan details the process to be followed in the event of self-presenting casualties. All staff including Reception and Triage require refresher training.	Refresher training sessions to be undertaken by Reception staff. Clinical staff will need to attend the full decontamination training once available.	Staff to be released from department to attend training once dates are released.	December 2018	October 2018 Reception action card updated and staff are aware of the procedure to follow. Awareness leaflet circulated to all ED staff.

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NHS Warrington and Halton Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/19/01/10**			
SUBJECT:	**Freedom to Speak up**			
DATE OF MEETING:	30 January 2019			
AUTHOR(S):	Jane Hurst, Deputy Director of Finance, Strategy			
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse			
LINK TO STRATEGIC OBJECTIVES:	SO1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience			
	SO2: We will .. Be the best place to work with a diverse, engaged workforce that is fit for the future			
	Choose an item.			
EXECUTIVE SUMMARY (KEY ISSUES):	The purpose of this paper is to update the Board on the activity of the Freedom to Speak Up (FTSU) Team and progress on the action plan for the self review tool.			
PURPOSE: (please select as appropriate)	Information	Approval	To note x	Decision
RECOMMENDATION:				
PREVIOUSLY CONSIDERED BY:	**Committee**	Strategic People Committee		
	Agenda Ref.			
	Date of meeting	23 January 2019		
	Summary of Outcome	noted		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

TRUST BOARD

SUBJECT	Freedom to Speak Up	AGENDA REF:	

1. BACKGROUND/CONTEXT

The purpose of this paper is to update the Board on the activity of the Freedom to Speak Up (FTSU) Team and progress on the action plan for the self review tool.

2. DISCLOSURES

The three quarters of 2018/19 (April to December) the FTSU team received the following disclosures.

Table 1 Disclosures in 2018/19

Quarter 1	2
Quarter 2	7
Quarter 3	9
Total	**18**

This compared to 11 disclosures for 10 months in 2017/18.

Benchmarking shows that we have a similar number of disclosures to other Trusts and the following table indicates similar sized Trusts in the North West.

Table 2: 2018/19 Quarter 2 FTSU disclosures

Trust name	Number of cases	Cases raised anon	Element of patient safety/ quality	Element of bullying or harassment	Suffering detriment
The Clatterbridge Cancer Centre NHS FT	5	0	1	4	0
Bridgewater Community Healthcare NHS FT	2	2	1	0	0
Warrington and Halton Hospitals NHS FT	7	1	3	3	0
Liverpool Heart and Chest Hospital NHS FT	3	3	1	2	0
East Cheshire NHS Trust	4	0	0	1	0
Alder Hey Children's NHS FT	1	1	1	0	0
The Christie NHS FT	16	0	2	12	0
Mid Cheshire Hospitals NHS FT	5	3	4	3	0
The Walton Centre NHS FT	1	0	1	0	0
Liverpool Women's NHS FT	15	1	6	4	4
Southport and Ormskirk Hospital	11	3	2	2	1
Countess of Chester Hospital NHS FT	0	0	0	0	0
Stockport NHS Foundation Trust	4	1	2	3	1
Tameside and Glossop Integrated Care FT	3	0	3	1	1

It is possible that the increased activity in quarter 2 and 3 relates to the increase in communication of the FTSU policy and process undertaken by the team. Some cases were reported and then chose not to take any further, they wanted to anonymously make the Trust aware or understand a procedure or policy. The cases can be grouped as follows:-

Table 3:- Types of disclosures in 2018/19

Behaviour and relationships	7
Patient safety	5
Staff dignity	5
Staff safety	1
Total	**18**

The behaviour and relationship issues have been across 7 different areas including operational and support functions all have been managed through discussion or support from HR. Many have just welcomed an opportunity to speak to someone and discuss an issue.

The patient safety related to 4 areas in the Trust and action taken was as follows:-

- one was addressed by estates,
- one related to staffing and the investment in nursing,
- one area received 2 patient safety disclosures and prompted ward accreditation to be undertaken earlier and evening spot checks and
- one dealt with through safety huddle.

Staff dignity related to 5 different areas although some where for the same areas other disclosures that had been received. Two wished to remain anonymous, one dealt with by ongoing investigation, one dealt with via the Ward Accreditation process and one is being dealt with through the grievance process.

The staff safety issue was linked to an investigation and assurance has been gained through the Ward Accreditation process and evening visits to the ward.

3. ACTIVITY OF THE FTSU TEAM APRIL TO DECEMBER

The team has been attending various meetings and training sessions and the following table gives an overview. In addition the champions highlight FTSU in their day to day activities including induction and training. Table 4 provides detail on these events.

Table 4: FTSU Activity 2018/19

	Number of sessions	Ave number attendees
Preceptorship training	4	20
CMT Forum	1	4
Nursing and Midwifery meeting	1	20
Workforce Committee	1	15
Operational People Committee	1	20
CBU managers	1	10
TOB	2	25
Housekeepers Forum	1	17
Safety Huddle – Hot Topic August w/c 30/7	5	25
Grand round	1	80 +
Junior Doctors	1	20
Council of Governors	1	20
HR Business Partners	1	3

4. SELF REVIEW TOOL ACTION PLAN

The self review tool was completed in August and shared with the Trust Board in September 2018. Since the review an action plan has been developed and is attached in Appendix 1.

There are 26 actions which the team are working to develop and embed best practice.

5. RECOMMENDATIONS

The Trust Board is asked to note the progress of Freedom To Speak Up.

No.	What are the principal actions required for development?	Action taken
1	Freedom to Speak Up is championed within our People Strategy due to be re-launched across the organisation in Autumn 2018.	This has been included
2	With a refresh of all Leadership Development at WHH to be documented in the People Strategy Strategic Delivery Plan, it is anticipated that FTSU will be embedded in all Leadership Development Programmes.	Work with Education and Development Team
3	Feedback activity to be developed by guardian and champions including thank you letter	To be discussed at the next FTSU meeting and involve Communication Team
4	Qualitative and quantitative measure require definition	To be discussed with Quality Team at the next FTSU meeting
5	Exec walkabouts	FTSU is included in the checklist
6	Ward accreditation assessment	FTSU is included in the checklist
7	Regular presentations to different group of staff – peoples champions/ TNAs / HCSWs etc. etc.	ongoing and recorded in reports to Committees and Board
8	FTSUG to arrange meeting with staff COG twice a year	Champion attended in October 2018
9	LIA results to be analysed.	FTSUG attends the LIA committee and links into FTSU issues where appropriate
10	Re do FTSU questionnaire	Questionnaire undertaken in October 2018 result shared in November Team Brief
11	To be added to the Board Posters to further communicate. This could also be added to organisational structure	To be included on future posters - discussed with Communications team
12	Suggestion to invite Lead Governor twice a year to CE and Chair meeting.	Arrange for next meeting
13	CBU teams could adopt formal visits to areas offering support re FTSU	CBU managers have been
14	Could it be added on annual staff review / PDR	To be discussed with HR
15	Ensure good links between FTSU team and E&D committee	FTSUG to continue to attend E&D Committee
16	Impact of lessons learnt needs to be monitored / checked needs to be learning briefing also go to quality governors meeting	Meeting arranged with Quality, Nursing and HR leads to discuss lessons learnt
17	Audit to be built in to the annual audit programme for 2019/20 MIAA to include Quality assuring a sample of disclosures	Meeting arranged in January to discuss with MIAA
18	Annual review of the policy	Taken to Audit Committee in November 2018
19	Consider other staff networks that the FTSU can link into.	Ongoing regular agenda item at FTSU meeting
20	Consider further detail in next annual report (Action Board Secretary)	Requested to Corporate Secretary
21	FTSUG to attend next CQC meeting	Requested invite
22	Team brief and annual review	FTSU is included in Team brief twice a year last one was November 2018
23	Suggest Bi annual review with medical director for triangulation of FTSU information	Meeting arranged for February 2019
24	Need to ensure FTSU is linked into this Learning Framework	Meeting arranged with Quality, Nursing and HR leads to discuss lessons learnt
25	Ensure FTSU is on the ops, quality and HR triangulation meeting agenda	Liaise with Medical Director
26	Ensure FTSU is on these forums - CMT forum, FY Forum, Junior Doctors Forum	Liaise with Medical Director through regular meetings, next meeting arranged for February

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/19/01/11**
SUBJECT:	**Guardian Quarterly Report on Safe Working Hours for Junior Doctors in Training October – December 2018**
DATE OF MEETING:	30 January 2019
AUTHOR(S):	Mark Tighe, Guardian of Safe Working Hours and Mick Curwen, Head of HR Strategic Projects
EXECUTIVE DIRECTOR SPONSOR:	Alex Crowe, Medical Director
LINK TO STRATEGIC OBJECTIVES:	SO1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience
	SO2: We will .. Be the best place to work with a diverse, engaged workforce that is fit for the future
	Choose an item.
EXECUTIVE SUMMARY (KEY ISSUES):	The junior doctor contract was implemented in the trust on 7.12.16 but with national safeguards that the junior doctors should not be working excessive hours which could affect their health and wellbeing and the service they deliver to patients. Each trust was required to appoint a Guardian of Safe Working whose primary role is to ensure that junior doctors do work safely and are able to access appropriate training and development opportunities. A system of Exception Reports allows junior doctors to report areas of non-compliance and provides the opportunity for the Guardian to monitor trends and issues. It is a requirement of the national contract that the Guardian submits a quarterly and annual report to the Board so that the Board can gain this level of assurance. The Board has previously received reports covering: - December 2016 to May 2017

	- June to September 2017 - October to December 2017 - January to March 2018 but also incorporating the Annual Report from April 2017 to March 2018. - April – June 2018 - July – September 2018 This report covers the quarter from October – December 2018. All our Foundation Doctors are now on this contract, as well as the newer appointments on the CT and ST grade. Integration of the new rota has been achieved successfully between the rota managers, HR, postgraduate department, and the Clinical and Educational Supervisors. All new doctors to the trust have tutorials on Exception Reporting and the New Junior Doctors Contract as part of their induction programme. There has been an increase in the number of exception reports filed in Q3 (35 to 45), and in total number of incidents (58 to 76), compared with Q1 and Q2, which undoubtedly is a reflection on the busier workload and higher acuity of patients in the winter months. The majority of ERs still relate to juniors working past their allocated hours, either due to understaffing, or managing high volumes of work or very unwell patients. The spike in cardiology ERs is explained later and now resolved. Lower numbers of ERs were submitted by senior trainees, and in this quarter, were predominantly in T+O. I was pleased to see that the vast majority of juniors are getting to their teaching and training opportunities, with only a very small number of ERs

<table>
<tr><td></td><td colspan="4">submitted due to inability to attend these sessions.

We still have problems with the sign-off meetings between the Educational Supervisors and the trainees, with large numbers of ERs having not been closed. I do continue to push for closure of the ERs with both trainees and consultants, but the responsibility does lie with the reporting doctor.

We have seen an increase in requests for compensatory payment rather than time-off in lieu (TOIL), which does raise the concern that some doctors may be exceeding their recommended hours. This was noted in Q3 and Q4 last year, and is a reflection that our doctors do not like to leave their wards understaffed in the busy winter months, if they take TOIL.</td></tr>
<tr><td>PURPOSE: (please select as appropriate)</td><td>Information</td><td>Approval</td><td>To note
X</td><td>Decision</td></tr>
<tr><td>RECOMMENDATION:</td><td colspan="4">The Board are requested to note the report and progress made with implementing the junior doctor contract and the level of assurance given that the junior doctors are working safely for their own health and wellbeing and the safety of patients.

Any concerns that the Board have should be reported back to the Guardian for his attention.</td></tr>
<tr><td rowspan="4">PREVIOUSLY CONSIDERED BY:</td><td colspan="2">Committee</td><td colspan="2">Strategic People Committee</td></tr>
<tr><td colspan="2">Agenda Ref.</td><td colspan="2"></td></tr>
<tr><td colspan="2">Date of meeting</td><td colspan="2">23 January 2019</td></tr>
<tr><td colspan="2">Summary of Outcome</td><td colspan="2">Agreed</td></tr>
<tr><td>FREEDOM OF INFORMATION STATUS (FOIA):</td><td colspan="4">Release Document in Full</td></tr>
<tr><td>FOIA EXEMPTIONS APPLIED: (if relevant)</td><td colspan="4">None</td></tr>
</table>

BOARD OF DIRECTORS

SUBJECT	Guardian Quarterly Report on Safe Working Hours for Junior Doctors in Training covering Q3: 1 October 2018 – 31 December 2018	AGENDA REF:	BM/19/01/11

1. Executive Summary

The New Junior Doctor Contract is well established at WHH. All our rotas are compliant, and in general the juniors are happy with their allocations. Our Junior Doctors' Forum occurs 3 monthly, and allows frank discussion with the junior doctors. The presence of the Medical Director and HR is appreciated by the trainees and the Guardian, and helps to identify and correct persistent ongoing concerns from the juniors. In addition, the juniors seem happy to engage with their consultants, Educational Supervisors and Guardian, if any new issues develop.

We have had an increase in submission of exception reports (ERs) to 15 per month in Q3, (from 10/month in Q1 and Q2), which is a reflection of the busier times over the winter months. Forty-five new ERs were submitted during this time covering 76 incidents. Only one was submitted as an immediate safety concern (ISC).

The vast majority of ERs (40/45) still relate to our F1 doctors working past their allocated time, usually on an ad hoc basis, but there has been a cluster from two areas, cardiology and orthopaedics.

Only four ERs relate to missed educational or training opportunities, three of which were from F1s. Only one ER was submitted due to a perceived lack of senior support on the wards.

Again, most ERs were submitted by juniors working on the medical wards (31/45 ERs), which is expected due to the higher workload and acuity in this specialty. A good number of ERs were submitted by one F1 in cardiology – he felt the senior trainees were naturally mainly on CCU, while he felt he was left to manage single-handed on C21. This appears now to have resolved, since both wards have now merged onto A3. On the whole, I have been impressed with the attempts to resolve the staffing shortages on the acute medical wards, and the F1s appear to be getting good support and teaching there. The spike in orthopaedic ERs relate to the prospective non-resident on call for the Registrars, which is being addressed. Personally, I feel the orthopaedic registrars should probably be resident out of hours, as the senior resident orthopaedic opinion overnight is often just an F2 doctor.

There are continued problems with the timeliness of review meetings between ES and trainee, once an ER has been submitted. I have encouraged the F1s to contact me as Guardian, if they are struggling to meet with their ES. I have contacted a number of

supervisors, both individually and collectively, to try and address this. However, I feel it is the responsibility of the trainee who puts in the report to chase the review meeting, as they are unable to obtain compensation until the ER is signed off.

We have seen an increase in compensatory payment, rather than time-off in lieu, which is concerning in our efforts to ensure maintenance of safe working hours.

Again, there has again been no escalation of an ER to a level 2 review or fine to the trust since the last Report.

2. Introduction

As a reminder, the role of the Guardian of Safe Working Hours under the Terms and Conditions of Service is to:

'provide boards with assurance that junior medical staff are safe and able to work, identifying risk and advising boards on the required response'

This Report covers the period from 1 October 2018 to 31 December 2018 and follows the format as recommended by NHS Employers.

<u>High level data</u>

Number of doctors / dentists in training (total):	72
Number of doctors / dentists in training on 2016 TCS (total):	72
Amount of time available in job plan for guardian to do the role:	1.5 PAs / 6 hours per week
Admin support provided to the guardian (if any):	Nil WTE
Amount of job-planned time for educational supervisors:	0.25 PAs per trainee up to a maximum of 0.5 PAs for further trainees

The 72 doctors in training at the trust are made up of 36 FY1 trainees and 36 FY2 trainees, all of which are on the new contract.

In addition, the Lead Employer (St Helens and Knowsley) employ trainees at ST1+ and CT1+ who rotate to different trusts as part of their training. At any one time, the trust usually has c90 trainees from the Lead Employer and the most recent rotations now include the vast majority of trainees on the new contract (c60). The Lead Employer is responsible for their own monitoring and Quarterly Report for the trainees they employ.

3. Exception Reports (with regard to working hours)

Specialty	No. exceptions raised Q2	No. Exceptions raised Q3	No. exceptions closed in Q2	No. exceptions outstanding in Q2
General Medicine – FY1	16 (26)	28 (32)	15 (19)	13 (13)
General Surgery – FY1	2	3	0	3
Trauma and Orthopaedics – FY1	1 (3)	1 (8)	0	1 (8)
Medicine – JST	7 (8)	1	0	1
Trauma and Orthopaedics – ST3	6 (15)	6 (16)	0	6 (16)
ENT – ST3	3 (4)	0	0	0
Paediatrics – Junior	0	1	0	1
Surgery – Junior	0	3 (11)	1 (7)	2 (4)
Emergency Medicine FY2	0	2 (4)	1 (3)	1
Total	35 (58)	45 (76)	17 (29)	28 (47)

NB.

1. The figures in brackets denote the total number of reported incidents. In some instances one Exception Report has been used to report more than one incident/issue. Therefore, a total of 45 exception reports were completed but these cover 76 incidents. The previous quarter was 35 exception reports and 58 incidents so there has been an increase in both exception reports and incidents.
2. The 76 incidents were submitted from a total of 17 trainees covering 17 Educational Supervisors, 7 of which do not appear to have yet engaged in the process over this period which is of concern.
3. There was one exception report completed in surgery which was classified as an 'Immediate Safety Concern' (ISC). This related to a deteriorating patient, where the junior doctor felt unsupported. He had not escalated appropriately to his relevant seniors, and this was reinforced to him on subsequent review. It was signed off at the Level 1 meeting. Over the last two years, there has generally been a good response when ISCs have been escalated the ISCs to the relevant teams.
4. 28 (47) exception reports remain open from Q3 and need resolving. However, it should also be noted, that in 11 (22) instances the trainee and Educational Supervisor have met to discuss the exception reports, but the trainee has not yet accepted the proposed

outcome from the Educational Supervisor, but neither have they escalated this to the next stage. This still leaves 17 (25) exception reports where there has been no dialogue.

5. Despite multiple prompts to the junior doctors, the problem of not getting the ERs signed off continues. It remains a focus of discussion at our Regional Guardian meetings, and has proved a difficult problem to correct among many trusts. The issue was covered at the induction of the new F1s and Lead Employer trainees in August. However, it does remain the responsibility of the juniors who put in the ERs to get them signed off.

Guidelines for exception reports state that reports should be completed by the doctor as soon as possible, but no later than 14 days of the exception. 40 (70) Exception Reports were submitted within 14 days and 5 (6) were outside this limit. This represents a compliance rate of 88% which is a slight deterioration from Q2 at 97%. If the doctor is seeking payment as compensation, the report should be submitted within 7 days. Upon receipt of a report, the Educational Supervisor should respond within 7 days. We have allowed some flexibility in the time allowed after submission of an ER, to claim for payment or TOIL. However, we have put a provisional limit at 3 months, and whenever possible, to only allow TOIL within their current placement.

Exception reports (response time)				
	Addressed within 48 hours	Addressed within 7 days	Addressed in longer than 7 days	Still open
FY1	2 (3)	1	12 (15)	17 (24)
JST	1 (3)	0	1 (7)	5 (7)
ST3	0	0	0	6 (16)

The above table shows that 4 (7) reports (8%) have been addressed by the Educational Supervisor within 7 days, and 15 (22) reports (33%) were addressed in more than 7 days and 28 (47) reports (62%) still remain open. This latter figure is of concern as the Educational Supervisors should have met to resolve the incidents but as highlighted earlier in this report, 11 (22) exception reports (24%) were discussed but the trainee has not accepted the outcome or escalated the report to the next stage.. The exception reports which have been resolved were largely resolved at the 'Initial Stage' but 2 Exception Report have been escalated to 'Level 1 Review Stage'.

Exception reports (type of issue)				
	Hours	**Education**	**Service Support**	**Working Pattern**
FY1	**29 (40)**	**3**	**0**	**0**
JST	**5 (15)**	**1**	**1**	**0**
ST3	**6 (16))**	**0**	**0**	**0**
Total	**40 (71)**	**4**	**1**	**0**

Clearly the overwhelming number of issues relate to the number of 'hours' (88%) that the trainees are being asked to work in addition to their contracted hours.

Exception Reports (Outcome)				
	Overtime Payment	Compensation and Work Schedule Review	Compensation: Time Off in lieu	No Further Action
FY1	9 (12)	0	3 (5)	4 (5)
JST	0	0	1 (7)	0
ST3	0	0	0	0
Total	9 (12)	0	4 (12)	4 (5)

Although 9 (12) exception reports resulted in an outcome of overtime (52%) and 4 (12) with time off in lieu (24%) the actual number of incidents which were resolved with TOIL was 41%. This is still lower than the trust would like but is still a relatively high percentage. This remains consistent with the national position taken from feedback at Guardian meetings.

The number of exception reports submitted by Lead Employer trainees is still quite small in Q3 at 6 (16) and has actually reduced compared with Q2 at 16 (26). Interestingly, all of these reports were submitted by a single trainee. In Q2 there were 7 (8) exception reports raised by JST trainees but this has increased to 13 (33) exception reports.

Junior Doctors on the 2002 Contract

It is important to remember that some junior doctors (employed by the Lead Employer) will remain on the 2002 contract for a number of years and will require their rotas to be monitored in line with their terms and conditions so that assurance can be given for all doctors in training and not just those on the new contract. A monitoring exercise was undertaken in November 2018 and the results are still being analysed.

4. Work Schedule Reviews

There have been no Work Schedule Reviews (WSR) recommended by the Education Supervisors at their initial meeting following submission of an exception report.

5. Locum Bookings

Bank and Agency

The normal arrangements for covering gaps on the rotas are for the trainees to be approached first to see what cover they can provide. Where gaps still remain, the shifts

which need covering are submitted via the CBUs to the Medical bank. Since 13 August 2018 the trust has used the Brookson system to record the requests for bookings.

The tables below show the shifts which were escalated to the Medical bank for filling on the Medical Bank. The first table shows the total shifts by specialty and the second table shows the reason. All of the shifts relate to FY2 trainees.

Locum Bookings (Bank and Agency) by Department/Specialty

Speciality	Requested Shifts	Paid Shifts	Shifts to Agency	Total Hours Requested	Paid Hours
A&E Medical Staff	8	2	2	163	24
Acute Medical Staff	20	7	7	252	81
Cardiology	103	56	56	4,060	420
Care of the Elderly & Stroke	334	250	250	2,672	1,941
Orthopaedic Medical Staff	49	18	18	579	215
Respiratory	25	8	8	384	65
Ward A2 ACUTE MEDICINE	66	56	56	528	421
Grand Total	**605**	**397**	**397**	**8,637**	**3,167**

Locum Bookings (Bank) by Reason

Booking Reason	Requested Shifts	Paid Shifts	Shifts to Agency	Total Hours Requested	Paid Hours
No Vacancy Reason	490	360	360	6,421	2,779
Additional Service Requirement	2	0	0	40	0
Annual Leave	11	5	5	852	37
Brookson Migration	5	0	0	45	0
On Call	2	0	0	37	0
Restricted duties	7	6	6	148	70
Sickness	6	0	0	102	0
Trust Vacancy	30	4	4	330	48
Vacancy (Internal cover)	15	14	14	183	167
Vacancy (Recruitment difficulties)	17	8	8	136	65
Winter Pressure	20	0	0	344	0
Grand Total	**605**	**397**	**397**	**8,637**	**3,167**

1. The above tables show that the main reason, by far, for requesting cover was due to vacancies.
2. Two specialties stand out in terms of requiring cover and these relate to Care of the Elderly and Cardiology with the prime reason known to be other vacancies with the specialties. Not surprisingly, these two specialties also account for the highest use of bank/agency staff.
3. The number of shifts requested to be covered this quarter has fallen significantly from c1300 shifts to 605 shifts.
4. The reason for the difference between requested shifts and the number of shifts given to agencies is due to subsequent cancellations from the CBUs.

6. Locum Work Carried Out by Trainees

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

Locum work by trainee						
Specialty	**Grade**	**Number of shifts worked**	**Number of hours worked**	**Number of hours rostered per week**	**Actual hours worked per week**	**Opted out of WTR?**
General Medicine	FY1	c7	56	757	757	N/K
General Surgery	FY1	c2.5	20	544	544	N/K
TOTAL	FY1	c9.5	76	1301	1301	N/K
Psychiatry – NW Boroughs	FY2	c6	48.5	1468	1468	N/k
Accident and Emergency	FY2	c37.5	300.25	352	352	N/K
General Medicine	FY2	c29	230	464.5	431	N/K
General Surgery/Urology	FY2	c20	157.5	464.5	464.5	N/K
Anaesthetics/ICU	FY2	c4.5	37.5	45	45	N/K
Total	FY2	c97	773.75	2794	2760.5	N/K

NB.

1. The number of shifts worked has been estimated as records only show the number of hours worked and have been based on 8 hour shifts
2. The number of hours worked per week takes account of vacancies but excludes sickness or other absences such as annual leave.
3. It is not known whether any of the trainees exceeded an average of 48 hours per week under WTR and whether they completed an opt-out form.
4. In comparison with the previous quarter, the number of hours/shifts covered has increased from 75 shifts/598.5 hours in Q2 to 95 shifts/773.75 hours in Q3. This is similar to Q3 in 2017/18 (Oct – Dec 2017) where c90 shifts/704.25 hours were covered.
5. The main areas where additional hours/shifts have been worked are general medicine, surgery and AED.
6. None of the extra hours worked related to Exception Reports which would suggest that TOIL is being used to compensate the trainees for working additional hours or the trainees have decided not to claim. All of the trainees have received information on how to make claims and this has been reiterated at the Junior Doctors Forum meetings.

7. Vacancies

There are no vacancies at FY1 covering the period from Oct – Dec 2018 and no trainees are on long term sickness or on maternity leave.

The table below shows the vacancies at **FY2 level only** from **Oct – Dec 2018**:

Specialty	Grade	Oct 18	Nov 18	Dec 18	Total gaps (average)	Number of shifts uncovered
Gastroenterology	**FY2**	**0**	**0**	**1.0**	**0.33**	**20**
Haematology	**FY2**	**0**	**0**	**1.0**	**0.33**	**20**
Total	**FY2**	**0**	**0**	**2.0**	**0.66**	**40**

NB

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

3. There were no FY2 trainees on maternity leave or on long term sickness.

8. Fines

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

No fines have been issued at WHH since the introduction of the new contract two years ago.

9. Qualitative Information

Junior Doctors Forum: The JDF takes place every 3 months, and is usually well attended. The joint meeting with Medical Director, Guardian and HR allows good discussion with the juniors and the chief registrar.

Education supervisors: Our ES are much better engaged, and I feel the problem with the outstanding ERs generally lies with the juniors. I have met with trainees on several occasions, to emphasise the importance of early sign-off of ERs.

Exception reports: Increasing number in the last 3 months reflects the winter pressures, with higher numbers of sick patients being admitted. This occurred at the same time last year, and is mirrored across regional trusts.

Compensation for extra duties worked: There have been more requests for TOIL in the last 3 months, with a 50/50 split between TOIL and payment. As Guardian, I would rather see TOIL, to ensure none of our trainees are exceeding their permitted hours. There have been no work schedule reviews in the 3 months, which would suggest our rotas are acceptable to the juniors.

Allocate training: There are drop-in sessions available for Educational Supervisors to assist in completion of ER reviews. The PowerPoint presentation from Allocate is pretty self-explanatory and comprehensive too, and this was presented recently at the T+O audit at their request.

10. Issues Arising

Our volume of exception reports (ER) have increased during Q3. This was to be expected as we move into winter pressures. It remains important that the juniors engage with the process, to ensure they are working safely within their allocated rotas.

A spike in ERs in cardiology related to the division of workload of the juniors between C21 and CCU. This led to the F1 often been left alone to manage C21, while the senior trainees were seeing the sicker patients on CCU. This has now been resolved, with the merger of C21 and CCU onto A3 in December.

There were 6 ERs submitted by the ST3 in orthopaedics, due to confusion regarding the prospective non-resident on call rota for this grade in T+O. This is being addressed by HR and the Educational Supervisor for this trainee.

Only one immediate safety concern was raised in this 3 month period, which was addressed and closed rapidly.

We have seen an increase in compensatory payment in Q3, rather than time-off in lieu (TOIL), following submission of an Exception Report. This raises the concern that certain juniors may be exceeding their maximum safe hours, but this is extremely difficult to police.

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

We need to ensure continued engagement of our Education Supervisors with our junior doctors, and continue to address the problem of persistent delays in participation of review meetings.

11. Action Taken to Resolve Issues

1) Training sessions are available for all Educational Supervisors as required, and mandated for juniors during their induction meeting.
2) Liaison with HR to calculate average hours for juniors across a rota cycle. The planned in house locum bank should help to spread the extra hours across the juniors to ensure they remain compliant.
3) There has been success in increasing staffing and junior support in high intensity areas. This has definitely been assisted by the appointment of nurse specialists and physician associates on the wards.
4) Continue to encourage TOIL as a solution to excess hours rather than compensatory payments, to avoid possible breach in hours and increased costs.
5) Work schedule reviews may be required in the future, especially in the medical rota, and medicine/surgery to ensure continued regular attendance at educationally beneficial sessions (formal teaching, theatre, clinics).

12. Summary

In Q3, there have been no major issues with the Junior Doctors Contract across the specialties. All our rotas remain compliant, the juniors are generally satisfied and engaged, and our HR department, rota managers, and Educational Supervisors have usually been supportive and responsive to any concerns amongst the junior doctors.

Apart from sporadic occasions, our juniors have been able to attend educational and teaching sessions, without recall to ward duty during this time frame.

We still have the persistent problem of sign-off of ERs. However, all completed reports have been signed off without resort to level 2 or guardian reviews. This was one of the main concerns from the BMA prior to implementation of the contract, and it is pleasing to see this continuing in our trust.

There are still areas where there are limited numbers of junior staff covering busy wards. Over the winter months, this raises concern in terms of workload, compliance to working hours, and opportunity to access educational sessions.

We need to ensure we provide continued training for Educational Supervisors, both in the expectations of their responses to exception reports, and instruction for use of the Allocate system.

In order to ensure compliance with junior doctors hours, Educational Supervisors should be encouraged to offer TOIL rather than compensatory payment wherever feasible. Work schedule reviews are mandatory where there is persistent infringement of hours or educational opportunities for our doctors.

13. Questions for Consideration

As Guardian of Safe Working Hours for the Junior Doctors in WHH, I am satisfied with the delivery and implementation of the new contract over the last two years in our trust. Please note and consider the assurances during this report.

However, we do need to be watchful that work schedules and working hours are maintained in future rotations, being mindful of the likely challenges facing the trust with service delivery, in the face of the likely reduction in training posts offered to the trust by HENW Deanery.

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

Mark Tighe
Guardian of Safe Working Hours

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/19/01/12**			
SUBJECT:	**Board Assurance Framework and Strategic Risk Register report**			
DATE OF MEETING:	30th January 2019			
AUTHOR(S):	John Culshaw, Head of Corporate Affairs			
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Medical Director & Deputy CEO			
LINK TO STRATEGIC OBJECTIVES:	All			
	Choose an item.			
	Choose an item.			
EXECUTIVE SUMMARY (KEY ISSUES):	Since the last meeting: • four new risks have been escalated to the BAF; • the ratings of four risks have been amended (three reduced, one increased); • the titles of two risks have been amended; • eleven risks have been de-escalated from the BAF Also included in the report are notable updates to existing risks			
PURPOSE: (please select as appropriate)	Information	Approval ✓	To note	Decision
RECOMMENDATION:	Discuss and approve the changes and updates to the Board Assurance Framework and Strategic Risk Register			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.	QAC/19/01/15		
	Date of meeting	8th January 2019		
	Summary of Outcome	The Committee reviewed, discussed and approved the amendments		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

BOARD OF DIRECTORS

SUBJECT	Board Assurance Framework	AGENDA REF:	BM/18/11/120

1. BACKGROUND/CONTEXT

This is an update of strategic risks on the Trust Strategic Risk Register. It has been agreed that the Board receives an update on all strategic risks and any changes that have been made to the strategic risk register, following review at Quality Assurance Committee. A Risk Review Group has been established reporting to Quality Assurance Committee, for oversight and scrutiny of strategic risks and for a rolling programme of review of CBU risks, to ensure risks are being managed and escalated appropriately.

The latest Board Assurance Framework (BAF) is included as Appendix 1.

2. KEY ELEMENTS

2.1 New Risks

Since the last meeting four new risks have been added to the BAF.

Risk #701	**Risk: Failure to provide continuity of services caused by the scheduled March 2019 Brexit resulting in difficulties in procurement of goods and services, workforce and the associated risk of the increase in cost of supplies**
Controls and Assurances	▪ Standard agenda item on the Trust wide Event Planning Group. ▪ Brexit Sub Group has been established with key managers and currently meeting weekly and reporting to the EPG. ▪ Supplies department completed the national self-assessment contract review. ▪ Service level business continuity plans are in the process of being updated. ▪ Regular updates to Trust Board on Trust preparedness. ▪ DH will stockpile a 6 week stockhold
Gaps	▪ National uncertainty on arrangements post March 2019 Brexit. ▪ Trusts being requested not to stock pile supplies. ▪ Risk to Supply BAU/CIP whilst resources are redirected to complete national work. ▪ National concern on shortages of radiopharmaceuticals and blood products. ▪ Potential price increases to supplies.
Initial Risk Rating	16 (4x4)
Residual Risk Rating	16 (4x4)

Risk #**695**	**Risk: Failure to meet NHS Cervical screening programme standards for failsafe of backlog of cervical cancer patients screening reviews, caused by requirements for smear takers across the Trust to have mandatory training & compliance with NHSCSP responsibilities resulting in non-compliance with cervical screening specification 2018/2019**
Controls and Assurances	Trust has now implemented NHS Cervical Screening Guidance in NHSCSP Publication 28 (1) and Disclosure of audit results in cancer screening best practice (2) I. There is now a ratified policy in place I /12/18 so we are now compliant II. The Recommendation from SQAS to implement policy for audit and disclosure has now been implemented. Patients diagnosed with cervical cancer will be informed of the audit and offered disclosure from December 2018 III. The Recommendation from SQAS to review screening histories of patients diagnosed with cervical cancer at the Trust from April 2013 to date and discussed at Colposcopy MDT if indicated. This is in progress. ▪ National Invasive Cervical Cancer Audit data collection from 2013 submitted ▪ Briefing paper and action was plan presented for Patient Safety & Clinical Effectiveness 30/10/18 and will be monitored by this committee.
Gaps	▪ Any patients diagnosed with cervical cancer prior to 2018 have not been informed of the audit. Based on the audit details a discussion will be taken at Colposcopy MDT meeting. Patients who require disclosure or possible duty of candour will need sensitive and skilled consultation.
Initial Risk Rating	15 (3x5)
Residual Risk Rating	15 (3x5)

Risk #**241**	**Risk: Failure to retain trainee doctors caused by lack of recruitment resulted in risk to reputation and service provision Shortage of locum Consultants on the Specialist register for Geriatrics- Deanery wish all CMT and above to be assigned to a COTE specialist- we only have 3 in SM at present.**
Controls and Assurances	▪ Regular monthly meetings taking place with HENW involving The Deanery. An agreed action plan has commenced. ▪ Regular weekly journal / educational meetings on Mondays co-ordinated by a clinical fellow. ▪ Most of Trust Locum Consultants have been approved as educational supervisors and are providing educational supervision to the ST3s in geriatric medicine ▪ Acute Care Services recruiting into MUM role ▪ Clinical Director to ensure that all trainees attend their mandatory training ▪ Work done around clinic attendance for trainees to ensure they can be released from wards to attend – record log in place. Working on plans to improve training opportunities/available clinics/etc. ▪ We are looking at all possible locum appointments and are considering to recruit off framework if necessary ▪ Working on getting more bank drs, rather than agency.

	▪ Establishment of Medical Trainees Experience Improvement Group ▪ Deputy Medical Director to have Director of Medical Education portfolio. ▪ Improving Medical Staffing and processes across key medical wards
Gaps	▪ Recruitment of substantive consultant physicians ongoing
Initial Risk Rating	12 (4x3)
Residual Risk Rating	12 (4x3)

Risk #**224**	**Risk: Failure to meet the emergency access standard caused by system demands and pressures. Resulting in potential risk to trust reputation, financial impact and below expected Patient experience**
Controls and Assurances	▪ Trust Bed Meeting 2 hourly from 08:00 to 18:00 ▪ Cooperation with Trust Partners - Social Care/RRT ▪ Discharge Lounge/Patient Flow Team ▪ Red to Green - Discharge Planning ▪ ED Escalation Tool/2 Hourly Board Rounds ED Medical and Nursing Controller ▪ Red Cross and Chloe Care Transport ▪ STP bid successful for FAU substantive Recruitment - In progress to support 5 day delivery model. ▪ Discharge Lounge opened 26th November 2018 ▪ Full ED business case approved for Q4 re: vision for ED Footprint creating assessment capacity. ▪ System actions agreed to mitigate bed capacity challenge throughout winter
Gaps	▪ Fully embedding actions associated with system wide capacity & demand review undertaken by Venn Consulting
Initial Risk Rating	16 (4x4)
Residual Risk Rating	16 (4x4)

2.2 Amendments to risk ratings

Since the last meeting, the risk ratings of four risks on the BAF have been amended.

The ratings of three risks have been reduced:

Risk #**133**	**Risk: Failure to successfully engage the Workforce, caused by the potential for an adverse working culture which resulted in 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 Trust's strategic objectives**
Initial Risk Rating	20 (4x5)
Previous Risk Rating	12 (4x3)
Amended Risk Rating	8 (4x2)

Risk **#120**	**Risk: 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 patients experience, may prolong their length of stay, and give rise to complaints and claims against the trust.**
Initial Risk Rating	20 (5x4)
Previous Risk Rating	16 (4x4)
Amended Risk Rating	12 (4x3)

Risk **#122**	**Risk: Failure to provide assurance regarding the Trust's safeguarding agenda being implemented across the Trust caused by gaps highlighted during external review may result in having an impact on patient safety and cause the Trust to breach regulations**
Initial Risk Rating	16 (4x4)
Previous Risk Rating	16 (4x4)
Amended Risk Rating	12 (4x3)

The rating of one risk has been increased

Risk **#125**	**Risk: Failure to maintain an old estate caused by restriction, reduction or unavailability of resources resulting in staff and patient safety issues, increased estates costs and unsuitable accommodation.**
Initial Risk Rating	20 (5x4)
Previous Risk Rating	9 (3x3)
Amended Risk Rating	16 (4x4)

2.3 Amendments to risk titles

Since the last meeting, the risk titles of two risks on the BAF have been amended.

I. Previously, risk #117 stated:

Failure to provide a spinal service for the local population, caused by a voluntary suspension of the service amid potential governance concerns, resulting in poor patient experience, potential safety concerns for those patients with delayed procedures or follow ups, reputation damage and potential regulatory and contractual issues.

It was agreed that it was amended to:

Failure to successfully counter the regulatory and contractual consequences, caused by the suspension of spinal services in September 2017, resulting in significant reputational damage.

II. Previously, risk #145 stated:

Failure to influence sufficiently within the Cheshire & Merseyside Healthcare Partnership 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.

It was agreed that it was split into two parts and amended to:

Influence within Cheshire & Merseyside

a) Failure to deliver our strategic vision, including two new hospitals and vertical & horizontal collaboration, and influence sufficiently within the Cheshire & Merseyside Healthcare Partnership and beyond, may result in an inability to provide high quality sustainable services may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position.

b) Failure to fund two new hospitals may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position.

2.4 Removal of Risks

Following a review of the risks, it was agreed that 11 risks are removed from the BAF:

RISK 118: Failure to have sufficient Middle Grade cover on critical care, caused by insufficient middle grade/registrar doctors to cover 3rd tier on calls, resulting in potential patient safety issues, operational impact and financial pressures due to locum costs.
The residual risk rating was 9 (3x3).

RISK 119: *Failure to have sufficient assurance in place regarding contractual and governance requirements in Sexual Health Services, resulting in potential patient safety issues, organisational and reputational risk.*
The residual risk rating was 12 (4x3).

RISK 128: *Failure to comply with the Thromboprophylaxis procedure/policy caused by poor completion of thromboprophylaxis risk assessments and follow up 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.*
The residual risk rating was 12 (4x3).

RISK 129: *Failure to stop Clinical variation, caused by lack of systems/process or failure of systems/to follow process resulted in lack of evidence based practice, potential patient harm and reputational impact.*
The residual risk rating was 12 (4x3).

RISK 141: *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*
The residual risk rating was 12 (4x3).

RISK 153: *Failure to attend mandatory resuscitation training caused by operational pressures resulting in low compliance rates and risk to patient and staff safety*
The residual risk rating was 15 (3x5).

RISK 261: *Failure to provide continuity of palliative care caused by remaining consultant leaving the trust on 23.2.18 resulted in no consultant in palliative care*
The residual risk rating was 9 (3x3).

RISK 280: *Failure to provide an adequate level of Consultant Microbiology cover caused by insufficient numbers of Consultant staff (as advised in RCPath guidelines),resulting in delays in patient management due to delayed communication of results, inability to attend ward rounds, inability to complete required workload & attend infection control meetings as required.*
The residual risk rating was 16 (4x4).

RISK 469: *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'*
The residual risk rating was 12 (4x3).

RISK 512: *Failure to have robust processes 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.*
The residual risk rating was 12 (3x4).

RISK 116: *Failure to deliver national and local performance targets will result in an impact on patient care, reputation and financial position.*
The residual risk rating was 20 (4x5).

2.3 Existing Risks - Updates

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
115	Failure to provide adequate staffing levels in some specialities and wards, caused by inability to fill vacancies, sickness, resulting in pressure on ward staff, potential impact on patient care and impact on Trust access and financial	• 'Keeping in touch' day took place on 22nd November for new starters • New starters in November include: - HCA – 10, Band 5 - 3 • Recruited in November and going through pre-employment checks; HCAs – Band 2 14.21 wte, Band 5 -	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
	targets.	14.56wte, Band 6 - 1.86 wte, Band 7 - 2.0 wte • HCA Recruitment event took place on 4th December for which 11 applicants were successful • First meeting of the NHSi Retention Collaborative on 22nd November 2018 – retention plan underway to include full data review and staff engagement. • NHSI site meetings planned for January 2019 in relation to the Retention Collaborative • Paediatric Staffing Review undertaken • Birthrate + Business Case approved	
134	Risk: Financial Sustainability a) Failure to sustain financial viability, caused by internal and external factors, leading to potential impact to patient safety, staff morale and enforcement/regulatory action being taken. b) Failure to deliver the financial position and a surplus places doubt over the future sustainability of the Trust. There is a risk that current and future loans cannot be repaid and this puts into question if the Trust is a going concern.	• Introduced the Financial Resources Group (FRG)that reports to FSC • CIP Workshops taking place to improve the CIP Position • Refreshing Financial Strategy • Memorandum of Understanding agreed with Bridgewater Community Trust	No impact on risk rating
145	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.	• Work plan agreed with StHK • Shared a presentation demonstrating Halton Hospital's suitability to host the Eastern Sector Cancer Hub with Clatterbridge and other stakeholders. This forms part of the formal decision making process on the location of the hub • Regular Strategy updates are provided to the Council of Governors. • GP Engagement event held, including engagement on clinical strategy • Clinical strategy engagement held with Trust Board • Submitted bid to provide UTCs in Runcorn & Widnes • Halton Healthy New Town programme formally reports to One Halton Board • Re-establishment of Joint Executive Oversight group (JOG) with StHK	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
		• Commissioned financial feasibility assessment for Halton Healthy New Town following unsuccessful bid to NHSE • Bid to One Public Estate for revenue funding to support development of outline business case	
117	Failure to provide a spinal service for the local population, caused by a voluntary suspension of the service amid potential governance concerns, resulting in poor patient experience, potential safety concerns for those patients with delayed procedures or follow ups, reputation damage and potential regulatory and contractual issues.	• Honorary contract in place for Consultants	No impact on risk rating
143	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	• Trial version of Solar Winds patching software tested. Senior IT staff are happy with the software and now have raised a purchase order to purchase the full software. • All CareCERT's are now completed and sent back to NHS England. • Automatic software has been purchased and will require a period of time to configure before we can automate majority of servers. • The Data Domain is now configured and has been tested with one server. The Server Manager will perform a phased migration of all other servers.	No impact on risk rating
88	Failure to implement the requisite GDPR (General Data Protection Regulation) policies, procedures and processes caused by increased competing priorities due to an outdated IM&T workforce plan resulting in areas of Data Protection non-compliance	• Cyber Security report produced to provide assurance about the new Data Protection Security Toolkit & security measures deployed in the Trust. • IT systems containing personal identifiable data moved into the new information asset register.	No impact on risk rating
186	Failure to provide HCAI surveillance data and take timely action. Caused by lack of IT software. Resulting in a risk of outbreaks of healthcare associated	• Received demonstration from software provider for potential solution • Visit planned to Alder Hey to observe an alternative software system. • Meeting held with Finance & IT to review funding options	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
	infection.	• Surveillance continuously in place in T&O. Assurance received on data – overall compliance is excellent for surveillance of surgical site infection (hip and knee replacement) for planned surgery. Action put in place by MSK CBU to ensure compliance for trauma cases. • Theatres were inspected by an Authorising Engineer for ventilation in November 2018. The report in summary concluded that operating theatre's no1 to no 8 are fit for purpose and the quality of servicing and maintenance carried out by the Trust Estates Team is of a very high standard and compliant.	

2.3 Risk Management Strategy Updates

The Risk review Group continues to meet monthly with the next meeting due to be held on 8th February 2019

3 RECOMMENDATIONS

Discuss and approve the changes and updates to the Board Assurance Framework and Strategic Risk Register

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/19/01/13**			
SUBJECT:	**WHH Clinical Strategy 2018-2023**			
DATE OF MEETING:	30th January 2019			
AUTHOR(S):	Stephen Bennett, Head of Transformation Lucy Gardner, Director of Strategy Alex Crowe, Director of Medical Education			
EXECUTIVE DIRECTOR SPONSOR:	Lucy Gardner, Director of Strategy Alex Crowe, Director of Medical Education			
LINK TO STRATEGIC OBJECTIVES:	All			
	Choose an item.			
EXECUTIVE SUMMARY (KEY ISSUES):	The WHH clinical strategy sets how each of our 33 individual clinical services will support the delivery of the organisation's strategic objectives over the next 5 years. The document is the culmination of significant engagement and conversation with internal clinical teams and external partner organisations. The clinical strategy shapes a vision for the future of our clinical services whilst simultaneously supporting the national direction towards integrated care and long-term sustainability.			
PURPOSE: (please select as appropriate)	Information	Approval X	To note	Decision
RECOMMENDATION:	It is recommended that the Trust Board approve the final version of the organisation's clinical strategy covering the next 5 years.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

Warrington and Halton Hospitals
NHS Foundation Trust

70 YEARS OF THE NHS 1948 - 2018

WHH Clinical Strategy 2018-2023

DRAFT

December 2018

Foreword

Foreword

We are proud to present our Clinical Strategy, which is built on the foundations of our Quality, People and Sustainability Framework (QPS).

This strategy sets out our commitment to becoming outstanding for our patients, our communities and each other.

We have embarked on an organisation-wide change journey called 'Getting to Good, Moving to Outstanding' – delivery of our clinical strategies is key to achieving this challenge.

Our clinical teams continually strive to improve services for our patients and our clinical strategy describes just some of the plans that each of our clinical teams have to deliver outstanding services to our patients over the next 1-5 years.

Our plans reflect national health and social care priorities, including working in partnership to provide care closer to patients' homes where possible as well as centralising more specialist services where necessary to ensure that patients always receive the best possible care.

We are committed to continually developing and improving our clinical services to best serve local people. A great example of this commitment is our ambition to build 2 new hospitals over the next 15 years to enable us to deliver services in modern, state of the art, caring environments.

Mel Pickup, Chief Executive Officer

Steve McGuirk, Chairman

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Welcome to Our Clinical Strategy

We are delighted to welcome you to our Clinical Strategy. This strategy sets out our commitment to make Warrington and Halton Hospitals NHS Foundation Trust (WHH) outstanding for our patients, our communities and each other. Delivery of our Clinical Strategy is enabled through our Quality, People and Sustainability strategies. Through delivery of our suite of strategies we will:

- Always put our patients first through high quality, safe care and an excellent patient experience.
- Be the best place to work with a diverse, engaged workforce that is fit for the future.
- Work in partnership to design and provide high quality, financially sustainable services in innovative and modern buildings.

Our Clinical Strategy outlines our aim to provide outstanding acute hospital services for the residents of Warrington and Halton, ensuring that services are provided locally where possible and centrally where necessary. It also outlines our ambition to provide more services in the community, closer to people's homes, by working with our partners including GPs, mental health service providers, and our local councils.

Our Clinical Strategy provides 5 year plans for each of our 33 clinical services, which have been developed by our clinical teams and are fully supported by the Trust Board and our partners.

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Background

Background

The challenges facing the NHS are multi-layered, sizeable and real. Growing demand for services from an ageing population, national and local workforce availability and recruitment challenges and political volatility mean that we currently operate in an unprecedented and ever-changing environment.

At Warrington & Halton Hospitals NHS Foundation Trust (WHH) we are responding to these challenges – through clinically led service improvement. We are doing this by working in partnership to ensure that we have the right services, in the right place, in the right environment, to meet the needs of the population we serve.

The publication of the NHS Five Year Forward View and many other reports including the Carter Review have outlined the opportunity and created a platform for strategic level change. Subsequently, the establishment of Sustainability & Transformation Partnerships (STPs) and Vanguard programmes during 2015/16 were intended to formulate plans to drive long-term financial sustainability and create robust workforce solutions to common challenges through improved regional health and social care integration.

As a member of the Cheshire & Merseyside Health & Care Partnership, there are a number of services currently provided in some form here at WHH that are subject to review at regional level. These include:

- Elective Care
- Urgent Care Services
- Women's & Children's Services (incl. maternity)
- Pathology Services
- Radiology
- Cancer Services

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In addition, following the recent amalgamation of Health and Social Care under a single Government Secretary of State, there is a renewed momentum behind the push for the creation of place-based integrated care systems (ICSs) designed around local populations.

Figure 1 below illustrates how the various systems and partnerships interact. The existence of these partnerships across the local, regional and national health economies provides the vehicles to drive system-wide transformation.

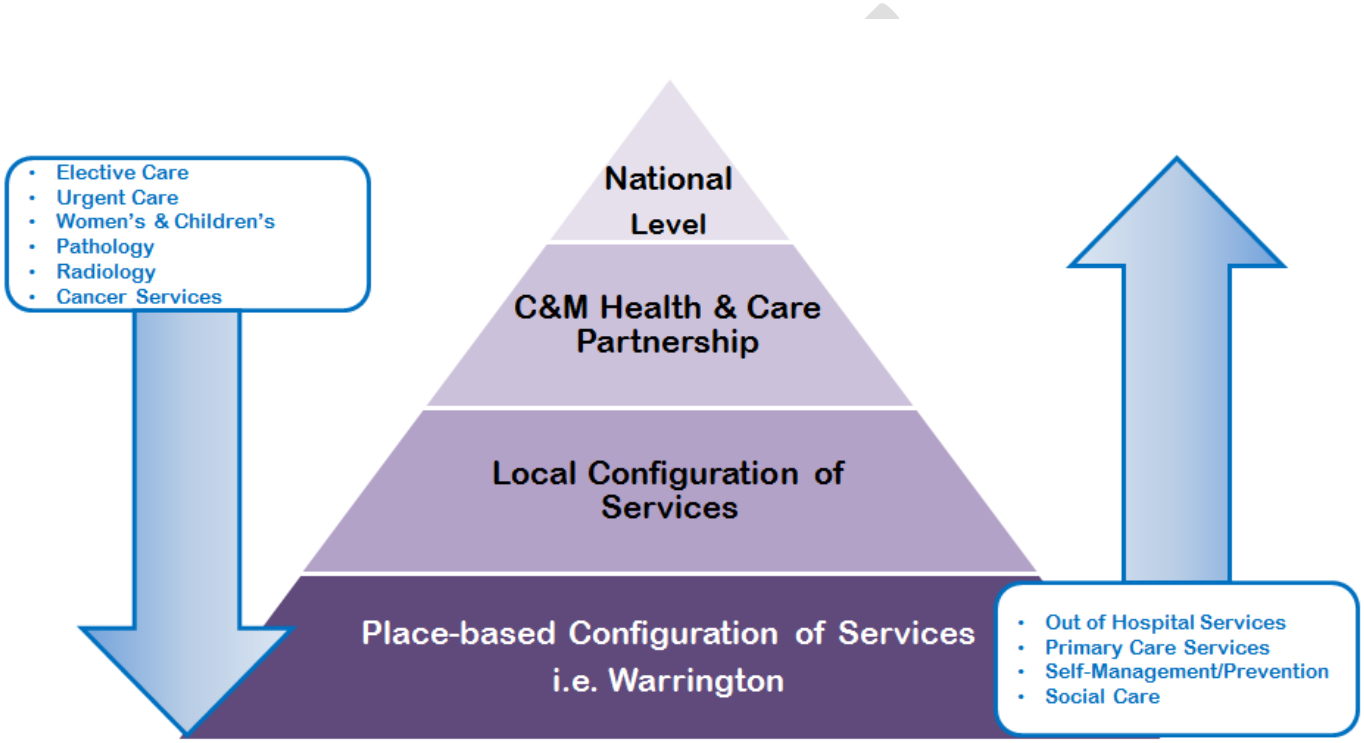

Figure 1

This clinical strategy is designed to complement the most recent Warrington & Halton Borough Councils' Joint Strategic Needs Assessments (JSNA), Warrington CCG Commissioning Prospectus and the One Halton Health & Wellbeing Strategy by outlining Warrington and Halton Hospitals' strategic plans to tackle some of our local regions' most pressing health and social care challenges.

2017/18 was a challenging year for our Trust, we have made significant improvements since then and continue to do so…

Q From a **quality** perspective, the Trust was formally rated as "Requiring Improvement" by the CQC. In response to this, we launched the *"Getting to Good, Moving to Outstanding"* programme and have recently completed the work required to deliver the extensive action plan aligned to that programme. In addition, the Trust has now established its new Quality Academy designed to help embed a standardised approach to quality improvement across the organisation.

P From a **people** perspective, the results of the latest staff survey told us that we had more work to do with regards engaging and empowering our staff to make change happen. In response to this, we have refreshed our organisational people strategy for the next 3 years with the aim of being the best place to work with a diverse, engaged workforce that is fit for the future. Linked to this, we have also embarked on an exciting engagement approach called *Listening into Action* which will bring about a culture of listening to staff and acting on what matters to them whilst putting patients at the heart of what we do, and it will support leaders to lead well.

S From a **sustainability** perspective, the Trust's outturn for the financial year was a deficit position of £14.7m and the estimated cost of backlog maintenance across the whole estate stood at around £14m and rising. In response, we continue to challenge ourselves to provide value for money and look for opportunities to improve the financial efficiency of all our services. In addition, we are making significant progress towards creating an exciting new vision for health, care and wellbeing services across both Warrington and Halton through the new Warrington Hospital and Halton Healthy New Town projects respectively.

We understand that in order to carry on providing the standards of care that we demand for our patients, we will need to continue at pace with the work around transforming our models of care. In order to deliver on our future ambitions and aspirations, we continue to build strategic alliances and partnerships with a range of other providers, commissioners, local authorities, GPs, primary care teams, voluntary and other public and private sector organisations. Alongside these partners we are working to redesign and integrate health and social care delivery, underpinned by digital technology and led by strong, clinical leadership.

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Our Vision and Objectives

Over recent months, we have consulted with staff, patients and external partners to reshape and redefine our overall organisational strategy.

Put simply, we aim to become an integrated provider of clinically and financially sustainable acute and community services providing outstanding care!

Our 3 strategic objectives under the **Quality** domain are:

Patient Safety -
We are committed to developing and enhancing our patients' safety through a learning culture where quality and safety is everyone's top priority

Patient Experience -
By focussing on patient experience we want to place the quality of patient experience at the heart of all we do, where "seeing the person in the patient" is the norm.

Clinical Effectiveness -
Ensuring practice is based on evidence so that we do the right things the right way to achieve the right outcomes for our patients.

Our 3 strategic objectives under the **People** domain are:

Attract and retain a diverse workforce aligned to our culture and values to ensure that we have the staff with the skills, attitude and behaviours to meet the needs of our population providing excellent and safe care.

Create the conditions to promote wellbeing and enable an engaged workforce to improve patient and staff safety and experience.

Develop a collaborative, compassionate and inclusive culture of collective leadership at all levels and organisational learning.

Our 3 strategic objectives under the **Sustainability** domain are:

Play a central role in our healthcare economies to support integrated place based care.

Work with other acute care providers to ensure that those services which need to be provided in an acute environment are the best they can be and are clinically and financially sustainable.

Provide our services in an estate that is fit for purpose, supported by technology, and aligned to the needs of our developing populations.

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Cheshire & Merseyside Health & Care Partnership

Regional Service Reviews

Cheshire & Merseyside Health & Care Partnership

The Trust is clear on its position with regards the service configuration work being explored at regional level.

C&M H&CP Review	WHH Current Position
Elective Care Services	We recognise that there are specialties or areas within specialties where outcomes/efficiency can be improved but we also recognise that there are many specialties where our performance is amongst the best regionally. Therefore we are committed to working in collaboration with other providers of elective care across the region to look for ways to improve our existing services and build on our current strengths.
Urgent Care Services	We expect to retain our current Emergency Department on the Warrington site as well as the Urgent Care Centre at Halton. We recognise the need to work closely with community providers and commissioners to find ways to manage demand away from a hospital setting wherever possible and safe to do so.
Women's & Children's Services	We are keen to retain and build on our strong Paediatric service and look for ways to strengthen and develop our existing Maternity services.
Pathology & Radiology Services	We are looking to play a key role in the proposed development of regional models around the provision of clinical support services. Our preferred option for the development of regional pathology services is to support the establishment of 3 hubs across Cheshire & Merseyside with some services retained on each local site.
Cancer Services	We would like to be considered strongly as the "eastern hub" for the provision of improved cancer services across Cheshire and Merseyside and believe we have put forward a compelling case as part of the ongoing review and consultation.

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Engagement to Date

Successful delivery of our ambitious future vision for the Trust is dependent upon the full engagement of our patients, staff and local system partners. Our clinical teams are leading the conversations around service configuration and improvement.

We have engaged WHH patients and families, staff and partner organisations to date through a range of engagement activities and events, including “What matters to me” conversations and more formal engagement events with our leaders. Engagement will continue throughout the delivery of our clinical strategies.

Partner	Engagement to Date
Patients and public	◦ "What matters to me?" conversations. ◦ Overview & scrutiny committee. ◦ Warrington & Halton Hospitals Annual General Meeting. ◦ Insight work for Halton Healthy New Town. ◦ Halton people's health forum. ◦ Christmas strategy stalls at Warrington and Halton Hospitals. ◦ Vintage rally at Victoria Park. ◦ Runcorn Shopping City for Halton Healthy New Town Masterplan.
Clinical Specialty Teams	◦ Presentation by Medical Director and Director of Strategy at medical cabinet. ◦ Individual meetings with each team. ◦ Collation and prioritisation of all ideas/aspirations. ◦ Halton Hospital and Wellbeing Campus service design event.
All WHH Staff	◦ SWOT (Strengths, Weaknesses, Opportunities & Threats) analysis of organisation. ◦ Collation and review of current strategic projects. ◦ Presentation/discussion at CBU management meetings. ◦ Strategy stall at WHH start of year conference. ◦ Team brief and trustwide communications. ◦ Christmas strategy stalls at Warrington and Halton Hospitals.
Local GPs	◦ One Halton & Warrington Together Board & Senior Change Team Discussions. ◦ Market stalls at GP engagement events.

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	◦ Halton Hospital and Wellbeing Campus service design event.
Commissioners	◦ One Halton & Warrington Together Board & Senior Change Team Discussions. ◦ Collaborative Sustainability group. ◦ Clinical quality focus group. ◦ Halton Hospital and Wellbeing Campus service design event.
Local NHS Organisations (e.g. North West Boroughs, St Helens & Knowsley NHS Trust)	◦ Exec-level meetings with other local providers to share emerging themes and ideas. ◦ Working groups formed with some partners to drive progress on agreed priority projects (e.g. acute collaboration programme with St Helens & Knowsley NHS Trust). ◦ One Halton & Warrington Together Board & Senior Change Team Discussions.
Bridgewater Community Health NHS FT	◦ Exec-level meetings with other local providers to share emerging themes and ideas. ◦ Memorandum of Understanding and workplan agreed to drive progress on agreed priority projects. ◦ Halton Hospital and Wellbeing Campus service design event.
Trust Board	◦ SWOT (Strengths, Weaknesses, Opportunities & Threats) analysis of organisation. ◦ Collation and review of current strategic projects. ◦ Warrington & Halton Hospitals Annual General Meeting. ◦ Focussed board strategy sessions. ◦ Board strategy delivery updates.
Local Authorities	◦ One Halton & Warrington Together Board & Senior Change Team Discussions. ◦ Overview & scrutiny committee. ◦ Halton Hospital and Wellbeing Campus service design event.◦ Warrington new hospital development group. ◦ Engagement with development of Warrington Health & Wellbeing strategy.
Voluntary Sector Organisations	◦ One Halton & Warrington Together Board & Senior Change Team Discussions. ◦ Halton Hospital and Wellbeing Campus service design event.

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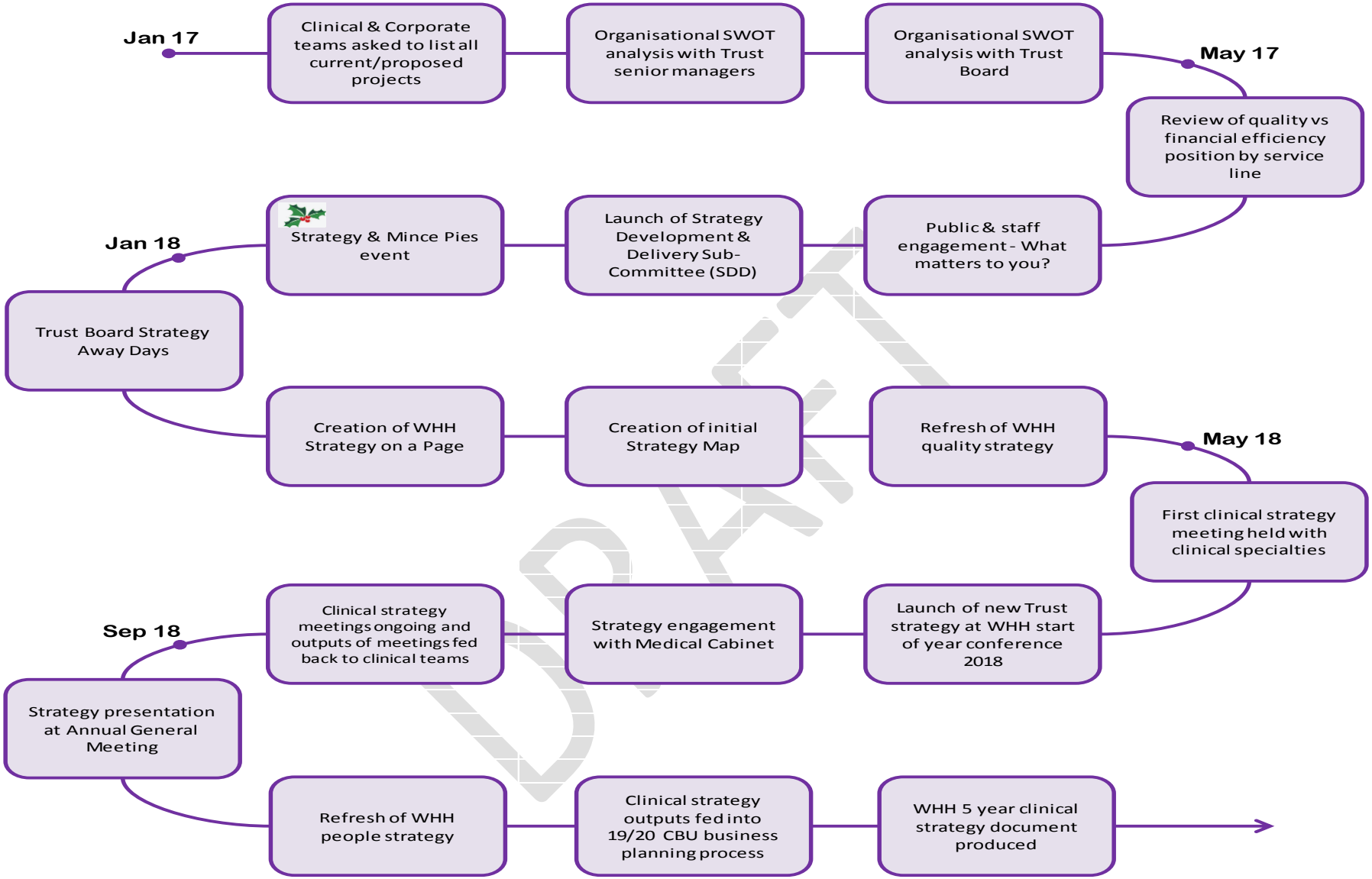
Our clinical teams are taking a lead role in the design and development of the future of their own services. This commenced with an initial series of individual specialty clinical strategy meetings held during the summer/autumn of 2018. The outputs from the clinical strategy meetings were shared by clinical leads with the wider services for comment and prioritisation.

The timeline below also illustrates some of the key milestones on the journey towards the development and delivery of the WHH overall strategy and clinical strategy:


Jan 17
Clinical & Corporate teams asked to list all current/proposed projects
Organisational SWOT analysis with Trust senior managers
Organisational SWOT analysis with Trust Board
May 17
Review of quality vs financial efficiency position by service line
Jan 18
Strategy & Mince Pies event
Launch of Strategy Development & Delivery Sub-Committee (SDD)
Public & staff engagement - What matters to you?
Trust Board Strategy Away Days
Creation of WHH Strategy on a Page
Creation of initial Strategy Map
Refresh of WHH quality strategy
May 18
First clinical strategy meeting held with clinical specialties
Sep 18
Clinical strategy meetings ongoing and outputs of meetings fed back to clinical teams
Strategy engagement with Medical Cabinet
Launch of new Trust strategy at WHH start of year conference 2018
Strategy presentation at Annual General Meeting
Refresh of WHH people strategy
Clinical strategy outputs fed into 19/20 CBU business planning process
WHH 5 year clinical strategy document produced

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How Will We Realise Our Vision?

In order to reinforce our commitment to clinical teams leading on the design and delivery of our future vision, we have met with representatives from each of the 33 clinical specialties over recent months to discuss their ambitions, opportunities and challenges.

At the initial meetings with the clinical teams, all known and available intelligence around specialty performance was shared and added to existing specialty-level information including market share data, Getting It Right First Time (GIRFT) feedback reports, Service Line Reporting (SLR) positions, national benchmarking data and Model Hospital metrics etc. Specialty teams were then asked to discuss their opportunities and challenges in the short, medium and long-term culminating in the formulation of a robust and coherent specialty-level clinical strategy as an output.

We recognise that operational pressures regularly present difficulties in terms of clinical teams finding the capacity to support strategic redesign work for their services, especially during winter months. Therefore, alongside the specialty discussions we have commenced work on an initial baseline review of medical staffing, aimed at ensuring we have “the right numbers in the right places”. The review will be completed in Q3/Q4 2018/19 and the outcomes will also help to inform the next stages of the clinical strategies for many services.

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The Quality Academy was set up in 2018 to help define organisational standards for care, monitor standards of delivery at team, specialty and Trust level and ensures that best practice around clinical improvement is shared widely.

Moving forwards, the Trust is supporting the clinical teams with the task of prioritising and subsequently delivering their own clinical strategies and providing support to do so via Transformation Team resource and the newly-established **Quality Academy**.

As part of the creation of the specialty clinical strategies, specialty teams were asked to consider the impact of any outcomes from Cheshire & Merseyside Health & Care Partnership "system-level" requirements and explore how horizontal and/or vertical integration may provide solutions to clinical, workforce or financial sustainability challenges.

Horizontal integration involves creating joined up services with other acute provider organisations. There are numerous examples across the organisation where clinical specialty teams have previously worked, or are currently working alongside other local acute providers. For example, there are some specialties working with local partners to create more robust and attractive on-call rotas covering more than one single site to address challenges around medical workforce shortages. There are other specialties delivering opportunities to share some facilities and estate with other local providers in anticipation of future changes to clinical pathways to make more efficient use of services across two different sites. There is also an ongoing national and regional programme of work focussed on the integration of pathology services.

Vertical integration involves creating joined-up services with providers of acute specialist organisations (upward vertical integration) or with providers of community-based services (downward vertical integration). The programme of work being delivered by the Trust Paediatric team is a good example of how vertical integration can provide solutions to some of our challenges around managing demand through the provision of appropriate capacity. Successful vertical integration involves services provided by other local specialist Trusts delivered in complete collaboration with Warrington and Halton. This means that our patients will have access to the latest treatments and clinical expertise from across Cheshire & Merseyside, but delivered closer to their home.

The Trust Paediatric Team has created a future strategy for their own service incorporating a possible expansion to the existing Paediatric Acute Response Team (PART) to manage an increased number of patients in an out-of-hospital setting. In parallel, the team are also delivering an expansion of paediatric surgical services to prevent Warrington children having to travel to Alder Hey for some types of routine surgery.

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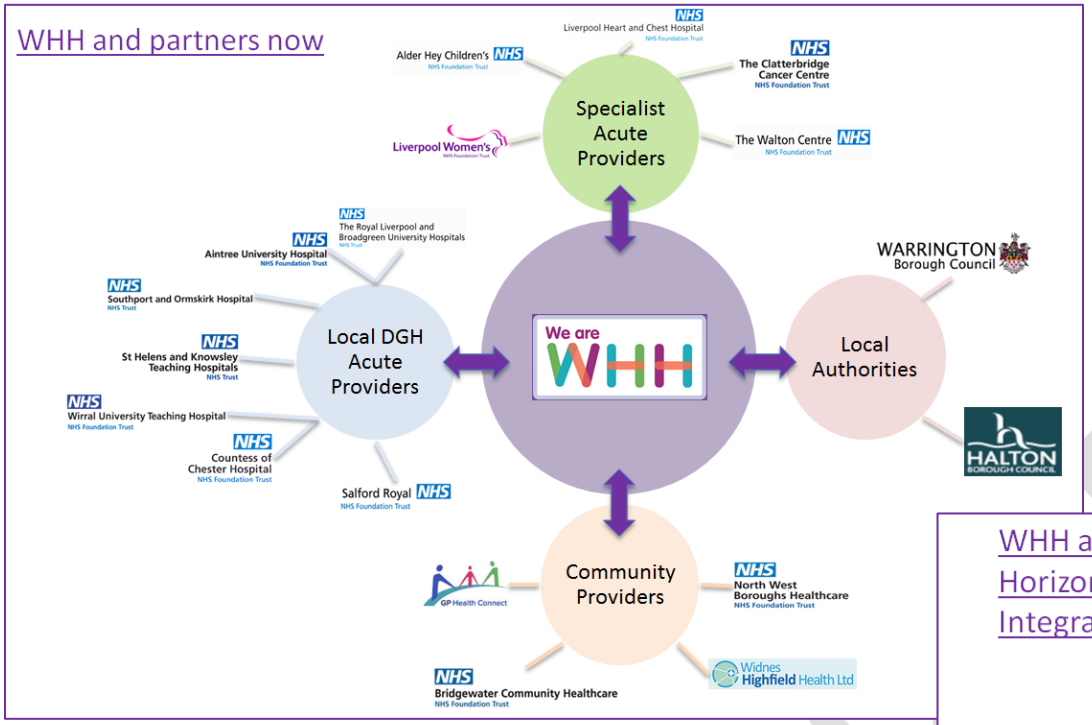
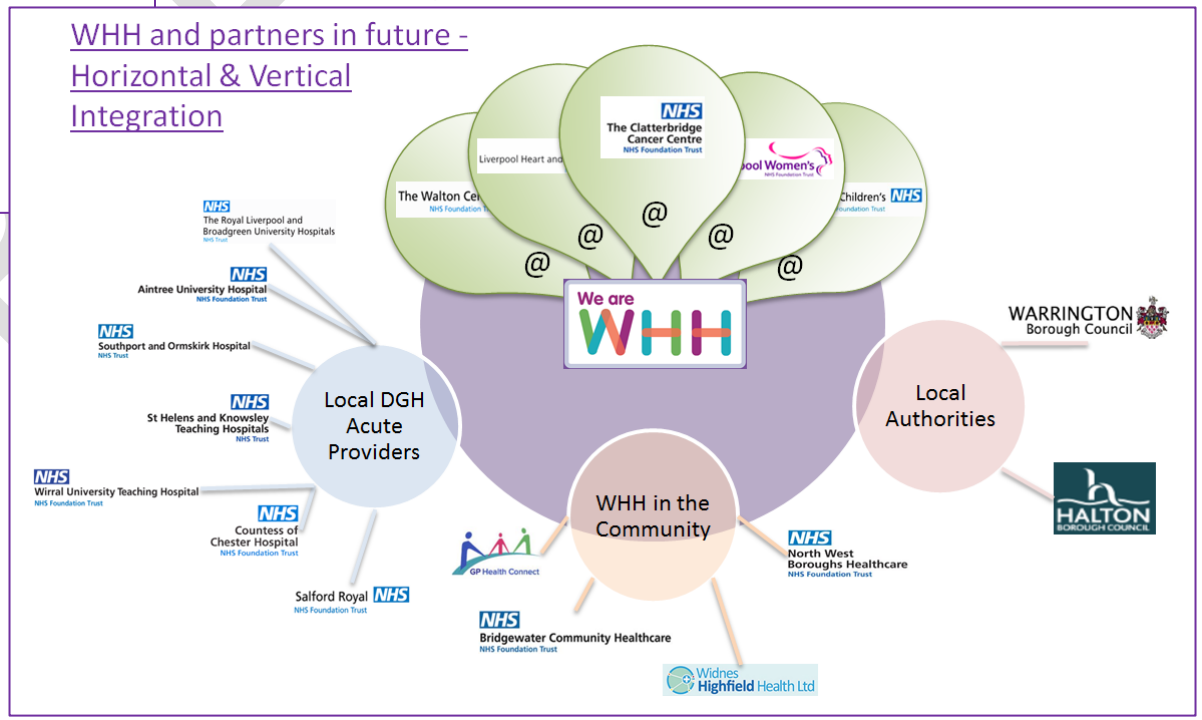


The Trust has built supportive and constructive relationships with our main commissioning organisations and other local providers to lay the foundations for effective service redesign now and in the future. These relationships have already led to significant investment in the development of a new model of out-of-hospital care for frail patients in Warrington with a similar model being developed for Halton patients.



Closer links have also been established with other external partners such as Local Authorities and organisations in the voluntary sector to support improvements and develop solutions to long-standing challenges around increasing demand, efficient discharge processes and out-of-hospital capacity. The development of plans for an Integrated Discharge Team and collaborative working around system-wide social care capacity are examples of the positive outcomes from these relationships.

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Our approach to designing and delivering the future clinical services has been based on a simple framework:

- Focussing on pathways and the needs of our patients and driving for the best possible outcomes.
- Working together and being open-minded to single/shared services if necessary.
- Exploring digital capabilities and how they can support the transformation of what we do for the better.
- Working within the parameters set but not allowing them to constrain our thinking.
- Functioning as a single leadership team at speciality/Clinical Business Unit level.
- Following appropriate protocols and governance.
- Looking to adopt the best processes; not just more of the same.
- Looking at how our services can be delivered efficiently across more than one site.
- Endeavour to reduce variability and numbers of touch points for our patients and staff.
- Looking to increase standardisation and flexibility.

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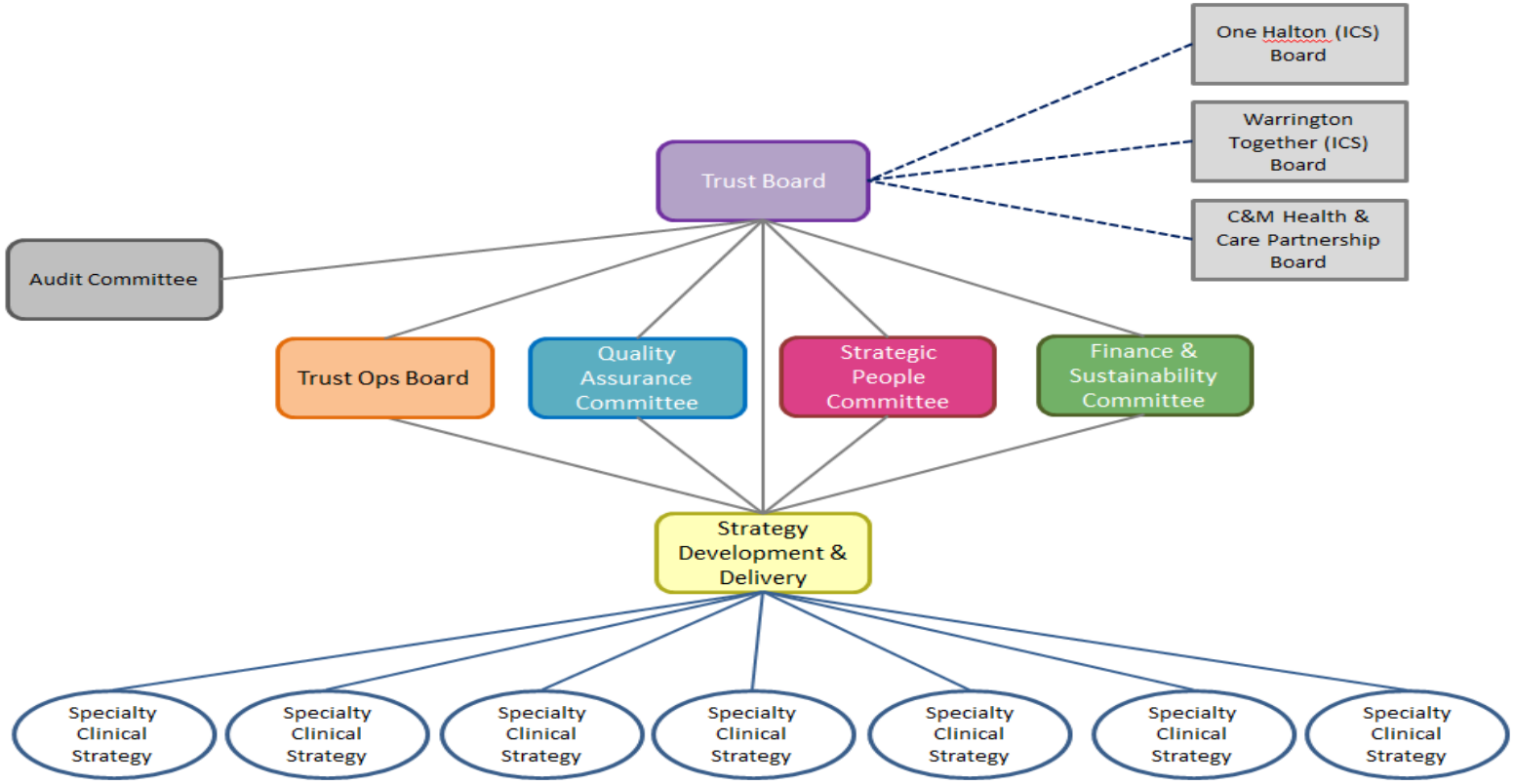
Governance

Governance

In order to provide assurance around quality and patient safety and also to ensure we are making sufficient progress to deliver the required changes, the delivery of specialty level strategies will be governed through 2 routes within the existing Trust governance structure.

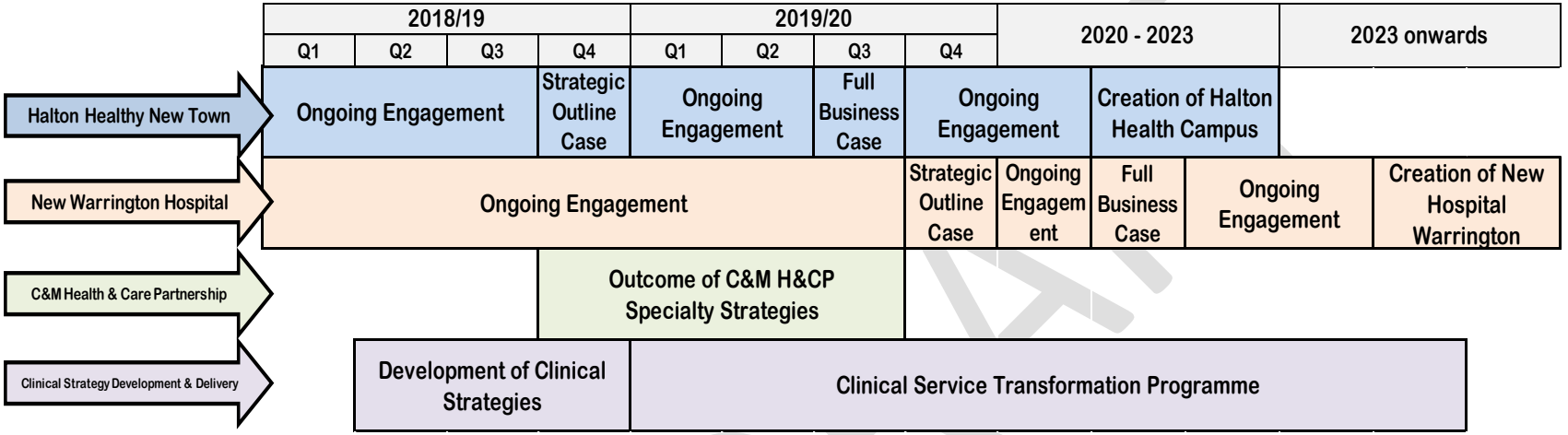


Key strategic priority projects will report via Strategy Development & Delivery Sub-Committee and the various board sub-committees to Trust Board.

Operational improvement projects will report via the regular QPS forums directly to the Trust Executive team.

Timeframes

The diagram below illustrates the expected timeframes for the development and delivery of specialty level clinical strategies, alongside key elements of the Trust overall strategy and milestones in the Cheshire and Merseyside Health and Care Partnership programme:



***WHH Specialty Services** are:*

Anaesthetics
Breast Surgery
Cancer Services
Cardiology
Care of the Elderly
Clinical Haematology
Critical Care
Dementia Services
Dermatology
Diabetes & Endocrinology
ENT
Frailty Service
Gastroenterology
General Surgery
G.I. Surgery
Neurology
Obstetrics & Gynaecology
Ophthalmology
Orthodontics & Oral Surgery
Paediatrics & Neonates
Pain Management
Palliative Care
Pathology
Pharmacy
Radiology
Renal Medicine/Nephrology
Respiratory Medicine
Rheumatology
Stroke Services
Therapy Services
Trauma & Orthopaedics
Urgent & Emergency Care
Urology

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Supporting Strategies

Supporting Strategies

Here is a list of our other strategies which support the delivery of the clinical strategy:

- Quality Strategy
  - Patient Experience Strategy
  - Nursing & Midwifery Strategy
  - Allied Health Professionals Strategy
  - Frailty Strategy
  - Quality Academy Strategy
- People Strategy
  - Equality, Diversity & Inclusion Strategy (in development)
  - Freedom to Speak Up Strategy
- IM&T Strategy
- Estates Strategy
- Finance Strategy

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IM&T (Digital) Strategy

The new generation of digital services will meet the needs of clinicians, patients and managers. Our digital vision will build upon the mandated minimum NHS technical standards. The clinical strategy will benefit from a blend of local, regional and national solutions that are able to talk to each other securely, are safe and upgradable. The associated health and social care benefits being considered by WHH over the next 5 to 10 years include:

1. **Optimisation** of systems and their datasets to facilitate the most efficient and effective care pathways and contribute to a high quality patient experience.
2. **Facilitating** safe and secure Remote Care opportunities where geographically dispersed skills and expertise offer enhanced care outcomes.
3. **Empowering** our citizens to care for themselves and take control of their own health and wellbeing via access to personalised online information and advice, thus nurturing Self-Management.
4. Play an active role as a Cheshire and Merseyside area innovator to deliver Digital **Excellence** such as Genomics, Precision Medicine, Research, Process Automation and Clinical Decision Support including Artificial Intelligence.
5. Surface our range of operational data as Historical and Real-Time Information in an appropriate format to aid **Effective Decision Making**.

Warrington & Halton Hospitals Recent Clinical Developments

Investing in Improvement

The Trust has already delivered significant improvements and innovations in clinical care, including investing significant resources in a range of new facilities and developments. These include:

Dementia Care

A £1 million specialist 'Forget-Me-Not' ward for care of patients with dementia was opened at the hospital creating a purpose built care environment for patients with dementia who need expert care services.

Intensive Care

The Trust's £7 million intensive care unit is one of the most state-of-the-art in the region and means that critical care and high dependency care is provided for up to 20 patients.

Emergency Department

Investment of around £2 million in redesigning our ED to create a purpose built resuscitation room with rapid assessment facilities and creation of 'sepsis bay' to support the award-winning sepsis pathway.

Discharge Suite

The new Discharge Suite opened fully in November 2018. The Discharge Suite facilitates earlier patient discharge, improving patient flow and providing a better experience for patients.

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Primary Care Streaming Area

Design and implementation of a bespoke area in ED, where patients presenting with a condition deemed to be manageable by a Primary care clinician, can be 'streamed' away from ED; partly funded by £1 million money awarded from a successful joint bid between the Trust and local CCG for an NHS England initiative. Opened November 2017.

Frailty Assessment Unit (FAU)

The FAU was designed as part of WHH Frailty Strategy in conjunction with the Trust's Frailty Nurse Consultant and the wider clinical team. The FAU consists of a purpose built area adjacent to the emergency department footprint and was created using estates funding from part of the £1 million money awarded from a successful joint bid between the Trust and local CCG for an NHS England initiative.

The FAU works on a "Home First" philosophy providing rapid access to a specialist multi-disciplinary team for people identified as living with frailty. The FAU provides a gold standard Comprehensive Geriatric Assessment within one hour of admission in a dedicated, purpose built area with patients having rapid access to diagnostics. The pilot phase commenced in June 2018 and recent funding was secured from the C&M Health and Social Care partnership to continue and further develop the model for another 12 months.

A3 Combined Cardiology Ward

Capital investment was agreed in 2018 for enabling works to facilitate the co-location of ward C21 and the Coronary Care Unit to create a single specialist cardiology unit on A3. This move has facilitated more streamlined patient pathways to improve quality and experience and reduce length of stay. It also supports the Cardiology team in their vision to create a Cardiology Centre of Excellence.

Women's Services Improvements

The creation of a Gynaecology Assessment Unit on ward C20 in summer 2018 delivers a 7 day assessment service to provide emergency facilities for women with pregnancy complications. Additionally, reconfiguration of the triage systems and the proposal to create a Midwifery Led maternity unit will further enhance the quality of care for our female patients.

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Halton Healthy New Town

The Trust has developed plans to create an innovative and pioneering health and wellbeing campus on the current Halton site. The plans form part of the Healthy New Towns programme supported by NHS England and the Halton proposals have large-scale support from a wide range of partners. The Trust is currently seeking financial support to bring the plans to life in the coming years.

New Warrington Hospital

The Trust is working alongside Warrington Borough Council to progress plans for a new hospital in Warrington. The plans have been formally included in the council's local plan and we are now working closely with council colleagues to identify funding to support a feasibility study on potential sites identified by the council, including our existing hospital site.

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Specialty Visions

Specialty "Vision Statements"

The vision statements below summarise the individual specialty level strategies. These vision statements are supported by detailed specialty level strategic objectives, which are incorporated into business plans on an annual basis.

Clinical Business Unit	Specialty	Vision for the Future
Digestive Diseases	Anaesthetics	To be certified as an Anaesthesia Clinical Services Accreditation accredited service delivered by a robust and highly skilled workforce delivering effective and responsive anaesthetic support across all parts of the organisation.
Digestive Diseases	Pain Management	To work in close collaboration with the Walton Centre (WCNN) team and our commissioners to align our service to the regional direction in relation to neuro and pain services, repatriating Warrington & Halton work back from WCNN where possible.
Digestive Diseases	G.I. Surgery	To expand the Upper GI service through either consultant recruitment or collaboration with nearby acute Trust and to progress plans to provide paediatric endoscopy at Warrington and Halton, enabling our patients to be treated closer to home.
Digestive Diseases	Gastro enterology	Implementation of colorectal optimal pathway to achieve cancer diagnosis standards with Cheshire and Merseyside Cancer Alliance. Development of hepatopancreaticobilliary clinics in the community to address growing demand for hepatatis C treatment alongside alcohol related conditions.
Digestive Diseases	General Surgery	To expand the use of Planned Investigations Unit to provide increased diagnostics and treatments in a dedicated clinical setting. Achieve and embed Keogh Standard 2 through the implementation of extended general surgery 7 day on-call cover. Provide more planned procedures as daycases rather than inpatient stays.
Digestive Diseases /Diagnostics & OPD	Breast Service	To identify and then mobilise a suitable location for the Breast Service, and work in collaboration with St Helens and Knowsley NHS Trust to develop a centre of excellence for assessment services locally.
Diagnostics & OPD	Clinical Haematology	To work in close collaboration with St Helens & Knowsley NHS Trust to develop and implement a service model across both organisations to tackle shared workforce challenges and deliver system-wide improvements in the quality of care for patients.
Diagnostics & OPD	Pathology	To continue to play a key role in the development of an effective and efficient model for pathology services across Cheshire & Merseyside that is fit for the future. Continue to provide local services and GP services as part of a 3 hub model, with one Eastern sector hub.
Diagnostics & OPD	Radiology	To future proof the provision of imaging services at Warrington and Halton by ensuring the right equipment and supporting infrastructure is in the right place alongside the right workforce to continue to deliver the standards of care

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		required against a background of growing demand. This will include continuing to work with the Countess of Chester especially in terms of joint appointments to deliver interventional radiology.
Integrated Medicine & Community	Frailty Service	To continue to work with partner organisations across both Warrington and Halton to further develop the Frailty Hub model of care. Moving towards establishing a robust and effective holistic community model of care to identify patients with frailty conditions and support them to live happy and healthy lives away in their own place of residence for as long as possible.
Integrated Medicine & Community	Dementia	To work with partner organisations across both Warrington and Halton to develop a wider system strategy for the management of dementia, which champions excellent dementia care both inside and outside the trust and empowers, encourages and supports patients living with dementia to make their own decisions.
Integrated Medicine & Community	Care of the Elderly	To build on the work to date to reposition the model of inpatient care for elderly patients by enhancing the role of the wider workforce in rehabilitation and avoiding deconditioning. Also working alongside social care partners to develop and deliver sustainable solutions to intermediate and social care capacity challenges.
Integrated Medicine & Community	Stroke Services	To continue to make progress towards the delivery of a split site stroke service with local partners to consolidate clinical expertise and resources around hyper-acute, acute and stroke rehabilitation care.
Integrated Medicine & Community	Palliative Care	Develop a hub and spoke model for palliative care with WHH as the hub, with community based spokes including hospices. Through hub and spoke palliative care and participation in the serious illness care programme ensure all patients and their families receive individual plans of care at end of life.
Medical Care	Cardiology	To use the creation of the new Acute Cardiac Care Unit as a catalyst for innovation and improvement. Working closely with cardiology teams at St Helens & Knowsley NHS Trust and specialist centres in Liverpool and Manchester as well as primary care colleagues, we will redesign clinical pathways and explore digital technology to provide more home-based treatments and put the Warrington Heart Centre on the map.
Medical Care	Critical Care	To continue to provide all levels of critical care and explore opportunities to provide level 3 care for a wider geographical footprint. Support more patients to receive intravenous medications and ventilation in their own homes.
Medical Care	Diabetes & Endocrinology	To transform diabetes care for our patients through digital innovation supporting a shift of care towards out of hospital management and supporting the growth of self-care and prevention.
Medical Care	Respiratory Medicine	To build on the excellent care provided in the respiratory centre on A7 by linking closely with external partners including the Cancer Alliance to implement new and improved lung cancer pathways and smoking cessation teams. Further develop and enhance links with community providers to support the provision of care closer to home and the promotion of self-care for patients with chronic respiratory conditions.

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Medical Care	Renal Medicine/ Nephrology	To work alongside the team from the Royal Liverpool Hospital to promote nephrology as a stand-alone clinical specialty and to raise the profile and understanding of the service and associated conditions with WHH staff. Maintain specialist input from the Royal Liverpool to ensure Warrington and Halton patients continue to receive a high standard of care. Continue to support identification of all opportunities for organ donation and transplantation to help respond to growing demand.
Medical Care	Neurology	Development of networked clinical pathways in collaboration with the Walton Centre. Focusssing initially on improving pathways for patients with headaches or epilepsy.
Musculoskeletal	Dermatology	To ensure inpatients at both Warrington and Halton hospitals have access to specialist dermatology input as required, through collaboration with other dermatology providers.
Musculoskeletal	Rheumatology	To work more closely with GPs and community colleagues to enable improved out of hospital management of chronic conditions, particularly acknowledging increased incidence of rheumatoid arthiritis and to explore the implementation of fracture liaison service to help prevent fractures.
Musculoskeletal	Therapies/ AHPs	To champion the principles of "*AHPs into action*" by designing and implementing modernised approaches to healthcare with a focus on reablement. Raising the profile of our therapy staff as a core and crucial component of ensuring effective and efficient patient flow both in and out of hospital.
Musculoskeletal	Trauma & Orthopaedics	To maximise the use of our excellent CMTC asset as a thriving regional hub for expert trauma and orthopaedic care linking with other local providers and partners. Alongside adopting modernised and digitally supported pathway improvements to avoid unnecessary hospital attendances.
Specialist Surgery	ENT	To work alongside Alder Hey Children's Hospital NHS FT to develop a model to support the repatriation of local, routine paediatric ENT procedures back to Warrington and Halton – providing care closer to home. To expand the delivery of ENT advice and treatment services outside the hospital trust. Also to work with other local acute trust partners to ensure worforce sustainability.
Specialist Surgery	Ophthalmology	To agree a permanent home for the ophthalmic service at WHH and design that space to deliver perfect patient flow and outstanding care. Work with partners to provide high volume low intensity services in the community and to ensure sustainability of acute surgical on-call.
Specialist Surgery	Orthodontics & Oral Surgery	Explore opportunities to expand our service to reduce waiting times and support fragile services in other local organisations to help ensure that all patients in Cheshire and Merseyside are able to access high quality and timely treatment.
Specialist Surgery	Urology	To modernise the service and ensure that we have the right skills and staff numbers in place to meet the demands of the service. This may involve working with other local providers to ensure the provision of sustainable, high quality services that are fit for the future and will enable us to establish a

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		urology investigations unit.
Specialist Surgery	Cancer Services	To successfully establish Halton as the "Eastern Cancer Hub" for Cheshire & Merseyside working in partnerhip with Clatterbridge Cancer Centre to bring clinical expertise and cutting edge research to improve cancer survival rates in the local population and beyond. Working with partners in the community we will deliver optimal pathways to ensure patients have cancer diagnosed or excluded promptly and receive timely multidisciplinary and holistic care, information and/or treatment and continued support.
Urgent & Emergency Care	Urgent & Emergency Care	To develop and implement plans to create an "Assessment Plaza" to increase the breadth and depth of assessment services at the front door of our hospitals. Also to continue at pace with the redesign of the inpatient assessment floor supported by a dynamic and contemporary workforce model. On our Halton site provide outstanding care in our Urgent Treatment Centre.
Women's & Children's	Obstetrics & Gynaecology	To look to "join up" care between in and out of hospital settings where appropriate ensuring it is safe, responsive, individualised and evidence-based at all times. Provide women with choice and work closely with Liverpool Women's to increase our births, enabling provision of sustainable maternity services.
Women's & Children's	Paediatrics, Paediatric Surgery & Neonates	To work closely with commissioners and regional partner organisations to define the future model of care for children's health across Cheshire and Merseyside, which empowers, protects and nurtures children and their families. Ensuring our care provided is always efficient, effective, responsive, safe, supportive and as close to home as possible with seamless access to specialist care when required, as demonstrated through joint working with Alder Hey.
Clinical Support	Pharmacy	To embed pharmacist prescribing and 7 day ward pharmacy services, supported by e-prescribing, and ensure all of the associated medicines optimisation benefits including those linked to patient care, improved flow and pharmacy support to wards are fully realised. To develop and implement plans to link more closely with community pharmacy, IV and medicines optimisation teams to support early and safe discharge for our patients. To support the safe introduction and use of new and increasingly complex therapeutic modalities.

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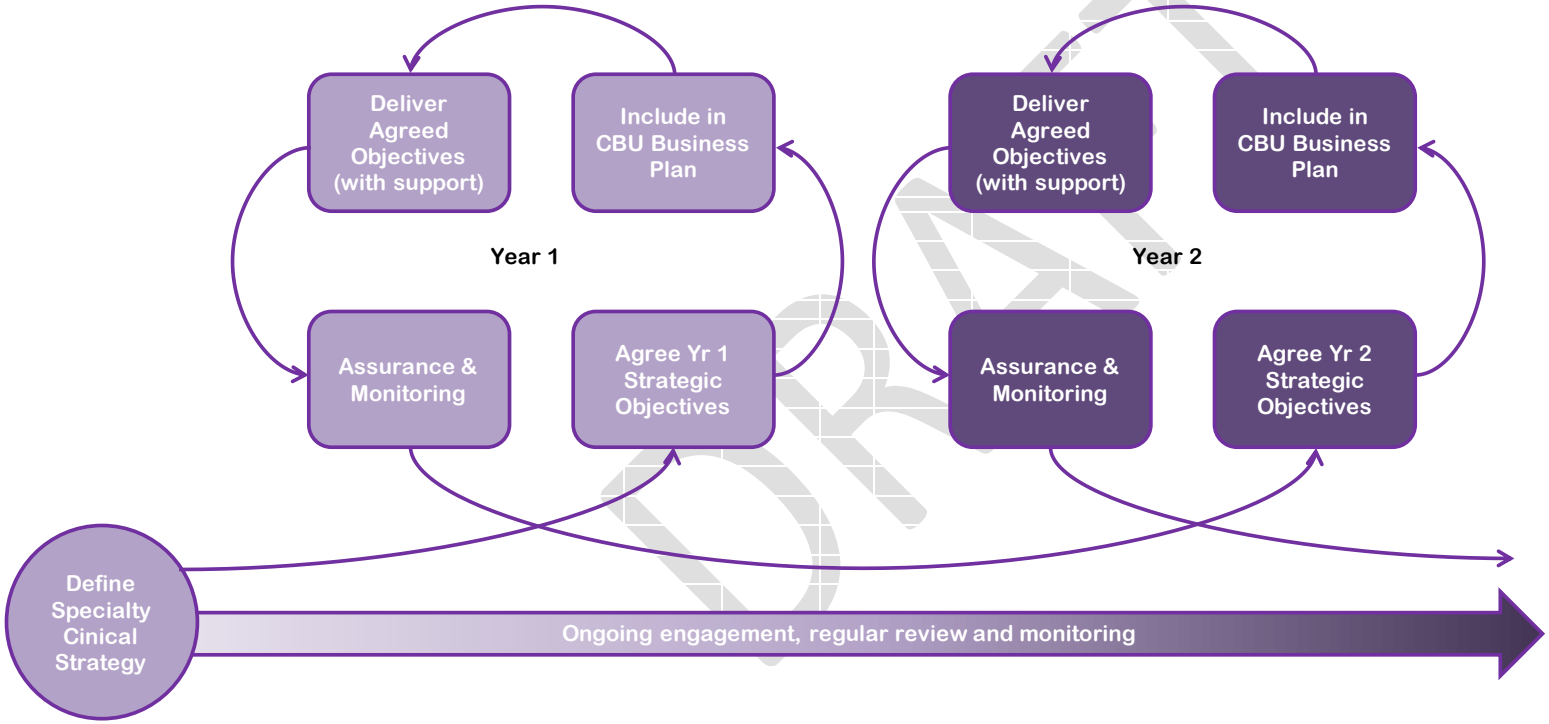
Conclusion

Together the 33 individual specialty strategies will enable Warrington and Halton Hospitals NHS FT to deliver its strategic clinical intent to provide outstanding clinical services for our patients, which are both clinically and financially sustainable. Through continuous improvement, innovations in clinical practice and collaboration with partners we will ensure that our acute services are outstanding and continue to expand our community provision, taking care closer to patients' homes wherever possible and keeping centrally where necessary.



We will continue to deliver our strategic vision through clinically led delivery of specailty level priorities each year, in collaboration with internal and external partners. In addition we will regularly review our clinical strategy at board level to ensure that we continue to respond to the needs of our populations in an ever changing environment.

Acknowledgments

Acknowledgements

There are a number of people/organisations we would like to thank for their inputs into the production of this clinical strategy:

Patients and the public
Warrington and Halton Hospitals NHS Foundation Trust staff, including:

- Clinical Business Unit Managers
- Lead Nurses
- Clinical Directors
- Clinical Leads
- All other representatives from clinical and operational teams that provided inputs
- Strategy & Transformation team

Warrington CCG
Halton CCG
Warrington Together Leadership & Senior Change team
One Halton Leadership team
Warrington Borough Council
Halton Borough Council
St Helens & Knowsley Teaching Hospitals NHS Trust
Bridgewater Community Healthcare NHS Foundation Trust
North West Boroughs Healthcare NHS Foundation Trust
GP Federations
Local Voluntary Sector Organisations
Acute & Specialist Trusts within Cheshire & Merseyside
Cheshire & Merseyside Health & Care Partnership

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We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/19/01/15**
SUBJECT:	**Scheme of Reservation and Delegation (SoRD) and Standing Financial Instructions (SFIs)**
DATE OF MEETING:	30th January 2019
AUTHOR(S):	John Culshaw, Head of Corporate Affairs
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Medical Director & Deputy CEO
LINK TO STRATEGIC OBJECTIVES:	All
	Choose an item.
	Choose an item.
EXECUTIVE SUMMARY (KEY ISSUES):	The review of the SoRD has primarily resulted in updates to the following areas: • Purpose and Scope • Duties and Responsibilities • Regulations and Control • Appointments and Dismissals • Strategy, Plans and Budgets • Audit Arrangements • Monitoring • Table A Further generic amendments have been made to both the type of language and syntax. The review of the SFIs has resulted in amendments to: • Update titles • Reflect current practice • Reflect organisational changes • Remove irrelevant references • Reflect current legislation •

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

RECOMMENDATION:	Discuss and approve the changes and updates to the SoRD & SFIs	
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	

NAME OF COMMITTEE

SUBJECT	Scheme of Reservation and Delegation (SoRD) and Standing Financial Instructions (SFIs)	AGENDA REF:	BM/19/01/15

1. BACKGROUND/CONTEXT

The SoRD details how the powers are reserved to the Board of Directors, while at the same time delegating to the appropriate level the detailed application of Trust policies and procedures.

The SFIs detail the financial responsibilities, policies and procedures to be adopted by the Foundation Trust. They are designed to ensure that its financial transactions are carried out in accordance with the law and government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the SoRD adopted by the Foundation Trust.

Further to the review and approval of Table B of the SoRD by the Board in November 2018, a review has taken place the complete SoRD, in tandem with a review of the SFIs.

The review was conducted by holding 'page turn' meetings to gather input from Executive Leads.

***Please note, due to the size of the documents and for ease of reference during the meeting, a version of the 'track changed' documents and a version of the documents with the changes accepted will be sent separately to the main Board papers.**

Should Governors or other interested parties require copies, they will be available on request

2. KEY ELEMENTS

The review of the SoRD has primarily resulted in updates to the following areas:

- Purpose and Scope
- Duties and Responsibilities
- Regulations and Control
- Appointments and Dismissals
- Strategy, Plans and Budgets
- Audit Arrangements
- Monitoring

- Table A

Further generic amendments have been made to both the type of language and syntax.

The review of the SFIs has resulted in amendments to:

- Update titles
- Reflect current practice
- Reflect organisational changes
- Remove irrelevant references
- Reflect current legislation

3. RECOMMENDATIONS

Discuss and approve the changes and updates to the SoRD & SFIs

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/19/01/16**			
SUBJECT:	**EU Exit Operational Readiness Guidance**			
DATE OF MEETING:	30 January 2019			
AUTHOR(S):	Emma Blackwell, Resilience Manager			
EXECUTIVE DIRECTOR SPONSOR:	Chris Evans, Chief Operating Officer			
LINK TO STRATEGIC OBJECTIVES:	SO1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience			
	Choose an item.			
	Choose an item.			
EXECUTIVE SUMMARY (KEY ISSUES):	To reassure the Board that the Trust is taking account of the provider actions outlined in the EU Exit Operational Readiness Guidance.			
PURPOSE: (please select as appropriate)	Information √	Approval	To note √	Decision
RECOMMENDATION:	To inform and reassure the Trust Board that ongoing pro-active EU Exit planning is taking place in line with information guidance being provided by the Department of Health and Social Care.			
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)***	Choose an item.			

WHH EU Exit Preparation

Introduction

This paper summaries the systems and contingency arrangements put in place by the Trust in preparation for a 'no deal' exit from the EU on the 29th March 2019 and assesses the current state of preparedness in relation to the actions for providers contained in the Department of Health and Social Care (DHSC) EU Exit Operational Readiness Guidance (December 2018).

Leadership

- Chris Evans, Chief Operating Officer and Accountable Emergency Officer is the Trust's Senior Responsible Officer for EU Exit preparation.
- Emma Blackwell, the Trust Resilience Manager is taking the Operational Lead in co-ordinating information, guidance and work streams to avoid duplication.
- A Brexit Working Group has been established, chaired by the Chief Operating Officer with representation at senior level from key areas of the Trust including Finance, Supplies, Pharmacy, HR and IM&T. The group meet formally to update plans and monitor progress and review new information and guidance as it becomes available. The group report into the Trust wide Event Planning Group which meets on a monthly basis.
- Members of the Brexit Working Group participated in a Cheshire Resilience Forum EU exit exercise which took place on the 14th January 2019.
- The Trust wide Business Continuity Plan was updated in November 2018 and provides detail of the command and control structure which would be implemented in the event of a disruption.
- The Trust Board have been briefed on preparedness for a no deal EU exit in September and November 2018 and January 2019.

Risk assessment and business continuity planning

The risks associated with a 'no-deal' exit from the EU have been added onto the Trust Strategic Risk Register and has been rated as a 16, this has been based on a worst case scenario. It is acknowledged that due to the uncertainty around any issues that may be caused due to a 'no deal' exit it is difficult to quantify the exact impact this will have on the organisation.

Under both the Civil Contingencies Act (2005) and the NHS England Emergency Preparedness, Resilience and Response Framework (2015) the Trust is required to have robust Business Continuity Plans in place. Business Continuity Plans have been developed for each service area and there is an overriding corporate document which was updated in November 2018.

The seven key areas that have been identified in the EU Exit Operational Readiness Guidance have all been risk assessed by the Heads of Department the outcomes and actions to date are summarised in the operational readiness tracker found in appendix 1.

Communication and escalation

Staff will be informed of the latest information, developments and potential impacts to the Trust via:-

- Daily Trust wide Safety Huddles
- Weekly staff communication bulletin reporting news and information to staff
- Trust Intranet for staff
- Public facing web site
- Targeted dissemination of national and regional guidance

The escalation route for issues potentially arising from the EU Exit is:

Reported by	Report to	Method
WHH Staff	Head of Department/ CBU Management Team	Email
Head of Department/ CBU Management Team	Resilience Manager	Emma.blackwell3@nhs.net
Resilience Manager	Chief Operating officer (SRO)	Chris.evans6@nhs.net
Chief Operating Officer (SRO)	Regional EU Exit Lead	England.euexitnorthwest@nhs.net

The DHSC has set up a national Operational Response Centre that will lead on responding to any disruption to the delivery of health and care services in England that may be caused or affected by the EU Exit.

Command and Control arrangements

The Trust operates a robust two tier on-call management system which enables senior managers to be contacted quickly in the event of an incident or operational problem outside of normal working hours. The arrangements for Friday 29th March and the weekend are:-

Date	Senior Manager	Executive
Friday 29th March 2019	Tom Liversedge	Dan Moore
Saturday 30th March 2019	Mark Rigby	Kimberley Salmon-Jamieson
Sunday 31st March 2019	Mark Rigby	Kimberley Salmon-Jamieson

Historically, staff are asked to ensure all annual leave is taken before the end of March. Managers need to review annual leave for the last week in March to ensure adequate arrangements can be implemented if we have to establish command and control arrangements.

Conclusion

The Trust continues to work on the latest national guidance to ensure we are prepared for any risks that may arise due to a 'no deal' exit. The actions for providers detailed in the Operational Readiness Guidance have been completed and will continue to be monitored via the Brexit working group.

Appendix 1 – Operational Readiness Track

Operational readiness tracker.xlsx

WHH EU Exit Operational Readiness @ 21.01.19

Ref	Area of activity	Lead	Action	Self Assessment RAG rating	Update	Issues
1	Supply of medicines and vaccines	Maria Keeley	Follow the Secretary of State's message not to stockpile additional medicines beyond their business as usual stock levels. No clinician should write longer prescriptions for patients.		Information was shared with the Pharmacy Team at the Safety Brief. Laminated action cards prepared and are available for staff to refer to.	
2	Supply of medicines and vaccines	Maria Keeley	Direct staff to promote messages of continuity and reassurance to people who use health and care services, including that they should not store additional medicines at home.		Information was shared with the Pharmacy Team at the Safety Brief. Laminated action cards prepared and are available for staff to refer to.	
3	Supply of medicines and vaccines	Maria Keeley	Be aware that UK-wide contingency plans for medicines supply are kept under review, and the Department will communicate further guidance as and when necessary.		Information was shared with the Pharmacy Team at the Safety Brief. Laminated action cards prepared and are available for staff to refer to.	
4	Supply of medicines and vaccines	Maria Keeley	Continue to report current shortage issues and escalate queries for medicine supply issues unrelated to current shortages through existing regional communication channels.		Information was shared with the Pharmacy Team at the Safety Brief. Laminated action cards prepared and are available for staff to refer to.	
5	Supply of medicines and vaccines	Maria Keeley	Meet at a local level to discuss and agree local contingency and collaboration arrangements. The Chief Pharmaceutical Officer will hold a meeting with the chairs of regional hospital and CCG Chief Pharmacist networks (and representatives of private hospital Chief Pharmacists) in January 2019 to help inform local plans.		Diane Matthew Chief Pharmacist will link into this network, and report back.	

6	Supply of medical devices and clinical consumables	Alison Parker	Note that there is no need for health and adult social care providers to stockpile additional medical devices and clinical consumables beyond business as usual stock levels. Officials in the Department will continually monitor the situation and if the situation changes, will provide further guidance by the end of January 2019.		A further communication has been issued by DHSC providing an update to the Self -Assessment Review. As a result DHSC has extended the number of suppliers to be managed centrally. A Q&A webinar has been held on the 17.01.19. The DHSC did not provide any assurance on plans in place. The Q&A was for non-clinical produces only (excluding food). It was stated that there is too much information to share, some information is commercially sensitive and there was a discrepancy of how many suppliers managed centrally has response (one stated 20% one stated 80%). The DHSC will look at the possibility of putting together a timeline. A communication will be issued w/c 21.01.19 around clinical consumable and they are hoping to issue guidance of food if some key ingredients are not available Questions that we not able to be asked have been emailed to DHSC directly: 1. How assured are you from the work you have undertaken regarding continuity of supply 2. What % of suppliers has responded that enable a detailed risk assessment to be undertaken for effective planning purposes. For those that haven't responded what plans are in place 3. With regard to food, what alternative are in place if fresh produce is stuck at ports 4. In terms of six weeks stock holding, is this perpetual or a finite six weeks – if finite what do you expect to have changed in six weeks that brings us back to business as usual 5. When will further details of the contingency plans in place be shared 6. What happens in your contingency plans fail	Alternative products may be offered without prior notice No clear plans and guidance issued from DHSC to provide assurance
7	Supply of medical devices and clinical consumables	Alison Parker	Send queries about medical devices and clinical consumables provided by NHS Supply Chain to your usual contact. If you receive medical devices and clinical consumables from other suppliers, you should contact them directly with any queries as you would normally do.		For those suppliers to be managed locally the Procurement Team is making further contact with them to see if they have updated plans following the recent Self-Assessment and parliamentary vote rejecting the deal that took place on the 15.01.19. We will assess the extend of the use of those suppliers and if they are alternatives in place; alternative suppliers would however, be faced with the same issues	Suppliers have not fully developed their plans as they are waiting for further information from the government
8	Supply of medical devices and clinical consumables	Alison Parker	Send queries regarding medical devices and clinical consumables to mdcc-contingencyplanning@dhsc.gov.uk.		No further action required other than to comply	
9	Supply of non-clinical consumables, goods and services	Alison Parker	Be aware that NHS Trust and Foundation Trust procurement leads have been asked to undertake internal reviews of purchased goods and services to understand any risks to operations if there is disruption in supply. This excludes goods and services that are being reviewed centrally, such as food, on which the Department has written to procurement leads previously.		The Self-Assessment issued by the DHSC has been completed and returned by the due date of the 30.11.18. For those suppliers to be managed locally the Procurement Team is making further contact with them to see if they have updated plans following the recent Self-Assessment and parliamentary vote rejecting the deal that took place on the 15.01.19. We will assess the extend of the use of those suppliers and if they are alternatives in place; alternative suppliers would however, be faced with the same issues	

10	Supply of non-clinical consumables, goods and services	Alison Parker	Continue commercial preparation for EU Exit as part of your usual resilience planning, addressing any risks and issues identified through your own risk assessments that need to be managed locally.		For those suppliers to be managed locally the Procurement Team is making further contact with them to see if they have updated plans following the recent Self-Assessment and parliamentary vote rejecting the deal that took place on the 15.01.19. We will assess the extend of the use of those suppliers and if they are alternatives in place; alternative suppliers would however, be faced with the same issues	
11	Supply of non-clinical consumables, goods and services	Alison Parker	Continue to update local business continuity plans to ensure continuity of supply in a 'no deal' scenario. Where appropriate, these plans should be developed in conjunction with your Local Health Resilience Partnership		Supplies BCP updated 18.1.19. A further update to the plan will be made, in the coming weeks as the situation re-Brexit becomes clearer	
12	Supply of non-clinical consumables, goods and services	Alison Parker	Submit the results of their self-assessment on non-clinical consumables, goods and services to contractreview@dhsc.gov.uk, if not done so already.		Completed by the due date of the 30.11.19	
13	Supply of non-clinical consumables, goods and services	Alison Parker	Act upon further guidance to be issued by the Department in January 2019. This will be based on analysis of NHS Trusts and Foundation Trusts' self-assessments.		A further communication has been issued by DHSC providing an update to the Self -Assessment Review. As a result DHSC has extended the number of suppliers to be managed centrally. A Q&A webinar has been held on the 17.01.19. See comments above in relation to this	
14	Workforce	Amanda Jordan	Assess whether your organisation has incurred a reduction in the number of EU nationals in your workforce before the UK leaves the EU.		The number of EU starters in 2017 and 2018 was 23 and 11 respectively. The number of EU leaver in 2017 and 2018 was 9 and 13 respectively. The number of EU nationals has therefore remained relatively stable and this does not present a risk to the Trust.	Need to put some reporting in place to monitor starters and leavers from the EU over the coming months. This will report through the Trust's Brexit group and through OPC and SPC.
15	Workforce	Amanda Jordan	Publicise the EU Settlement Scheme to your health and care staff who are EU citizens.		The Trust was a pilot site with the Home Office for the EU Settlement Scheme in September 2018, with a follow up session in December 2018 prior to the launching the scheme to the public. 29/97 of our potentially affected staff engaged in the pilot. Once the scheme is launched nationally to the public we will continue to publicise and encourage our staff to make early applications. This is expected by 30th March 2019.	To retain these rights to live work in the UK **after 31 December 2020**, EU citizens must apply for UK immigration status under the EU Settlement Scheme. Further guidance is expected on implications of those affected haven't applied or been granted settled status by this time and we continue to monitor government guidance.
16	Workforce	Amanda Jordan	Monitor the impact of EU Exit on your workforce regularly and develop contingency plans to mitigate a shortfall of EU nationals in your organisation, in addition to existing plans to mitigate workforce shortages. These plans should be developed with your Local Health Resilience Partnership, feed into your Local Resilience Forum(s) and be shared with your local commissioner(s). Consider the implications of further staff shortages caused by EU Exit across the health and care system, such as in adult social care, and the impact that would have on your organisation.		Workforce data demonstrates that the EU workforce is relatively stable (see above). Assumption is that the 29 who have already applied for settled status will remain. The Trust is linked into the Resilience forum and will provide data as required. The Trust already has retention and recruitment plan due to staff vacancies, this is intended to mitigate some of the risk of further staff shortages.	Need to put some reporting in place to monitor starters and leavers from the EU over the coming months. This will report through the Trust's Brexit group and through OPC and SPC.
17	Workforce	Amanda Jordan	Undertake local risk assessments to identify any staff groups or services that may be vulnerable or unsustainable if there is a shortfall of EU nationals.		A review of workforce data demonstrates that EU national are generally proportioned across all services of the trust and no specific staff groups or services can be identified as at risk.	Ongoing monitoring will be required as above.
18	Workforce	Amanda Jordan	Ensure your board has approved business continuity plans that include EU Exit workforce planning, including the supply of staff needed to deliver services.		Not currently in place but no risk currently identified.	
19	Workforce	Amanda Jordan	Notify your local commissioner and regional NHS EU Exit Team at the earliest opportunity if there is a risk to the delivery of your contracted services.		No current risk identified.	Ongoing monitoring will be required as above.

20	Workforce	Amanda Jordan	Escalate concerns through existing reporting mechanisms.		Issues will be reported via the Director of HR&OD and the BREXIT sub group chaired by the COO.	
21	Workforce	Amanda Jordan	Send queries on workforce to WorkforceEUExit@dhsc.gov.uk.		Queries regarding the EU Settlement Scheme have been fed in to the home office via the pilot phase undertaken at the trust. Further queries will be forwarded as they arise.	
22	Professional regulation	Amanda Jordan	Inform your staff that health and care professionals (including UK citizens), whose qualification has been recognised and who are registered in the UK before 23:00 on 29 March 2019, will continue to be registered after this point.		Need to review the regulations and liaise with the recruitment team.	No active EU recruitment at present.
23	Professional regulation	Amanda Jordan	Inform your staff that health and care professionals (including UK citizens), who apply to have their qualification recognised in the UK before 23:00 on 29 March 2019, will have their application concluded under current arrangements.		Need to review the regulations and liaise with the recruitment team.	No active EU recruitment at present.
24	Professional regulation	Amanda Jordan	Await further information from the Government on the future arrangements for health and care professionals (including UK citizens) with an EU/EEA or Swiss qualification, who apply to have their qualification recognised in the UK from 23:00 on 29 March 2019.		The Trust continues to wait for further government guidance on this issue.	Lack of clarity on this issue may result in issues for existing candidates and new candidates post EU exit date which could affect the ability to recruit to key vacancies.
25	Reciprocal Healthcare	Steve Barrow	Note that, in a no deal scenario, the current arrangements for reciprocal healthcare and for overseas visitors and migrant cost recovery will continue to operate until 29 March 2019, depending on the reciprocal agreements that are concluded.		The guidance has been cascaded to those mangers and staff that identify and charge for overseas visitors.	No issues identified at the current time.
26	Reciprocal Healthcare	Steve Barrow	Continue to support individuals who apply for NHS authorised treatment or maternity care in another member state (the S2 and cross-border healthcare processes).		The guidance has been cascaded to those mangers and staff that identify and charge for overseas visitors.	No issues identified at the current time.
27	Reciprocal Healthcare	Steve Barrow	Maintain a strong focus on correctly charging those who should be charged directly for NHS care.		The guidance has been cascaded to those mangers and staff that identify and charge for overseas visitors.	No issues identified at the current time but training will be required should reciprocal arrangements change.
28	Reciprocal Healthcare	Steve Barrow	Ensure there is capacity available for any further training that may be required if there are changes to the reciprocal healthcare arrangements. This should be undertaken by the Overseas Visitor Management team, and guidance and support materials will be made available to support this training.		The guidance has been cascaded to those mangers and staff that identify and charge for overseas visitors.	No issues identified at the current time but training will be required should reciprocal arrangements change.
29	Research and clinical trials	Nemonie Marriott	Note that the Government has guaranteed funding committed to UK organisations for certain EU funded projects in the event of a 'no deal' scenario. This includes the payment of awards where UK organisations successfully bid directly to the EU while we remain in the EU, and the payment of awards where UK organisations are able to successfully bid to participate as a third country after exit, until the end of 2020.		N/A	
30	Research and clinical trials	Nemonie Marriott	Provide information about your Horizon 2020 grant. This should be actioned as soon as possible. Further guidance can be found here and all queries should be sent to EUGrantsFunding@ukri.org.		N/A	
31	Research and clinical trials	Nemonie Marriott	Contact officials at EU-Health-Programme@dhsc.gov.uk with information regarding your Third Health Programme grant, and any queries that you have, as soon as possible.		N/A	

32	Research and clinical trials	Nemonie Marriott	Follow the Government's guidance on the supply of investigational medicinal products (IMPs) for clinical trials in a 'no deal' scenario, if you sponsor or lead clinical trials or clinical investigations in the UK.		N/A WHH does not act as a sponsor	
33	Research and clinical trials	Nemonie Marriott	Consider your supply chains for those IMPs, medical devices, in vitro diagnostic devices, advanced therapy medicinal products, radioisotopes and other clinical consumables, used in clinical trials and investigations, which originate from, or travel through, the EU and EEA as soon as possible if you sponsor or lead clinical trials or investigations in the UK.		N/A WHH does not act as a sponsor	
34	Research and clinical trials	Nemonie Marriott	Liaise with trial and study Sponsors to understand their arrangements to ensure that clinical trials and investigations using IMPs, medical devices, IVDs, advanced therapy medicinal products, radioisotopes and other clinical consumables which come from, or via, the EU or EEA, are guaranteed in the event of any possible border delays. If multiple sites are involved within the UK, then co-ordinate with the lead site or Chief Investigator in the UK, or organisation managing the clinical trial/investigation, e.g. Clinical Research Organisation, to ensure a single approach to the Sponsor.		WHH is currently in contact with trial sponsors and Clinical Research Organisations.	
35	Research and clinical trials	Nemonie Marriott	Respond to any enquires to support the Department's comprehensive assessment of the expected impact of a 'no deal' exit on clinical trials and investigations. The Department is working closely with the NHS to gain a greater understanding of who might be affected by supply issues.			
36	Research and clinical trials	Nemonie Marriott	Continue participating in and/or recruiting patients to clinical trials and investigations up to and from 29 March 2019. This should occur unless you receive information to the contrary from a trial Sponsor, organisation managing the trial or clinical investigation, or from formal communications that a clinical trial or clinical investigation is being impacted due to trial supplies.			
37	Data sharing, processing and access	Alison Jordan	Investigate your organisation's reliance on transfers of personal data from the EU/EEA to the UK, especially those that are critical to patient care and/or would have a serious impact upon the system if they were disrupted.		Statutory instrument in place that deems EU countries as adequate. Guidance on data sharing with EU countries will be released by the ICO in February 2019.	Completion of all flow mapping to identify data processed in the EU is incomplete
38	Data sharing, processing and access	Alison Jordan	Note that many organisations tend not to disaggregate personal and non-personal data. As such, please be aware that restrictions on personal data may have knock-on effects on data more generally.		See below	See below
39	Data sharing, processing and access	Alison Jordan	Follow the advice from The Department for Digital, Culture, Media and Sport and the ICO on data protection in a 'no deal' scenario, which can be viewed on gov.uk and on the ICO website, in particular to determine where to use and how to implement standard contractual clauses.		Flow mapping to identify cloud computing whereby data flows are regarded as international transfers because data is processed or stored outside of the UK.	Paper to IGCRSC on adequacy decision of UK and it's impact if European Commission determines that UK is not adequate. Appropriate safeguards of EEA senders of data to UK which may be outside of EEA.

40	Data sharing, processing and access	Alison Jordan	Ensure that your data and digital assets are adequately protected by completing your annual Data Security and Protection Toolkit assessment. This self-audit of compliance with the 10 Data Security Standards is mandatory to complete by the end of March 2019, but completing it early will enable health and adult social care providers to more quickly identify and address any vulnerabilities.		DSP Toolkit assessment submitted in October 2018. March 2019 assessment will be completed as part of IG work plan. DSP Toolkit action plan is a standing agenda item at the Information Governance and Corporate Records Sub-Committee which reports to Quality Assurance Committee.	DSP Toolkit action plan report to IGCRSC shows areas of weakness and non-compliance with some mandatory standards.
41	Finance	Steve Barrow	Record costs (both revenue and capital) incurred in complying with this guidance. Costs with a direct financial impact should be recorded separately to opportunity costs. Providers should discuss these costs with their regional NHS EU Exit support team. Feedback from providers will inform decisions on whether further guidance on cost collection is required.		In order to complete the suppliers self assessment tool agency staff were used within the procurement team for a period of 3 weeks at a cost of £2,000.	No further issues identified at the current time but additional costs will continue to be collated.

From the Permanent Secretary
Sir Chris Wormald

39 Victoria Street
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permanent.secretary@dh.gsi.gov.uk

21 December 2018

To: All Providers and Commissioners of NHS Services

Dear Colleagues,

EU Exit Operational Readiness Guidance for the health and care system

Earlier this month, the Secretary of State for Health and Social Care issued information on the Government's revised border planning assumptions to industry and the health and care system. These letters focused on supply chain implications in the event that the United Kingdom (UK) leaves the European Union (EU) without a ratified agreement on 29 March 2019 – a 'no deal' exit.

As you will be aware, the Government and the EU have now agreed the basis upon which the UK will leave the EU in March 2019. 'No deal' exit is not the Government's policy, but it is our duty to prepare for all scenarios. Since the Secretary of State's letter in August, and with the assistance of our arm's-length bodies and industry, the Department for Health and Social Care has strengthened its national contingency plans for 'no deal'. With just over three months remaining until exit day, we have now reached the point where we need to ramp up 'no deal' preparations. This means the Department, alongside all other government departments, will now enact the remaining elements of our 'no deal' plans.

Delivering the deal remains the Government's top priority and is the best 'no deal' mitigation. But in line with the Government's principal operational focus on national 'no deal' planning, actions must now be taken locally to manage the risks of a 'no deal' exit.

To inform preparations, I have included the EU Exit Operational Readiness Guidance alongside this letter, which has been developed and agreed with NHS England and Improvement. This guidance sets out the local actions that providers and commissioners of health and adult social care services in England should take to prepare for EU Exit. The guidance will also be shared with colleagues in the devolved

Department of Health & Social Care

administrations to assist them with their preparations as part of UK-wide contingency plans.

This guidance will be sent to all health and care providers, including adult social care providers. I recognise that, while health and social care face similar issues, there is some variation. I am therefore sending a letter in parallel to local authorities and adult social care providers.

The Department, with the support of NHS England and Improvement, and Public Health England, has set up a national Operational Response Centre. This will lead on responding to any disruption to the delivery of health and care services in England, that may be caused or affected by EU Exit. The Operational Response Centre will co-ordinate EU Exit-related information flows and reporting across the health and care system.

The Operational Response Centre will also work closely with all of the devolved administrations to ensure a co-ordinated approach across the UK. The Operational Response Centre will not bypass existing regional reporting structures; providers and commissioners of NHS services should continue to operate through their usual reporting and escalation mechanisms.

NHS England and Improvement will also establish local, regional and national teams to enable rapid support on emerging local incidents and escalation of issues into the Operational Response Centre as required.

NHS providers and commissioners will be supported by NHS England and Improvement local teams to resolve issues caused or affected by EU Exit as close to the frontline as possible. These issues will be escalated to regional level, as required. Where issues are impacting across the health and care system at a national level, the Operational Response Centre will co-ordinate information flows and responses.

In addition to operational support, I recognise the uncertainty that you face, and the Government will therefore continue to update you, as necessary, to inform your preparations for EU Exit.

I encourage you to view the relevant gov.uk page which contains all the relevant information published by the Department, as well as other government departments. This page will be updated regularly so that everyone is aware of developments and actions to take.

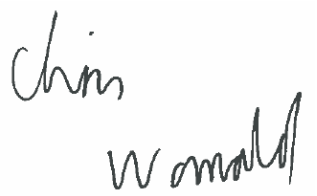
Finally, I would like to thank you and your teams for your continued hard work and for the efforts that lie ahead. I would also like to thank the many national organisations who are contributing to the Department's EU Exit work. Your dedication to

From the Permanent Secretary
Sir Chris Wormald

Department of Health & Social Care

implementing readiness plans for EU Exit and maintaining a world-leading health and care service are greatly appreciated.

Yours sincerely,



SIR CHRIS WORMALD
PERMANENT SECRETARY