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NHS
Warrington and
Halton Hospitals
NHS Foundation Trust

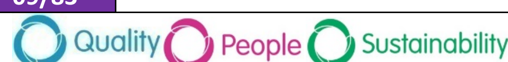
WHH Board of Directors Meeting Part 1

Wednesday 26th September 2018
9.30am-1.00pm
Trust Conference Room

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

Wednesday 26 September 2018 time 09.30 -1.00pm
Trust Conference Room, Warrington Hospital

REF BM/18	ITEM	PRESENTER	PURPOSE	TIME	
BM/18/ 09/78	Organ Donation Presentation – Cara Hart, Specialist Nurse for Organ Donation & Andy Higgs, Consultant		Presentation	09.30	N/A
BM/18/ 09/79	Welcome, Apologies & Declarations of Interest	Steve McGuirk, Chairman	N/A	09.45	Verbal
BM/18/ 09/80	Minutes of the previous meeting held on 25 July 2018	Steve McGuirk, Chairman	Decision	09.50	Encl
BM/18/ 09/81	Actions & Matters Arising	Steve McGuirk, Chairman	Assurance		Encl
BM/18/ 09/82	Chief Executive's Report incl: (a) NHSI elective care (b) Brexit Contingency Planning (Briefing note to be provided by CE) (c) Summary of NHS Providers Board papers	Simon Constable Executive Medical Director & Deputy Chief Executive	Assurance	09.55	Verbal
BM/18/ 09/83	Chairman's Report	Steve McGuirk, Chairman	Information	10.05	Verbal



REF BM/18	ITEM	PRESENTER	PURPOSE	TIME	
BM/18/ 09/84	Integrated Performance Dashboard M5 and Assurance Committee Reports - Pg 33	All Executive Directors	Assurance	10.15	Enc
(a)	- Quality Dashboard incl: ○ Monthly nurse staffing report	Kimberley Salmon-Jamieson Chief Nurse			Enc
(b)	- Key Issues report Quality and Assurance Committee (4.09.2018)	Margaret Bamforth, Committee Chair			Enc
(c)	- Sustainability Dashboard - Finance and Sustainability Committee (22.08.2018 + [19.09.2018 to be tabled])	Terry Atherton, Committee Chair			Enc
(d)	People Dashboard - Strategic People Committee (19.09.2018 To be tabled) refreshed ToR & Workplan	Anita Wainwright, Committee Chair			
BM/18/ 09/85	Spinal Services Update	Simon Constable Deputy Chief Executive/ Executive Medical Director	Assurance	10.45	Verbal

REF BM/18	ITEM	PRESENTER	PURPOSE	TIME	
BM/18/ 09/86	Annual Health + Safety Report – Pg 141	Kimberley Salmon-Jamieson Chief Nurse	Assurance	10.55	Enc
BM/18/ 09/87	Director of Infection Prevention and Control (DIPC) (a) Annual Report – pg 163 (b) Quarterly report – pg 221	Kimberley Salmon-Jamieson Chief Nurse	Assurance	11.05	Enc

BM/18/ 09/88	CQC Update Report – pg 232	Kimberley Salmon-Jamieson Chief Nurse	Assurance	11.15	Enc
BM/18/ 09/89	Safeguarding Children's Annual Report – pg 250	Kimberley Salmon-Jamieson Chief Nurse	Assurance	11.25	Enc
BM/18/ 09/90	Quarterly Mortality Review report – pg 280	Simon Constable Executive Medical Director & Deputy Chief Executive	Assurance	11.30	Enc
BM/18/ 09/91	Flu Campaign 2017 / 18 – Lessons Learned – pg 292	Michelle Cloney Director of HR & OD	Assurance	11.35	Enc

BM/18/ 09/92	Emergency Preparedness Annual Report – pg 308	Chris Evans Chief Operating Officer	Assurance	11.40	Enc

People

BM/18/ 07/93	Bi-Annual Nurse Staffing Report – pg 317	Kimberley Salmon-Jamieson Chief Nurse	Assurance	11.45	Enc
BM/18/ 09/94	GMC Re-validation Annual Report – pg339	Simon Constable Executive Medical Director & Deputy Chief Executive	Assurance	11.55	Enc
BM/18/ 09/95	Freedom to Speak up - Guardian Bi-Annual report & Toolkit – pg 350	Jane Hurst Deputy Director of Finance	Assurance	12.00	Enc
BM/18/ 09/96	Warrington & Halton Hospitals FT and Warrington and Vale Royal College Memorandum of Understanding – pg 384	Michelle Cloney Director of HR & OD	Decision	12.10	Enc
BM/18/ 07/97	Guardian of Safe Working Quarterly Report – pg 391	Alex Crowe Medical Director	Assurance	12.20	Enc
BM/18/ 09/98	People Strategy – pg 407	Michelle Cloney Director of HR & OD	Approval	12.30	Enc

GOVERNANCE

BM/18/ 09/99	Strategic Risk Update – pg 421	John Culshaw Head of Corporate Affairs	Assurance	12.40	Enc
BM/18/ 09/100	Risk Management Strategy Annual Report – pg 434	Kimberley Salmon-Jamieson Chief Nurse	Assurance	12.45	Enc

BM/18/ 09/101	Any Other Business	Steve McGuirk, Chairman	N/A	12.50	Verbal
	Date of next meeting: 28 November 2018				

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Warrington and Halton Hospitals NHS Foundation Trust
Minutes of the Board of Directors meeting held in Public (Part 1) on Wednesday 25 July 2018
Trust Conference Room, Warrington Hospital

Present	
Terry Atherton (TA)	Deputy Chair, Non-Executive Director
Mel Pickup (MP)	Chief Executive
Margaret Bamforth (MB)	Non-Executive Director
Simon Constable (SC)	Executive Medical Director/ Deputy Chief Executive
Chris Evans (CE)	Chief Operating officer
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 (LG)	Director of Transformation
Pat McLaren (PMcL)	Director of Community Engagement
Joanna Craven (JCr)	Foundation Yr 1 Junior Doctor
Michelle Cooper (MC)	Foundation Yr 1 Junior Doctor
Rezhaw Karadaghi (RK)	Foundation Yr 1 Junior Doctor
Julie Burke (JB)	Secretary to Trust Board (Minutes)
Observing	
Dalton Boot	Public Governor
Norman Holding	Lead Governor
Alison Kinross	Public Governor
Apologies	
Steve McGuirk (SMcG)	Chairman
Jean-Noel Ezingeard (JNE)	Non-Executive Director

Agenda Ref BM/18/07/	
BM/18/07/57	**Junior Doctor Update/Trainee Engagement** Joanna provided a summary of progress to-date to develop Trello, which is a free App to support development of workstreams. Ways to improve communication with Junior Doctors had been raised through the Jnr Doctors Forum to help understand where gaps were occurring. Joanna had facilitated the utilisation of the App for workstreams between Doctors and the Trust. Work 'Boards' in the App had been developed and membership groups set up to enable Doctors to be able to see work within each workstream and add to these as appropriate. Work commenced in December 2017, there are 36 members and 8 active workstreams contributing to improved quality of services, service improvement and management/ leadership for Jnr Doctors to work alongside management. Two workstreams have been completed, a specialist training programme and a surgical teaching programme which includes changes in Jnr Doctor handover. Trello is part of the Jnr Doctor Induction Programme to raise awareness. It is hoped an increased number of Jnr Doctors sign up to Trello, particularly SHO and above within the next 3-6 months, and use of the App

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	encouraged. In 12 months the aspiration is to have an established program within the Trust which can be used alongside the Jnr Doctors Forum to generate quality improvement within the hospital and improve conditions for juniors AW thanked JC for her summary and asked how as NEDs they could support and encourage sign up to use of the App to increase the number of users, Michelle said this will vary within each workstream but would aid better communication between senior managers and Junior Doctors. In terms of administration JCr explained all users can amend any board, a lead for each is required but this is not an onerous task and would not result in or adversely impact on where there are rotations. The work had provided the opportunity to meet with registrars and develop foundation teaching programmes. AC had been instrumental in his support, supporting when issues had been identified and allowing clinicians to find solutions to resolve these issues. Further endorsement by the Board would support this further and JCr reassured the Board that it would not be perceived that the Board were overseeing the work associated with Trello. Information had been shared through the Quality Academy and Medical Cabinet. **The Board wholeheartedly validated and supported the approach and look forward to receiving an update in 6 months on progress and thanked the Doctors for their presentation.** **Role Model Badge**. TA presented Margaret Bamforth, Non-Executive Director a WHH Role Model badge to recognise her contribution and valued support Deputising for the Chairman at the Trust's NHS 70th Birthday celebrations on 5 July.
BM/18/07/58	**Welcome, Apologies & Declarations of Interest** The Chair opened the meeting, introductions were made and newly elected Governor Dalton Boot was welcomed to the meeting. Apologies: as above. Declarations of Interest: None were noted
BM/18/07/59	**Minutes of the meeting held 27 June 2018** The minutes of 27 June 2018 were agreed as an accurate record of proceedings.
BM/18/07/60	**Actions and Matters Arising** Outstanding / ongoing actions were noted. The remaining action was on the agenda.
BM/18/07/61	**Chief Executive's report** MP provided an update on matters for the Board to note since the last meeting. The Trust had ran a number of events as part of the NHS 70th birthday celebrations, culminating in a day of celebrations on 5 July throughout the hospital for staff and patients with a Tea-Dance at Halton on 4 July and a very successful Dragon Boat event at the beginning of the month. Recognition and thanks were extended to the Communications and Engagement Team for their contribution in organisation of these events. MP explained progress relating to C&M Healthcare Partnership where there is a recognition that changes are needed system-wide for a sustainable health and social care system. The Partnership had convened in September with an emphasis on the development of local based systems and has established workstreams to support delivery of transformational change. A Transformation Fund had been established to pump prime projects, top sliced from CCG allocations of £7m to be released in 2 waves, the first in June and second in September. Each 'Place' was able to bid a maximum of £500k through a discretionary programme. Funds will

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	be disseminated nationally with £50k available for similar clusters of service within similar communities which will make up the overall 'Place' in C&M of which there are 9. Warrington bid supported to strengthen care to be delivered to patients who may use A&EC or have conditions amenable to ambulatory care and Warrington had received £500k. Members of the Executive Team are members of the Senior Change Team with other key staff. The transformational bid for Halton had not been successful, initial decision had been not to submit a bid but feedback had now been given to Halton to strengthen their bid, to deliver a hub as an alternative to hospital admissions. The Healthcare Partnership had submitted a revised capital bid to DoH for consideration in Wave 4 capital allocations. Each Partnership had submitted revised bids to be costed centrally with outcome of successful bids expected in September. Warrington had prioritised 1 bid to mark early intention of a new hospital for Warrington which had been fully supported by all Board members acknowledging funding will not be awarded in this round of bids. The Halton bid was for Halton Healthy New Town (HHNT) and a further third iteration will be submitted, this was the only bid submitted from Halton Place on 16 July. MP informed the Board that a HHNT Design event had recently taken place with a number of staff to designing any future proposals for services that could be delivered out of Halton, the aspiration continues for this, with the outcome of the bid expected in the Autumn, with continued close working with herself and the SRO of Halton Place. In relation to a new hospital for Warrington a second meeting had taken place with Commissioners, Councillors, including the Chair of the Health Scrutiny Committee, and planning representatives. Specification is to be refined to be ready for market to identify design partners with the expertise to take proposals to the next stage. Members of the Trust Senior Team will begin to visit sites where new hospitals have been or are in the process of being built to share good practice.
BM/18/07/62	**Chairman's Report** The Chairman had not raised specific matters for the Board.
BM/18/07/63	**IPR Dashboard** Quality measures. The Chief Nurse provided an overview of Quality KPIs in month: - Incidences remain red with 108 open incidents over 40 days, a decrease from 11 in May. KSJ Chairs a weekly harm meeting with CBU leads for oversight of progress against agreed action plan to reduce incidences. - Safety Thermometer, overall indicator red due to the maternity indicator, Adults and Children trajectory achieved. Awaiting national guidance to ensure consistent reporting within Maternity. - 1 case of MRSA reported, root cause analysis to be undertaken, findings and learning will be shared with Emergency Department to mitigate against future occurrences. KSJ advised these were within Specialist Medicine, a root cause analysis is underway which will be reported to the Quality Assurance Committee for assurance of actions. - Significant improvement reported in complaints over 6 months with 1 open case. Concerted efforts to resolve complaints within 25 days. - FFT A&E remains challenging, robust action plan to support bringing performance back on

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track.

- In relation to Sepsis Anti-biotic indicator, KSJ reassured the Board that a meeting had taken place with Drs and Nurses to agree a focussed action plan.
- Discussion took place regarding Falls data. KSJ advised consistency of how type of falls are recorded, and if they should be recorded as a fall, ie when a patient is lowered to the ground, clarity will be provided through Falls Collaboration work with NHSI.
- In relation to Ward Accreditation, KSJ advised that 4 Wards had been successfully assessed, the plan is to assess all wards this year.
- Safe-staffing reports. KSJ provided an overview of the 3 reports for April, May and June. Staffing challenges due to low levels of staffing and significant pressures on both sites. Mitigating actions in place to ensure safe staffing within wards with constant review and movement of staff to affected wards. There had been 46 escalated beds, in April and May, reducing to 42 in June. The first tranche of recruited Health Care Support Workers, 15 last week and 10 this week will support these pressures.

- **KSJ to review the clinical governance briefing to highlight key points of note.**
- **The Board noted the Quality update and Safe Staffing report.**

Quality Assurance Committee Chair Key Issues Report 1 May

The Key Issues Report was taken as read Margaret Bamforth, Chair of Committee highlighted:

- DNACPR presentation had been received which correlated with the Resus training data and non-compliance of Level 2 training, reassurance given in a number of areas where progress had been made. The issue had been escalated at a number of Assurance Committees, and additional measures put in place to alert staff, including individual emails to appropriate staff from the Medical Director, dedicated morning and evening classroom based training sessions. Full compliance is required by July and will be monitored.

Access and Performance measures. The Chief Operating Officer provided an overview of KPIs:

- A&E 4 hour wait progressive improvement reported in line with NHSI trajectories, achieving 90.98% in June, with Q1 performance of 89.60%, missing the set PSF trajectory of 90% and associated funding for Q1.

  DTOCs within 24 hrs remain a challenge, Standard operating procedures with teams at ward level to support the process.
- Cancelled Ops, increase from 10 in May to 18 in June, predominantly due to unforeseen absence and patient cancellations within 24 hour period of the procedure.
- Continued reduction of escalated beds reported, with 30 beds at the end of July 2018, 22 on C22 which will be moved to Halton. CE explained there has been verbal agreement from Halton Council to fund these beds and there is an exit strategy in place to mitigate this capacity in the coming months.
- Ambulance Handovers – deterioration in 30>60 minutes, handover practitioner in post which will support handovers.
- Two week breast symptomatic 84.75% achieved in May (validated position), appointments offered earlier in the 2 week pathway, performance mainly due to patient choice
- Diagnostics – action plan in place to achieve trajectory be the end of August. Measures in place to support Cardiac Echo's and CT to clear the backlog throughout August 2018.

Workforce measures. The Director of HR & OD provided an overview of KPIs in month:

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	- Sickness absence, slight reduction, in month, intensive support relating to RTW and managing sickness absence. MC reassured the Board that RTW are taking place and documented, albeit a slight delay in electronic recording. - Mental Health First Aider training commenced, first cohort completed training last month with a cohort in September and waiting list for October. - Enhanced Sickness Call Service pilot to commence 1 August for Nurses and HCSW to telephone a Senior/Lead Nurse or Matron to report their absence which will enable a review of sickness patterns to support improvement. - In relation to agency workers, MC advised a new provider had been successful following a regional procurement exercise. A business case, to extend the current pilot of Medical Agencies to include all staff groups with exception of Nursing, to go to Executives. - In relation to IJ query relating to the Top 10 agency workers, MC advised that they workers had individually been approached to encourage transfer to Trust contract / internal bank. It should be noted that these individuals work in Hard to Recruit to posts and they do not wish to be directly employed. MC advised they will and will continue to be monitored and reviewed. **The Board noted the Workforce Committee Chairs reports.** Finance and Sustainability measures. The Director of Finance + Commercial Development provided an overview of KPIs in month: - Challenging financial position remains with position at end of Q1 of £6.7m deficit. FSC had debated this at length and requested a cost pressures deep dive review, schemes not switched off, reasons, mitigations and next steps for August FSC. £0.2m PSF funds not achieved due to A&E performance. - AMG explained that the national Pay Award will be applied in July salaries and backpay for 1 April to 30 June will be paid in August salaries. Funding has been received for July and will continue to be received on a monthly basis for the remainder of the year. - The Board was asked to note the challenge relating to the creditor and debtor position which is assessed on a daily basis. In relation to CIP, LG reported the current CIP position, £340k delivered against £600k target, behind plan by £260k. Mitigating actions were presented and discussed at FSC including CBUs and Corporate leads to deliver tactical schemes in full and Executive leads to review transformation schemes/additional schemes to fill the gap agreed at ICIC and Executive team. Progress report to be reported to Finance Resources Group. Additional scrutiny and monitoring of plans will be through the newly formed Finance Resources Group and continued bi-weekly monitoring from NHSI Finance and Sustainability Chairs Key Issues Report - July TA escalated to the Board, FSC had requested a report / review into relationship with a specific debtor and concerns regarding CIP position, and had requested review of cost pressures. **The Board noted the June Chair's Key Issues Report. July report to be circulated.**
BM/18/07/64	**Proposed amendments to Trust KPI Quality Section** The Chief Nurse provided an overview of key points for the Board to note and to approve the changes and recommendations within the Quality Section only. The proposed removal of KPIs within the report are monitored via a number of Assurance Committees within the

	governance structure The Quality Assurance Committee had supported these amendments on 1 May. Falls target had been discussed earlier and collection and recording of data may change to split variance in level of falls and particular incidences. The action plan will continue to be monitored at Patient Safety and Clinical Effectiveness Committee. • **The Board noted and approved the amendments within the Quality section of the IPR.**
BM/18/07/65	**RCS Spinal Services Report Update** The Executive Medical Director reported progress to date. A joint communication plan is being prepared to share the legal redacted report with stakeholders, patients and families and meetings are taking place. The Trust is now part of discussions with all spinal providers in Cheshire and Merseyside for the provision of a high quality, single spinal surgery service for the region, with the intention of keeping access for patients as local as possible with 2 workstreams, one for specialist spinal trauma and one for complex deformity and cancer work. Learning from the report will be disseminated through the C&M Spinal Network. • **The Board noted the report.**
BM/18/07/66	**Annual Complaint s Report 2017-18** The Chief Nurse highlighted key areas for the Board to note which had been presented and approved at the Quality Assurance Committee on 1 May: - Significant improvement and reduction in the backlog of complaints, 21 at the end of March compared with 120 at the same time last year. Overall improvement is due to a number of factors, including improvement in timeliness of responses, complaints handling training for staff and the establishment for oversight of the Complaints Quality Assurance Group, Chaired by the Chairman. The Trust is working to 25 day resolution for completion of complaints. Significant improvement noted within UEC to resolve complaints and clear their backlog. - The PALS Team support resolution of complaints by visiting wards to resolve before they reach a formal process. KSJ explained that a pilot is underway in 2 CBUs to telephone complaints to resolve over the telephone or invitation extended to meet complainants, supported by PALS and Matrons to resolve with supportive training for staff. This will then be rolled out across CBUs and adopted for both PALS enquiries and formal complaints. - In answer to query raised relating to PALS average response times, KSJ explained this is improving and the establishment and location of the newly established PALS office will support this. • **The Board noted the report and approved the recommendations. The Board extended their congratulations to Chief Nurse and team for the significant improvement within the last 18 months.**
BM/18/07/67	**Learning from Experience Summary Report** The Chief Nurse highlighted key points for the Board to note within the report which had been discussed at length at the May Quality Assurance Committee. A newsletter will be developed for staff to share learning and best practice. • **The Board noted the update report.**

BM/18/07/68	**CQC Update Report** The Chief Nurse highlighted key points for the Board to note on progress against the CQC action plan. - 154 actions out of 271 completed. Of the 226 reports due at the end of June, 162 had been received, dates and further evidence had been requested to demonstrate compliance for 44 reports and reports or requests for extensions for 16 actions which were due at the end of June. - The Board were asked to note the breakdown of performance of each action type and compliance at core service level. For further assurance, KSJ advised that an audit will be undertaken on actions completed to further test how embedded these are. In relation to Red and Amber breaches KSJ assured the Board controls are in place to monitor these. - In relation to the fundamental breaches, an Executive lead is assigned to each and reported a significant improvement relating to MCA and Consent reported to G2G Steering Group. - To provide further assurance to the Audit Committee, KSJ advised that as Chair of the Weekly Harm meetings closure of SIs/actions are approved by herself, Senior Nursing Team, and the Medical Director to close. In relation to the 'must' and 'should' dos, KSJ explained these are associated with escalated beds and additional resources and the next meeting of G2G will review what can be speeded up. Radiology 'must' dos will now be signed off. KSJ reassured the Board that risks had been reflected on the Risk Register for monitoring and oversight. - **The Board noted the report.**
BM/18/07/69	**Medicines Management Annual Report** The Executive Medical Director highlighted key points for the Board to note within the report which is received annually by the Board demonstrating how medicines are managed within the Trust. The Report had been approved at the May Quality Assurance Committee. There were no matters to highlight to the Board, incident reporting is within expectations. EPMA will support improved safety within prescribing, particularly the interface with the Trust and primary care, especially for medication reconciliation. • **The Board noted the Report.**
BM/18/07/70	**Progress on Lord Carter Report Recommendations and Use of Resource Assessment (UoRA)** The Director of Finance + Commercial Development highlighted areas to note in the report which indicated compliance against the recommendations within the Lord Carter Report. The report included a combined Lord Carter and UoRA dashboard to support collection of evidence to submit prior to an assessment day where the Trust will evidence its progress on improving the 5 identified KLOEs. The narrative is provided by the UoRA workstream, reporting to the G2G Steering Group, providing further assurance that areas are being addressed and monitored. AMG explained some of the benchmarking data is 2015-16 and will be updated as new data is received. Data for model hospital is available for inclusion. • **The Board noted the report.**
BM/18/07/71	**Scan 4 Safety** The Director of Finance + Commercial Development highlighted areas for the Board to note on this mandated DoH initiative as part of its E-Procurement strategy. Support to proceed to a Feasibility Study to identify the costs, risks, benefits and timescales had been endorsed at Finance and Sustainability Committee and Trust Operational Board in June. AMG explained

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	part of the study will be for WWH to visit sites where this is currently being used. **The Board endorsed the undertaking of the Feasibility Study as requested.**
BM/18/07/72	**Patient Experience Survey** The Chief Nurse highlighted areas to note which show an overall improvement on 42 of the survey questions compared with 8 questions in 2016. The Trusts response rate was 35%, slightly less than the 2016 response rate of 40% and 2015 of 44%. Significant improvement on 9 questions, compared to 1 question in 2016. There were no questions whereby the Trust worsened by 5% or more, which is significantly better than the 2016 survey, where 18 questions fell in this category. Significant improvement across all areas reported, triangulating a number of action plans, information and reporting in place within the Trust. In relation to improved DTOCs, Length of Stay and discharge length delays, this along with MDT, and safety bundle form part of the Ward Accreditation Scheme. Operational monitoring will be through Trust Operational Board and Quality elements through Quality Assurance Committee. • **The Board reviewed and noted the report and the significant overall improvement.**
BM/18/07/73	**Strategic People Committee** The Director of HR and OD highlighted areas to note within the report which summarised the Governance Structure in place from September 2017. The Strategic People Committee (SPC) had been disbanded in September 2017 and replaced by the Workforce Committee, as a Sub Group of the Trust Operational Board. The reintroduction of an Assurance Committee for the People agenda had been discussed and supported at Board development sessions and Audit Committee as a gap for such a Committee. The proposed changes were highlighted: - The re-establishment of the SPC, Chaired by Non-Executive Director from September 2018, to enable the oversight by the Trust Board for the People agenda. - Establishment of an Operational People Committee as a Sub-Committee to the SPC. - Amendment to the ToR to the Trust Operational Board to remove Workforce Committee as a Sub-Committee from September 2018. • **The Board endorsed and approved the changes, subject to formal ratification at the Audit Committee on 26 July.**
BM/18/07/74	**Quarterly Strategic Risk Register (SRR) + Board Assurance Framework (BAF)** JC reported no new risks had been added to the Risk Register. JC advised that the Workforce Committee had requested escalation of the risk relating to Resuscitation Training which the Quality Assurance Committee will be asked to endorse inclusion on the BAF at its September meeting, following the Risk Review Group meeting on 20 July. - The Board were asked to note updates on existing risks since the last Board, relating to financial sustainability, Falls, DNACPR MCA, safeguarding which had have oversight at the relevant Assurance Committees. - JC advised that the BAF had been transferred to Datix, providing a more user-friendly report for updates. • **The Board noted the report and approved the changes/amendments to the Strategic Risk Register.**

BM/18/07/75	**Committee Chairs Annual Report - Quality Assurance Committee** The report was taken as read with no matters to highlight to the Board. • **The Board reviewed and approved the report.**
BM/18/07/76	**ToR and Annual Cycle of Business** (i) **Council of Governors** JC reported that the ToR and Cycle of Business had been approved at the May Council of Governors and highlighted the changes (1) strengthening requirement for Governor attendance and (2) changes in administration section. • **The Board noted and approved the CoG ToR and Annual Cycle of Business.** (ii) **Financial Resources Group (FRG)** Finance Sustainability Committee had approved the establishment of the FRG to replace ICIC in its current form, and extend the remit of the FRG to cover a wider range of financial performance to support the sustainability of Trust services. The FRG will be a Sub-Committee of the FSC. • **The Board approved the establishment of the FRG and its ToR** There were no items to discuss under AOB and the meeting closed.
	Next meeting to be held: Wednesday 26 September 2018

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BOARD OF DIRECTORS ACTION LOG

AGENDA REFERENCE:	BM/18/09/82	SUBJECT:	TRUST BOARD ACTION LOG	DATE OF MEETING	26 September 2018

1. ACTIONS ON AGENDA

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
BM/18/05/34 ii	24.05.2018	HEE visit 29 June	Report following the visit on 29 June	**Medical Director**	26.09.2018		Report not yet received from HEE	

2. ACTIONS COMPLETED AND CLOSED SINCE LAST MEETING

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

ROLLING TRACKER OF OUTSTANDING ACTIONS

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
BM/18/01/01	31.01.2018	Partnership with King Edward Memorial Hospital Mumbai	Update Report to November Trust Board	**Medical Director**	28/11/2018		27.6.2018. AC advised that Certificate of Sponship submitted monthly to date had been rejected. It is hoped that these will be accepted in July following recent government legilsation. 3 visa applications submitted and outcome awaited following recent government legislation.	
BM/18/05/39 c	24.05.2018	IPR Dashboard – Workforce Indicators	Split of all absences categories including stress to be provided to JNE outside of the provide to JNE outside of the meeting.	**Director of HR and OD**	When information received		June 2018 Information shared with JNE 27.6.2018. MC reported that national benchmarking information is still awaited and this will be forwarded when available.	
BM/18/06/56	27.06.2018	Resubmission of Operational Plan	To be presented to CoG in August.	**Director of F + Comm Dpment**	16.08.2018		28.06.2018. Added to CoG agenda.	
BM/18/07/57		Junior Doctor Update/Trainee Engagement (Trello)	6 mth progress/update presentation	**Medical Director**	30.02.2019			

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(red)	Action overdue or no update provided	(green)	Update provided and action complete
(amber)	Update provided but action incomplete		

Wellington House
133-155 Waterloo Road
London SE1 8UG

Wednesday 22nd August 2018

To: Mel Pickup, **CEO**
Copy: Steve McGuirk, **Chair**
Lyn Simpson, **Regional Director**

Dear colleague

Elective care expectations

I recognise this year has already been very challenging and staff are working very hard to deliver high quality care to patients right across the NHS and transform services for patients despite operational pressures.

Whilst I acknowledge the challenges associated with the delivery of the emergency care pathways, we are seeing a worrying picture where overall Trust activity levels and service performance are not in line with recently submitted plans. In addition we are seeing only seasonal reductions in long stays in hospital and bed occupancy is not being sufficiently reduced to enable appropriate flow and performance. This is of significant concern and requires our collective focus.

We have previously outlined our expectations with regards to the delivery and management of elective activity and these expectations were supported by additional national funding to support a step increase in activity levels. These were reflected in the 2018/19 plan your Board developed, approved and submitted back to us.

Under current trajectories, trusts will not deliver for current elective care patients and there is a future significant financial performance risk resulting from non-delivery of activity income plans.

52 week waiters

I am writing to you with a focus on long waiters on the RTT waiting list specifically patients waiting over 52 weeks. The position on 52 weeks requires urgent attention and the delivery of elective care performance is critical to this to ensure patients receive timely, reasonable and appropriate level of care.

It is important that not only do waiting lists not increase, but the number of long waiters on the RTT waiting list are reduced. The expectation, at a minimum, is that the number of patients waiting over 52 weeks is reduced by at least 50 per cent with the overall objective of zero 52 week waiters.

Your trust's performance

Appendix one shows the Q1 position for your Trust and the variance against your plan. I am sure that you and your Board will have reviewed your Q1 activity performance and activity figures with concern.

This autumn provides an important window of opportunity to get back on track with delivering your agreed elective plan ahead of winter. Focus needs to be given to reducing long waiters but also delivering the required reductions in long stays in hospital to reduce patient harm and bed occupancy, as set out in Pauline Philip's letter of 13th June.

Action required

I would therefore ask you to ensure:

1. the importance of delivering elective care performance and activity levels alongside emergency care and finance is recognised by your trust's senior leadership and given sufficient scrutiny at Board level;
2. there is an appropriate week by week trajectory in place and being met, for reducing the number of 52 week waiters to eliminate these ahead of winter wherever possible, in order to ensure that the March 2019 commitment is delivered; and
3. by early September the trust has reviewed and forecast its 2018/19 activity and performance commitments to ensure you are back on track. Where you determine that you will no longer be able to meet the activity and performance commitments in your Board approved plan you work with your commissioners to determine how these gaps will be closed through use of capacity in other trusts and/or the independent sector. Any contingency plan for work carried out by other trusts or the independent sector should be available to mobilise by mid-September.

Please see appendix two for further assurance requests to enable the delivery of the above.

Please can you therefore provide the following information to your regional director by Wednesday 5 September:

- your appraisal of what is driving the elective activity and performance set out above;
- forecast for how and by when, any year to date elective activity under-performance will be recovered; and
- the actions you are and will take to realise the theatre in-session productivity opportunity that your trust has agreed currently exists.

Activity monitoring

We shall be monitoring elective activity and performance levels very closely. As part of this we shall be publishing the RTT PTL each week to all acute trusts and CCGs showing by trust the number of 52 week waiters, with the expectation that we see week by week improvements throughout the rest of the year. You can access this data by registering at https://future.nhs.uk/ and accessing the 'National Reporting' section of the website.

NHS England is writing to CCGs to also inform them of the above requirements.

Your regional director(s) and Pauline Philip will be working closely with you during this period to provide support as required. Please do not hesitate to contact them with any queries.

Thank you for your continued effort and support.

Yours sincerely,

Ian Dalton CBE
Chief Executive, NHS Improvement

Appendix one – current performance as at Q1

	Provider	Warrington and Halton Hospitals NHS Foundation Trust
	Region	North
RTT waiting list	Total waiting list size (March 2018)	18,827
	Total waiting list size (June 2018)	17,872
	RTT waiting list size in provider plan for March 2019	18,800
52 week waits	52 + waits (March 2018)	0
	52+ waits (June 2018)	0
	Number of 52 week waiters in provider plan for March 2019	0

Demand	Variance in referrals (GP) received YTD (percentage variance from provider plan)	-5.54%
Outpatients	Total first outpatient activity YTD variance from plan (percentage variance from plan)	0.12%
Day case	Day case elective volume (Spells) YTD variance from plan (% variance from plan)	-14.60%
Elective ordinary	Elective ordinary admissions YTD (percentage variance from plan)	-7.48%
Total elective	Total Elective (% variance from plan)	-13.67%

Key to colour coding in appendix 1 – Q1 summary

Total waiting list size (March 2018)	No data		
Total waiting list size (June 2018)	>March 18	<March 18 but > March 19	<March 19
RTT waiting list size in provider plan for March 2019	>March 18		
52 + waits (March 2018)			
52+ waits (June 2018)	>March 18	<March 18 but > March 19 plan	=0
Number of 52 week waiters in provider plan for March 2019			

Variance in referrals (GP) received YTD (percentage variance from provider plan)	>6% above trust plan	>3% above trust plan	
Total first outpatient activity YTD variance from plan (percentage variance from plan)	10% or more below trust plan	4-10% below trust plan	>5% above trust plan
Daycase elective volume (Spells) YTD variance from plan (% variance from plan)	10% or more below trust plan	4-10% below trust plan	>5% above trust plan
Elective ordinary admissions YTD (percentage variance from plan)	10% or more below trust plan	4-10% below trust plan	>5% above trust plan
Total Elective (% variance from plan)	10% or more below trust plan	4-10% below trust plan	>5% above trust plan

Appendix two: Further assurance requests

a) Assurance that your organisation is:

- delivering planned activity and RTT treatment (clock stop) volumes;
- booking patients in (clinically appropriate) chronological order ;
- clear about what is driving elective underperformance – recognising that it is often not due to a capacity /demand imbalance that people may assume. The elective care intensive support team have developed a range of tools for Trusts to use to assist with this;
- ensuring as a first step that there are zero 52 week waiters on non-admitted pathways or where day case treatment is required; and
- actively validating elective pathways

b) Where referral demand and clock starts are above plan you are working with commissioners to ensure they address this situation.

c) Reporting and reviewing progress as a board each month until you are assured these leading measures are back on track, including:
   - number of patients waiting over 40 and 52 weeks by specialty, by admitted/non-admitted pathway, with and without TCI dates.

d) By early September the trust has reviewed its forecast its 2018/19 activity and performance commitments to ensure it is back on track. Where you determine that you will no longer be able to meet the activity and performance commitments in your Board approved plan you work with your commissioners to determine how these gaps will be closed through use of capacity in other trusts and/or the independent sector. Any contingency plan for work carried out by other trusts or the independent sector should be available to mobilise by mid-September.

From the Rt Hon Matt Hancock MP
Secretary of State for Health and Social Care

39 Victoria Street
London
SW1H 0EU

020 7210 4850

23 August 2018

Dear Colleagues,

GOVERNMENT'S PREPARATIONS FOR A MARCH 2019 'NO DEAL' SCENARIO

I am writing to provide an update on the Government's ongoing preparations for a March 2019 'no deal' Brexit scenario and what the health and care system needs to consider as we step up preparations over the autumn and in the period leading up to March 2019.

The Government has made significant progress in negotiations with the EU and remains confident we will leave with a good deal for both sides, that supports existing and future healthcare collaboration. However, as a responsible government, we continue to prepare proportionately for all scenarios, including the unlikely outcome that we leave the EU without any deal in March 2019.

Along with other Government departments, the Department of Health and Social Care has stepped up its planning for a 'no deal' scenario. We now have robust plans in place to protect patient safety and healthcare provision. Today's announcement concerns our preparations to ensure that the NHS, other service providers, and ultimately patients continue to get the supplies they need, in a timely way.

Continuity of Supply

Today the Government has set out a new scheme to ensure a sufficient and seamless supply of medicines in the UK in the event of a 'no deal' Brexit. In the unlikely event we leave the EU without a deal in March 2019, based on the current cross-Government planning scenario we will ensure the UK has an additional six weeks supply of medicines in case imports from the EU through certain routes are affected. This is the current planning assumption but will of course be subject to revision in light of future developments.

Under the medicines scheme, pharmaceutical companies should ensure therefore they have an additional six weeks supply of medicines in the UK on top of their own normal stock levels. The scheme also includes separate arrangements for the air freight of medicines with short shelf-lives, such as medical radioisotopes. The

Government is working closely with companies who provide medicines in the UK to ensure patients continue to get the medicines they need. I am today also writing to pharmaceutical companies with more details.

Hospitals, GPs and community pharmacies throughout the UK do not need to take any steps to stockpile additional medicines, beyond their business as usual stock levels. There is also no need for clinicians to write longer NHS prescriptions. Local stockpiling is not necessary and any incidences involving the over ordering of medicines will be investigated and followed up with the relevant Chief or Responsible Pharmacist directly.

Clinicians should advise patients that the Government has plans in place to ensure a continued supply of medicines to patients from the moment we leave the EU. Patients will not need to and should not seek to store additional medicines at home.

I am also today writing to medical devices and clinical consumables companies to set out further details of plans to ensure a continuity of supply of these products as well.

Given the significant amount of work that has now been done, I am confident this gives a clear basis for the health and care sector and the life sciences industry to plan so that patients can continue to receive high quality care unhindered.

Other Preparatory Activity

The Government is also putting in place measures to manage the other potential implications for the health and care sector, including, for example, future immigration rules; continuity of research funding and pan-European clinical and research collaborations; and future reciprocal healthcare arrangements.

There are three points in particular that I would note at this stage.

First, I would like to take this opportunity to reiterate that the Government recognises the valuable contribution that EU citizens make to the UK, including those working in the health and care system. The Home Office have recently launched a toolkit to assist employers in reassuring and supporting EU citizens already resident in the UK and their dependents to apply for settled status. Details have already been communicated to you and I would encourage you to draw these to the attention of your staff.

Second, the Government recently announced that doctors and nurses are now exempt from the cap on skilled worker visas. This means that there will be no restrictions on the number of doctors and nurses who can be employed through the Tier 2 visa route – giving you the ability to recruit more international doctors and nurses to provide outstanding patient care when required.

Third, the Treasury is extending the government's guarantee of EU funding to underwrite the UK's allocation for structural and investment fund projects under this EU Budget period to 2020. The Treasury is also guaranteeing funding in event of a no deal for UK organisations which bid directly to the European Commission so that they can continue competing for, and securing, funding until the end of 2020. This ensures that UK organisations, such as charities, businesses and universities, will continue to receive funding over a project's lifetime if they successfully bid into EU-funded programmes before December 2020.

We have created a new page at https://www.gov.uk/government/collections/information-for-the-health-and-care-sector-about-planning-for-a-potential-no-deal-brexit that brings together this and other information relevant to your organisations and it will continue to be updated over the coming months. Our intention is that where you need to take specific action, you will be given sufficient notice and clear guidance on the steps to be taken.

Business Continuity Plans
In the meantime, where appropriate, preparations for a March 2019 'no deal' scenario should be seen in the context of the work you are already doing to update your existing business continuity plans in line with the NHS England EPRR Core Standards and the NHS England EPRR Annual Assurance process. As it is a requirement that the EPRR assurance report is taken to your public board meetings I am assured your Accountable Emergency Officer will have oversight of this work. You will wish to have your business continuity teams/directorate leads, and other relevant colleagues as necessary who may not normally be involved in this process, ready to refresh those plans as new information becomes available over the coming months.

Further Information
You will already have well-established points of contact in national organisations to assist on specific areas. Please use these if you have queries about any areas which require further clarification. For updates on this, and other health-related issues, please visit https://www.gov.uk/government/collections/information-for-the-health-and-care-sector-about-planning-for-a-potential-no-deal-brexit where key information will be collated.

Yours ever,

Matt

MATT HANCOCK

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/18/09/83**
SUBJECT:	**Planning and preparedness for the potential impacts on the Trust of the scheduled March 2019 'Brexit'.**
DATE OF MEETING:	26th September 2018
ACTION REQUIRED	**For Information and reassurance**
AUTHOR(S):	Keith A Preston
EXECUTIVE DIRECTOR SPONSOR:	Chris Evans Chief Operating Officer
LINK TO STRATEGIC OBJECTIVES:	SO3: To deliver well managed, value for money, sustainable services
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	BAF1.4: Business Continuity
	BAF1.4: Business Continuity
	BAF1.4: Business Continuity
STRATEGIC CONTEXT	
EXECUTIVE SUMMARY (KEY ISSUES):	To reassure The Board that The Trust is being proactive in identifying potential Business Continuity challenges, as the UK moves towards the scheduled March 2019 'Brexit'.
RECOMMENDATION:	To inform and reassure The Trust Board that ongoing pro-active Brexit planning is taking place which is proportionate and responsive to the current and future information available.

PREVIOUSLY CONSIDERED BY:	**Committee**	Event Planning Group
	Agenda Ref.	EPG/120918/07
	Date of meeting	12th September 2018
	Summary of Outcome	The Event Planning Group noted the contents of the report.
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: *(if relevant)*		

BOARD OF DIRECTORS

SUBJECT	Planning and preparedness for the potential impacts for the Trust of the scheduled March 2019 'Brexit'	AGENDA REF:	BM/18/09/83

1. BACKGROUND/CONTEXT

On 29th March 2019 the UK is scheduled to exit the European Union- Brexit. Negotiations are ongoing to agree the terms of departure but at this stage the exit may be with agreed terms/deal, or with no agreed terms/deal ' No Deal'

On 23 August 2018 Matt Hancock, Secretary of State for Health and Social Care, wrote to all health and social care organisations to update them on the government's ongoing preparations to protect patients and health and social care services in the event of a March 2019 "no deal" scenario, should this occur.

The letter sets out what the health and social care system needs to do to step up preparations on the ground to ensure business continuity.

In particular it announces a new scheme to ensure a sufficient and seamless supply of medicines, in collaboration with pharmaceutical companies, which will mean that hospitals, GPs, pharmacies and patients will not need to "stockpile" unnecessarily.

The Government is also putting in place measures to manage the other potential implications for the health and care sector, including, for example, future immigration rules; continuity of research funding and pan-European clinical and research collaborations; and future reciprocal healthcare arrangements.

The letter directed NHS Organisations to actively include Brexit implications, and in particular a 'No Deal' Brexit as an element of existing and ongoing organisational and Departmental/CBU Business Continuity Planning.

2. KEY ELEMENTS

Government Information August 2018

In August 2018 The UK Government also published the first tranche of a series of papers setting out how the UK plans to deal with a range of issues in the event that we leave the EU in March 2019 without an agreement.

The papers stress that both the UK and EU are working hard to negotiate a positive deal and that "no deal" is unlikely. However they point out that until they can be certain of the outcome of negotiations, as a responsible Government they have a duty to prepare for all eventualities, however unlikely, and to ensure business continuity.

The technical notices are not intended to give operational support or guidance to NHS bodies about how to contingency plan locally. They promise more detailed guidance from Government/arms' length bodies in the near future, and in some cases further consultations. For example the medicines/medical devices/clinical trials paper promises more comprehensive technical note in Autumn 2018.

Medicines, Medical Devices and Clinical Trials

Five of the papers published so far cover health related issues:

- How medicines, medical devices and clinical trials would be regulated

  N.B. Individual NHS bodies are directed not to stockpile medicines, suppliers will have this responsibility.

- Submitting regulatory information on medical products
- Batch testing medicines
- Ensuring blood and blood products are safe
- Quality and safety of organs, tissues and cells

Staffing

The letter confirms that Government recognises the valuable contribution that EU citizens make to the UK, including those working in the health and care system. The Home Office have recently launched a toolkit to assist employers in reassuring and supporting EU citizens already resident in the UK and their dependents to apply for settled status.

The Government recently announced that doctors and nurses are now exempt from the cap on skilled worker visas. This means that there will be no restrictions on the number of doctors and nurses who can be employed through the Tier 2 visa route

In advance of the UK's exit from the EU on 29 March 2019, the UK government has committed to protect the rights of EU citizens and their family members currently living in the UK. EU citizens must apply for UK immigration status under the EU Settlement Scheme. The scheme launches in 2019, but here at WHH the Human Resources Dept. are participating in a pilot scheme, working in conjunction with The Home Office

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

Pending further Government advice where appropriate, preparations for a March 2019 'no deal' scenario should be seen in the context of the work already ongoing to update existing business continuity plans in line with the NHS England EPRR Core Standards and the NHS England EPRR Annual Assurance process.

This work is overseen by Chris Evans the Trust Accountable Emergency Officer, supported by The Resilience Manager and members of the Trust wide Events Planning Group (EPG)

The actions required at this stage are for The Trust:

1. To demonstrate awareness and central co-ordination of potential Brexit issues
2. To be proactive in anticipating Brexit challenges
3. To take into account Deal and No Deal scenarios
4. To seek and consider advice and information from established NHS professional organisations and bodies
5. To respond promptly to any definitive Government guidance/ direction
6. To be particularly aware of the additional challenges that a 'No Deal' Brexit may bring
7. To brief and where necessary reassure staff and patients
8. To brief The Board on actions/progress to date
9. To include Brexit issues as an extension of current Trust Business Continuity Planning
10. To update and refresh Business Continuity Plans as relevant and reliable information becomes available

Trust Resources on Brexit issues

- Chris Evans the Chief Operating Officer and Accountable Emergency Officer (AEO) will be the Executive Strategic Lead on Brexit issues for The Trust.
- The Trust Resilience Mangers will take the Operational Lead in co-ordinating Brexit information, guidance and work streams and limit duplication of work.
- Brexit issues were briefed at the Trust EPG meeting on 12th September 2018.
- Brexit issues will then be a standing agenda item at the monthly EPG meetings.
- Medicines Management Brexit issues will be led by Diane Matthew- Chief Pharmacist
- Supplies Management Brexit issues will be led by Alison Parker- Ass. Director- Supplies
- Human Resources Brexit issues will be led by Helen Dickson - HR Manager
- Communications Brexit issues to be led by Pat Mclaren- Head of Communications
- Monitoring and assessment of Brexit finance issues to be determined

Supplies and Pharmacy representatives are scheduled to attend a Dept. Of Health Conference on 2 October 2018 where Brexit issues will be discussed

4. IMPACT ON QPS?

UK Brexit negotiations are ongoing at UK &EU Government level. The exact terms of withdrawal from the EU and potential impacts on the NHS are at this time unknown. However it is recognised that the there is a potential to impact on Quality. People and Sustainability.

Until Brexit terms are clear and we have definitive Government guidance, ongoing developments must be monitored and risk limiting strategies considered

5. MEASUREMENTS/EVALUATIONS

Trust achievements will be evaluated by the EPG

6. TRAJECTORIES/OBJECTIVES AGREED

Initial actions identified to be reviewed and updated at monthly EPG meetings

7. MONITORING/REPORTING ROUTES

EPG will monitor progress , reporting to The Board via Chris Evans, as the Accountable Emergency Officer

8. TIMELINES

First briefing to EPG - 12 September 2018

Briefing paper to Public Board 26th September 2018

9. ASSURANCE COMMITTEE

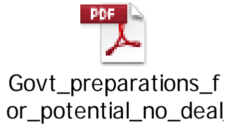
EPG and Quality Committee

10. RECOMMENDATIONS

That this initial report and actions contained are noted, and The Board reassured that potential Brexit impact on Trust Business Continuity is both pro active and reactive to the developing information available.

Attachment

Letter from Secretary of State for Health - Matt Hancock 23.8.18



Summary of board papers – statutory bodies

NHS Improvement board meeting – 26 July 2018

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

Chair's report

- Lord Carter and Lord Darzi have been reappointed for a second term as non-executive directors at NHS Improvement (NHSI). There are four new non-executive director appointments joining the board at the beginning of August: Sir Andrew Morris, Wol Kolade, Laura Wade-Grey and Tim Ferris MD.

Chief Executive's Report

- NHSI's contribution to developing the 10 year plan for the NHS will include:
  - The creation of strategic plans which outline how the 10 year plan's priorities will be delivered
  - A new approach to capacity planning that supports the NHS in matching financial resources with the workforce and physical capacity needed to meet demand
  - A review of the NHS financial architecture, including tariff, control totals and sustainability funding
  - An expansion and acceleration of NHSI's productivity and efficiency work
  - Providing a clearer vision and roadmap for the development of integrated care systems
  - Developing plans for more proactively developing the provider landscape.

Update on actions taken in response to Independent review into Liverpool Community Health NHS Trust (LCH)

- The board received an update on actions agreed at the March board meeting in response to the recommendations of the Kirkup report into issues at LCH. These actions include:
  - The roll-out of regional talent boards, led by NHS Leaders Academy. The plan is to have all regional talent boards up and running by Q4 2018/19.
  - NHSI will conduct a detailed review of risk in standalone community providers.
  - NHSI will carry out a review of former LCH services. This will take place by 31 March 2019.
- NHSI commissioned an independent investigation to clarify the circumstances under which roles were found or facilitated for individuals identified in the report as bearing some responsibility for the issues at LCH. The findings are published here.

Update on NHSI Maternity Programme

- NHSI will provide further guidance to trusts on understanding the safety landscape in maternity services; *Exploring the Golden Thread* is due to be published in late summer 2018.

Quality report

- There are currently no providers rated 'outstanding' by CQC for the 'safe' domain. NHSI's policy team are working with CQC to understand why this is the case.

Care Quality Commission board meeting – 18 July 2018

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

Chief Executive's report (from the board meeting on 13 June 2018)

- Regarding the performance report, CQC is embedding a new tool to report on inspectors' activity. On average, 34% of Inspector time is spent on monitoring and 36% on inspecting and publishing reports.
- The Department of Health and Social Care (DHSC) made a Written Ministerial Statement to Parliament on 23rd of May entitled 'Terms of reference for the review of the Fit and Proper Persons requirement'.
  - The statement refers to CQC and sets out the arrangements for the review:
    - Tom Kark QC is leading the review
    - Document review began in July 2018
    - Principal evidence-gathering will take place in August and September 2018
    - The review is expected to report in autumn 2018.
  - The review will consider the scope, operation and purpose of the Fit and Proper Person Test as a means of preventing the re-deployment or re-employment of senior NHS managers where their conduct has fallen short of the values of the NHS.
- CQC will submit written evidence to the independent review of gross negligence manslaughter and culpable homicide, which is overseen by Dame Clare Marx. The review will report back in early 2019.
- CQC recently published Driving improvement: case studies from nine adult social care services and Driving improvement: case studies from 10 GP practices; the themes of improvement in general practice include clinical and management leadership, avoiding professional isolation, and the value of the whole practice working as a team and a multidisciplinary model.
- CQC has published the results of the 2017 adult inpatient survey.
- On 28 June CQC published its response document to the independent healthcare consultation.

Executive team's report

- CQC published *Beyond barriers*, the final report on their local system reviews, on 3 July 2018. We summarise the key findings here, which included that people experience the best care when organisations work together to overcome a fragmented system. The report found that while there were examples of good practice in all 20 systems, barriers to collaboration remain at local and national levels.
- On 20 June 2018 the Gosport Independent Panel, chaired by Rt Reverend James Jones KBE, issued its report into care at Gosport War Memorial Hospital between 1989 and 2000. The panel reported that the lives of over 450 people were shortened as a direct result of the approach used in some wards to the prescribing and administering opioids and other drugs, and that, while records were missing, probably at least another 200 patients were similarly affected. Over many years there was a failure by a series of individuals and institutions, including regulators, to investigate or act appropriately.
  - Since the period covered by the report there have been major changes in clinical governance and regulation including the redevelopment of CQC approach to inspections, the role of the national and local Freedom to Speak Up Guardians to support staff who wish to raise concerns and the way CQC works with other national organisations to share and act on information of concern.

- However, there are a series of issues that are relevant to the CQC's current work, including investigation of staff and relatives' concerns about care and the regulatory response when such concerns are raised. CQC is reviewing the implications of the Panel's finding on the regulation of hospital and primary care services and a full update will be brought to a forthcoming board meeting.
- In the first two months of the year, the Hospitals team undertook 453 units of inspection (96% of the expected average of 235 per month against a target of 100%). There has been an increase in the backlog of Hospitals reports in line with the increase in the directorate's activity.
- On 19 July CQC published a report bringing together the findings from its review of the timeliness and governance of radiology reporting in trusts, which is based on an analysis of data provided to CQC by 151 acute trusts and 19 community trusts between August-October 2017.
- CQC gave evidence to the Health and Social Care Select Committee on Tuesday 3 July as part of their inquiry into prison health and social care.
- On 22 June CQC published *The state of care in urgent primary care services* which showed that most of these services are providing good care despite workforce and commissioning pressures.
- CQC continues to work with the Department of Health and Social Care and system partners to agree its role in oversight of the proposed new Deprivation of Liberty Safeguards system.

Updating surveillance information

- CQC is proposing to produce an online resource on the use of technology in monitoring and supporting care. It will focus on telecare, telemonitoring, digital care records, mobile health apps, and overt/covert video and audio, and will cover what the use of technology means for how CQC regulates.
  - This will replace the 2015 information on using hidden cameras and related guidance for providers.

Health Education England board meeting – 17 July 2018

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

Finance report 2018/19 Month 2

- There has been a delay in some areas paying and recharging the cost of GP trainees pay. This has hampered work to fully understand the impact of the junior doctors new pay contract.

Diversity and Inclusion Strategic Framework 2018 – 2022

- Health Education England (HEE) has developed a strategic framework to ensure it remains committed to the values of diversity and inclusion for the next four years (2018-22).
  - HEE will use its influence with stakeholders to further diversity and inclusion within medical and clinical education and the wider healthcare system.

Highlights from Local Education and Training Board (LETB) updates

- South of England LETB
  - The committee discussed how the South has seen the greatest reduction in commissions across the country and agreed that Local Workforce Action Boards should work with academic institutions to address this.
  - Mental health workforce plans are in the process of being developed for each STP. Work has been done with NHSE and NHSI to support this and align the plans with investment.
  - The committee discussed the TOPOL review looking at advances in technology and how these will impact on the clinical NHS workforce and the way HEE trains staff.
- North LETB
  - Updates from STP areas included the Greater Manchester Strategic Workforce Board and Collaborative which has considered establishing Integrated Health & Social Care Careers Hubs.
  - The committee received an update on developing an ALB joint 'workforce offer' for the North.
- London's LETB
  - The Medical Education Reform programme has identified reforms for re-structuring the medical education curricula so that training programmes will assure prospective employers that their business needs are being considered within the course structures.
  - General Practice Charter Mark pilot (which focused on the care of the elderly in South London, 2015-18) has demonstrated some positive impacts and is to be rolled out across London, where a future structure may include other disciplines (public health and other professional careers such as nursing).
- Midlands and East LETB
  - Discussion on the workforce strategy consultation centred around 'big ticket' items such as skills passports, engagement of the health and social care sector, and when wider engagement with communities will take place.

NHS England board meeting – 4 July 2018

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

Chair and chief executive reports

- NHS England (NHSE) will work closely with Health Education England on the linked 10 year workforce strategy, as well as local government and Public Health England on prevention and intervention. The Department of Health and Social Care, in partnership with NHSE, will be making capital prioritisation decisions between now and next public meeting. The larger question of capital, looking over 10 years, will be linked to 10 year plan.

Developing the NHS long term plan: evidence based interventions

- A consultation has been launched on the future of evidence based interventions. The programme has been developed and jointly led by NHSE, NICE, NHS Improvement, the Academy of Medical Royal Colleges, and NHS Clinical Commissioners. The consultation is on the design principles, the 17 interventions that should initially be targeted, the proposed clinical criteria, the activity goals that should be set, and the twelve delivery actions. It is proposed that these should be included in the NHS Standard Contract. The consultation is open until 28 September.

Primary care services

- There is renewed attention on the development of primary care networks. A reference guide is being developed to support regions to establish networks. An overarching NHSE programme of work is also being developed and a Primary Care Network Programme is being established.
- Primary care reform: NHSE and the BMA are looking to make significant changes to the GP contract – the most substantial changes to the contract since 2004. These specifically focus on QOF and future-proofing for digital-first primary care.

NHS finance report (month two)

- At month two NHSE is reporting a year to date underspend of £22m (0.1%). This is broadly in line with plan. At month two commissioners are forecasting to deliver 95% of savings plans (around £3.1bn). CCGs are reporting a "net risk" of £325m at month two – this relates to contract over performance and shortfalls on efficiency schemes. This compares with £443m at month two last year.

Net Expenditure	Year to Date				Forecast Outturn			
	Plan £m	Actual £m	Under/(over) spend £m	Under/(over) spend %	Plan £m	FOT £m	Under/(over) spend £m	Under/(over) spend %
CCGs	13,747.2	13,745.5	1.7	0.0%	83,079.5	83,079.5	0.0	0.0%
Direct Commissioning	3,971.1	3,970.6	0.5	0.0%	25,193.3	25,193.3	0.0	0.0%
NHSE Running & central programme costs (excl. depreciation)	210.6	182.1	28.5	13.5%	5,513.5	5,483.4	30.1	0.5%
Other including technical and ringfenced adjustments	(4.8)	4.4	(9.2)		10.0	56.4	(46.4)	
Total non-ringfenced RDEL under/(over) spend	**17,924.1**	**17,902.6**	**21.5**	**0.1%**	**113,796.3**	**113,812.6**	**(16.3)**	**(0.0%)**

Contact: Georgia Butterworth, Senior Policy Officer, georgia.butterworth@nhsproviders.org
Adam Wright, Senior Policy Officer, adam.wright@nhsproviders.org

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/18/09/84**
SUBJECT:	**Integrated Performance Dashboard**
DATE OF MEETING:	26th September 2018
ACTION REQUIRED	**For Discussion**
AUTHOR(S):	Marie Garnett – Head of Contracts and Performance
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse Alex Crowe – Acting Medical Director & Chief Clinical Information Officer Michelle Cloney – Director of Human Resources & Organisational Development Andrea McGee - Director of Finance & Commercial Development Lucy Gardner – Director of Transformation Chris Evans - Chief Operating Officer
LINK TO STRATEGIC OBJECTIVES:	All
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	All
STRATEGIC CONTEXT	To provide the Trust Board with assurance in relation to performance in the following areas: • Quality • Access and Performance • Workforce • Finance Sustainability
EXECUTIVE SUMMARY (KEY ISSUES):	**Quality** The Trust continues to work through the backlog of incidents which is on a downward trajectory. Root Cause Analysis (RCAs) is being undertaken around Venous Thromboembolism (VTE). Actions from the Falls collaboration are being implemented. **Access & Performance** A deep dive review of A&E performance is underway as the Trust narrowly fell short of the improvement trajectory. The Trust did not meet the 14 day breast symptomatic standard due to breaches associated

	with patient choice. Cancelled operations on the day for non-clinical reasons remains a challenge due to bed pressures at peak times. **Workforce** The Trust continues to reduce sickness absence in month. Return to work compliance has reduced. The HR team is working with CBUs to address. Agency nurse spend remains high, however Agency medical and Agency allied health professional spend has reduced. **Finance** The Trust has signed up to a control total of £16.9m deficit which includes Provider Sustainability Funding (PSF) of £4.9m. The planned deficit for the month ending 31st August 2018 was £10.0m. The Trust has achieved an actual deficit of £10.1m which is £0.1m above plan. Performance against the year to date control total (excluding Provider Sustainability Funding) is £11.3m deficit which is in line with plan. This financial position does not include PSF monies of £0.2m as Quarter 1 A&E 4 hour performance of 89.6% was achieved, below the 90% requirement.
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/18/09/84

1. BACKGROUND/CONTEXT

The RAG rating for all 70 indicators from September 2017 to August 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 - 25 in August increased from 24 in July.
- Amber – 11 in August increased from 10 in July.
- Green – 31 in August increased from 28 in July.
- Not RAG rated – 3 in August the same number as July.

In July, The Board approved the addition of 4 Quality indicators to the IPR. Therefore the overall number of indicators has increased from 66 to 70.

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 July's validated position.

Quality

Quality KPIs

There are 9 Red indicators in August, an increase of 2 in month.

The 6 indicators which were Red in July and remain Red in August are as follows:

- Incidents – the Trust had 151 open incidents which were over 40 days old in August, an increase from 129 in July.
- Healthcare Acquired Infections MRSA – the Trust reported 1 case of MRSA in April 2018 against a national threshold of zero tolerance; therefore this indicator will be Red for the remainder of the year.

- Sepsis Anti-biotic AED – the Trust achieved 88% in July (validated position) a decrease from June's position of 89% against a target of 90%.
- Total Falls & Harm Levels – there were 83 falls in August, an increase from 79 in July.
- Friends & Family Test (A&E and UCC) – the Trust achieved 86% in August, an increase from July's performance of 84% against a target of 87%.
- Mixed Sex Accommodation Breaches (MSA) – there were 19 Mixed Sex Accommodation Breaches in August, an increase from 7 in July, against a target of 0.

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

- VTE Assessment – the Trust achieved 90.81% in July (validated position) a decrease from June's position of 96% against a target of 95%.

There are 2 new indicators to the Quality Dashboard which have been rated Red in month:

- Healthcare Acquired Infections CDIFF – there were 5 cases of CDIFF reported in month, an increase from 1 in July against a target of less than 2.
- Healthcare Acquired Infections Gram Negative – there were 6 cases of E-coli reported in August, the same number as July against a target of less than 2. The Trust has exceeded the number of E-coli infections against the planned improvement trajectory.

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

- Medication Safety – there were no incidents of harm in August.

There is 1 Sepsis indicator which cannot be RAG rated this month as the results will not be received from Public Health England until Q3.

Access and Performance

Access and Performance KPIs

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

The 6 indicators which were Red in July and remain Red in August are as follows:

- A&E Waiting Times 4 hour national target – the Trust achieved 87.5% including walk ins and 85.24% excluding walk ins in August, a decrease from July's performance of 90.46% including walk ins and 88.69% excluding walk ins against a target of 95%.
- Breast Symptoms 14 days – the Trust achieved 88.41% in July's validated position, a decrease from June's performance of 92.41% against a target of 93%.
- Ambulance Handovers 30>60 minutes – there were 157 patients who experienced a delayed handover in August, an increase from 94 in July.

- Ambulance Handover at 60 minutes or more – there were 42 patients who experienced a delayed handover in August, an increase from 21 in July.
- Discharge Summaries % sent within 24 hours – the Trust achieved 87.57% in August, a slight decrease from July's performance of 87.67% against a target of 85%.
- Cancelled operations on the day (for non-clinical reasons) – there were 16 cancelled operations in August, a decrease from 17 in July.

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

- A&E Waiting Times improvement trajectory – the Trust achieved 87.5% including walk ins and 85.24% excluding walk ins in August, the Trust's improvement trajectory for August was 88.8%.
- Cancer 62 days urgent – the Trust achieved 83.72% in July's validated position, a decrease from June's validated position of 86.96% against a target of 85%.

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

- Diagnostic waiting times – the Trust achieved 99.59% in August, an improvement from July's performance of 98.5% against a target of 99%.
- Cancer 14 days – the Trust achieved 93.13% in July's validated position an improvement from June's position of 92% against a target of 93%.

PEOPLE

Workforce KPIs
There are 3 indicators rated Red in August, a decrease from 5 in July.

The 2 indicators which were Red in July and remain Red in August are as follows:

- Non-Contracted Pay – remains above budget at 14% of total pay from July to August.
- Agency Nurse Spend – increased to £0.32m in August, which exceeds the ceiling of £0.22m.

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

- Return to Work – the Trust achieved 71.34% in August, a decrease from 80.06% in July against a target of 85%.

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

- Sickness Absence – the Trust achieved 4.39% in August, an improvement from 5.08% in July against a target of greater than 4.2%.

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

- Agency AHP Spend – reduced to £0.126m in August which is below the ceiling of £0.127m.
- Average Length of Service (Top 10 Agency Workers) – this has reduced from 36 months in July to 29 months in August.

SUSTAINABILITY

Finance and Sustainability KPIs

There are 5 Red rated Finance and Sustainability indicators in August, an increase from 4 in July.

The 4 indicators which are Red in August are as follows:

- Operating Surplus/Deficit – the actual deficit is £10.1m which is £0.1m above the planned deficit of £10.0m. The Trust has signed up to a control total of £16.9m deficit which includes Provider Sustainability Funding (PSF) of £4.9m. Excluding the PSF, the Trust is on plan.
- Better Payment Practice Code (BPPC) – the challenging cash position results in a year to date performance of 52% which is 43% below the national standard of 95%.
- Agency Spending – the actual year to spend is £4.5m which is £0.9m above the year to date ceiling of £3.6m.
- Cost Improvement Programme – the year to date savings are £0.6m which is £0.8m below the £1.4m planned savings.

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

- Fines & Penalties – NHS England has levied a penalty of £0.015m due to the partial achievement of CQUIN in Q1.

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

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

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 impact on cash and will lead to the need for further loans. An urgent assessment of budgets and CIP is underway, which will inform the forecast for the Trust.

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.

The operating position has restricted the amount of cash available for investment so the capital programme is under constant review to ensure that schemes undertaken are required for the delivery of service needs and mitigation of safety and risk issues. There are proposed changes to the capital programme, which have been supported by the Finance and Sustainability Committee on 19th September 2018. These have been summarised in Table 1 below.

Table 1: proposed changes to the 2018/19 capital programme.

Scheme	Value £000
Additional Funding Required	
Pharmacy Essential Power Supply (1)	6
Ward A9 Bathroom Upgrade (2)	28
Pathology Anaerobic Cabinet (externally funded) (3)	20
Meditech Restoration (4)	22
Sub total	**76**
Funding by	
External Funding	(20)
Contingency	(56)
Sub total	**(76)**
Total	**0**

(1) Dedicated essential power and network points required to use a calibrated and maintained temperature monitoring system for refrigerators containing high value medication.
(2) Completion of the conversion of a bathroom on Ward A9 to a storage room.
(3) A new Anaerobic cabinet in Pathology. Additional costs are covered by capital receipt.
(4) Restoration of the corrupt Meditech database to enable continued access for patient requirements.

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
- 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 September 2017 – August 2018

	KPI	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 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 September 2017 – August 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												

Appendix 1 – KPI RAG Rating September 2017 – August 2018

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

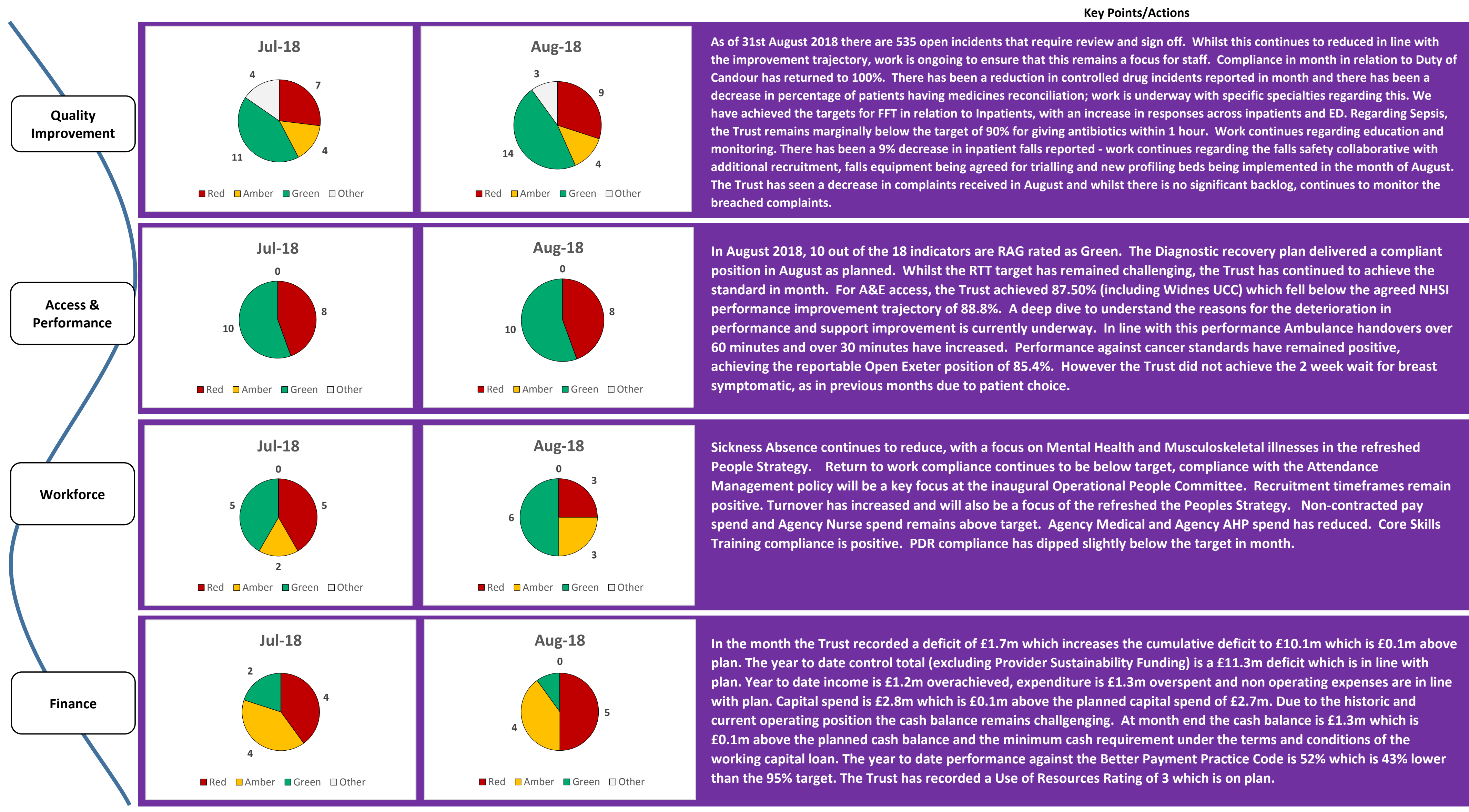
Appendix 2

Integrated Dashboard - August 2018

Key

Use of Resources Assessment Indicator UoR

Key Points/Actions



As of 31st August 2018 there are 535 open incidents that require review and sign off. Whilst this continues to reduced 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 has returned to 100%. There has been a reduction in controlled drug incidents reported in month and there has been a decrease in percentage of patients having medicines reconciliation; work is underway with specific specialties regarding this. We have achieved the targets for FFT in relation to Inpatients, with an increase in responses across inpatients and ED. Regarding Sepsis, the Trust remains marginally below the target of 90% for giving antibiotics within 1 hour. Work continues regarding education and monitoring. There has been a 9% decrease in inpatient falls reported - work continues regarding the falls safety collaborative with additional recruitment, falls equipment being agreed for trialling and new profiling beds being implemented in the month of August. The Trust has seen a decrease in complaints received in August and whilst there is no significant backlog, continues to monitor the breached complaints.

In August 2018, 10 out of the 18 indicators are RAG rated as Green. The Diagnostic recovery plan delivered a compliant position in August as planned. Whilst the RTT target has remained challenging, the Trust has continued to achieve the standard in month. For A&E access, the Trust achieved 87.50% (including Widnes UCC) which fell below the agreed NHSI performance improvement trajectory of 88.8%. A deep dive to understand the reasons for the deterioration in performance and support improvement is currently underway. In line with this performance Ambulance handovers over 60 minutes and over 30 minutes have increased. Performance against cancer standards have remained positive, achieving the reportable Open Exeter position of 85.4%. However the Trust did not achieve the 2 week wait for breast symptomatic, as in previous months due to patient choice.

Sickness Absence continues to reduce, with a focus on Mental Health and Musculoskeletal illnesses in the refreshed People Strategy. Return to work compliance continues to be below target, compliance with the Attendance Management policy will be a key focus at the inaugural Operational People Committee. Recruitment timeframes remain positive. Turnover has increased and will also be a focus of the refreshed the Peoples Strategy. Non-contracted pay spend and Agency Nurse spend remains above target. Agency Medical and Agency AHP spend has reduced. Core Skills Training compliance is positive. PDR compliance has dipped slightly below the target in month.

In the month the Trust recorded a deficit of £1.7m which increases the cumulative deficit to £10.1m which is £0.1m above plan. The year to date control total (excluding Provider Sustainability Funding) is a £11.3m deficit which is in line with plan. Year to date income is £1.2m overachieved, expenditure is £1.3m overspent and non operating expenses are in line with plan. Capital spend is £2.8m which is £0.1m above the planned capital spend of £2.7m. Due to the historic and current operating position the cash balance remains challgenging. At month end the cash balance is £1.3m which is £0.1m above 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 52% which is 43% lower than the 95% target. The Trust has recorded a Use of Resources Rating of 3 which is on plan.

Warrington and Halton Hospitals NHS Foundation Trust

Integrated Dashboard - August 2018

Quality Improvement - Trust Position

Description	Aggregate Position	Trend	Variation

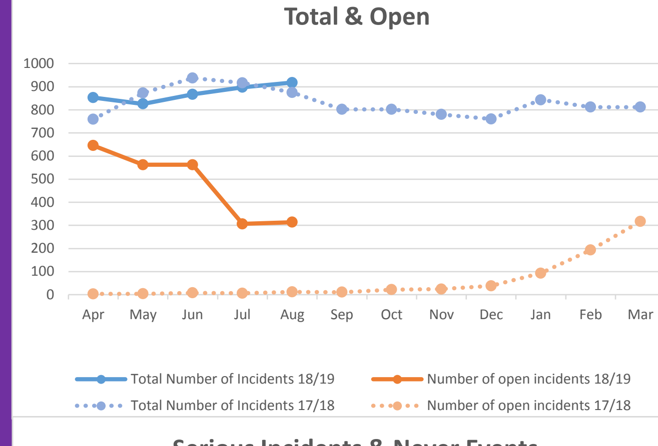
Patient Safety

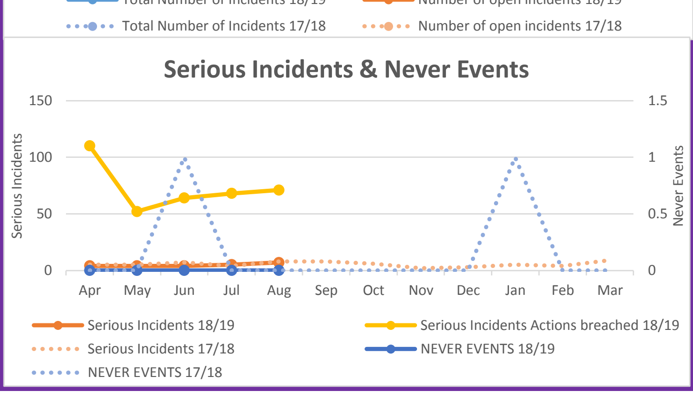
Incidents

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

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



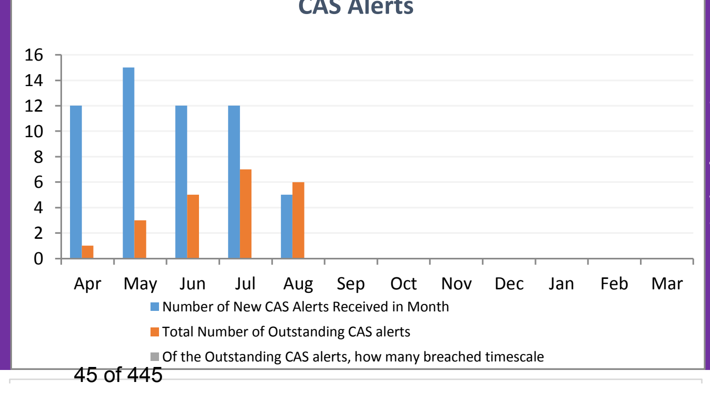


As of 31st August 2018, there are 535 open incidents which require review and sign off. 452 relate to CBUs with the remaining incidents for Corporate or External Organisations. This represents a downward trajectory in line with the CQC action to close all backlog incidents. This is monitored at the monthly Getting to Good Steering Group.

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

The Central Alerting System (CAS) is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and others, including independent providers of health and social care. Timescales are individual dependant upon the specific CAS alerts.

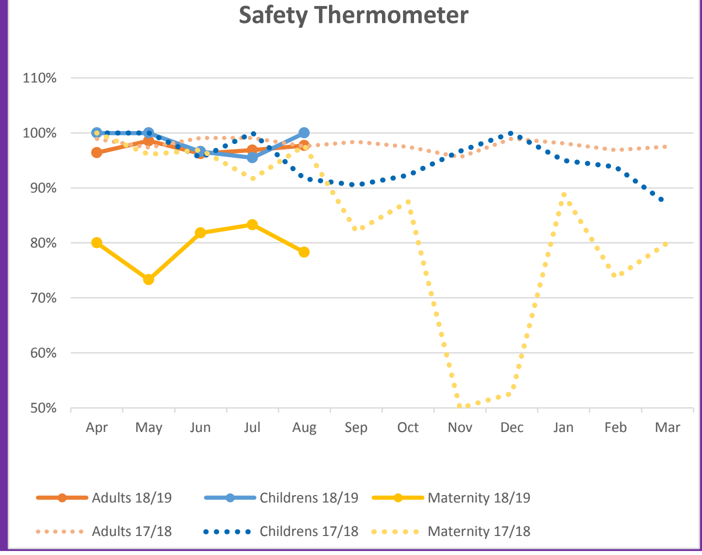
All CAS alerts should be reviewed and actioned within their individual timeframes.



We received 5 alerts in August, of which 3 have been closed.
There are 6 open alerts within the CAS system for the Trust.
We have no alerts past the close by date.

Integrated Dashboard - August 2018

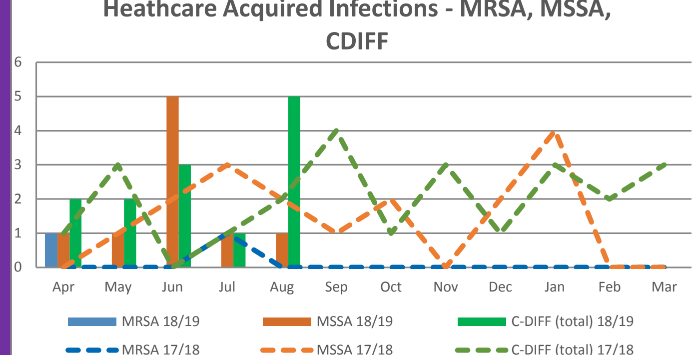
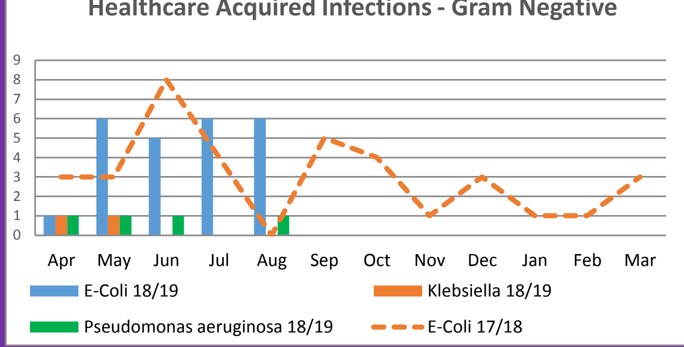
Quality Improvement - Trust Position

	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.	Duty of Candour	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; these were subsequently completed. These breaches occurred in May 2018, since then 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 August, the Adult Classic Safety Thermometer shows 5 Falls with Harm and 6 VTEs, with no individual ward being of concern. All Lead Nurses and Matrons have been advised to exercise extra vigilance in these indicators. Overall this meant a harm free percentage of 97.69%. The Maternity ST showed 78.3% harm free, the 2 areas of harm were 3rd degree tear and Post Partum Haemorrhage - the mothers' perception of their safety was 100% positive. As part of the Maternity Safety Champions work, an improvement plan is in place which is monitored at Quality Assurance Committee. The Children's ST was 100% Harm Free.

Duty of Candour chart: Number (0–8) / Percentage (0%–100%); Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
- Number of serious incidents - DoC applies 18/19
- Number of moderate harm incidents - DoC applies 18/19
- % Compliance rate with DoC (serious incidents) 18/19
- % Compliance rate with DoC (moderate incidents) 18/19

Integrated Dashboard - August 2018

Quality Improvement - Trust Position

	Description	Aggregate Position	Trend	Variation
Healthcare Acquired Infections **MRSA** **Red: 1 or more** **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**	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 by ward A7 in April 2018 this was considered avoidable. Work is in progress with AED to promote timely blood culture sampling. Clostridium difficile - 5 hospital onset cases reported in August 2018. Root cause analysis investigations are in progress. Ward A7 has an increased incidence in cases. Ribotyping results are awaited. MSSA - 1 hospital onset case was reported in August. Investigations are in progress. 3 of the 9 cases FYTD are peripheral cannula related and 1 case due to sampling delay. Additional training has been carried out on cannula management. Gram negative bloodstream infections in August: E. coli 6 hospital onset cases; Klebsiella - 0 hospital onset cases and 1 case of Pseudomonas aeruginosa. A GNBSI action group has been established to review key themes from surveillance data and identify preventative action. Use of investigation toolkits has been implemented from the start of Q2.

Integrated Dashboard - August 2018

Quality Improvement - Trust Position

	Description	Aggregate Position	Trend	Variation
VTE Assessment Red: <95% Green: 95% or above based on previous months' figures due to timescales for validation of data	Venous thromboembolism (VTE) is the formation of blood clots in the vein. This data looks at the % of assessments completed in month and the incidents of preventable harm. We also look at the number of RCA's completed in relation to VTE's.	The target for completion and documentation of VTE risk assessment on admission is 95%. Regarding the VTE backlog, weekly meetings are being held, chaired by the Medical Director where it has been agreed that additional capacity to clear the backlog from 15/16, 16/17, 17/18 (risk assessed by harm and occurrence of PE).	VTE Assessment (chart: % Target for completion; % Completion of assessments 18/19; % Completion of assessments 17/18) Root Cause Analysis (chart: No of RCAs completed in month that have caused harm 18/19; No of RCAs completed in month 18/19; No of RCAs completed in month 17/18)	Over the previous 2 VTE workshops, 8 RCA's have been closed following review which found no harm caused by the Trust, and 9 RCA's reported as moderate harm. 3 of these cases required DOC. There are currently 4 RCA's from May 2017 to date that have been reviewed by AMD and ACN for patient safety that require further investigation. 2 RCA's are currently outstanding review by the AMD and CAN for patient safety. 30 RCA's are currently with Consultants under review.
Safer Surgery Red: <100% Green: 100%	The Safe Surgery check list is monitored through OMIS BI and checked and validated via 20 case per month by Head of theatre services.	The target is to achieve 100%.	Safer Surgery (chart: 18/19; 17/18)	We have reviewed ALL surgical procedures conducted since April 2017 as to whether a checklist was completed. In the month of August 100% of check lists were reviewed and the overall score was 100% compliant.

Integrated Dashboard - August 2018

Quality Improvement - Trust Position

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

Description	Aggregate Position	Trend	Variation
Screening of all eligible patients - acute inpatients. Screening of all eligible patients admitted to emergency areas AED. Inpatient received treatments and empiric review within three days of prescribing antibiotics. Emergency patients received treatment and empiric review within three days of prescribing the antibiotics.	The target is to achieve 90%	CQUIN - Sepsis Screening (chart: Apr, May, Jun, Qtr1, Jul, Aug, Sep, Qtr2, Oct, Nov, Dec, Qtr3, Jan, Feb, Mar, Qtr4; 60%–100%; Target, AED Screening 18/19, Inpatient Screening 18/19, AED Screening 17/18, Inpatient Screening 17/18) CQUIN - Sepsis Antibiotics & Empiric Review (chart: Apr, May, Jun, Qtr1, Jul, Aug, Sep, Qtr2, Oct, Nov, Dec, Qtr3, Jan, Feb, Mar, Qtr4; 0%–100%; Target, AED Antibiotic Administered 18/19, Inpatient Antibiotic Administered 18/19, Antibiotic review 18/19)	Data for antibiotic review is now submitted directly to PHE by Pharmacy. Q1 data has been submitted. PHE have informed results will not be available for Q1 until Q3 - this has been raised as a concern. Q1 inpatient achieved over 90% for both screening and antibiotics, whilst ED met the screening target but missed the antibiotic target by 1% (89%). Q2 - inpatients areas are on target to meet the 90% for both screening and antibiotics within 1 hour. In July and August 100% of patients were screened for Sepsis, but the antibiotic target was missed in both months, with a trajectory dip below 90% for the quarter if results are similar in September 2018. A Task and Finish group has been established and the first meeting held with an action plan drafted.

Integrated Dashboard - August 2018

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.	**Number of Falls** Apr-17 May-17 Jun-17 Jul-17 Aug-17 Sep-17 Oct-17 Nov-17 Dec-17 Jan-18 Feb-18 Mar-18 Total falls 18/19 · Total falls 17/18	The total number of inpatient falls has decreased from 79 to 71 which is a decrease of 9% on the previous month. Total number of all falls inclusive of staff and patients has increased from 89 to 93 an increase of 4% on the previous month. In terms of cumulative numbers of total falls for 2018/19 compared against the same period last year there is a decrease of 6% .
			Number of Falls - Moderate, Severe & Death Apr-17 May-17 Jun-17 Jul-17 Aug-17 Sep-17 Oct-17 Nov-17 Dec-17 Jan-18 Feb-18 Mar-18 Moderate Harm 18/19 · Severe Harm & Death 18/19 · Moderate Harm 17/18 · Severe Harm & Death 17/18	Two serious harms were recorded in August. Common themes highlighted from falls are assessment and accurate identification of risk. The Trust Enhanced Care policy will support staff to address this. Weekly harm meetings continue with falls walks to clinical areas. Contributory factors to falls are also discussed at TWSB every weekday morning.
Pressure Ulcers Grade 4 Red: 1 or more Grade 3 Red: More than 3 Green: 3 or less Grade 2 Red: More than 7 Green: 7	Pressure ulcers, also known as pressure sores, bedsores and decubitus ulcers, are localised damage to the skin and/or underlying tissue that usually occur over a bony prominence as a result of pressure, or pressure in combination with shear and/or friction.	Grade 4 hospital acquired (avoidable and unavoidable) Grade 3 hospital acquired(avoidable and unavoidable) Grade 2 hospital acquired (avoidable and unavoidable)	**Pressure Ulcers** Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Grade 4 un-avoidable 18/19 · Grade 4 avoidable 18/19 · Grade 3 un-avoidable 18/19 · Grade avoidable 18/19 · Grade 2 unavoidable 18/19 · Grade 2 avoidable 18/19 · Grade 4 avoidable 17/18 · Grade 3 avoidable 17/18 · Grade 2 avoidable & unavoidable 17/18	RCA panels continue to be undertaken and the outcome is not added to dashboard until it is clear if they were deemed avoidable/unavoidable. The total numbers for grade 2 pressure ulcers in June is 4 with the outcome from the panel deeming 2 of them to be avoidable. Grade 3 pressure ulcer from ICU in April deemed avoidable. Mini RCA hearings completed for all pressure ulcers up to end of June. 2 RCAs still to be heard for July (C22 and C23). RCA hearing on 18/09/2018 for grade 2 pressure ulcers:- June - B1 July - C22 & C23 August - Delivery suite (2), A2, A9. Pressure ulcers in maternity - Action plan in place.

Integrated Dashboard - August 2018

Quality Improvement - Trust Position

Description	Aggregate Position	Trend	Variation
Medication Safety Red - any incidents of harm. Green - no incidents of harm. Overview of the current position in relation to medication, to include; medication reconciliation, controlled drugs incidents and medication incidents relating to harm.	The target for Medication Safety is a zero tolerance for incidents of harm.	**Medication Safety** Legend: Controlled drugs incidents 18/19; Medication Incidents relating to harm 18/19; Controlled drugs incidents 17/18; Medication Incidents relating to harm 17/18; % Medication reconciliation 18/19; % Medication reconciliation 17/18	The % of Medicine Reconciliation completed within 24 hours and overall is lower than the previous 2 months (24%↓ & 67%↓) due to lower % in Digestive Diseases, MSK, Specialist Surgery and Womens & Childrens Health. 24.1%↓ of Medicine Reconciliation were completed within 24 hours of admission and 45.8%↓ within 48 hours of admission. The number of Controlled Drug incidents reported in Aug (13) is lower than the previous month (18): 4 in Urgent & Emergency Care↑, 2 in Digestive Diseases↓, 2 in Specialist Medicine↓, 1 in ABC↓, 1 in MSK↔, & 1 in Specialist Surgery ↑. Learning is being identified so that it can be disseminated to individuals and collectively. The harm incident reported in July in Specialist Medicine has been reviewed and downgraded.
Staffing - Average Fill Rate Red: 0-79% Amber: 80-89% Green: 90-100% Percentage of planned verses actual for registered and non registered staff by day and night	Target of >90%. The data produced excludes CCU, ITU and Paediatrics.	**Staffing - Average Fill Rate** Legend: Day - registered nurses/midwives 18/19; Night - registered nurses/midwives 18/19; Day - registered nurses/midwives 17/18; Night - registered nurses/midwives 17/18; Day - care staff 18/19; Night - care staff 18/19; Day - care staff 17/18; Night - care staff 17/18	We continue to closely monitor actual versus planned hours.

Integrated Dashboard - August 2018

Quality Improvement - Trust Position

	Description	Aggregate Position	Trend	Variation
Staffing - Care Hours Per Patient Day (CHPPD)	Care Hours Per Patient Day = (Hours of registered nurses + Hours of healthcare support workers) / Total number of inpatients	The data produced excludes CCU, ITU and Paediatrics and does not have an associated target.	Staffing - Care Hours Per Patient Day (CHPPD)	We continue to monitor CHPPD as part of the daily responsive plans regarding care delivery.
Mortality ratio - HSMR Red: Greater than expected Green: As or under expected	Hospital Standardised Mortality Ratio (HSMR 12 month rolling). The HSMR is a ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in- hospital deaths (multiplied by 100) for 56 specific Clinical Classification System (CCS) groups.	Target for Green would be to be within expected ranges.	HSMR	We are as expected for HSMR. Our HSMR is currently at 103. Work continues regarding the implementation of our Learning from Deaths Policy.
Mortality ratio - SHMI Red: Greater than expected Green: As or under expected	Summary Hospital-level Mortality Indicator (SHMI 12 month rolling). SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.	Target for Green would be to be within expected ranges.	SHMI	SHMI source data is not currently available. NHS Digital has not been able to provide HED with the normal data used to produce SHMI related modules. They have also not been able to provide HED with any further information regarding when this data will become available so we continue to use the last known position of 104.70 which is within the expected range.

Integrated Dashboard - August 2018

Quality Improvement - Trust Position

	Description	Aggregate Position	Trend	Variation
Total Deaths	Total Deaths (including A&E) - We screen all deaths within the Trust to ascertain if any harm has been caused. If harm has been caused it is subject to a further review by the Mortality Review Group.	There is no target against this indicator.	**In-Hospital Deaths** 140 120 100 80 60 40 20 0 Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Total Hospital Deaths 18/19 — Total Hospital Deaths 17/18	All the 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 these may be potentially avoidable mortality, is reported as a Serious Incident and subject to a full Root Cause Analysis before avoidability is confirmed.
NICE Compliance Red: <75% Amber: 75% to <100% Green: 100%	The National Institute for Health and Clinical Excellence (NICE) is part of the NHS and is the independent organisation responsible for providing national guidance on treatments and care for people using the NHS in England and Wales and is recognised as being a world leader in setting standards for high quality healthcare and are the most prolific producer of clinical guidelines in the world.	The target is to achieve 100% compliance against all NICE guidance.	**NICE Compliance** 100% 90% 80% 70% 60% 50% 40% 30% 20% 10% 0% Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Target — Compliance 18/19 — Compliance 17/18	There are a total of 4 pieces of NICE Guidance which are outside the 90 day assessment period: Trust Wide 1. QS15 - Patient Experience, a Task and Finish Group has been set up for this. 2. NG89 - VTEs in over 16's - work has commenced regarding completion of baseline assessment. ABC 1. NG80 - Asthma, partially completed baseline assessment, which is being finalised. Urgent & Emergency Care 1. NG94 - Emergency and Acute Services in over 16's, which is currently being assessed.

Integrated Dashboard - August 2018

Quality Improvement - Trust Position

Description	Aggregate Position	Trend	Variation

Patient Experience

Complaints

Overall review of the current complaints position, including; Number of complaints received, number of dissatisfied complaints, total number of open complaints, total number of cases over 6 months old, total number of cases in backlog where they have breached timeframes, number of cases referred to the Parliamentary and Health Service Ombudsman and the number of complaints responded to within timeframe.

Red - Trust not meeting improvement trajectories or complaints open over 6 months old.
Amber - No complaints over 6 months old, Trust meeting backlog improvement targets
Green - No backlog, complaints responded to within agreed timescales.
Please note that the above RAG rating will be reviewed following the completion of the complaints improvement plan.

The Trust now holds no complaints over 6 months but has 6 complaints that have breached their deadline. Timeliness in responding has decreased in August (51% May, 67% June, 83% July, August 69%). The Trust has had an increase in complainants who have been dissatisfied but this could be due to amount of complaints that have been closed over the last two months. The Trust has received the least amount of complaints since the financial year began. Note that the Trust has cleared the backlog of complaints, we will be reviewing the RAG ratings in line with timeliness KPIs e.g. Green = 90%

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%.

For the 3rd consecutive month we have surpassed the 95% target for inpatients and day cases Friends and Family feedback with 97% of patients recommending our services.
In addition the response rate has also increased from 29.5% to 32.2%.

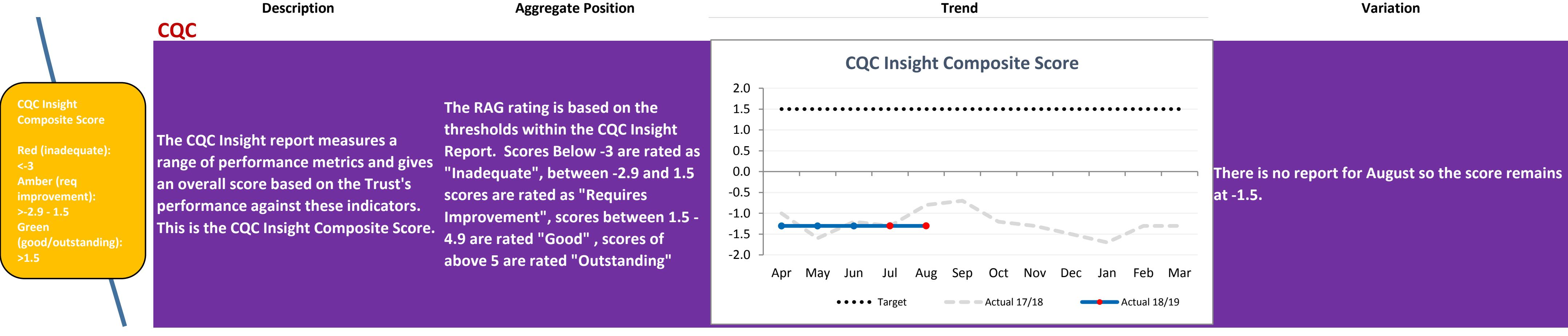
Integrated Dashboard - August 2018

Quality Improvement - Trust Position

	Description	Aggregate Position	Trend	Variation
Friends and Family (A&E and UCC) Red: Less than 87% Green: 87% or more	Percentage of AED (Accident and Emergency Department) patients recommending the Trust : Patients are asked - How likely are you to recommend our AED to friends and family if they needed similar care or treatment?	The target set is to achieve over 87%.	Friends and Family (A&E and UCC)	There has been a 2% increase in patients recommending our A&E and Urgent Care services rising to 86%, with a target of 87%. There has also been an increase in the response rate from 17.6% in July to 20% in August 2018.
Mixed Sex Accommodation Breaches Red: 1 or more Green: Zero	We submit data to NHS England in relation to the number of occurrences of unjustified mixing in relation to sleeping accommodation.	There is a target of zero tolerance.	Mixed Sex Accommodation Breaches	There have been 19 reported mixed sex accommodation breaches in August with 14 occurring in the ICU and 5 in CCU. CCU breaches were directly related to side room usage for the isolation of infectious patients.

Integrated Dashboard - August 2018

Quality Improvement - Trust Position



Integrated Dashboard - August 2018

Mandatory Standards - Access & Performance - Trust Position

	Description	Aggregate Position	Trend	Variation
Diagnostic Waiting Times 6 Weeks Red: Less than 99% Green: 99% or above	All diagnostic tests need to be carried out within 6 weeks of the request for the test being made. The national target is 99% or over within 6 weeks. This metric also forms part of the Trust's Sustainability and Transformation Plan (STP) Improvement trajectory. The proposed tolerance levels applied to the improvement trajectories are also illustrated.	The Trust achieved 99.59% in August 2018.	Diagnostic Waiting Times 6 Weeks	The Diagnostic target met the planned trajectory to be compliant in August. This resulted in a performance of 99.59% against a target of 99%. The business case for additional support and equipment has been agreed. Compliance against this standard is being monitored and is expected to continue to be compliant going forward.
Referral to treatment Open Pathways Red: Less than 92% Green: 92% or RTT - Number of patients waiting 52+ weeks Green = 0, otherwise Red	Percentage of incomplete pathways waiting within 18 weeks. The national target is 92% This metric also forms part of the Trust's STP Improvement trajectory. The proposed tolerance levels applied to the improvement trajectories are also illustrated.	The Trust achieved 92.27% in August 2018.	Referral to treatment Open Pathways	The Trust achieved the 18 week referral to treatment target, achieving 92.27% against a target of 92%; this is a difficult target which remains challenging given the continued pressure experienced by the Trust and cancellations. Additional validation support is continuing to assist the central team and all specialities not achieving this standard have individual recovery plans in place for the remainder of the year. These are already showing improvement especially in those challenged areas such as MSK.
Four Hour Standard - National Target Red: Less than 95% Green: 95% or above Four Hour Standard Waiting Times - STP Trajectory Red: Less than trajectory Green: Trajectory or	All patients who attend A&E should wait no more than 4 hours from arrival to admission, transfer or discharge. The national target is 95% This metric also forms part of the Trust's STP improvement trajectory. The proposed tolerance levels applied to the improvement trajectories are also illustrated.	The Trust achieved 87.5% (including walk in) and 85.24% (excluding walk in) in August 2018.	A&E Waiting Times - 4hr target	The Trust achieved 87.50% (including Widnes UCC) which narrowly fell below the agreed NHSI performance improvement trajectory of 88.8%. It was anticipated that the planned de-escalation of winter bed capacity in August would provide a challenge to maintaining improvements in performance. A deep dive review is underway to understand the specific reasons for the underachievement and identify actions to an support improvement in performance. A silver command rota remains in place which provides senior management presence in the patient flow office to ensure that challenges are actioned in a timely manner. There is a zero tolerance on non-admitted breeches for 2018/19 and performance has improved from 41% of total breaches in April 2018, to 34% in August. These are reviewed on a daily basis.

Integrated Dashboard - August 2018

Mandatory Standards - Access & Performance - Trust Position

Standard	Description	Aggregate Position	Trend	Variation
Cancer 14 Days Red: Less than 93% Green: 93% or above	All patients need to receive first appointment for cancer within 14 days of urgent referral. The national target is 93%. This target is measured and reported on a quarterly basis.	The Trust achieved 93.13% in July 2018 - please note cancer validation is not completed until 8 weeks after the end of the reporting period.	Cancer 14 Days	The Trust achieved the Cancer 14 Day target in July . The August data is in draft format and will only be released once fully validated and uploaded in August.
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 88.41% in July 2018 - please note cancer validation is not completed until 8 weeks after the end of the reporting period.	Breast Symptoms 14 Days	The 2 week wait for Breast Symptomatic failed in July and this was mainly attributed to breaches associated with patient choice. The Womens & Childrens CBU has undertaken a deep dive review and action has been taken with additional capacity being made available.
Cancer 31 Days First Treatment Red: Less than 96% Green: 96% or above	All patients to receive first treatment for cancer within 31 days of decision to treat. This national target is 96%. This target is measured and reported on a quarterly basis.	The Trust achieved 98.48% in July 2018 - please note cancer validation is not completed until 8 weeks after the end of the reporting period.	Cancer 31 Days First Treatment	The Trust achieved this target in July 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 July 2018 - please note cancer validation is not completed until 8 weeks after the end of the reporting period.	Cancer 31 Days Subsequent Surgery	The Trust achieved this target in July 2018.

Trend chart axes: % Performance (left), Number pf patients (right); months Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar. Legend: No. of Patients 18/19, No. of Patients 17/18, Target, % 18/19, % 17/18.

Integrated Dashboard - August 2018

Mandatory Standards - Access & Performance - Trust Position

	Description	Aggregate Position	Trend	Variation
Cancer 31 Days Subsequent Drug Red: Less than 98% Green: 98% or above	All patients to receive a second or subsequent treatment for cancer within 31 days of decision to treat – anti cancer drug treatments. The national target is 98%. This target is measured and reported on a quarterly basis.	The Trust achieved 100% in May 2018 - please note cancer validation is not completed until 8 weeks after the end of the reporting period.	Cancer 31 Days Subsequent Drugs	The Trust achieved this target in July 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 83.72% in July 2018 - please note cancer validation is not completed until 8 weeks after the end of the reporting period.	Cancer 62 Days Urgent	The Trust did not hit the threshold in July 2018 for the reallocated position with a performance of 83.7%. The Trust did achieve the Open Exeter position at 85.5% for July 2018 which is the reportable position. From Q3 the Trust will be monitored against the reallocated position.
Cancer 62 Days Screening Red: Less than 90% Green: 90% or above	All patients must wait no more than 62 days from referral from an NHS screening service to first definitive treatment for all cancers. The national target is 90%. This target is measured and reported on a quarterly basis.	The Trust achieved 90.91% in July 2018 - please note cancer validation is not completed until 8 weeks after the end of the reporting period.	Cancer 62 Days Screening	The Trust achieved this target in July 2018.

Integrated Dashboard - August 2018

Mandatory Standards - Access & Performance - Trust Position

Indicator	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 157 patients where the ambulance handover was between 30 and 60 minutes in August 2018.	Ambulance Handovers at 30 to <60 minutes	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 August.
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 42 patients where the ambulance handover was more 60 minutes in August 2018.	Ambulance Handovers at 60+ minutes	Ambulance handovers remain a challenge particularly when we have peaks in attendances within an hour, the number of handovers greater than 60 minutes has increased in line with performance. Work continues to focus on reducing number waiting over 30 minutes.
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 87.57% in August 2018.	Discharge Summaries	The Trust continues to drive compliance improvement across all CBUs. This is monitored via the weekly & monthly KPI meetings.
Discharge Summaries - Number NOT sent within 7 days Red: Above 0	If the Trust does not send 95% of discharge summaries within 24hrs, the Trust is then required to send the difference between the actual performance and the 95% required standard within 7 days of the patients discharge.	All discharge summaries in order to meet the 95% threshold were sent in August 2018.	Discharge Summaries - Number NOT sent within 7 days (target = 0)	The Trust achieved this target in August 2018.

Chart: Ambulance Handovers at 30 to <60 minutes — y-axis 0–350; months Apr–Mar; legend: No. of Patients 18/19, Target, No. of Patients 17/18.

Chart: Ambulance Handovers at 60+ minutes — y-axis 0–160; months Apr–Mar; legend: No. of Patients 18/19, Target, No. of Patients 17/18.

Chart: Discharge Summaries — % Performance 0%–100%; Number of patients 0.00–8,000.00; months Apr–Mar; legend: No. of Patients 18/19, No. of Patients 17/18, Target, % 18/19.

Chart: Discharge Summaries - Number NOT sent within 7 days (target = 0) — y-axis 0–1500; months Apr–Mar; legend: 18/19 No. not sent within 24hrs that resulted in <95%; 17/18 No. not sent within 24hrs that resulted in <95%; 18/19 Of the no. required to hit 95% how many not sent within 7 days; 17/18 Of the no. required to hit 95% how many not sent within 7 days.

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 16 operations cancelled on the day due to non-clinical reasons in August 2018.	Cancelled operations on the day for non-clinical reason	This has remained a challenge in August with bed pressures at peak times continuing.
Cancelled Operations on the day for a non-clinical reason - Not offered a date for readmission within 28 days of the cancellation	All service users who have their operation cancelled on the day or after admission for a non-clinical reason, should be offered a binding date for readmission within 28 days.	All patients whose operation was cancelled on the day for non-clinical reasons whom was not readmitted within 28 days in August 2018.	Cancelled operations on the day for non-clinical reason - Not offered date for readmission within 28 days	There were no breaches of the 28 day target recorded this month.

Integrated Dashboard - August 2018

Workforce

	Description	Aggregate Position	Trend	Variation
Sickness Absence Red: Above 4.5% Amber: 4.2% to 4.5% Green: Below 4.2%	UoR Comparing the monthly sickness absence % with the Trust Target (4.2%) previous year, and North West average	Sickness absence has decreased to 4.39% against a target of 4.2%.	Monthly Sickness Absence	Sickness absence has reduced in month and is similar to the same period last year. The main reasons for absence are Mental Health and Musculoskeletal illnesses. These will be a key focus in the Trust refreshed People Strategy.
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 August is currently reported at 71.34% against a target of 85%.	Monthly Return to Work %	Return to Work Interview compliance continues to be below target. The management of sickness absence and compliance with the policy will be a key focus of the inaugural meeting of Operational People Committee in October 2018. The HR team will continue to support CBUs around Return to work compliance.
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 decreased to 61 days against a target of 65 days.	Recruitment	Recruitment timeframes are within the target and the HR and OD Directorate continues to review candidate experience. The main delay currently is in obtaining references. The Trust is working as part of a regional streamlining group to develop and implement actions around recruitment timescales.

Integrated Dashboard - August 2018

Workforce

	Description	Aggregate Position	Trend	Variation
Turnover Red: Above 15% Amber: 13% to 15% Green: Below 13%	UoR A review of the turnover percentage over the last 12 months	Trust Turnover has increased to 13.5% against a target of 13%.	Turnover %	Staff turnover has increased in month and is now 0.5% above target. The refreshed People Strategy will include a focus on how we retain talent within the organisation.
Non Contracted Pay Red: Greater than Budget Green: Less than Budget	UoR A review of the Non-Contacted pay as a percentage of the overall pay bill year to date	Expenditure on pay in August 2018 was £15.2m against a budget of £15m.	Non Contracted Spend vs Budget	Total pay spend in August 2018 was £15.2m against a budget of £15m. Contracted pay spend was £13m and the remaining £2.2m was spent on temporary staffing including agency, bank, overtime and WLIs. Temporary staffing usage was 14.7% in August 2018.
Agency Nurse Spend Red: Greater than Previous Yr Green: Less then	UoR A review of the monthly spend on Agency Nurses	Agency Nurse Spend was £318k and Bank Nurse Spend was £328k in August 2018.	Agency & Bank Nurse Spend	Throughout August 2018 there were 8,640 hours of agency work undertaken at a cost of £318k . AMU escalation has remained open and there has been a need for up to 2 staff per shift on Ward C21 in relation to a patient who required additional support. Throughout August 2018 there were 10,900 hours of bank work undertaken at a cost of £328k. 45 new Health Care Assistants and 30 Registered Nurses will begin work with the Trust in October 2018.

Integrated Dashboard - August 2018

Workforce

Indicator	Description	Aggregate Position	Trend	Variation
Agency Medical Spend Red: Greater than Previous Yr Green: Less then	UoR A review of the monthly spend on Agency Locums	Medical Agency Spend was £433k and Bank Medical Spend was £289k in August 2018.	Agency & Bank Medical Spend	Throughout August 2018 there were 4,747 hours of agency work undertaken at a cost of £433k. The dashboard shows a decrease in medical agency spend in month and an increase in medical agency hours worked. This demonstrates the work of the Temporary Staffing Team in providing additional control around bookings and negotiating rates and commission. Medical agency spend continues to be lower than the same period last year however is the most costly element of temporary staffing spend. Medical bank spend in August 2018 reduced slightly in month, although remains above the same period last year.
Agency AHP Spend Red: Greater than Previous Yr Green: Less then Previous Yr	UoR A review of the monthly spend on AHP Locums	AHP Agency Spend was £126k in August 2018.	Agency & Bank AHP Spend	AHP Agency spend decreased in month, in line with trends last year. AHP agency processes have now been brought centrally into the Bank and Agency Team.
Core/Mandatory Training Red: Below 70% Amber: 70% to 85% Green: Above 85%	A summary of the Core/Mandatory Training Compliance, this includes: Conflict Resolution, Equality & Diversity, Fire Safety, Health & Safety, Infection Prevention & Control, Information Governance, Moving & Handling, PREVENT, Resuscitation and Safegarding.	Core Skills Mandatory Training Compliance was 88% in August 2018 against a target of 85%.	Core/Mandatory Training	Core Skills Training remains above target overall. Focus in now on specific topics with low compliance, particularly Resuscitation Training.

Integrated Dashboard - August 2018

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 84% in August 2018 against a target of 85%.	PDR (chart: Target, Actual; Sep-17 to Aug-18)	PDR compliance has dipped 1% below target and again will be a key focus for the inaugural meeting of Operational People Committee in October 2018.
Average cost of the top 10 highest cost Agency Workers Red: Greater than previous month Green: Less than	UoR Monthly costs for the top 10 highest cost Agency Workers	The monthly cost for the top earning agency workers ranged from £69k to £23k, with the average cost being £36k.	Average cost of the top 10 highest cost agency workers (chart: Monthly Cost; Sep-17 to Aug-18)	The average cost of agency workers has decreased in comparison with last month. Medical and AHP agency processes have been centralised into the Bank and Agency Team, providing additional grip, control and challenge to agency. Admin and Clerical will be brought centrally in the next month.
Average length of service of the top 10 longest serving agency workers Red: Greater than previous month	The length of service (months) of the Top 10 agency workers who have been working at the trust for a minimum of 3 shifts per week for a consecutive period of 6 weeks.	The length of service for the longest serving agency workers ranged from 52 months to 20 months with the average length of stay being 29 months.	Average length of service of the top 10 longest serving agency workers (chart: Length of service (months); Sep-17 to Aug-18)	The refreshed People Strategy has a focus on taking a different approach to candidate attraction in order to fill vacancies across the workforce, which in turn will address agency usage.

Integrated Dashboard - August 2018

Sustainability & Mandatory Standards - Finance

Key	Description	Aggregate Position	Trend	Variation
Financial Position Red: Deficit Position Amber: Actual on or better than planned but still in deficit Green: Surplus	UoR Operating surplus or deficit compared to plan.	The actual deficit in the month is £1.7m which increases the cumulative deficit to £10.1m	**Financial Position** £m: 5.0, 0.0, -5.0, -10.0, -15.0, -20.0 Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar In month Plan 18/19; In month Actual 18/19; Actual 17/18; Cumulative Plan 18/19; Cumulative Actual 18/19	The cumulative deficit of £10.1m is £0.1m below plan. The year to date control total (excluding Provider Sustainability Funding) is a £11.3m 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	UoR Cash balance at month end compared to plan (excluding cash relating to the hosting of the Sustainability and Transformation Partnership).	The current cash balance of £1.2m equates to circa 2 days operational cash.	**Cash Balance** £m (Cash): 2.5, 2.0, 1.5, 1.0, 0.5, 0.0 £m (Loans): 80, 70, 60, 50, 40, 30, 20 Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Plan 18/19; Actual 17/18; Actual 18/19; Loans 18/19	The current cash balance of £1.3m which is £0.1m above plan.
Capital Programme Red: Off plan <80% - >110% Amber: Off plan 80-90% or 101 - 110% Green: On plan 90%-100%	UoR Capital expenditure compared to plan (The capital plan has been increased to £10.2m as a result of additional funding from the Department of Health, Health Education England and Cantreat for equipment and building enhancements).	The actual capital spend in the month is £0.7m which increases the cumulative spend to £2.8m.	**Capital Programme** £m: 12.0, 10.0, 8.0, 6.0, 4.0, 2.0, 0.0 Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Plan 18/19; Actual 17/18; Actual 18/19	The cumulative capital spend of £2.8m is £0.1m above the planned capital spend of £2.7m.

Integrated Dashboard - August 2018

Sustainability & Mandatory Standards - Finance

RAG criteria	Description	Aggregate Position	Trend	Variation
Better Payment Practice Code Red: Cumulative performance below 85% Amber: Cumulative performance between 85% and 95% Green: Cumulative performance 95% or	UoR Payment of non NHS trade invoices within 30 days of invoice date compared to target.	In month the Trust has paid 96% of suppliers within 30 days which results in a year to date performance of 52%.	Better Payment Practice Code (chart)	The cumulative performance of 52% is 43% below the national standard of 95%, this is due to the challenging cash balance and the need to manage cash very closely. Improvement in month is due to the receipt of the £7.9m working capital loan in July which enabled payment of many aged invoices and prompt payment in August of a significant value of invoices for the Health and Care Partnership for Cheshire and Merseyside.
Use of Resources Rating Red: Use of Resource Rating 4 Amber: Use of Resource Rating 3 Green: Use of Resource Rating 1 and 2	UoR Use of Resources Rating compared to plan.	The current Use of Resources Rating is 3. Capital Servicing Capacity, Liquidity, I&E margin are scored at 4 whilst Agency Ceiling and performance against control total is scored at 2.	Use of Resources Rating (chart)	The current Use of Resources Rating of 3 is in line with the planned rating.
Fines and Penalties Red: Greater than zero Green: Zero	Monthly fines and penalties	Fines and Penalties are levied by commissioners as outlined in the contracts.	Fines & Penalties (chart)	The Trust has been informed by NHS England that CQUINs were only partially met for Q1. The penalty for partial achievement was £15k. The Trust has agreed with commissioners in Warrington & Halton to reinvest any fines and penalties as part of the sustainability contract.

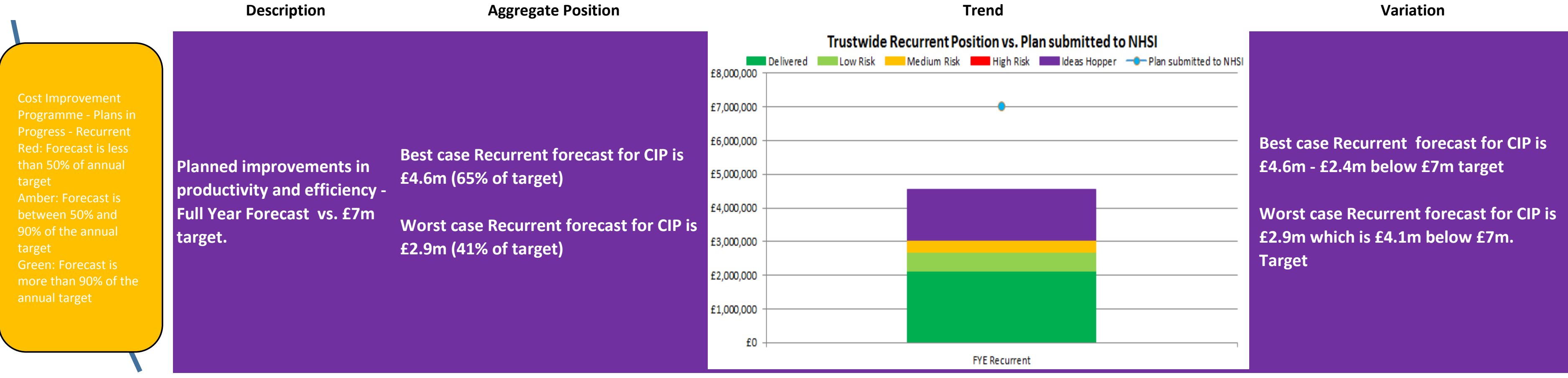
Integrated Dashboard - August 2018

Sustainability & Mandatory Standards - Finance

Indicator	Description	Aggregate Position	Trend	Variation
Agency Spending Red: More than 105% of ceiling Amber: Over 100% but below 105% of ceiling Green: Equal to or less than agency ceiling.	UoR Agency spend compared to agency ceiling	The actual agency spend in the month is £0.9m which increases the cumulative spend to £4.5m	Agency Spending	The cumulative agency spend of £4.5m is £0.9m (24%) above the cumulative agency ceiling of £3.6m.
Cost Improvement Programme - In year performance to date Red: 0-70% Plan delivered YTD Amber: 70-90% Plan delivered YTD Green: >90% Plan delivered YTD	Cost savings delivered compared to plan.	CIP savings delivered M5 £0.2m vs target £0.4m M5 YTD CIP £0.6m delivered vs YTD target £1.4m (46% of target).	CIP Delivered @ M05 YTD Vs. Target	CIP savings delivered in M5 are £0.2m behind plan. YTD M5 the Trust is £0.8m 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	Planned improvements in productivity and efficiency - In Year forecast vs £7m target.	Best case In-year forecast for CIP is £3m (43% of target). Worst case In-year forecast for CIP is £2.8m (41% of target).	Trustwide Cumulative In Year Position vs. Plan submitted to NHSI	Best case In-Year forecast for CIP is £3m - £4m below £7m target. Worst case In-year forecast for CIP is £2.8m - £4.2m below £7m target.

Integrated Dashboard - August 2018

Sustainability & Mandatory Standards - Finance



	Description	Aggregate Position	Trend	Variation
Cost Improvement Programme - Plans in Progress - Recurrent Red: Forecast is less than 50% of annual target Amber: Forecast is between 50% and 90% of the annual target Green: Forecast is more than 90% of the annual target	**Planned improvements in productivity and efficiency - Full Year Forecast vs. £7m target.**	**Best case Recurrent forecast for CIP is £4.6m (65% of target)** **Worst case Recurrent forecast for CIP is £2.9m (41% of target)**		**Best case Recurrent forecast for CIP is £4.6m - £2.4m below £7m target** **Worst case Recurrent forecast for CIP is £2.9m which is £4.1m below £7m. Target**

Appendix 3

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

	Month			Year to date			Forecast		
Income Statement	**Budget £000**	**Actual £000**	**Variance £000**	**Budget £000**	**Actual £000**	**Variance £000**	**Budget £000**	**Actual £000**	**Variance £000**
Operating Income									
NHS Clinical Income									
Elective Spells	2,947	2,391	-556	14,201	12,873	-1,327	33,894	33,894	0
Elective Excess Bed Days	9	12	4	42	71	28	101	101	0
Non Elective Spells	4,945	4,915	-30	24,523	25,174	651	59,030	59,030	0
Non Elective Excess Bed Days	169	364	195	836	1,304	468	2,013	2,013	0
Outpatient Attendances	2,915	2,795	-120	14,045	14,054	10	33,522	33,522	0
Accident & Emergency Attendances	1,077	1,180	103	5,595	6,109	514	13,451	13,451	0
Other Activity	5,673	6,040	367	28,077	28,281	204	69,120	69,120	0
Sub total	**17,734**	**17,697**	**-37**	**87,319**	**87,866**	**546**	**211,131**	**211,131**	**0**
Non NHS Clinical Income									
Private Patients	5	-2	-7	26	68	42	152	152	0
Non NHS Overseas Patients	4	0	-4	18	29	11	44	44	
Other non protected	95	56	-39	475	372	-103	1,135	1,135	0
Sub total	**104**	**54**	**-50**	**519**	**469**	**-50**	**1,331**	**1,331**	**0**
Other Operating Income									
Training & Education	641	643	2	3,205	3,208	2	7,693	7,693	0
Donations and Grants	0	98	98	0	98	98	0	0	0
Provider Sustainability Fund (PSF)	329	329	0	1,400	1,177	-223	4,942	4,942	0
Miscellaneous Income	1,575	1,819	244	7,873	8,727	854	20,503	20,503	0
Sub total	**2,545**	**2,889**	**344**	**12,479**	**13,210**	**731**	**33,138**	**33,138**	**0**
Total Operating Income	**20,383**	**20,640**	**256**	**100,317**	**101,545**	**1,227**	**245,600**	**245,600**	**0**
Operating Expenses									
Employee Benefit Expenses	-14,981	-15,194	-213	-75,230	-76,724	-1,493	-179,196	-179,196	0
Drugs	-1,419	-1,461	-42	-7,117	-6,748	368	-17,026	-17,026	0
Clinical Supplies and Services	-1,721	-1,862	-141	-8,686	-8,938	-252	-20,582	-20,582	0
Non Clinical Supplies	-3,100	-3,103	-3	-15,503	-15,547	-44	-36,874	-36,874	0
Depreciation and Amortisation	-501	-492	9	-2,503	-2,441	62	-6,007	-6,007	0
Restructuring Costs	0	0	0	0	0	0	0	0	0
Total Operating Expenses	**-21,722**	**-22,112**	**-390**	**-109,039**	**-110,398**	**-1,359**	**-259,686**	**-259,686**	**0**
Operating Surplus / (Deficit)	**-1,338**	**-1,472**	**-134**	**-8,721**	**-8,853**	**-132**	**-14,086**	**-14,086**	**0**
Non Operating Income and Expenses									
Profit / (Loss) on disposal of assets	0	1	1	0	1	1	0	0	0
Interest Income	3	6	3	15	26	11	36	36	0
Interest Expenses	-72	-73	-2	-390	-392	-2	-813	-813	0
PDC Dividends	-181	-181	0	-907	-907	0	-2,174	-2,174	0
Net Impairments	0	0	0	0	0	0	0	0	0
Total Non Operating Income and Expenses	**-250**	**-248**	**2**	**-1,282**	**-1,272**	**9**	**-2,951**	**-2,951**	**0**
Surplus / (Deficit)	**-1,588**	**-1,720**	**-132**	**-10,003**	**-10,125**	**-123**	**-17,037**	**-17,037**	**0**
Donations & Grants Income	0	-98	-98	0	-98	-98	0	0	0
Depreciation on Donated & Granted Assets	13	14	1	65	68	3	156	156	0
Performance against Control Total inc PSF	**-1,575**	**-1,804**	**-229**	**-9,938**	**-10,156**	**-218**	**-16,881**	**-16,881**	**0**
Less PSF	-329	-329	0	-1,400	-1,177	223	-4,942	-4,942	0
Performance against Control Total exc PSF	**-1,905**	**-2,133**	**-228**	**-11,338**	**-11,333**	**5**	**-21,823**	**-21,823**	**0**
Activity Summary	**Planned**	**Actual**	**Variance**	**Planned**	**Actual**	**Variance**	**Planned**	**Actual**	**Variance**
Elective Spells	3,142	2,876	-266	15,139	14,020	-1,119	36,135	36,135	0
Elective Excess Bed Days	36	53	17	174	293	119	415	415	0
Non Elective Spells	3,107	2,873	-234	15,410	14,399	-1,011	37,091	37,091	0
Non Elective Excess Bed Days	694	1,510	816	3,441	5,402	1,961	8,283	8,283	0
Outpatient Attendances	27,173	26,131	-1,042	130,925	129,552	-1,372	312,490	312,490	0
Accident & Emergency Attendances	9,195	9,255	60	47,781	48,818	1,037	114,866	114,866	0
Use of Resources Ratings	**Planned Metric**	**Actual Metric**	**Variance Metric**	**Planned Metric**	**Actual Metric**	**Variance Metric**	**Planned Metric**	**Actual Metric**	**Variance Metric**
Metrics									
Capital Servicing Capacity (Times)				-4.78	-4.31	0.48	-2.69	-2.69	0.00
Liquidity Ratio (Days)				-7.3	-30.8	-23.4	-14.3	-14.3	0.0
I&E Margin (%)				-9.91%	-10.01%	-0.10%	-6.87%	-6.87%	0.00%
Performance against control total (%)				0.00%	-0.10%	-0.10%	0.00%	0.00%	0.00%
Agency Ceiling (%)				0.00%	24.42%	24.42%	0.00%	0.00%	0.00%
Ratings									
Capital Servicing Capacity (Times)				4	4	0	4	4	0
Liquidity Ratio (Days)				3	4	1	4	4	0
I&E Margin (%)				4	4	0	4	4	0
Performance against control total (%)				1	2	1	1	1	0
Agency Ceiling (%)				1	2	1	1	1	0
Use of Resources Rating				**3**	**3**	**0**	**3**	**3**	**0**

Appendix 4

2018/19 Capital Programme

Proposed Amendments

Description	Approved Programme 2018/19	Approved Amendments M1 - M4 2018/19	Proposed Amendments M5 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
Backlog - Upgrade BMS system include survey	0	0	0	0
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	0	0	404
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	728	0	0	728
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 (ext. funded)	0	84	0	84
Discharge Lounge/Bereavement Office	0	208	0	208
Essential Power Supply - Halton Pharmacy	0	0	6	6
Bathroom A9	0	0	28	28
Kendrick Wing Fire - Estates	0	411	0	411
Kendrick Wing Fire - F & F	0	33	0	33
Kendrick Wing Fire - Miscellaneous	0	72	0	72
Pharmacy Clinical Trials Room	0	16	0	16
	2,736	**887**	**34**	**3,657**
Medical Equipment				
AER Machines (4 W 2 H)	700	0	0	700
Warrington MRI Scanner (replacement)	1,200	0	0	1,200
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) (ext. funded)	0	77	0	77
Obstretrics Simulation Monitors (HEE) (ext. funded)	0	7	0	7
Anaerobic Cabinet	0	0	20	20
Kendrick Wing Fire -Medical Equipment	0	363	0	363
Neonatal Monitors		35	0	35
	2,416	**340**	**20**	**2,776**
IM&T				
Technology & Devices refresh and developments	500	(26)	0	474
Procurement of Lorenzo work list activity	0	38	0	38
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) (ext. funded)	0	100	0	100
Meditech Restoration	0	0	22	22
Kendrick Wing Fire - IT	0	174	0	174
	1,272	**286**	**22**	**1,580**
CQC Reserve	500	(3)	0	497
Kendrick Wing Fire Balance	0	1,347	0	1,347
Contingency	624	(189)	(56)	379
Totals	**7,548**	**2,668**	**20**	**10,236**

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM 18/09/84 a(i)**
SUBJECT:	**Safe Staffing Assurance Report - July**
DATE OF MEETING:	26th September 2018
ACTION REQUIRED	**The Board of Directors are asked to note the contents of the report**
AUTHOR(S):	**Rachael Browning – Associate Chief Nurse**
EXECUTIVE DIRECTOR SPONSOR:	**Kimberley Salmon –Jamieson –Chief Nurse**
LINK TO STRATEGIC OBJECTIVES:	SO1: To ensure that all care is rated amongst the top quartile in the North West of England for patient safety, clinical outcomes and patient experience
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	BAF2.2: Nurse Staffing
	BAF1.3: National & Local Mandatory, Operational Targets
	BAF1.1: CQC Compliance for Quality
STRATEGIC CONTEXT	SO1: To ensure that all care is rated amongst the top quartile in the North West of England for patient safety, clinical outcomes and patient experience.
EXECUTIVE SUMMARY (KEY ISSUES):	Ward staffing data continues to be systematically reviewed to ensure we safely staff our wards and provide mitigation and action when actual falls below 90% of planned staffing levels. It is recommended that the Board of Directors receive a monthly Safe Staffing paper highlighting areas where average fill rates fall below 90% of actual versus planned, along with mitigation to ensure safe, high quality care is consistently delivered. NHS Improvement (NHSI) have recently provided guidance for Acute Trusts (June 2018), with a recommendation that all Trusts submit CHPPD data as part of the monthly Strategic Data Collection Service (SDCS) Staffing return. Warrington and Halton Hospitals NHS Trust, currently collect and report CHPPD data on a monthly basis. However, we have taken the opportunity to undertake a benchmarking exercise against each of the recommendations made by NHSI, which will be included in next month's report.
RECOMMENDATION:	It is recommended that the Board of Directors note and approve the monthly Safe Staffing Assurance Report.
FREEDOM OF INFORMATION STATUS	Release Document in Full
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None

Safe Staffing Assurance Report

The purpose of this paper is to provide transparency with regard to the nursing and midwifery ward staffing levels during July 2018. It forms part of the expectation set out in the National Quality Board (NQB) guidance published in 2016 that Boards take full responsibility for the quality of care provided to patients, and, as a key determinant of quality, take full responsibility for nursing, midwifery and care staffing capacity and capability. Action plans in place are in response to NQB detailed in Appendix 3 and 4. The Trust has a duty to ensure nursing and midwifery staffing levels are sufficient to maintain safety and provide quality care. This paper provides assurance that any shortfalls on each shift were reviewed and addressed as required with mitigating actions, including staffing levels and skill mix. It is well documented that nurse staffing levels make a difference to patient outcomes (mortality and adverse events, including levels of harm), patient experience, and quality of care and the efficiency of care delivery.

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

The safer staffing data consists of the actual numbers of hours worked by registered nursing and health care support staff on a shift by shift basis, measured against the numbers of planned hours to calculate a monthly fill rate for nights and days by each ward. A monthly fill rate of 90% and over is considered acceptable nationally.

Care Hours Per patient Day
NHSI have provided a number of key recommendations for Acute Trusts (June 2018) with a recommendation that all Trusts are to submit CHPPD data as part of the monthly Strategic Data Collection Service (SDCS) Staffing return. Warrington and Halton Hospitals NHS Trust currently collect and report CHPPD data on a monthly basis, however we have taken the opportunity to benchmark the organisation against the key recommendation to ensure we are following best practice and utilising the data as effectively and efficiently as possible, this will form part of the staffing paper in September 2018.

The July Trust wide staffing data was analysed and cross-referenced for validation by the Deputy Chief Nurse, Lead Nurses, and the Associate Chief Nurse (Clinical Effectiveness).

Key Messages
Although some areas are above the 90% target year to date, it is acknowledged that the percentage of Registered Nurses/Midwives in the day is below the target. However, mitigation and responsive plans are in place to ensure that the safe delivery of patient care is discussed at every bed meeting and escalated as appropriate. Shift fill rates continue to improve month on month.

Recruitment remains a priority for the senior nursing team with further recruitment open days planned for Registered Nurses including an external event hosted by The Nursing Times in September 2018.

The number of additional beds open across the Trust has reduced, with the closure of C20 escalation bay this month. In July 18 the Trust has an additional 41 beds in use, 22 beds on Ward C22, with escalation beds on Ward A3 (10) AMU (8) and A5 (1), which are reviewed daily to determine the additional staffing required to ensure patient safety.

Patient Harm by Ward
We reported 4 Grade 2 pressure ulcers in July for wards A9, C22 and C23, Each of these cases are being reviewed by the Tissue Viability nurse and the Associate Chief Nurse, Patient Safety to identify themes and shared learning. We had 1 case of CTD in the month of July on Ward A8, which is awaiting a panel review meeting.

There are no moderate falls to report this month.

No cases of MRSA have been reported In July.

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

Monthly Safe Staffing Report – July 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
	[blue]	= above 100%	[green]	= above 90%		[amber]	= above 80%		[red]	= below 80%							
SWC	SAU	930	922.5	697.5	600	99.2%	86%	-	-	-	-	-	-	-	-	-	
SWC	Ward A5	1782.5	1352.25	1302	1322.5	75.9%	101.6%	1095.75	1069.5	1069.5	851	97.6%	79.6%	1023	2.4	2.1	4.5
SWC	Ward A6	1782.5	1477.5	1302	1328.5	82.9%	102%	1069.5	1058	1069.5	793.5	98.9%	74.2%	992	2.6	2.1	4.7
SWC	Ward CMTC	1334	1286	828	757.5	96.4%	91.5%	713	713	713	713	100%	100%	318	6.3	4.6	10.9
SWC	Ward B4	809	782.5	404.5	397	96.7%	98.1%	356.5	356.5	356.5	609.5	100%	171%	153	7.4	6.6	14.0
SWC	Ward A9	1782.5	1524	1426	1281	85.5%	89.8%	1069.5	1069.5	1069.5	1081	100%	101.1%	990	2.6	2.4	5.0
SWC	Ward B11	1931.3	1921.7	775	745	99.5%	96.1%	1649.2	1584.4	0	0	96.1%	-	400	8.8	1.9	10.6
SWC	NCU	1782.5	1570.5	356.5	276	88.1%	77.4%	1782.5	1403	365.5	345	78.7%	94.4%	344	8.6	1.8	10.4
SWC	Ward C20	921	858	690	690	93.2%	100%	690	690	0	161	100%	-	363	4.3	2.3	6.6
SWC	Ward C23	1426	1191.5	713	647	83.6%	90.7%	770.5	747.5	713	690	97%	96.8%	306	6.3	4.4	10.7
SWC	Delivery Suite	2495.5	2279.5	356.5	191.5	91.3%	53.7%	2495.5	2418.5	356.5	333.5	96.9%	93.5%	212	22.2	2.5	24.6
ACS	Ward A1	1937.5	1887	1525	1627.5	97.4%	106.7%	1627.5	1530	651	729.5	94%	112.1%	868	3.9	2.7	6.7
ACS	Ward A2	1426	1283.5	1476.5	1363	90%	92.3%	1069.5	1092.5	770.5	874	102.2%	113.4%	868	2.7	2.6	5.3
ACS	Ward A3	1370	1025.5	1610	1345	74.9%	83.5%	943	839.5	1357	1391.5	89%	102.5%	844	2.2	3.2	5.5
ACS	Ward A4	1679	1518	1426	1263.5	90.4%	88.6%	1069.5	987	1069.5	1092.5	92.3%	102.2%	992	2.5	2.4	4.9
ACS	Ward A8	1782.5	1458.5	1782.5	1675.5	81.8%	94%	1069.5	897	1782.5	1685	83.9%	94.5%	1054	2.2	3.2	5.4
ACS	Ward B12	1058	1065.5	2495.5	1977	100.7%	79.2%	713	713	1782.5	1675	100%	94%	651	2.7	5.6	8.3
ACS	Ward B14	1426	1339.5	1426	1437	93.9%	100.8%	713	713	713	1023.5	100%	143.5%	744	2.8	3.3	6.1
ACS	Ward B18	1426	1219	1426	1295.5	85.5%	90.8%	1069.5	943	1069.5	1124	88.2%	105.1%	744	2.9	3.3	6.2
ACS	Ward B19	1069.5	1023.5	1426	1217.5	95.7%	85.4%	713	713	1069.5	1097	100%	102.6%	744	2.3	3.1	5.4
ACS	Ward A7	1782.5	1511	1460.5	1382	84.8%	94.6%	1426	1311	1472	1207.5	91.9%	82%	1033	2.7	2.5	5.2
ACS	Ward C21	1069.5	1221.3	1069.2	1215	114.2%	113.6%	713	713	1287.9	1069.5	100%	83%	725	2.7	3.2	5.8
ACS	CCU	1426	1383.5	356.5	166.25	97%	46.6%	1069.5	1069.5	0	0	100%	-	214	11.5	0.8	12.2
ACS	ICU	4991	4496.5	1069.5	891.25	90.1%	83.3%	4991	4462	713	460	89.4%	64.5%	455	19.7	3.0	22.7

Appendix 2

July 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%	86%	-	-	**Vacancy rate:** - 1.0wte Band 5 **Action taken:** - ECF completed to recruit to post.
Ward A5	75.9%	101.6%	97.6%	79.6%	**Vacancy rate:** - RN 2.0wte Band 5 vacancies. 1 paternity leave and 2.61wte maternity leave. CSW- 3.35wte recruited 2 awaiting start dates, 1.35wte vacancy remains. Sickness rate - June- 2.58% **Action taken:** - x2 newly qualified starting Sept 18. Daily review by the matron to review staffing levels and acuity, staff moved from other areas to support.
Ward A6	82.9%	102%	98.9%	74.2%	**Vacancy rate:** - RN 3.31wte vacancies 1.8wte maternity leave. CSW-5.48wte vacancies Sickness rate - 4.91% **Action taken:** - 1.22wte HCA recruited, one due to start August 18, awaiting further start dates. RN 1wte to start Sept 18. Daily review by the matron to review staffing levels and acuity, staff moved from other areas to support.
CMTC	96.4%	91.5%	100%	100%	**Vacancy rate:** 1.0wte Band 6 vacancy, awaiting interview Sickness rate - 9.3% **Action taken:** Daily staffing review against acuity and activity. Sickness absence being managed in line with Trust policy.
B4	96.7%	98.1%	100%	171%	**Vacancy rate:** - RN 2.21wte out to advert. 2 Associate Nurses commencing in Jan 19 when qualified. CSW 2wte, awaiting start date from recruitment for 1, leaving 1 vacancy. Sickness rate - June 3.28% **Action taken:** Staffing and activity reviewed daily. x1 step down patient has required 1:1 care at night and additional staff have been provided.
Ward A9	85.5%	89.8%	100%	101.1%	**Vacancy rate:** 0.54wte Band 6, 2.0 Band 5 new recruits due to commence in Sept 18. 1.0wte maternity leave. 4.0 Band 2 awaiting recruitment checks. Sickness rate - June 7.5% **Action taken:** All vacancies filled and awaiting start dates. Staff have returned from long term sickness and are being managed in line with Trust policy.
Ward B11	99.5%	96.1%	96.1%	-	**Vacancy Rate:** No issues with vacancies **Action taken:** Staffing reviewed daily and support provided if necessary.
NCU	99.5%	96.1%	96.1%	-	**Vacancy rate:** 3.70wte Band 7 recruited to but not yet in post. Sickness rate 8.16% long term and short term sickness. **Action taken:** - sickness managed as per hospital policy. Vacancies recruited into

					awaiting start dates, agency used on a day to day basis depending on activity and acuity.
Ward C20	88.1%	77.4%	78.7%	94.4%	**Vacancy rate:** -1.0wte Band 6 1 HCA, 1 Housekeeper, recruited but not in post yet. Sickness rate - 6.89% **Action taken:** - NHSP used to fill short term shifts until staff in post. HK start date July 18, HCA start date Sep 18. Sickness being managed in line with Trust policies.
Ward C23	83.6%	90.7%	97%	96.8%	**Vacancy Rate:** : No issues with vacancies, sickness remains and pressure on staffing **Action taken:** Staffing reviewed daily by the matron and staff moved to support if required. Sickness is being managed in line with Trust policy.
Delivery Suite	91.3%	53.7%	96.9%	93.5%	**Vacancy Rate:** 4 HCA vacancies all have been recruited too. Sickness remains and pressure on staffing. **Action taken:** Daily review of staffing and staffed moved from other areas depending on acuity and occupancy. C23 supported with HCA cover when required. Sickness is being managed in line with Trust policy.
Ward A1 - AMU	93.2%	100%	100%	-	**Vacancy rate:** - Recruitment ongoing vacancies at Band 6/5/4. Sickness rate - 3 LTS CSW 1 LTS WC, short term sickness managed as per policy **Action taken:** – Daily review of staffing and acuity, staff moved from other areas to support. Sickness being managed in line with Trust policies.
Ward A2	83.6%	90.7%	97%	96.8%	**Vacancy rate:** - 4.82wte Band 5, 8.43wte HCA, following uplift in staffing business case. Sickness rate - 2.3 HCA **Action taken:** - recruitment on going, awaiting start dates for 4 full time RNs in Sept 2018. HCA x 3 full time. Ongoing NHSP and agency requested to support safe staffing, acuity reviewed daily.
Ward A3 Opal	91.3%	53.7%	96.9%	93.5%	**Vacancy rate:** - 1.23wte RN Sickness rate- 1.97% **Action taken:** - New qualified member of staff and 1.0wte HCA due to start Sept 18. Ward move planned in early August.
Ward A4	97.4%	106.7%	94%	112.1%	**Vacancy rate:**- RN 1.23wte Sickness rate- 1.97% **Action taken:** - New band 5 and 1.0wte HCA due to start Sept 18. Staffing reviewed daily against acuity and activity.
Ward A8	90%	92.3%	102.2%	113.4%	**Vacancy rate:** - 10 full time posts vacant, with a recruitment and support plan in place. Sickness rate - 1.0wte LTS minimal ST sickness throughout the month of July 2018 **Action taken:** - recruitment of 1 ward manager full time, 3 full time band 6 sister posts, 2 band 5 full time nurses should be in post by early October 2018. 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-	74.9%	83.5%	89%	102.5%	**Vacancy rate:** - 5wte HCA vacancies following the nurse staffing business case, due to commence in Sept 18.

me-not)					**Action taken**: - Daily review by the matron to review staffing levels and acuity, staff moved from other areas to support.
Ward B14	90.4%	88.6%	92.3%	102.2%	**Vacancy rate:-** RN 1.00 Band 5and 1 HCA both recruited to an due to commence in Sept 18. **Action taken:** - Staffing reviewed daily against acuity and activity.
Ward B18	81.8%	94%	83.9%	94.5%	**Vacancy rate:** -3.5wte RN vacancies and 4.6 HCA vacancies. 1 new RN due to start in the next month and 2 HCA's currently working on the ward **Action taken:** - Recruitment ongoing, staffing reviewed on daily basis by matron and ward manager
Ward B19	100.7%	79.2%	100%	94%	**Vacancy rate:** -3.53wte RN and 5.22wte HCA Sickness rate – 2wte band 5 staff. **Action taken:** - unable to fill band 5 posts on ward; have spoken to lead nurse about development post for 12 months as band 6. All HCA posts recruited to, waiting for staff members to have start dates. Ward reviewed daily for acuity and staffing.
Ward A7	93.9%	100.8%	100%	143.5%	**Vacancy rate: -** 1.0wte RN 1.0wte HCA **Action taken:** - New band 5 and 1.0wte HCA due to start Sept 18. Staffing reviewed daily against acuity and activity.
Ward C21	85.5%	90.8%	88.2%	105.1%	**Vacancy rate: -** Vacancies minimal any shortfalls in staffing relate to sickness absence. **Action taken:** Staffing reviewed daily against acuity and activity. Sickness being managed appropriately in line with trust policies.
Coronary Care Unit	95.7%	85.4%	100%	102.6%	**Vacancy rate:** - No vacancies **Action taken:** Staffing reviewed daily against acuity and activity, staff support other areas when required.
Intensive Care Unit	84.8%	94.6%	91.9%	82%	**Vacancy rate:** - 1wte Band 5 plus 1wte secondment and 3wte supernumerary new starters. Sickness rate - 9% (5.84wte RN LTS) plus 2.4wte RN maternity leave. **Action taken:** - Band 5 vacancies recruited to with new starters in September and conversion of remaining posts to 5wte Band 6 posts to aid retention of senior staff. 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
July 2018

Appendix 3

NQB Benchmark Recommendations – July 2018

The National Quality Board (NQB) staffing publication (2016) described three main expectations of NHS Provider Boards to ensure their organisation has the right culture, leadership and skills in place for safe, sustainable and productive staffing. They are also responsible for ensuring proactive, robust and consistent approaches to measurement and continuous improvement, including the use of a local quality framework for staffing that will support safe, effective, caring, responsive and well led care.

Safe, Effective, Caring, Responsive and Well-Led Care		
Measure and Improve - patient outcomes, people productivity and financial sustainability - - report investigate and act on incidents (including red flags) - - patient, carer and staff feedback -		
- Implementation Care Hours per Patient Day (CHPPD) - - develop local quality dashboard for safe sustainable staffing -		
Expectation 1	**Expectation 2**	**Expectation 3**
Right Staff 1.1 evidence-based workforce planning 1.2 professional judgement 1.3 compare staffing with peers	**Right Skills** 2.1 mandatory training, development and education 2.2 working as a multi-professional team 2.3 recruitment and retention	**Right Place and Time** 3.1 productive working and eliminating waste 3.2 efficient deployment and flexibility 3.3 efficient employment and minimising agency

The National Quality Board has recently published (January 2018) a further improvement resource for safe, sustainable and productive staffing, in adult in patient wards. The resource is part of a suite of speciality resources, which underpin the overarching NQB expectations for safe staffing. The NQB have made a number of recommendations to support and aid decision making in acute trusts in determining the nurse staffing requirements for adult inpatient settings.

A benchmarking exercise was undertaken to review the recommendations in February 2018, detailing our current position and the expected actions to be taken in order for Warrington and Halton Hospitals to meet their recommendations. The recommendations have been updated further in July 2018 to demonstrate the further progress undertaken against the recommendations as part of the Trust's Workforce and Recruitment and Retention strategies.

No	Recommendation	Current Position	Actions
1.	A systematic approach should be adopted using an evidence-informed decision support tool triangulated with professional judgement and comparison with relevant peers.	WHH have Safe Care (SNCT) in place to record patient acuity. CHPPD reported in the monthly Board report. Model Hospital comparative data available 6 monthly staffing reviews are in place in the Trust led by the Chief Nurse.	Next 6 monthly review is due to be undertaken in April 2018. **July 18 – Update** CHPPD is part of the workforce dashboard presented at the Trust Recruitment and Retention meeting. Nursing R&R KPIs Apr-18.pdf Full Trust wide staffing review has been undertaken by the Chief Nurse. 6 monthly acuity assessment undertaken and will be presented in the Board report.
2.	A strategic staffing review must be undertaken annually or sooner if changes to services are planned.	6 monthly updates provide for Trust Board. A trust wide strategic staffing review has been undertaken by the senior nursing team, Chief Nurse and Transformation Manager. A business case has been drafted following this review with regards to Nurse and Health Care Support worker staffing	Non Ward based Nursing review due to commence. Business case to be presented to the Executive Team, Finance and Sustainability Committee and Board of Directors for consideration. BC 18-12 Nursing Establishment - BOD **July 18 – Update** Business case has been approved by the Board, with a significant investment in nurse staffing agreed. Recruitment plans underway to implement the business case requirements. Non ward based nursing referred deferred until later in the year.
3.	Staffing decisions should be taken in the context of the wider registered multi-professional team.	A twice daily staffing meeting is undertaken to review trust wide staffing requirements. This includes a review of ward acuity utilising the Safe Care system. A template of ward staffing is available on the shared drive, with an overall RAG rating of Nurse staffing across the trust. Consideration given to non-nursing posts, Pharmacy	Audit of staffing escalation process to be undertaken in March 2018. **July 18 – Update** Audit of staffing escalation undertaken.

		Techs and AHP support – we need to explain what this is.	CQC staffing escalation audit with :
4.	Consideration of safer staffing requirements and workforce productivity should form part of the operational planning process.	Any operational and /or service redesign undertakes a Failure Modes Analysis process. This includes an assessment of staffing and staff management, to ensure a staffing model and staff with the necessary skills are in place. Currently WHH are reviewing a contemporary ward model pilot. Redesigning the model of care for a clinical setting, based on the needs of the patient who no longer need acute care. The staffing model will be determined using an MDT approach.	Contemporary Ward Model Project commenced in March 2018. Plan for TNA's and nurse apprenticeship programme, will be reviewed at the next Recruitment and Retention meeting in March 18 **July 18 – Update** TNA plan in place and is discussed at the Recruitment and Retention meeting.
5.	Action plans to address local recruitment and retention priorities should be in place and subject to regular review.	Recruitment and Retention strategy in place, with an associated action plan. 2 senior nurses are the Trust contact for nurse recruitment. Monthly Recruitment and Retention Group, data and staffing dashboards reviewed. New post recruited to Workforce Improvement Lead – commences April 18 WHH is part of the Wave 3 National Programme for support for recruitment and retention.	Recruitment and Retention staff engagement workshop planned for 27th April 2018. **July 18 – Update** Workforce Lead in post. WHH was not selected as part of the WAVE 3 programme, although we are able to access some of their guidance, resources and methodologies. In response to the significant investment from the staffing business case a successful targeted recruitment campaign has taken place for HCSW staff. 45 WTE were recruited during this process.
6.	Flexible employment options and efficient deployment of staff should be maximised across the hospital to limit the use of temporary staff.	Flexible working options are available in the Trust. WHH are looking to introduce a night only contract for staff. Nurses with a specialist interest have been recruited as part of the Registered Nurse with a Special Interest (RNSI) campaign. Staffing escalation processes in place, daily staffing meetings and staffing heat map.	Implementation of the night only contract for staff. Action plans for Wave 3 will be formulated in May 2018 when the visit takes place. **June 2018** – WHH not part of Wave 3. Recruitment and Retention strategy has been refreshed for 2018 which will have a particular focus on night only contracts and a commitment to retaining staff who are due to retire in the next 2yrs.

7.	A local dashboard should be in place to assure stakeholders regarding safe and sustainable staffing. The dashboard should include quality indicators to support decision making	Daily staffing template with rationale for decision making recorded, is updated twice daily and stored on the shared drive. E-Roster KPI's in place, these are shared with the senior nursing team on a monthly basis.	E-Roster KPI report will form part of the Matron Lead Nurse Workforce Operational meeting, which commences in March 2018. eRostering Dashboard Mar 18.xls **July 18 – Update** Operational staffing meetings include the Erostering KPI's. Fortnightly Staffing Meeting Agenda 15 0
8.	Organisations should ensure they have an appropriate escalation process in cases where staffing is not delivering the outcomes identified.	Escalation process in place for nurse staffing. Daily staffing meetings in place. Late Senior Nurse on duty for staffing 5-8pm.	Audit of staffing escalation process to be undertaken in March 2018. Review of the Trust On Call to create a 7 day Senior Nurse presence on site- Review due to be completed 30th May 18 - Lead Deputy Chief Nurse. **July 18 – Update** On call process remains unchanged, Matron late rota and Site Manager rota in place for 7 day cover across the site.
9.	All organisations should include a process to determine additional uplift requirements based on the needs of patients and staff	WHH has undertaken a strategic staffing review, which has identified that further uplift is required. 6 monthly staffing review in place and presented to Board by the Chief Nurse.	Business case to be presented to the executive team for consideration as above which requests uplift to move from 20% to 23% using NQB guidance and national recommendations as the benchmark. **July 18 – Update** Business case successful and uplift agreed to 23%.
10	All organisations should investigate staffing related incidents and their outcomes on patients and staff, and ensure action and feedback.	Datix web system used to identify incidents - need to mention learning Ward staff at WHH can apply a Red Flag to a shift when a staffing issue negatively affects (or when there is a potential effect on) patient care, this is done via the	Action:- • Remind the Ward Managers about Red Flags and how to apply them. • Remind the Matrons/Lead Nurses about how to appropriately respond to a Red

		SafeCare module within our e-rostering system. The Red Flags are a list of detrimental effects described by NICE in 2014. Up to now the use of the Red Flag system has been very limited. Safety monitoring report, details incidents including staffing incidents -? Quality dashboard presented monthly.	Flag in their area • Monitor usage and response to Red Flags • Create Red Flag report o Feed back to Ward Managers around the Red Flags in their department o Use the information to provide assurance on the safe staffing of our wards o **July 18 – Update** Further work undertaken to ensure Red Flags are reported and actioned. Red Flag Presentation.pptx Safety Alert Red Flags April 2018.doc

Rachael Browning
Associate Chief Nurse, (Clinical Effectiveness)
July 2018

Appendix 4

NQB Benchmark Recommendations – June 2018

The National Quality Board (NQB) staffing publication (2016) described three main expectations of NHS Provider Boards to ensure their organisation has the right culture, leadership and skills in place for safe, sustainable and productive staffing. They are also responsible for ensuring proactive, robust and consistent approaches to measurement and continuous improvement, including the use of a local quality framework for staffing that will support safe, effective, caring, responsive and well led care.

Safe, Effective, Caring, Responsive and Well-Led Care		
Measure and Improve - patient outcomes, people productivity and financial sustainability - - report investigate and act on incidents (including red flags) - - patient, carer and staff feedback -		
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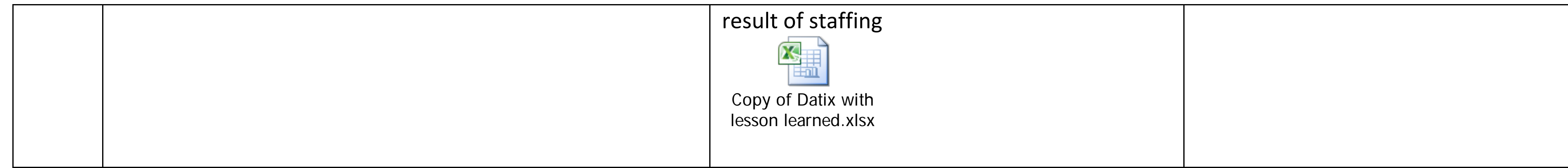
The National Quality Board has recently published (January 2018) a further improvement resource for safe, sustainable and productive staffing, in adult in patient wards. The resource is part of a suite of speciality resources, which underpin the overarching NQB expectations for safe staffing. The NQB have made a number of recommendations to support and aid decision making in acute trusts in determining the nurse staffing requirements for adult inpatient settings.

No	Recommendation	Current Position	Actions
1.	Boards are accountable for assuring themselves that appropriate tools (such as the NICE recommended Birthrate Plus tool for midwifery staffing) are used to assess multi-professional staffing requirements	Birthrate Plus assessment 2015. Warrington Final BR+ Report_07.11.1	Currently reassessing on new models of care to increase continuity, due to be completed June 2018
2.	Boards are accountable for assuring themselves that results from using workforce planning tools are cross checked with professional judgement and benchmarking peers	The Heads of Midwifery across Cheshire and Merseyside meet monthly and have scheduled a benchmarking meeting regarding staffing September 2018	Cheshire and Merseyside Heads of Midwifery to meet in September 2018 to discuss staffing
3.	Boards must review midwifery staffing annually, aligned to their operational and strategic planning processes and review of workforce productivity, as well as a midpoint review every six months in line with NICE Guideline NG4	A review of staffing is performed weekly using the NHSE workforce tool and reviewed by the senior midwifery team and actions taken to rectify staffing shortfalls including: ▪ Managing staff sickness using Trust Guidance ▪ Developed a midwifery bank and recently increased the number of midwives on the bank NHSE Figures.xlsx	▪ Weekly review of staffing ▪ Acuity levels monitored continuously using the acuity tool from Birthrate Plus on the Labour Ward
4.	Boards are accountable for assuring themselves that staffing reviews use the RCOG, RCoA and OAA guidelines on effective maternity staffing resources	Medical staffing is based on RCOG guidance and has been reviewed January to April 2018. Currently there are nine doctors on the middle grade rota: ▪ Four full time trainees ▪ Three less than full time trainees ▪ One full time non training non-career	

		grade doctor ▪ One a less than full time non training, non-career grade doctor This leaves a half a gap on the middle grade rota that is covered by short term locums During the four week period, no middle grade sessions on Labour Ward were filled by consultants acting down Middle grade rota sheet 1.xlsx Middle grade rota sheet 2.xlsx Middle grade rota Sheet 3.xlsx Middle grade rota sheet 4.xlsx Obstetric Staffing policy.doc	
5.	Boards are accountable for assuring themselves that sufficient staff have attended required training and development and are competent to deliver safe maternity care	Outline of mandatory training performed and compliance rates: CNSTMaternity-Actions-Board-report14apr	
6.	Organisations should have actions plans to address local recruitment priorities, which are subject to regular review	There are no problems retaining or recruiting staff. Currently up to full establishment and have recently recruited more midwives from outside the Trust for the Midwifery Bank	
7.	Flexible employment options and efficient deployment of trained staff should be maximised across the hospital to	Flexible working options provided across the maternity service. Currently have offered 21	

	limit numbers of temporary staff	staff flexible working opportunities, including fitting work around childcare arrangements and supporting midwives who are currently breastfeeding. All leaders from each area meet each week day morning to address staffing shortfalls at a Safety Huddle, this is where staff are moved flexibly between areas if necessary	
8.	Organisations should have a local dashboard to assure stakeholders about safe and sustainable staffing. The dashboard should include quality indicators to support decision making	A local dashboard has recently been developed which includes midwife to birth ratio and sickness rates. It currently includes maternity outcome data and is sent to all maternity staff monthly, it also feeds into the regional dashboard for Cheshire and Merseyside 2018-02-RWW-Maternity-Dashboard.xlsx	
9.	Establishments should include an uplift to allow for the management of planned and unplanned leave to ensure that absences can be managed effectively	Within Birthrate Plus assessment in 2015 the uplift was 20%.	Birthrate Plus assessment due in June 2018 uplift to increase to 23% in line with the rest of the Trust
10	Organisations must have mandatory training, development and education programmes for the multidisciplinary team and establishments must allow for staff to be released for training and development	See recommendation 4. Currently compliance rates are: ▪ Obstetric staff 83.3% ▪ Anaesthetists 58.8% ▪ Midwives 94.6% ▪ Healthcare assistants 87.5% Mandatory training is also included in our	The increase in staffing uplift, due in our new Birthrate Plus assessment will help to increase compliance rates

		local dashboard, see recommendation 8	
11.	Organisations must take an evidence based approach to supporting efficient and effective team working. Services should regularly review red flag events and feedback from women, regarding them as an early warning system	Red flags are reviewed in each area and data collected if red flag is triggered. These have been reviewed January to April 2018 Each area has its own red flags: **Triage / ANDU** Delay of 30 minutes or more between presentation and triage = none Delay of more than 60 minutes of review by Doctor = 2 **Labour Ward** Missed or delayed care (e.g. delay of 60 minutes or more in washing and suturing) = none Delay of two hours or more between admission for induction and start of the process = 3 Any occasion when one midwife is unable to provide continuous one to one care in labour = none **Ward** Missed medication during an admission to hospital (e.g. diabetes medication) = none Delayed recognition and action on abnormal vital signs (e.g. sepsis or urine output) = none	
12	Organisations should investigate staffing related incidents, outcomes on staff and patients and ensure action, learning and feedback	26 incidents January to April 2018, including lessons learnt. Feedback of incidents disseminated to all staff via governance processes, including a monthly newsletter. Duty of Candour performed as necessary, to inform women and their families of any harms or near misses caused as a direct	

		result of staffing  Copy of Datix with lesson learned.xlsx	

This report is a benchmark against the Improvement Resource for Maternity Staffing by the National Quality Board (2018). The resource outlines a systematic approach for identifying the organisational, managerial and clinical setting factors that support safe staffing of maternity services. It makes recommendations for developing models of care, staffing, tools and monitoring and acting on staffing issues and risk to meet women's needs. it builds on standards and recommendations from the RCM (2016), RCOG (2017) and the Care Quality Commission (CQC) (2016) and is informed by the National Institute for Health and Care Excellence (NICE) and midwifery staffing guideline (NG4).

Tracey Cooper
Head of Midwifery
July 2018

BOARD OF DIRECTORS

AGENDA REFERENCE:	BM 18/09/84 a(ii)
SUBJECT:	Safe Staffing Assurance Report - August
DATE OF MEETING:	26th September 2018
ACTION REQUIRED	The Board of Directors are asked to note the contents of the report
AUTHOR(S):	Rachael Browning – Associate Chief Nurse
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon –Jamieson –Chief Nurse
LINK TO STRATEGIC OBJECTIVES:	SO1: To ensure that all care is rated amongst the top quartile in the North West of England for patient safety, clinical outcomes and patient experience
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	BAF2.2: Nurse Staffing
	BAF1.3: National & Local Mandatory, Operational Targets
	BAF1.1: CQC Compliance for Quality
STRATEGIC CONTEXT	SO1: To ensure that all care is rated amongst the top quartile in the North West of England for patient safety, clinical outcomes and patient experience.
EXECUTIVE SUMMARY (KEY ISSUES):	Ward staffing data continues to be systematically reviewed to ensure we safely staff our wards and provide mitigation and action when actual falls below 90% of planned staffing levels. It is recommended that the Board of Directors receive a monthly Safe Staffing paper highlighting areas where average fill rates fall below 90% of actual versus planned, along with mitigation to ensure safe, high quality care is consistently delivered. NHS Improvement (NHSI) have recently provided guidance for Acute Trusts (June 2018), with a recommendation that all Trusts submit CHPPD data as part of the monthly Strategic Data Collection Service (SDCS) Staffing return. Warrington and Halton Hospitals NHS Trust, currently collect and report CHPPD data on a monthly basis. However, we have taken the opportunity to undertake a benchmarking exercise against each of the recommendations made by NHSI, which in include in Appendix 3 as part of this month's report.
RECOMMENDATION:	It is recommended that the Board of Directors note and approve the monthly Safe Staffing Assurance Report.
FREEDOM OF INFORMATION STATUS	Release Document in Full
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None

Safe Staffing Assurance Report

The purpose of this paper is to provide transparency with regard to the nursing and midwifery ward staffing levels during July 2018. It forms part of the expectation set out in the National Quality Board (NQB) guidance published in 2016 that Boards take full responsibility for the quality of care provided to patients, and, as a key determinant of quality, take full responsibility for nursing, midwifery and care staffing capacity and capability. Action plans in place are in response to NQB detailed in Appendix 3 and 4. The Trust has a duty to ensure nursing and midwifery staffing levels are sufficient to maintain safety and provide quality care. This paper provides assurance that any shortfalls on each shift were reviewed and addressed as required with mitigating actions, including staffing levels and skill mix. It is well documented that nurse staffing levels make a difference to patient outcomes (mortality and adverse events, including levels of harm), patient experience, quality of care and the efficiency of care delivery.

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

The safer staffing data consists of the actual numbers of hours worked by registered nursing and health care support staff on a shift by shift basis, measured against the numbers of planned hours to calculate a monthly fill rate for nights and days by each ward. A monthly fill rate of 90% and over is considered acceptable nationally.

Care Hours Per patient Day
NHSI have provided a number of key recommendations for Acute Trusts (June 2018) with a recommendation that all Trusts are to submit CHPPD data as part of the monthly Strategic Data Collection Service (SDCS) Staffing return. Warrington and Halton Hospitals NHS Trust currently collect and report CHPPD data on a monthly basis, however we have taken the opportunity to benchmark the organisation against the key recommendations to ensure we are following best practice and utilising the data as effectively and efficiently as possible, this forms part of this report in Appendix 3.

The August Trust wide staffing data was analysed and cross-referenced for validation by the Deputy Chief Nurse, Lead Nurses, and the Associate Chief Nurse (Clinical Effectiveness).

Chart 1 illustrates this data to August 2018, which is showing a gradual improvement; this will continue to be monitored via the Trust monthly safer staffing report.

Chart 1

Financial year	Month	Cumulative count over the month of patients at 23:59 each day	CHPPD – Registered Staff	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	14878	4.2	2.9	7.1
2018/19 Total		76127.5	3.9	2.9	6.8

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 with further recruitment open days planned for Registered Nurses including an external event hosted by The Nursing Times on the 15th September 2018.

The number of additional beds open across the Trust has reduced significantly in August with the opening of B3 at Halton and transfer for Ward A3 to C22. In August the Trust has the following additional beds open AMU (8) and A5 (1), both areas are reviewed daily to determine the additional staffing required to ensure patient safety.

Patient Harm by Ward

In August 2018 we reported 4 x Grade 2 pressure ulcers in July for wards A9, A2 and 2 on Delivery Suite on Maternity. Each of these cases are being reviewed by the Tissue Viability nurse and the Associate Chief Nurse, Patient Safety to identify themes and shared learning. There have been 4 x patient falls with moderate or major harm falls reported this month as detailed below in chart 2;

Chart 2 - Falls with Harm – August 2018

Ward	Harm
B14	Moderate Harm #wrist
A1	Major Harm #NOF
B19	Major Harm - Intraparenchymal haemorrhage
A7	Patient death - Large subdural haematoma

All of the above falls are currently being investigated as part of the Serious Incident reporting process.

Infection Incidents

We had 5 cases of CDT in the month of August on Wards, A2, ICU, A8 and 2 cases on A7, all of these cases are currently being investigated with review meeting planned in November 2018.

No cases of MRSA have been reported in August.

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

Monthly Safe Staffing Report – August 2018

	Day	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	922.5	697.5	660	99.2%	94.6%	0	0	0	0	-	-	0	-	-	-
SWC	Ward A5	1782.5	1316.75	1302	1305.25	73.9%	100.2%	1069.5	1069.5	713	805	100%	112.9%	1023	2.302.1	4.4	
SWC	Ward A6	1782.5	1334	1302	1345.5	74.8%	103.3%	1069.5	1069.5	713	793.5	100%	111.3%	992	2.4	2.2	4.6
SWC	Ward CMTC	1276.5	1264	690	690	99%	100%	713	713	598	598	100%	100%	240	8.2	5.4	13.6
SWC	Ward B4	762	743	397	418	97.5%	105.3%	253	253	253	264.5	100%	104.5%	64	15.6	10.7	26.2
SWC	Ward A9	1782.5	1493.5	1426	1418	83.8%	99.4%	1069.5	1069.5	1069.5	1081	100%	101.1%	974	2.6	2.6	5.2
SWC	Ward B11	2170	2144.6	799.6	816.3	98.8%	102.1%	1649.2	1616.8	0	0	98%	-	359	10.5	2.3	12.8
SWC	NCU	1782.5	1728.5	356.5	218.5	97%	61.3%	1782.5	1518	356.5	322	85.2%	90.3%	434	7.5	1.2	8.7
SWC	Ward C20	955	869	713	677	91%	95%	713	713	0	1	100%	-	368	4.3	1.8	6.1
SWC	Ward C23	1426	1058	713	586.5	74.2%	82.3%	759	747.5	713	517.5	98.5%	72.6%	322	5.6	3.4	9.0
SWC	Delivery Suite	2495.5	2179.5	356.5	266.5	87.3%	74.8%	2495.5	2418.5	356.5	299	96.9%	83.9%	212	21.7	2.7	24.4
ACS	Ward A1	2325	1724	1937.5	1714.5	74.2%	88.5%	1627.5	1675	651	787.5	102.9%	121%	964	3.5	2.6	6.1
ACS	Ward A2	1426	1246.5	1476.5	1269.5	87.2%	86%	1069.5	1104	1069.5	874	103.2%	81.7%	868	2.7	2.5	5.2
ACS	Ward A3	1725	1266	2070	1535	73.4%	74.2%	1035	931.5	1725	1280	90%	74.2%	1054	2.1	2.7	4.8
ACS	Ward A4	1690.5	1459.5	1425	1308	86.3%	91.8%	1069.5	989	1069.5	1000.5	92.5%	93.5%	992	2.5	2.3	4.8
ACS	Ward A8	1058	1055.5	2495.5	2200	99.8%	88.2%	713	713	1782.5	1723	100%	96.7%	744	2.4	5.3	7.6
ACS	Ward B12	1426	1244	1426	1334	87.2%	93.5%	713	713	713	724	100%	101.5%	744	2.6	2.8	5.4
ACS	Ward B14	1426	1193	1426	1313	83.7%	92.1%	1069.5	839.5	1069.5	1098	78.5%	102.7%	744	2.7	3.2	6.0
ACS	Ward B18	1069	1032	1420	1335	96.5%	94.0%	713	724.5	1069.5	112.7	101.6%	105.4%	744	2.4	3.3	5.7
ACS	Ward B19	1189.5	916.5	1069.5	1180	77%	110.3%	713	713	782	897	100%	114.7%	649	2.5	3.2	5.7
ACS	Ward A7	1782.5	1468	1426	1446.5	82.4%	101.4%	1426	1451	1069.5	1288	101.8%	120.4%	1023	2.9	2.7	5.5
ACS	Ward C21	1069.5	1057.4	1046.5	1559.5	98.9%	149%	713	713	1069.5	1719	100%	160.7%	651	2.7	5.0	7.8
ACS	CCU	1426	1367.5	356.5	224.5	95.9%	63%	1069.5	1069.5	0	0	100%	-	223	10.9	1.0	11.9
ACS	ICU	4991	4559.75	1069.5	770.5	91.4%	72.0%	4991	4588.5	713	517.5	91.9%	72.6%	491	18.6	2.6	21.3

Appendix 2

August 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:** - 1.0wte Band 5 **Action taken:** - ECF completed to recruit to post.
Ward A5	73.9%	100.2%	100%	112.9%	**Vacancy rate:** - RN 2.0wte Band 5 vacancies. 1 paternity leave and 2.61wte maternity leave. CSW- 3.35wte recruited 2 awaiting start dates, 1.35wte vacancy remains. Sickness rate - July- 2.97% **Action taken:** - x2 newly qualified starting Sept 18. Daily review by the matron to review staffing levels and acuity, staff moved from other areas to support.
Ward A6	74.8%	103.3%	100%	111.3%	**Vacancy rate:** - RN 3.31wte vacancies 1.8wte maternity leave. CSW-3.56wte vacancies Sickness rate - July- 3.46% **Action taken:** - 1.22wte HCA recruited, one commenced in post August 18, awaiting further start dates. RN 1wte to start Sept 18. Daily review by the matron to review staffing levels and acuity, staff moved from other areas to support.
CMTC	99%	100%	100%	100%	**Vacancy rate:** 1.0wte Band 5 vacancy due to band 6 secondment Sickness rate - July - 7.98% **Action taken:** Daily staffing review against acuity and activity. Sickness absence being managed in line with Trust policy.
B4	97.5%	105.3%	100%	104.5%	**Vacancy rate:** - RN 1.82 wte 2 Associate Nurses commencing in Jan 19 when qualified. CSW 2wte, awaiting start date from recruitment for 1, leaving 1 vacancy. Sickness rate - July 3.47% **Action taken:** Staffing and activity reviewed daily.
Ward A9	83.8%	99.4%	100%	101.1%	**Vacancy rate:** 0.54wte Band 6, 2.0 Band 5 new recruits due to commence in Sept 18. 1.0wte maternity leave. 4.0 Band 2 awaiting recruitment checks. Sickness rate - July 2.43% **Action taken:** All vacancies filled and awaiting start dates. Staff have returned from long term sickness and are being managed in line with Trust policy.
Ward B11	98.8%	102.1%	98%	-	**Vacancy Rate:** 3wte band 5, 1.0wte CSW 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	97%	61.3%	85.2%	90.3%	**Vacancy rate:** 1.78 wte band 6, 0.65 band 4 nursery nurse Sickness rate - July - 5.2%. **Action taken:** - sickness absence

					managed in line with Trust policy, agency used on a day to day basis depending on activity and acuity particularly for HCA support.
Ward C20	91%	95%	100%	-	**Vacancy rate:** -1.0wte Band 6 1 HCA recruited Sickness rate - 6.44% **Action taken:** - NHSP used to fill short term shifts until staff in post. HCA start date Sep 18. Sickness being managed in line with Trust policies.
Ward C23	74.2%	82.3%	98.5%	72.6%	**Vacancy Rate:** : 1.88wte band 6 and 1.29wte CSW Sickness rate – July – 3.03% **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	87.3%	74.8%	96.9%	83.9%	**Vacancy Rate:** 3.0wte band 5 / 5 midwives Sickness rate – July 6% remains and pressure on staffing. **Action taken:** Daily review of staffing and staffed moved from other areas depending on acuity and occupancy. C23 supported with HCA cover when required. Sickness is being managed in line with Trust policy.
Ward A1 - AMU	74.2%	88.5%	102.9%	121%	**Vacancy rate:** - Recruitment ongoing vacancies at 1.0wte band 6 and 3.0wte band 5. Sickness rate – 3% **Action taken:** – 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	87.2%	86%	103.2%	81.7%	**Vacancy rate:** - 3.0wte Band 5, Sickness rate – 9% **Action taken:** 3.0wte band 5 commencing in October 2018. Ongoing NHSP and agency requested to support safe staffing, acuity reviewed daily.
Ward A3 Opal	73.4%	74.2%	90%	74.2%	**Vacancy rate:** - 1.23wte RN Sickness rate- 1.97% **Action taken**: - New qualified member of staff and 1.0wte HCA due to start Sept 18. Ward move to C22 happened in early August, which resulted in a reduction in the number of beds on the ward.
Ward A4	86.3%	91.8%	92.5%	93.5%	**Vacancy rate:**- RN 1.23wte Sickness rate- 1.27% **Action taken:** - New band 5 and 3.0wte HCA due to start Sept 18. Staffing reviewed daily against acuity and activity.
Ward A8	99.8%	88.2%	100%	96.7%	**Vacancy rate:** - 10 full time posts vacant, with a recruitment and support plan in place. Sickness rate - 3.0wte LTS minimal ST sickness throughout the month of August 2018 **Action taken:** - recruitment of 1 ward manager full time, 3 full time band 6 sister posts, 2 band 5 full time nurses should be in post by early October 2018. 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)	87.2%	93.5%	100%	101.5%	**Vacancy rate:** - 11wte CSW vacancies following the nurse staffing business case **Action taken:** - 3 CSW due to start in Oct 18 and 1 apprentice leaving a vacancy of 7.1 wte Daily review by the matron to review staffing levels and acuity, staff moved from other areas to support.
Ward B14	83.7%	92.1%	78.5%	102.7%	**Vacancy rate:**- RN 1.00 Band 5and 1 HCA both posts recruited to and new staff due to commence in Sept 18. **Action taken:** - Staffing reviewed daily against acuity and activity.
Ward B18	96.5%	94.0%	101.6%	105.4%	**Vacancy rate:** -3.5wte RN vacancies and 4.6 HCA vacancies. 1 new RN due to start in the next month and 1 CSWD recently started and 2 CSW redeployed from other wards **Action taken:** - Recruitment ongoing, staffing reviewed on daily basis by matron and ward manager
Ward B19	77%	110.3%	100%	114.7%	**Vacancy rate:** -2.39wte RN and 5.22wte HCA Sickness rate - July - 7.1%. **Action taken:** - all CSW vacancies recruited to and start dates in place for Oct 18 1 band 5 requested a transfer to the ward. Ward reviewed daily for acuity and staffing.
Ward A7	82.4%	101.4%	101.8%	120.4%	**Vacancy rate:** - 6.23wte RN 3.64wte HCA **Action taken:** - 2 band 5 due to start in Sept and 2 in January 18 and 1.0wte HCA due to start Sept 18. Staffing reviewed daily against acuity and activity.
Ward C21	98.9%	149%	100%	160.7%	**Vacancy rate:** - 5.80 wte CSW **Action taken:** Staffing reviewed daily against acuity and activity, additional staffing has been require this month to support a patient who was awaiting transfer to a more suitable care setting for his ongoing needs. Sickness being managed appropriately in line with trust policies.
Coronary Care Unit	95.9%	63%	100%	-	**Vacancy rate:** - 0.72wte RN, 1.57 CSW **Action taken:** Staffing reviewed daily against acuity and activity, staff support accessed from other areas when required.
Intensive Care Unit	91.4%	72.0%	91.9%	72.6%	**Vacancy rate:** - minimal vacancies Sickness rate - July - 5.51% plus 2.4wte RN maternity leave. **Action taken:** - Band 5 vacancies recruited to with new starters in September and conversion of remaining posts to 5wte Band 6 posts to aid retention of senior staff. 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
August 2018

Appendix 3

Care Hours per Patient Day – Benchmarking Plan for NHS Improvement Guidance for Acute Trusts August 2018

Lord Carter highlighted issues in February 2016 in his report, Operational Productivity and Performance in NHS Acute Trusts, relating to unwarranted variation and inconsistencies in reporting and recording staff deployment. The 'Model Hospital' portal provided by NHS Improvement (NHSI) gives access to national benchmarking information for nurse and midwifery staffing. The resource assesses staffing using two metrics:

- Care Hours Per Patient Day (CHPPD) - The hours of registered nurses/midwives and support workers available divided by the total number of inpatients.
- Weighted Activity Unit (WAU) – A cost and case mix adjusted measure that is based on the cost of providing one in-patient elective admission (£3,500)

CHPPD has since become the principle measure of nursing, midwifery and healthcare support staff deployment on inpatient wards.

How CHPPD is calculated

Calculation:

Day Shift Hours + Night Shift Hours worked by both Nursing Support Staff and Registered Nurses and Midwives

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Approximation of every 24 hours of in-patient admissions by taking a daily count of patients in bed at 23:59

This figure is aggregated each day over the month in question, using this data following which the CHPPD is calculated.

The Benefits of CHPPD

- It provides a single comparable figure that can simultaneously represent both staffing levels and patient requirements.
- It facilitates comparisons between wards in a Trust and between comparable organisations.
- It differentiates between Registered Nurses and Midwives, from Healthcare Support Workers to ensure skill mix is well described

Reporting and assessment against key considerations

NHSI have provide a number of key recommendations for Acute Trusts (June 2018) to use as a benchmarking tool and recommended that all Trusts are required to submit CHPPD data as part of the monthly Strategic Data Collection Service (SDCS) Staffing return . Warrington and Halton Hospitals NHS Trust currently collect and report CHPPD data on a monthly basis; however we have taken the opportunity to benchmark the organisation against the key recommendation to ensure we are following best practice and utilising the data as effectively and efficiently as possible.

No	Recommendation	Current Position	Actions
1.	To ensure there is a clear process for Safe Staffing monthly returns to be quality assured as well as clinically validated within the organisation prior to submission? This will help ensure accuracy, completeness and robustness of reported CHPPD data.	WHH have a clear and robust process for the monthly staffing return. Data is collected at CBU and ward level, which is reviewed and validated by the Associate Chief Nurse and Deputy Chief Nurse. The data collected and report is planned vs actual staffing levels and CHPPD.	Action Completed.
2.	Ward and speciality names to be routinely checked for alignment across other national data returns	Ward and speciality names have been reviewed and are accurate. The Senior Information Analyst will review to ensure these are aligned to the other national data returns.	Senior Information Analyst (HW) to confirm alignment.
3.	Develop an active process for Model Hospital speciality and ward names alignment to be validated and updated with all changes alerted to NHSI?	Model Hospital information submission is taken from the Strategic Data Collection Service (SDCS) (Unify Staffing return) which is check and validated on a monthly basis. Changes are made if required on a monthly basis by amending the ward information. From August 2018, we will include any changes in the narrative box on the monthly submission form. Senior Information Analyst will review to see if there is a designated form for notifying the team of any future changes.	Senior Information Analyst (HW) to confirm if there is any further action to be taken.
4.	To have an understanding as well as assurance to determine if the level of variation in the Trusts nationally reported CHPPD on Model Hospital is warranted or unwarranted?	CHPPD is currently reported monthly on the Integrated Performance Report. CHPPD will be included in the monthly SDCS staffing return, with narrative to record variation seen. WHH will commence this in August 2018 with a baseline assessment of the data.	It is important to note that the Model Hospital data is 2 months behind the SDCS staffing return data, therefore after the baseline assessment reporting on CHPPD will variation will form part of the 6 monthly board staffing paper.
5.	To ensure the Trust have an understanding of reported	Ward level CHPPD data is available in the E-	

	CHPPD by ward compared to national averages and also with appropriate comparable wards at peer trusts as part of their establishment setting and review process?	Rostering system. – Training will be provided for the ward managers on accessing the information. Further work to be undertaken with the senior nursing team and ward managers providing a masterclass on CHPPD. Information Analyst reviewing the Model Hospital data to determine if ward level compassions can be made.	Training session for Ward Managers to access the CHPPD data at ward level – September 2018. Masterclass training for the Senior Nursing Team on CHPPD – September/October 2018. Review of Model Hospital Data to determine in peer level comparisons can be made at ward level – DB and JMcC.
6.	Ensure ward establishments set using NICE endorsed evidenced based tools such as The Safer Nursing Care Tool (SNCT) and Birthrate Plus, in line with NQB and underpinned by auditable clinical judgement?	Ward establishments are set at WHH using a range of evidence based tools; • Using systematic evidenced based acuity data utilising the Safer Nursing Care Tool (SNCT) • Benchmarking with Peers for example Care Hours per Patient Days (CHPPD) through the Model Hospital. • NICE Guidance and 1:8 minimum staffing: patient ratios • Birth Rate Plus in Maternity • British Association OF Perinatal Medicine (BAPM) in the Neo Natal Unit. • Professional judgement 6 monthly staffing reviews are undertaken Trust wide and presented in the Board Paper. Annual Staffing reviews undertaken by the Chief Nurse.	

7.	Ensure tools are used consistently and exactly as instructed in the implementation guidance in an auditable manner	Training has been provided for the senior nursing team and Ward Managers for using the SNCT acuity tool in the E-rostering system. A process of peer validation is undertaken by the Lead Nurses and Matrons, with all wards reviewed at the daily staffing meeting. A formal process or peer review at ward level is required every 3 months to ensure consistency.	Matron for Informatics (EC) to introduce a peer review system for the data input on the SNCT in the rostering system – September 2018.
8.	Is the set establishment as signed off at budget setting by finance, workforce, operational and clinical leads being expressed in terms of care hours (and could therefore be convertible to CHPPD) to enable comparisons and triangulation with nationally reported CHPPD?	Ward establishments are signed off as part of the budget setting process. This is following review and agreement at CBU level and validation by the Associate Chief Nurse, Deputy Chief Nurse and Chief Nurse. The establishments are currently presented in the number of trained and untrained staff per shift with corresponding whole time equivalent staff by grade.	Ward establishments need to display CHPPD. Ward Staffing meeting in place to review staffing establishments and will include CHPPD requirements too going forwards – August 2018.
9.	To have systems and processes in place to capture the CHPPD that is planned on daily rosters Can this be reviewed on a shift to shift basis?	CHPPD is displayed at ward level on the e-rostering system. Training is planned for staff to access and display this on a daily basis. The new ward entrance boards will include CHPPD in the daily staffing information. CHPPD is record for a 24hr period therefore it cannot be record by shift, but can be reviewed on a shift by shift basis.	Action complete.
10	To have systems and processes in place to capture the CHPPD that is actually delivered on daily rosters Can this be reviewed on a shift to shift basis?	Systems in place to captured record and display CHPPD by ward on daily roster. The data can be reviewed on a shift to shift basis.	Action complete

11	Can this then be compared and tracked against establishment CHPPD?	This is not currently in place as we don't have defined establishment CHPPD in place yet.	Staffing reviews in August 2018 will finalise the ward establishment, which will include CHPPD at ward level.

Staff Key

Rachael Browning - Associate Chief Nurse (RB)

Dan Birtwistle – Contracts and Performance Manager (DB)

Ellis Clarke – Informatics Matron (EC)

Jen McCartney – Workforce Improvement Lead (J McC)

Helen Wood -Senior Information Analyst (HW)

BOARD OF DIRECTORS CHAIR'S KEY ISSUES REPORT

AGENDA REFERENCE:	BM 18 09 84 (b)	COMMITTEE OR GROUP:	Trust Board	DATE OF MEETING	26th September 2018

Date of Meeting	4th September 2018
Name of Meeting + Chair	Quality Assurance Committee, Chaired by Margaret Bamforth
Was the meeting quorate?	Yes

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/ mandate to receiving body	Follow up/ Review date
QAC/18/09/97	Patient Story	A patient story was presented to the QAC that had come out of a complaint made through Healthwatch. It was a complicated story with accounts of both good and poor care. An action plan had been developed and training put in place to address the more negative aspects of the care provided. The family had expressed their wishes that their story should be told to enable learning to be supported.	The Committee received and discussed the patient story	
QAC/18/09/99	**Learning From Deaths - Deep Dive Review**	The report provided a review of the implementation of the new process of the collection and publishing of information on deaths that has been in operation since January 2018. The report provided examples of the learning that comes from the structured reviewing of deaths. There was agreement that there needed to be further consideration of family involvement.	The Committee noted the report and requested that the improvement plan and outcomes come back to the Committee along with the mortality benchmark analysis for LD when complete	**QAC Nov 2018**

		Highlights of the report included: • Details of the Mortality Review Group (MRG) • Number of Deaths and Structured Judgement Reviews (SJR); • Criteria for inclusion/exclusion for reviewing deaths in the MRG; • Process for identifying the need for an SJR; • Themes from SJRs and any learning; • Themes from focused reviews; • Good Practice.		
QAC/18/09/94	**Getting to Good (G2G) Steering Group**	• 198 fully compliant reports had been completed, 10 reports required further evidence, 13 are on track to be completed, 37 have an agreed amended date for completion and 17 actions had no report or request for extension. A comprehensive list was provided of those actions where there had not been a report provided. An update on the fundamental breached was included. • MIAA had undertaken an audit of a sample of actions of the CQC Action Plan. In the main, the findings demonstrated that whilst good progress has been made towards implementing the action plan, there is a need to further embed the established systems and processes to ensure they are operating consistently. It was noted that in some cases, the compliant actions were only recently implemented and as such there was limited evidence available to	A further MIAA audit of the action plan has been requested.	**QAC Nov 2018 / Jan 2019**

		demonstrate compliance.		
QAC/18/09/101	**Lessons Learning Framework**	An update was provided on the progress in the last 12 months including: • Improving governance systems and reporting; • Cascading and roll out of training to support improved investigations and learning ; • Individuals and collective learning systems in place to enable dissemination of lesson learned; • Investment in this agenda to include Trust specialist Investigation Team and the Quality Academy; • Integrated governance structures in place to identify requirements for quality improvement; • A renewed focus on innovation – to flag and highlight where we are doing well and encouraging and promoting staff to have ideas, which are enabled.	• The Committee to received and noted the report. • August 2018 Newsletter to be circulated to NEDs?	
QAC/18/09/102	**Learning From Experience Report**	The Key elements of the report were outlined. Of note was: • Open Incidents reduced to 531 (from 619 in Q4); • a significant decrease in staff incidents to 185 from 302 in Q4 and medicines to 195 from 213 in Q4; • Backlog to resolve incidents cleared and significant improvement in timeliness of responses to resolve	• The Committee reviewed and noted the report.	**QAC Jan 2019**

		complaints; • 5 day service now established in PALS office; • Increase in overall complaints in Q1 reported, mainly attributed to communication/customer care issues.		
QAC/18/09/104	**Safe Staffing Report – 6 monthly review**	The report provided an overview of the current position in the nursing workforce. • The Trust is currently reporting a deficit in the required numbers for nurse staffing of 58.06wte. However, with associated increases in nurse staffing levels and establishment uplifts to 23% following the successful nurse staffing business case, this position is expected to improve going forwards. • Nursing Recruitment & Retention strategy delivery is continuing, resulting in 43 RNs and 45 HCAs • Monitoring arrangements are now in place to review staffing on a daily basis. The number of staff is triangulated with staffing incidents and the recent introduction of 'red flag' events. This provides greater assurance and a transparency to the governance processes to ensure adequate safe staffing levels and well as indicators of safety and effectiveness across the organisation.	The Committee to noted and reviewed the report	**March 2019**
QAC/18/09/105	**DIPC Quarterly Report**	The Committee received the report and the key points noted were: • 7 C. difficile cases in Q1 – all cases were	The Committee reviewed and noted the report.	**QAC Jan 2019**

		considered unavoidable by the CCG review panel • 1 MRSA bacteraemia case – considered avoidable. The patient likely had this bloodstream infection prior to admission and sampling opportunity was missed in AED • 7 MSSA bacteraemia cases – 3 considered avoidable as associated with peripheral cannula management; 1 related to missed sampling opportunity • 12 E. coli bacteraemia cases – the Trust is above trajectory to meet the reduction target set by NHSI for 2021 • Near miss incident - healthcare worker developed chickenpox, whilst working in a high risk area despite vaccination • Decontamination incident in CMTC theatres. Incident meeting held and appropriate action taken • Ward kitchens require improvements to Estate		
QAC/18/09/106	**Ward Quality Metrics**	The report provided a review of the new Quality Metrics programme that commenced in February 2018. The metrics are designed to inform at two levels in the organisation; 1. Reporting at ward level 2. Reporting at Trust level, to inform the Chief Nurse and Board. During the reporting period:	The Committee received and noted the report. The Ward Accreditation report will be presented to Trust Board in November 2018.	**Trust Board November 2018**

We are WHH

		• 72% of the domains were green; • 21% amber; • 7% red Areas for targeted improvement were highlighted as follows: • Record Keeping • Pain Management • Learning Disabilities		
QAC/18/09/111	**GPDR Readiness Action Plan progress + IG Update**	An updated on the GDPR action plan was presented to the Committee: Of the 84 actions in the plan: • 61 are green • 17 are amber • 6 are red	• The Committee noted the report and items of assurance and escalation • Action plan to be presented to next Audit Committee	**Audit Committee Nov 2018**
QAC/18/09/110 QAC/18/09/113 QAC/18/09/114 QAC/18/09/115 QAC/18/09/116 QAC/18/09/117 QAC/18/09/118 QAC/18/09/119	**Annual Reports & Sub-Committee reports**	The Committee received the following Annual Reports & High level briefing reports: • Risk Management Strategy Annual Report • Infection Control Sub Committee • Health and Safety Sub Committee • Safeguarding Sub Committee • Patient Safety+ Clinical Effectiveness Sub Committee • Patient Experience Sub Committee • Complaints Quality Assurance Group • Research and Development Quarterly Report	The Committee received the reports	

CHAIR'S KEY ISSUES REPORT

AGENDA REFERENCE:	BM/18/09/84 c	COMMITTEE OR GROUP:	Trust Board	DATE OF MEETING	26 September 2018

Date of Meeting	22nd August 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/18/08/101	Pay Assurance Dashboard Monthly Report	• In month pay £0.9m above plan and year to date £1.3m above plan (in month variance is due to AfC pay award). • In month £13.6m contracted spend and £2.3m temporary spend (bank and agency has increased in month). • Headcount remained stable in month and as at 31 July 191 WTE nursing gaps and 40 WTE medical gaps. • HCA and RN recruitment progressing well. • 100% of 16/17 job plans and 92% of 18/19 job plans for consultants and SAS doctors completed. • Business case to use some savings from Direct Engagement model to invest temporary staffing team to further control usage and costs and streamline processes. • Future report to include progress against agency ceiling.	The Committee reviewed, discussed and noted the report but requested inclusion of agency ceiling metric.	FSC September 2018

FSC/18/08/101	Harmonisation Report	• Harmonisation of on call split into 4 phases. • Service improvement not financial exercise but there are savings.	The Committee reviewed, discussed and noted the report.	
FSC/18/08/102	Risk Register	• No new risks but updates on performance targets, financial sustainability, staffing levels and Anaesthetic cover in Critical Care.	The Committee reviewed, discussed and noted the report.	FSC September 2018.
FSC/18/08/103	Corporate Performance Report	• Service performance score of 1 (due to failure to meet A&E target). • July A&E performance (including Widnes Walk in Centre) is 90.46% which is 2.66% above trajectory of 87.80% (August is challenging). • Diagnostics target for July not met • RTT target for July met. • Cancer targets for June met apart from Breast Symptomatic two week wait. • DNA rate improving due to text reminder service. • The number of beds open for escalation is minimal. • A&E Programme Board approved additional funding for running costs of Frailty Assessment Unit.	The Committee reviewed, discussed and noted the report.	FSC September 2018
FSC/18/08/104	Monthly Finance report	• Month 4 position reviewed at £1.7m monthly deficit and £8.4m year to date deficit. • Use of Resources score is 3	The Committee reviewed, discussed and noted the report and the financial challenges faced.	FSC September 2018

		• Month 4 CIP underachieved • All PSF included except Q1 A&E • Pay award costs included but increase in cost covered by income over recovery. • Improvement in monthly and year to date BPPC due to working capital loan to fund deficit. • £0.8m of interest charges resulting from capital and working capital loans. • Significant level of debt with one particular company, next steps to be considered and to be added to Strategic Risk Register. • Proposed amendments to capital programme approved.		
FSC/18/08/105	Specialist Medicine SLR Deep Dive	• Per 17/18 SLR exercise Elderly Care shows loss of £8.3m. • Opportunities include preventing admissions and reducing length of stay. • Benchmarking with peers and Mid Cheshire shows above average length of stay for elderly care emergency admissions excluding stays of less than 1 day.	The Committee reviewed, discussed and noted report and to present findings to Trust Board.	
FSC/18/08/106	Cost Pressures Report	• 18/19 budget setting exercise resulted in 25 unfunded pressures totalling £2.8m that Executives and managers were required to manage. • As at 31 July 16 have been managed and 9 have not been managed (although two cost pressures will stop by end of September). • That remains 7 pressures with cost to date of £0.2m and potential annual cost of £1.1m.	The Committee reviewed, discussed and noted the report and requested quarterly updates	FSC October 2018

		• There are some plans in place for 7 pressures but not complete and not implemented but many rely on substantive recruitment. •		
FSC/18/08/107	CIP Report	• In year schemes total £4.9m with recurrent value of £4.0m. • At month 4 target is £1.0m and savings achieved are £0.5m. • Cost avoidance schemes total £0.1m. • Forecast CIP is £4.4m and cost avoidance is £0.3m. • Reduction in CNST premium can contribute to in year position (at least £0.3m but possibility of bonus reduction). • Still pursuing tactical and transformational opportunities to close the gap.	The Committee reviewed, discussed and noted the report	FSC September 2018
FSC/18/08/108	Strategy Delivery Report	• Updates on schemes to deliver clinical and financial sustainability including Warrington Together, One Halton, Patient Flow, Community Services, Collaboration, Clinical Strategies and Outpatients, Warrington New Hospital and Halton Healthy New Town. • £20k secured from NHSE to undertake feasibility study of Halton site.	The Committee reviewed, discussed and noted the report	

Strategic People Committee Chair's Report

Agenda Ref	BM 18/09/84 (e)	COMMITTEE:	Strategic People Committee	DATE OF MEETING	19 September 2018	CHAIR:	Anita Wainwright, Non-Executive Director

Attendance

Anita Wainwright	Non-Executive Director (Chair)
Ian Jones	Non-Executive Director
Kimberley Salmon-Jamieson	Chief Nurse
Lucy Gardner	Director of Transformation
Deborah Smith	Deputy Director of HR and OD
Mick Curwen	Head of Strategic HR Projects

Apologies

Michelle Cloney	Director of HR and OD
Andrea McGee	Director of Finance and Commercial Development
Chris Evans	Chief Operating Officer
Simon Constable	Executive Medical Director and Deputy Chief Executive
Pat McLaren	Director of Community Engagement

In attendance

Janet Oxley (JO)	Executive Assistant (notes)
Spencer McKee	Head of Medical Staffing and Education
Dan Moore	Deputy Chief Operating Officer

AGENDA ITEM	LEAD OFFICER	Issue / Exception Report	Recommendation / Assurance/ Action/Decision
SPC/18/09/01 Terms of Reference and Cycle of Business	Anita Wainwright, Non-Executive Director	Chair welcomed all members to the inaugural meeting of the Strategic People Committee. The Terms of Reference were discussed and agreed with amendments, as was the Work Plan.	The Terms of Reference and Work Plan are attached below. PDF Strategic People Committee ToR Sept PDF SPC 18 09 01 d DRAFT Strategic Peo Trust Board are asked to approve both documents.

SPC/18/09/02 Director of HR and OD Report	Deborah Smith, Deputy Director of HR and OD	The Director of HR and OD Report was received by the Committee. Trust Board are asked to note in particular the section on the workforce implications of Brexit.	The Home Office have published a toolkit for employers to assist in supporting employees. In addition, the Trust has participated in a pilot of the EU Settlement Scheme application process. The Home Officer has attended the Trust to provide dedicated support staff through the process. Of the 58 potentially eligible staff, 28 took part in the pilot.
SPC/18/09/03 Refreshed People Strategy	Deborah Smith, Deputy Director of HR and OD	Following the launch of the new WHH Strategy and a number of national publications on workforce in the NHS, the People Strategy has been refreshed to bring it in line with these changes. The draft People Strategy was presented to the committee for discussion and comments. There was good engagement with the draft strategy and valuable feedback received. The People Strategy was approved with amendments.	The People Strategy presentation is attached below. PDF People Strategy Launch 2018 Present The People Strategy was endorsed by the SPC to go to Trust Board (September 2018) for approval.
SPC/18/09/04 BAF and Risk Register	Mick Curwen, Head of Strategic HR Projects	The Committee received an update on workforce related risks from the Board Assurance Framework and the HR and OD risk register.	The Committee were asked to consider 2 risks in particular: 1. *A risk relating to overtime payments.* The Committee agreed to escalate this risk to the Board via the Board Assurance Framework. 2. *Failure to complete local induction for temporary staff caused by non-compliance with the policy resulting in possible risk to patients and staff.* The Committee have requested additional information relating to the root causes of this risk to be provided in the next meeting.

SPC/18/09/05 Getting to Good, Moving to Outstanding – Staff	Deborah Smith, Deputy Director of HR and OD	The Committee received a paper on the progress to date on the Trust-wide workforce elements of the work undertaken in the Getting to Good, Moving to Outstanding Steering Group which focused on: • PDR Compliance • Mandatory Training Compliance • Role Specific Training Compliance • Customer Service Training • Resuscitation Training	The Committee would like to highlight Resuscitation Training compliance to the Trust Board. In August 2018 compliance was 64% against a target of 85%. A number of actions are being taken to achieve 85% by 31 October 2018. In order to achieve this, 1000 must attend training in the next 2 months. The Resuscitation Training Team will increase capacity for all of the planned sessions throughout September and October 2018 to provide capacity for approximately 1,300 staff to attend the training throughout September and October 2018. Dedicated administrative resource has been allocated to work on promoting attendance on a daily basis and weekly return figures are being collated. 110 staff have attended training in the first 2 weeks in September. The Chief Nurse and Deputy Chief Operating Officer have confirmed that any barriers to attendance have been addressed and there it is a matter of releasing staff. Their senior leaders are working to support this on a daily basis.
SPC/18/09/10 Workforce Race Equality Standard	Deborah Smith, Deputy Director of HR and OD	The Committee received a paper on the Trust Workforce Race Equality Standard. The WRES consists of nine indicators, measuring BME Staff Experience when compared to white Staff Experience.	The WRES report is attached below. PDF SPC - WRES Report - Sept 18.pdf The key actions following the report relate to understanding the data in more detail. The Trust is ambitious in our approach to making sustained changes around these indicators and the outcomes

			will feed into the new Equality, Diversity and Inclusion Strategy.
SPC/18/09/14 Premium Pay Spend Review Chair's Log	Deborah Smith, Deputy Director of HR and OD	The Chair of Premium Pay Spend Review Group escalated to the Committee the current Trust achievement against agency ceiling. In July 2018 this was 23%, which increased to 24% in August 2018	Trust Board are asked to note the ceiling %, which is reported via Finance and Sustainability Committee. The Premium Pay Spend Review Group undertake a number of work streams to address agency spend, including a review of high priority areas, centralisation of temporary staffing models and a medical workforce establishment review and workforce plan.

DRAFT TERMS OF REFERENCE
STRATEGIC PEOPLE COMMITTEE

1. PURPOSE

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

The Strategic People Committee will seek assurance on the:

- Trust's approach, plans and processes for the delivery of the People Strategy,
- Efficient and effective use of resources,
- CQC Well Led Domain specifically on culture, quality improvement and collaborative leadership development:
  - Key Lines of Enquiry (KLOE)1: Leadership, capacity, capability to deliver high quality sustainable care
  - Key Lines of Enquiry (KLOE)3: Culture of high quality sustainable care
  - Key Lines of Enquiry (KLOE)7: Are people who use services, public, staff and external partners engaged and involved to support high quality sustainable services.
  - K8: Robust systems and processes for learning, continuous improvement and innovation
- Controls and systems in place to support line managers to make effective decisions in the deployment of staff,
- Redesign of the workforce so that it remains fit for the future, and
- Plans to recruit and retain staff at all levels and how this is reducing the reliance on temporary workers, and

The Committee will oversee strategic actions to enable the trust to deliver the WHH Strategy and specifically the People Strategic Objectives. In addition the Committee will provide assurance to Trust Board that the Strategic People Objectives will support our quality outcomes of providing:

- Clinical effectiveness
- A safe organisation
- Excellent patient experience

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

2. FREQUENCY OF MEETINGS

Meetings shall be held bi-monthly.

3. MEMBERSHIP

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

- Non-Executive Director (Chair)
- Non-Executive Director (Deputy Chair)
- Director of HR & OD
- Deputy Director HR & OD
- Chief Operating Officer

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

- Medical Director
- Chief Nurse
- Director of Transformation
- Director Finance & Commercial Development
- Director of Community Engagement
- Head of HR Strategic Projects

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

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

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

4. QUORUM

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

5. AUTHORITY

The Strategic People Committee is authorised by the Trust Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Strategic People Committee. The Strategic Committee may also receive a specific request to provide further assurance on a defined area of work from the Audit Committee.

6. REPORTING

Governance

The Strategic People Committee will have the following reporting responsibilities:

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

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

7. DUTIES & RESPONSIBILITIES

Duties – decision making:

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

Duties – advisory:

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

Duties – monitoring:

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

Duties of members:

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

Sub-Committees (Groups):

- Operational People Committee
- Premium Pay Spend and Review Group
- Triangulation Group

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

8. ATTENDANCE

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

9. ADMINISTRATIVE ARRANGEMENTS

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

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

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

Papers are to be submitted in the following format:

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

10. REVIEW / EFFECTIVENESS

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

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

Appendix A

NHS
Warrington and Halton Hospitals
NHS Foundation Trust

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

Council of Governors

Trust Board
Chair SMcG
Deputy Chair TA

FT Office

Audit Committee
Chair IJ SID

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

NARC
Chair SMcG

Charitable Funds
Chair JNE

Finance and Sustainability Committee
Chair TA
- Finance Resources Group, Chair DoF
- PPSRG Sub-cttee, Chair DHR&OD
- CPG, Chair SB
- OPD Transformation Sub-cttee, Chair CE COO

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

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

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

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

Warrington and Halton Hospitals NHS
NHS Foundation Trust

TERMS OF REFERENCE REVISION TRACKER

Name of Committee:	STRATEGIC PEOPLE COMMITTEE
Version:	DRAFT V4
Implementation Date:	September 2018
Review Date:	March 2019
Approved by:	Draft v3 approved by TRUST BOARD (July 2018) Draft v4 – to be presented to September TRUST BOARD
Approval Date:	

REVISIONS

Date	**Section**	**Reason on Change**	**Approved**
May 2018	Draft TORs v1		Amendments – AW / MC
June 2018	Draft TORs v2		Amendments – AW / MC
July 2018	Draft TORs v3 – to include Appendix A: Governance Flow Chart - for use to proceed to seek approval		Amendments – AW / MC
July 2018	Appendix A – Amendment to Key – Explanation of Sub Committee / Groups to Assurance Committees		Amendments – AW / MC
September 2018	1. **Purpose** – clarification on Well Led KLOEs to be reported to SPC and further confirmation of role of SPC as an assurance committee 2. **Membership** – Written approval by quorate membership rather than full membership 3. **Duties & Responsibilities** – Section on Decision Making. Clarity on SPC role to assure actions taken to recruit and retain our workforce Section on Monitoring. Scope of Employee		Amendments agreed by members of the Strategic People Committee 19 September 2018 for approval to Trust Board (September 2018)

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

	Relations Case Report clarified and to be included in workplan 4. **Subcommittees** – to include Triangulation Group		

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

We are WHH

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Work Plan 2018 - 2020

DRAFT STRATEGIC PEOPLE COMMITTEE (SPC)											
Topic	**Lead**	**September 2018**	**November 2018**	**January 2019**	**March 2019**	**May 2019**	**July 2019**	**September 2019**	**November 2019**	**January 2020**	**March 2020**
Apologies for Absence	Chair	√	√	√	√	√	√	√	√	√	√
Declarations of Interest	Chair	√	√	√	√	√	√	√	√	√	√
Minutes of the last meeting	Chair	√	√	√	√	√	√	√	√	√	√
Matters Arising	Chair	√	√	√	√	√	√	√	√	√	√
Action Log	Chair	√	√	√	√	√	√	√	√	√	√
Terms of Reference	Chair	√			√						√
Annual Cycle of Business	Chair	√			√						√
Committee Chairs Annual report to Trust Board	Chair				√						√
Director of HR & OD report	Director HR & OD	√	√	√	√	√	√	√	√	√	√
BAF & Risk Register – Staff	Head of HR Strategic Projects	√	√	√	√	√	√	√	√	√	√
WHH People Strategy Report	Deputy Director HR & OD	√			√			√			√
CQC – Getting to Good, Moving to Outstanding - Staff	Director HR & OD	√	√	√	√	√	√	√	√	√	√
Educational Governance Annual Report	Head of Education Development & Wellbeing					√					
HENW/GMC Annual Reports: • **GMC Patient Survey Response Report** • **HENW Local Education Provider (LEP) Report** • **HENW Monitoring Visit (Annual Assessment Visit)** • **GMC National Trainee Survey**	Medical Director + Deputy CEO		√ √ √ √						√ √ √ √		
Medical Appraisal + GMC Revalidation Annual Report	Medical Director + Deputy CEO	√						√			
Policies and Procedures Report (as required)	Head of HR Strategic Projects	√	√	√	√	√	√	√	√	√	√
Employee Relations Report	Deputy Director HR & OD	√	√	√	√	√	√	√	√	√	√
Pay and Terms & Conditions – National & Regional Policy Updates	Head of HR Strategic Projects	√	√	√	√	√	√	√	√	√	√
National Staff Opinion Survey	Deputy Director HR & OD					√					
Freedom to Speak Up	Chief Nurse	√				√				√	
Guardian Quarterly Report on Safe Working Hours for Junior Doctors in Training	Medical Director		√		√		√		√		√
Equality and Diversity – Strategy Update	Deputy Director HR & OD		√			√			√		
Equality and Diversity – Regulated Reports (as required)	Deputy Director HR & OD										
• **Equality Duty Assurance Report (EDAR) PSED Standard (for sign off)**				√						√	
• **Workforce Equality Assurance Report (WEAR) PSED Standard (for sign off)**				√							
• **Equality Delivery System 2 (EDS2) – within OPC Chairs Log**					√						
• **Gender Pay Report – – within OPC Chairs Log**					√						
• **Workforce Race Equality Standard (WRES) – within OPC Chairs Log**		√					√				
• **Workforce Disability Equality Standard (WDES) - within OPC Chairs Log**								√			
Facilities Time Off Annual Report	Head of HR Strategic Projects						√				
VIP + Celebrity Visits Policy Annual Report	Director of Community Engagement				√						√
Engagement and Recognition Annual Report	Director HR & OD / Director of Community Engagement				√						√
Trust Board Monthly Staffing Report – Key Issues Report	Chief Nurse	√	√	√	√	√	√	√	√	√	√
Trust Strategic Projects – Exception Report (People)	Director of Transformation	√	√	√	√	√	√	√	√	√	√
Operational People Committee	Director HR & OD	√	√	√	√	√	√	√	√	√	√
Premium Pay Spend + Review Sub Committee	Deputy Director HR & OD / Head of Workforce Transformation	√	√	√	√	√	√	√	√	√	√
Triangulation Meeting	Executive Medical Director	√	√	√	√	√	√	√	√	√	√

WHH PEOPLE STRATEGY 2018-2021

Strategic People Committee Engagement

Welcome

- **How the strategy was developed**
- **Delivering the Strategy**
- **How we will measure success**
- **How we will monitor progress**

National Context:

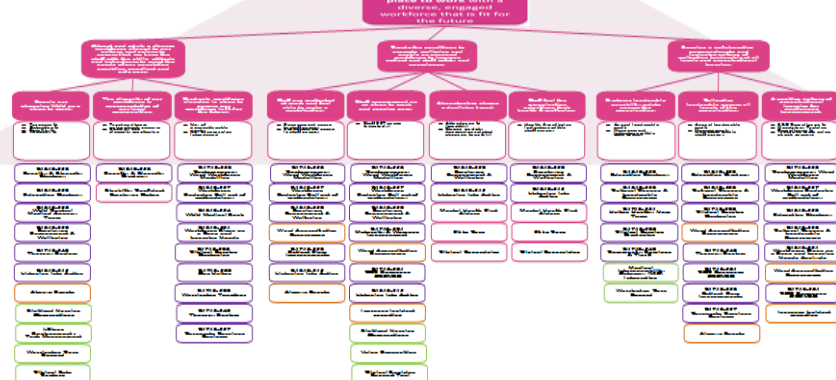
- 'Developing People, Improving Care', National Improvement and Leadership Development Board
- 'Facing the Facts, Shaping the Future', Public Health England

Regional Context:

- Cheshire and Mersey Strategic Workforce Programme

WHH Context:

- WHH Strategy on a Page and People Strategic Objectives
- WHH Strategy Map



Engagement

WHH Staff

- Staff Opinion Survey 2017
- Perfect Day Event
- HR and OD Directorate Event

WHH Leaders

- WHH Start of the Year Conference 2018

WHH Directors and Non-Executive Directors

- Strategic People Committee September 2018

WHH PEOPLE STRATEGY 2018-2021

Delivery

NHS
Warrington and Halton Hospitals
NHS Foundation Trust

70 YEARS OF THE NHS 1948 - 2018

The HR and OD Directorate will work in partnership with CBUs and Corporate Services to deliver the People Strategy.

Success Measures

‘We will create the conditions to promote wellbeing and enable an engaged workforce to improve patient and staff experience’	
• Reduction in mental health related sickness absence • Reduction in musculoskeletal health related sickness absence • Improving number of staff believe that we value their health and wellbeing	• Improving number of staff recommend WHH as a place to work and receive treatment • Pioneering teams adopt LIA • Increasing numbers of staff receiving the annual flu vaccination • Continuous improvement via the Ward Accreditation Programme
‘We will attract and retain a diverse workforce aligned to our culture and values, to ensure that we have the staff with the skills to deliver excellent patient care’	
• Reduction in difficult to fill vacancies across the Trust • Reduction in the number of staff leaving the Trust • Achievement of the measures within the Equality, Diversity and Inclusion Policy • Production of strategic workforce plans	• Improvement in the number and quality of annual appraisals • All available staff, including bank workers, have completed mandatory training • Improving number of staff tell us that they have received high quality non-mandatory development
‘We will develop a collaborative, compassionate and inclusive culture of collective leadership and organisational learning’	
• Reduction in Dignity at Work employee relation cases • Increase in internal promotions • All staff have access to Quality Improvement training within the Trust, tailored to their needs	• Quality improvement plans are in place for all areas • Improved recruitment and retention of leadership positions • Improving numbers of staff tell us that their managers and leaders are supportive, communicate well and that they feel valued

Success Measures

Measuring Success

We will measure how well we are delivering against the People Strategy through our new People Strategy Dashboard.

People Strategy Dashboard
370 Warrington and Halton Hospitals NHS Foundation Trust

Employee Wellbeing and Engagement

Attraction, Retention and Inclusion

Leadership and Learning

Progress

Monitoring Progress

Detailed delivery plans will underpin each of the People Pledges. Our progress against our People Pledges will be monitored via the Strategic People Committee, which reports to Trust Board. Key Performance Indicators will be monitored by the Operational People Committee.

Questions

STRATEGIC PEOPLE COMMITTEE

AGENDA REFERENCE:	**SPC/18/XXX/XXX**
SUBJECT:	**Workforce Race Equality Standard Report**
DATE OF MEETING:	19 September 2018
ACTION REQUIRED	**For approval**
AUTHOR(S):	Michelle Halliwell, Equality and Diversity Specialist
EXECUTIVE DIRECTOR SPONSOR:	Michelle Cloney, Director of HR & OD
EXECUTIVE SUMMARY	As per statutory requirements, the organisation submitted and published their Workforce Race Equality Standard Information in August 2018. Our data indicates that whilst the experiences of White and BME staff are equitable against some of the indicators, work is still required. An action plan identifying the work to be undertaken will be published on our external website in line with National timescales. Our Action Plan will be monitored via the Equality and Diversity Sub Committee.
RECOMMENDATIONS:	Members of the Strategic People Committee are asked to approve the WRES data and action plan.
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None

Strategic People Committee

SUBJECT	Workforce Race Equality Standard Report	AGENDA REF:	

1. BACKGROUND

Introduced in 2016, the Workforce Race Equality Standard (WRES) is in place to ensure employees from Black and Minority Ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace.

The WRES consists of nine indicators, measuring BME Staff Experience when compared to White Staff Experience.

Our WRES data is required to be submitted nationally and along with an action plan, is required to be published on our externally facing internet page.

Our 2018 WRES Data and associated actions have been discussed at the Equality and Diversity Sub Committee. The below outlines the key points and actions planned in relation to each of the indicators.

2. KEY ELEMENTS

The table below includes both the WRES data and action plan.

WRES Indicator		2018 Data	Analysis	Action
1	Percentage of staff in each of the AfC Bands 1-9 OR Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall	**Non-Clinical:** **Under Band 1 = 0.05%** **Band 1 = 0.47%** **Band 2 = 0.16%** **Band 3 = 0.09%**	From this we can see that the majority of our Non-Clinical BME staff are employed within the lower bands, with the percentage of BME staff in each band decreasing as the banding increases, though there is a slight peak at band 6.	• To review development opportunities to BME staff and how these are promoted. • To review data of applications of BME staff to various roles • To utilise BME focus group in addressing barriers.

	workforce	**Band 4 = 0.07%**	There are no BME staff represented from Band 7 upwards in our Non-Clinical Roles at Warrington and Halton.	Work should continue from 2017 WRES action plan to promote and support BME staff in utilising initiatives such as apprenticeships, the "stepping up" program and Edward Jenner, with a view to utilise the BME focus groups in assessing any barriers to development and progression of BME Staff within the Trust.
		Band 5 = 0.05%		
		Band 6 = 0.09%		
		Band 7/8/9/VSM = 0%		
		Clinical:	The majority of our Clinical BME Staff are employed within Band 2, 5, and 6. The majority are employed at the Band 5 level which may be explained by overseas recruitment into roles such as nursing. These figures decrease from band 5, with no BME representation in Band 8c to VSM.	
		Under Band 1 = 0.02%		
		Band 1 = 0%		
		Band 2 = 1.13%		
		Band 3 = 0.07%		
		Band 4 = 0.14%		
		Band 5 = 2.23%		
		Band 6 = 0.82%		
		Band 7 = 0.28%		
		Band 8a = 0.05%		
		Band 8b = 0.02%		
		Band 8c/8d/9/VSM = 0%		
		Medical & Dental	A high number of our BME staff are also represented within the Medical and Dental Staff Group, specifically within our Consultant roles. This may also be attributed to overseas recruitment.	
		Consultants = 1.81%		
		Senior Medical Managers = 0.09%		
		Non-Consultant Career Grade = 0.80%		
		Trainee Grades =		

		0.82% **Other = 0.66%**		
2	**Relative likelihood of White staff being appointed from shortlisting compared to BME Staff across all posts**	**1.61**	This indicates that White Staff are more likely than BME Staff to be appointed from shortlisting, throughout the period of 2017/2018 and requires further analysis to ensure appropriate actions are taken.	• To review applicant data across bands 7+ to look for trends and identify area of focus and action. • After review of data, to assess the possibility of including a BME representative on certain interview panels. • Further actions to follow on review of more detailed data. • This is analysis of ethnicity patterns in recruitment reports from NHS jobs and will be included as part of EDS2 evidence.
3	**Relative likelihood of BME staff entering the formal disciplinary process compared to White staff (over two years)**	**1.08**	This indicated BME staff were more likely to enter the formal Disciplinary procedure than White Staff however, this was not a statistically significant variance but the data will continue to be monitored.	• To continue to monitor the data
4	**Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff**	**0.33**	This indicates that BME Staff are more likely than White Staff to access CPD and Non-mandatory training, which may be representative of a large proportion of our BME staff being in Clinical and Medical and Dental posts.	• Review how data is recorded for staff training • Evaluate what training is being accessed by BME staff in an attempt to evaluate why White Staff aren't accessing this training.
5	**KF 25. Percentage of staff experiencing harassment,**	**White = 21.73%** **BME = 17.89%**	2018 has seen a decrease in the % of BME staff reporting that they have experienced	• To utilise the focus group in assessing any causes behind this decrease.

	bullying or abuse from patients, relatives or the public in last 12 months		harassment, bullying or abuse from patients, relatives or the public in the last 12 months (decrease of 12% from 2017 data).	• To review DATIX information to see if this correlates to the staff survey results. • Compare this data against other Trusts • After further assessment, review actions to follow.
6	**KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months**	**White = 21.56% BME = 20.16%**	2018 has seen a decrease of 5% in BME staff reporting to have experienced harassment, bullying or abuse from staff in the last 12 months when compared to 2017 figures. Based on the WEAR Report, there were no allegations of harassment or bullying raised by BME staff in 2017, with 2016 seeing 6% of allegations raised being from BME Staff. With the difference between those reporting experience of Bullying, harassment or abuse and those actually raising a formal allegation, this may require further action to ensure staff are aware of the processes available to them, and whether these are effective.	• To utilise the focus group in assessing any causes behind this decrease. • To review Employee Relations information to see if this correlates to the staff survey results. • Compare this data against other Trusts • After further assessment, review actions to follow.
7	**KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion**	**White = 90.20% BME = 75%**	2018 has seen a sharp decrease in the % of BME staff reporting that they believe the Trust provides equal opportunities for career progression or promotion.	• To review information and data on career progression for staff between Bands 5-6, as these are our highest bands populated with BME staff. • To be raised as a discussion point in focus group, and follow up on actions from Focus Groups held in September 2017. • The WRES Action Plan from 2017, should

				be reviewed in light of these figures, with both actions on this to be analysed regarding their effectiveness, with specific reference to the safeguarding reports and the support and promotion of opportunities available to staff. This will require a review through the EDSC, involvement with the education and training teams, review of processes for accessing training and how this is promoted, and for feedback and suggestions from the BME Focus Group. • Review the targeted development opportunities available through the NWLA
8	**Q17. In the last 12 months have you personally experienced discrimination at work from any of the following?** **b) Manager/team leader or other colleagues**	**White = 4.91%** **BME = 6.56%**	This has maintained for 2018. The % remains small and it does not appear that race is a significant cause in 2017.	• To benchmark this data against other Organisations • To continue to monitor
9	**Percentage of the Board who identify as BME compared to White Staff.**	**0% of the Board are BME**	The current Board of Voting Members and the Board Executive Membership all identify as White.	• To contact the Head of Corporate Affairs, with a view to explore board diversity and future opportunities i.e. reviewing recent Board level recruitment processes for good practice. • To review if the Trust has a non-executive E&D Lead, with an aim to put this in place.

3. RECOMMENDATIONS

Members of the Strategic People Committee are asked to approve the WRES data and action plan.

BOARD OF DIRECTORS

<table>
<tr><td>AGENDA REFERENCE:</td><td>BM/18/09/86</td></tr>
<tr><td>SUBJECT:</td><td>Health & Safety Annual Report</td></tr>
<tr><td>DATE OF MEETING:</td><td>26th September 2018</td></tr>
<tr><td>ACTION REQUIRED</td><td>Review, Discuss and approve</td></tr>
<tr><td>AUTHOR(S):</td><td>Ursula Martin, Director of Governance & Quality</td></tr>
<tr><td>EXECUTIVE DIRECTOR SPONSOR:</td><td>Kimberley Salmon-Jamieson, Chief Nurse
Choose an item.</td></tr>
<tr><td colspan="2"></td></tr>
<tr><td>LINK TO STRATEGIC OBJECTIVES:</td><td>All</td></tr>
<tr><td colspan="2"></td></tr>
<tr><td>EXECUTIVE SUMMARY
(KEY ISSUES):</td><td>This paper provides an update on Health and Safety Management and compliance ratings throughout the Trust. The following are improvements that have been made throughout the year
A review of the Trust’s Health & Safety Strategy, policies and reporting has been undertaken.
A review of the Trust’s Health and Safety Sub Committee has been undertaken including frequency, terms of reference and assurance reporting.
There has been a number of Health & Safety improvements put in place including
Flooring has been replaced with non-slip flooring in many areas or new flooring to reduce hazard tape and STFs
Weekly inspections of corridors to identify damage that could cause injury – raise issues to Estates before incidents occur
Gates have been installed on some linen cupboards to hold in bags of dirty linen to stop overflowing onto corridors
Heavier matting at entrance doors to prevent tripping and ruffling of carpets
Embedded matting at Croft Wing entrance to prevent slip and trips
Metal barriers installed at car park near bus stop to stop short cuts across pot hole area where cars park and also around pavement to stop people crossing road in busy areas
Asked for beds to be taken to the first floor near to Pathology and Theatre to prevent congestion</td></tr>
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	on ground floor, damage caused by tugs, possible collisions etc ▪ Clinical waste wheelie bins not open as much due to daily campaign of inspections – vastly reduced – some areas now have more than one bin due to amount of waste ▪ Slips, Trips and Falls – wet floor signage has been placed at front entrances so they can be put in situ immediately to warn of wet floor until mopped up ▪ Moved clinical waste bins from Labour Ward to corridor so not visible to patients and visitors ▪ Replaced metal foot plate at Store Halton as rotting away. New one now in situ and no incidents should occur ▪ External walkabouts identify broken flags, obstacles etc to prevent slips and trips, more undertaken at Halton which have identified numerous broken flags ▪ No timetable of inspections now to Managers therefore ad hoc inspections to see the wards and departments. Increased inspections also have made departments better – good housekeeping ▪ Constant reminders to Estates regarding barriers around contractors and workmen especially when in the roof spaces. This had seen a massive improvement now and are always in place when workmen are about	
RECOMMENDATION:	Discuss and note the Report	
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Committee
	Date of meeting	August 2018
	Summary of Outcome	Quality Committee was assured that progress was being made across all areas in the Health & Safety Strategy
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

1. BACKGROUND/CONTEXT

This annual report describes health and safety (H&S) activity within the Trust from April 17 to March 18. The management of health and safety is a critical component of the overall Governance agenda, with the safety of patients and staff being a core value.

There has been a significant change in H&S management over the past 6 years. In 2012 the Trust had been issued with a number of improvement notices and had quarterly visits from the HSE. The Trust now has a level of compliance within all relevant H&S legislation. This is supported by a robust and structured H&S Management System. To support the management system there are a wide range of policies and guidance documents available which have been developed and implemented across the Trust. The system supports the organisation in ensuring as safe and healthy environment for patients, visitors, staff and contractors.

2. KEY ELEMENTS

2.1 HEALTH AND SAFETY INTERNAL CONTROL

2.1.1. Health & Safety Training

The existing mandatory training programme is reviewed annually to ensure all staff are gaining the knowledge and skills required to manage H&S and to ensure training is easily accessible to staff.

The programme consists of:

- Health and Safety Awareness Training for all Staff – This is a general awareness of health and safety law and how it is managed throughout the Trust. The training can be accessed via a practical bases session or e-learning.
- Health and Safety Awareness for Senior Managers and Doctors – This is a training booklet which provides up to date information on current legislation and corporate manslaughter
- DATIX training – This training is for managers and staff who are required to record risks on the DATIX risk module

There have been specific courses run throughout the year which include:

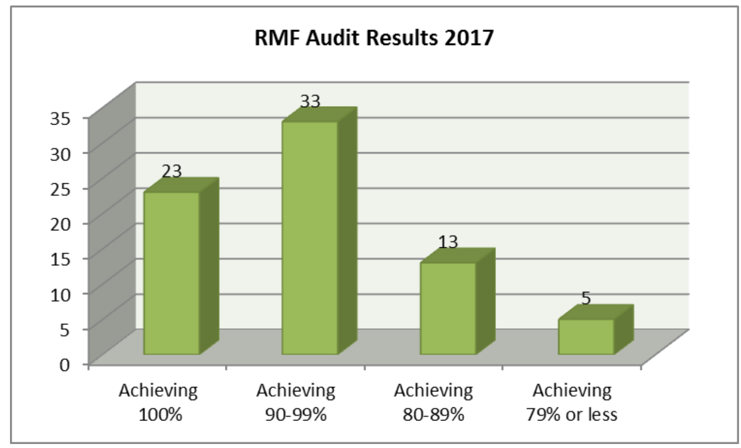
- Working at Height (Ladder training)
- Non Clinical investigation form training
- Manual Handling training
- COSHH training
- Tool box talk on RIDDOR
- DSE training
- Smoking Awareness Campaign

2.1.2 Risk Management Framework Audit Results April 2017 to March 2018
The Risk Management Framework (RMF) is the basis of the H&S Management System for the Trust. This provides a structure for managers to follow to ensure compliance with legislation in their areas of work. The tool is the process by which, the Trust can provide assurance that there is an effective system of internal control to monitor H&S risks and continually improve to provide a safe and healthy environment.

The RMF consists of a number of standards each supported by a set of Performance Criteria and policies and guidance. The standards and criteria have been taken from key legal requirements relating to health and safety.

For 2017/18, the Health and Safety Team carried out the RMF audits and visited 72 wards and departments.

The initial results of the audit found that 23 wards and departments achieved 100% compliance, with the other 49 wards and departments provided with an action plan listing the improvements required.



Managers were supported with guidance to meet the needs of the RMF, though it was noted that changes in staff and ward areas impacted on completion of action plans e.g. other Managers trying to work through unfamiliar handed over action plans.

Going forward to the new financial year, with the introduction of a new risk assessment process, including the DATIX RISK Management module and, an Integrated Risk Management Self-Assessment Tool; Managers will have more opportunity to assess their areas of business and ensure they have the necessary documentation and evidences in place.

2.1.3. Health and Safety Policies, Guidance, Information and Advice
There are a wide range of policies and guidance documents developed and now embedded across the organisation.

During the past 12 months the following policies and guidance documents have been reviewed and approved at the Health and Safety Sub Committee meeting:

CAS Policy	Lifting Operations & Lifting Equipment Policy
Manual Handling Policy	Manual Handling of Plus Size Patient
Health and Safety Policy	New and Expectant Mothers Policy
Non Clinical Slips, Trips and Falls Policy	Management of Electrical Safety Policy
RIDDOR Policy	Asbestos Policy
Smoke Free Policy	First Aid Policy
DSE Policy	Stress Policy
Risk Assessment Policy	Management of Sharps & Inoculations Policy

Currently all H&S policies and guidance documents are up to date and are compliant with current H&S legislation.

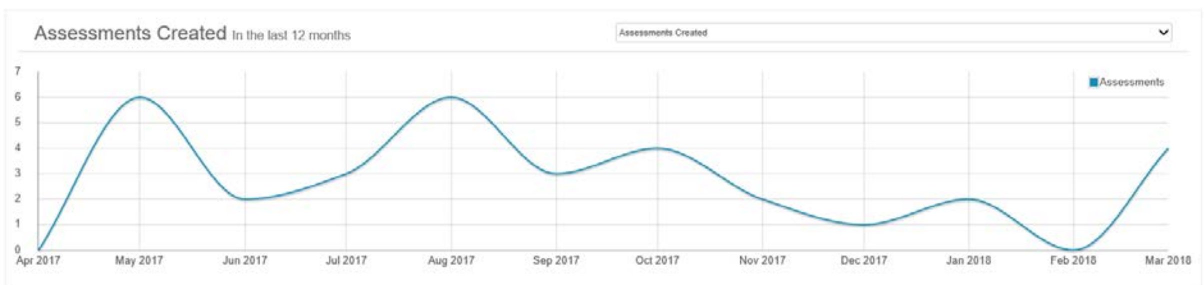
2.1.4. Control of Substances Hazardous to Health (COSHH)

The Trust has in place the Sypol database for the management of COSHH.

All staff who are responsible for the management of COSHH have had the relevant training. During 2017/2018, 30 new staff were trained. There is a programme of training dates organised throughout 2018 and staff can also have ad hoc training sessions on a 1-1 basis

There are 1,441 individual COSHH assessments available with new assessments being added on a regular basis and there are 1,305 different materials used within the Trust.

The graph below shows the number of new assessments completed by staff during the last 12 months



The CMS has recently undergone a series of enhancements to provide an even more comprehensive COSHH management tool. One of the upgrades was to provide more accurate and sophisticated risk ratings based on acute and chronic risks. For both these types of risks, the Trust are only at 2% for both these high risk ratings

This type of risk is now identified on the risk assessments which is clearly evident when opening each assessment

Scenario Details | Activities | Controls | Material Details | Hazards | Considerations | Health | Emergency | Supplier | COSHH Control Sheet | Access History

HIGH ACUTE RISK	HIGH CHRONIC RISK
Assessment Id	1921562
Date Created	28/05/2013 12:36:00
Date Reviewed	25/05/2017 10:07:00
Next Review Date	25/05/2018 10:07:00 Based on HIGH Risk
Quantity used	SPRINKLE
Frequency of use	Daily
How many people are exposed?	1
Are there any susceptible workers?	No
Susceptible categories	
Other susceptible categories	
Being used outside of the normal temperature range?	No
Are any other people put at risk from indirect exposure?	No
How are they exposed?	
Activities	

Act No.	Method	Area	Exposure	Acute Risk	Chronic Risk
3	Hand applying	Inside Well Ventilated	1/2 to 2 hours per shift	MEDIUM	MEDIUM
19	Hand applying	Confined Space	Up to 1/2 hour per shift	HIGH	HIGH

Additional Work Practices	USE NEAT ON SINK, BATHS AND TOILETS
Control measures	WEAR GLOVES AND APRON DURING USE. DISPOSABLE CLOTHS USED AFTER EACH TASK.
Safer Substitute Chosen	No

Scenario Details | Activities | Controls | Material Details | Hazards | Considerations | Health | Emergency | Supplier | COSHH Control Sheet | Access History

MEDIUM ACUTE RISK	MEDIUM CHRONIC RISK
Assessment Id	170727
Date Created	06/12/2011 10:34:00
Date Reviewed	09/01/2018 13:48:00
Next Review Date	09/01/2021 13:48:00 Based on MEDIUM Risk
Quantity used	1
Frequency of use	Daily
How many people are exposed?	1
Are there any susceptible workers?	
Susceptible categories	
Other susceptible categories	
Being used outside of the normal temperature range?	No
Are any other people put at risk from indirect exposure?	No
How are they exposed?	
Activities	

Act No.	Method	Area	Exposure	Acute Risk	Chronic Risk
70	Dissolving	Inside Well Ventilated	Up to 1/2 hour per shift	MEDIUM	MEDIUM

Additional Work Practices	
Control measures	
Safer Substitute Chosen	Yes

Scenario Details | Activities | Controls | Material Details | Hazards | Considerations | Health | Emergency | Supplier | COSHH Control Sheet | Access History

LOW ACUTE RISK	LOW CHRONIC RISK
Assessment Id	2129068
Date Created	08/04/2014 08:20:00
Date Reviewed	04/04/2017 08:18:00
Next Review Date	04/04/2022 08:18:00 Based on LOW Risk
Quantity used	< 25 wipes
Frequency of use	Daily
How many people are exposed?	1
Are there any susceptible workers?	No
Susceptible categories	
Other susceptible categories	
Being used outside of the normal temperature range?	No
Are any other people put at risk from indirect exposure?	No
How are they exposed?	
Activities	

Act No.	Method	Area	Exposure	Acute Risk	Chronic Risk
2	Hand applying	Inside Well Ventilated	1/2 to 2 hours per shift	LOW	LOW

Additional Work Practices	
Control measures	
Safer Substitute Chosen	No

Other graphs provided identify the Trust's health, environmental and physico-chemical hazards.

Any substances used with a high risk rating are managed with a robust safe operating procedure following advice from the safety data sheet and/or manufacturer.

2.1.5. Display Screen Equipment

From 1st April 2017 to 31st March 2018, the Health and Safety Department carried out 41 individual DSE workstation assessments on members of staff. The aim of the assessments were to ensure there was no risk of injury or ill health to staff and to ensure any existing medical conditions were not exacerbated by work equipment.
By conducting the assessments and gathering necessary details, it can avoid the member of staff going off sick for any periods of time.

Out of the 41 completed assessments, over 30 either had a medical condition, was pregnant or had had an injury. 29 recommendations were for new chairs with fully adjustable back rests. Other advice consisted of footrests, a new mouse and/or wrist rests. Adjustments were required to the majority of workstations such as height adjustment of monitors, re-arrangement of equipment on desks and advice provided not to cradle telephone handsets with the shoulder, neck and head.

2.1.6 Management of Sharps

The Trust has in place a clear process for the prevention of exposure to blood borne viruses. Safer sharps have been implemented throughout the Trust and areas who could not find a suitable alternative are required to have an equipment specific risk assessment in place. A recent audit found that we did have those risk assessments in place.

An annual audit reviews risk assessments in place and ensures the incident procedure is laminated and visible on each Ward.

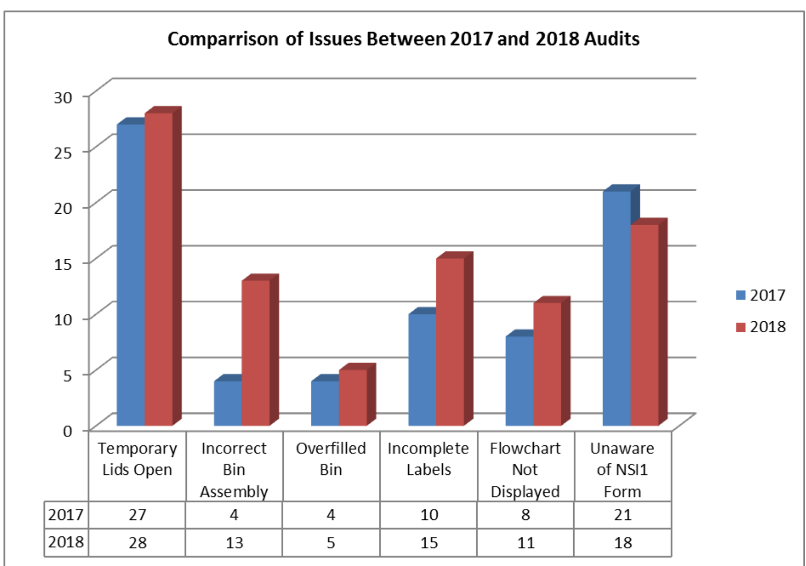
The Head of Safety and Risk has reinstated the Safer Sharps Working Group which was formed with Workplace Health and Wellbeing and Infection Control. The Safer Sharps Working Group is there to reduce the risk to staff, patients and the Trust through tools of training, audit and reporting.

The H&S department carries out an annual sharps audit for the Trust in quarter 2 of each financial year, with aims and objectives described as below:

- Check areas of compliance, identifying the type of device used in each area
- To identify any non-safe devices and ascertain why they are still in use
- To calculate the amount of non-safety devices (old stock) still in circulation
- To ensure all sharps training is up to date

An independent audit is also provided to the Trust by Daniels, the supplier of sharps safety equipment, and carried out in quarter 3.

Overview of sharps audit findings comparing 2017 and 2018



	Temporary Lids Open	Incorrect Bin Assembly	Overfilled Bin	Incomplete Labels	Flowchart Not Displayed	Unaware of NSI1 Form
2017	27	4	4	10	8	21
2018	28	13	5	15	11	18

Although the incident reports have reduced, the results from the recent April 2018 audit were disappointing.

- 28 areas had did close the temporary lids on the sharps bins. This is an action on the CQC report relating to Theatres.
- Bins were found to be overflowing in 5 areas
- 13 bins were not assembled correctly

The H&S Team are going to do a sharps campaign to raise awareness and education around the safer sharps agenda. This will involve stalls at the front of the hospital and a communications updates on various issues surrounding the sharps agenda e.g. closer of bins, correct labelling, ensuring staff are trained.

The sharps agenda will continue to be managed and monitored by the safer sharps group, overseen by the Health and Safety Sub Committee. A further sharps audit will be carried out once the campaign has been completed.

2.1.7 Non Clinical Manual Handling

Manual Handling audits are now incorporated into the Risk Management Framework. To date all Wards/Departments are compliant with non-clinical manual handling. All have suitable and sufficient risk assessments in date and training figures are high. A full programme of training dates is now in place for 2018/19.

As of the end of April 2018, the Trust's non patient manual handling training figures was identified as the following:

	Level 1
Clinical Services	85%
Corporate Services	92%
Trust Total	**89%**

2.1.8 Health and Safety Sub Committee

The Health and Safety Sub Committee continue to meet bi-monthly and is supported by the Trust Health and Safety Advisers. Attendance at the meetings continues to be well received and there has been representation from various departments. The meeting enables Departmental safety leads to be updated with health and safety information, allows them to bring to the meeting any issues that require clarification or sharing, and is also a learning forum.

2.2. HEALTH AND SAFETY COMMUNICATIONS AND SUPPORT

2.2.1. Guidance and Information

The H&S team, over the past two years, have developed a number of pages on the Trust HUB (now the Extranet) to provide support and advice to Wards and Departments on a wide range of H&S topics.

Information includes:

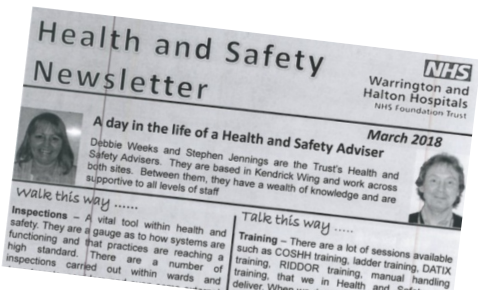
- A Health and Safety Library Page – which provides an A-Z list of all H&S guidance documents, templates and checklists
- Example risk assessments – this provides an example of risk assessment for each standard within the risk management framework
- Advice pages on specific topics which include, Slips, Trips and Falls, Stress, COSHH, DSE, Housekeeping, Good Practice, Working at Height
- A programme of practical training dates for various topics
- Copy of safety alerts developed for any particular issue that may need immediate attention.

2.2.2. Health and Safety Newsletter

A H&S newsletter has been developed by the H&S team. This is a bi-monthly newsletter which is disseminated to all Wards/Departments across the Trust. The newsletter keeps staff informed of "hot topics" and also raises awareness of safety issues across the Trust. The aim is to provide staff with an insight of what has been happening in the H&S agenda during the previous two months.

The fifth edition of the newsletter is currently ready to be presented at the Health and Safety Sub Committee before being sent out to all staff.

Issue have provided photographs of poor practice to ensure learning but has also highlighted evidence of good practice. An example would be areas of good housekeeping.



Health and Safety Newsletter

NHS Warrington and Halton Hospitals NHS Foundation Trust

A day in the life of a Health and Safety Adviser

March 2018

Debbie Weeks and Stephen Jennings are the Trust's Health and Safety Advisers. They are based in Kendrick Wing and work across both sites. Between them, they have a wealth of knowledge and are supportive to all levels of staff

Walk this way ......

Inspections – A vital tool within health and safety. They are a gauge as to how systems are functioning and that practices are reaching a high standard. There are a number of inspections carried out within wards and

Talk this way .....

Training – There are a lot of sessions available such as COSHH training, ladder training, DATIX training, RIDDOR training, manual handling training, that we in Health and Safety can deliver. When we do train, we try to get as close

2.3 HEALTH AND SAFETY INSPECTIONS

2.3.1. Inspections

It is Trust policy that the health and safety inspections are carried out by the Health and Safety Team (H&S) every quarter; this includes all Wards and Departments on both hospital sites.

For this year, within each quarterly inspection period of both hospital sites, H&S revised the inspection format to have two six weekly programmes within each quarter to enabling a second inspection to be carried out.

The benefit of this is to have a more detailed view on the response to actions and compliance under taken.

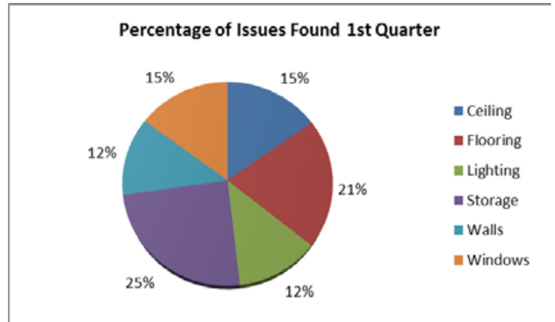
From April 2017 to March 2018, 451 inspections where carried out and when looking at the results of issues identified, the findings are split into two categories:

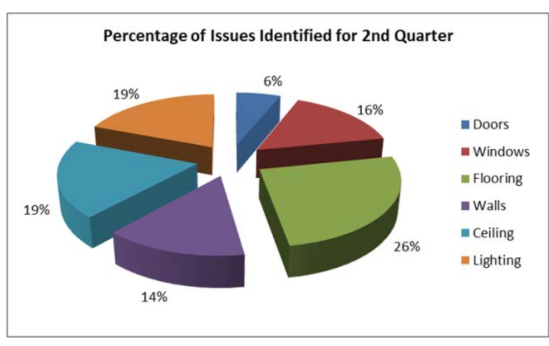
- Buildings and Environment Issues
- Procedural Issues

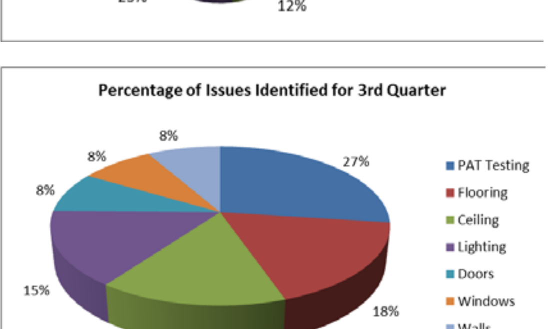
2.3.2. Building and Environment issues:

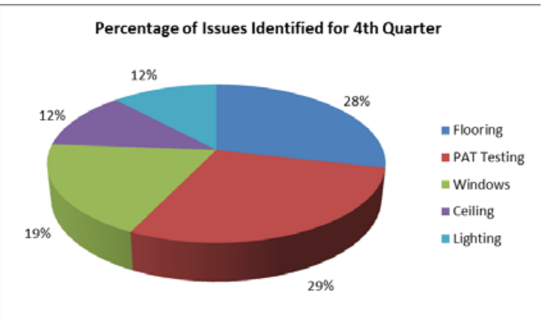
This takes into account the age and structure of the Warrington and Halton estate and its diverse nature.

When inspecting, evidence of remedial work is looked for and new and outstanding issues noted; this particularly affects areas such as ceilings, flooring, lighting, walls and windo









The condition of the buildings features highly the inspection of all areas. It is acknowleged there is some limitation within the system both financially and in resource, to enable all identified issues to be recitified at once.

Importantly it is the manangement of issues identified that was sought and in the majority of instances, the Housekeeper or department Manager was able to provide evidence, whether being a job number or the maintenance of the situation e.g. hazard tape on the floor.

2.3.3. Procedural issues
This takes into account what is considered management responsibilities: daily and monthly checks are carried out, test and examination dates of equipment within the department in date and good practice and overall cleanliness.

There are twelve categories to this part of the inspection and evidence was demonstrated if the process had been completed e.g. record of flushing dates.

2.3.4. Common themes:

- Sharps procedural management such as completing labels on sharp boxes, and that the correct use of temporary lids in undertaken;
- First aid records of monthly stock checks, to see that the first aid kit is suitably stocked;
- Kitchen inspection regarding the overall cleanliness and appropriate storage of items;

- Equipment was highlighted relating to evidence of testing and planned maintenance being carried out;
- Furniture condition and usability of furniture; being the correct type for the area (DSE chairs);
- Storage cleanliness and appropriate usage of the area and storage of articles.

Where evidence wasn't available this is raised to the responsible manager with the presentation of findings.

2.3.5 Inspections of Internal Corridors

Corridor inspections for both Warrington and Halton Hospital are carried out regularly through each week by the Health and Safety Team. Findings are recorded and significant issues e.g. damage or waste - raised immediately to the relevant departments. Reports are generated from the inspections and also practice issues highlighted to all staff through Communication or alert emails.

During inspection of the main corridors of Halton hospital, the level of housekeeping is very good and it is rare that any items are found stored there during inspections.

Inspections happen more frequently at Warrington due to its busy nature and staff are reminded when necessary of the improvements they need to undertake. The frequency of reporting has led to visible improvements, with support being undertaken by Facilities.

During the inspection of the corridors, many issues have been identified such as:

- Mattresses and beds stored on corridors
- Clinical equipment broken on corridors
- Open waste bins

Support has been provided along the main Appleton thoroughfare near Accident and Emergency. During full capacity, discussion took place to ensure trolleys were not left in this area of the corridor. The main risk was restricting space as the internal tugs manoeuvre here, with staff and patients are walking in this space.

2.4 HEALTH AND SAFETY INCIDENTS

2.4.1. Incidents Reportable to the Health & Safety Executive (HSE)

All non-clinical incidents are reviewed daily by the Health and Safety Department and allocated to the appropriate manager for actioning. Data is collected in relation to any lost time incidents due to injury or ill-health. H&S liaise directly with the managers to ensure if the incident is reportable to the HSE and to monitor any time lost.

All incidents reportable under Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) require a level 1 investigation. A report of incident data is produced bi-monthly and reviewed by the Health and Safety Sub Committee.

The Table below shows an overview of all RIDDOR Incidents between April 17 to March 18

Department	Brief Description	Injuries Reported	Days Lost
Ward B12	Slip, Trip and Fall	Fracture	267
Ward A1	Physical Assault	Strains/Sprains	7
Theatres	Manual Handling	Strains/Sprains	25
Education Centre	Another kind of accident	Strains/Sprains	33
SAU	Struck by object	Contusions and bruising	203
B14	Physical Assault	Strains/Sprains	19
C21	Physical Assault	Strains/Sprains	79
Theatres	Manual Handling	Strains/Sprains	21
A&E	Slip, Trip and Fall	Strains/Sprains	15
Grounds	Slip, Trip and Fall	Strains/Sprains	10
Ward B12	Physical Assault	Contusions and bruising	45
ITU	Slip, Trip and Fall	Contusions and bruising	104
Maternity	Manual Handling	Strains/Sprains	16
Grounds	Slip, Trip and Fall	Strains/Sprains	103
Main Corridor	Slip, Trip and Fall	Fracture	89
C22/A4	Another kind of accident	Strains/Sprains	50
Catering	Struck by object	Contusions and bruising	88
A1	Exposure to harmful substance	Burn	18
Grounds	Slip, Trip and Fall	Fracture	72
Grounds	Slip, Trip and Fall	Fracture	21
A7	Manual Handling	Strains/Sprains	42
B18	Manual Handling	Strains/Sprains	17
Radiology	Manual Handling	Strains/Sprains	11
			1427

There were 4 incidents with over a 100 days lost time with 2 of those going over 200 days. The table below gives a brief overview of the incidents.

Department	Brief Description	Injuries Reported	Days Lost
Ward B12	**Slip, Trip and Fall**	**Fracture**	**267**
Incident: Staff member fell over an unsighted piece of equipment besides a patient's bed. The member of staff sustained a fractured shoulder and the rehabilitation of the injury was difficult.			
SAU	**Struck by object**	**Contusions and bruising**	**203**
Incident: Staff member was supporting a patient in a restricted space of a toilet. The patient was unsteady and preventing a fall, the staff banged against the door and injured their back.			
ITU	**Slip, Trip and Fall**	**Contusions and bruising**	**104**
Incident: Staff member fell over equipment by a patient's bed. The staff member suffered severe lower facial injury resulting in corrective dental surgery.			

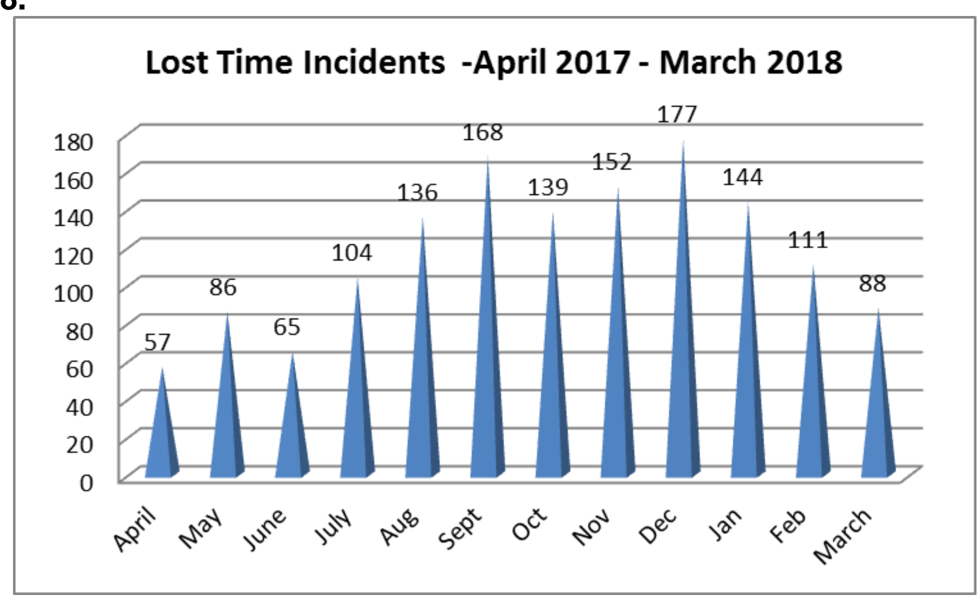
Department	Brief Description	Injuries Reported	Days Lost
Grounds	**Slip, Trip and Fall**	**Strains/Sprains**	**103**
Incident: Staff member tripped over a raised flagstone whilst walking through the grounds at Warrington Hospital and sustained a back injury.			

2.4.2 Lost Time Incident Data

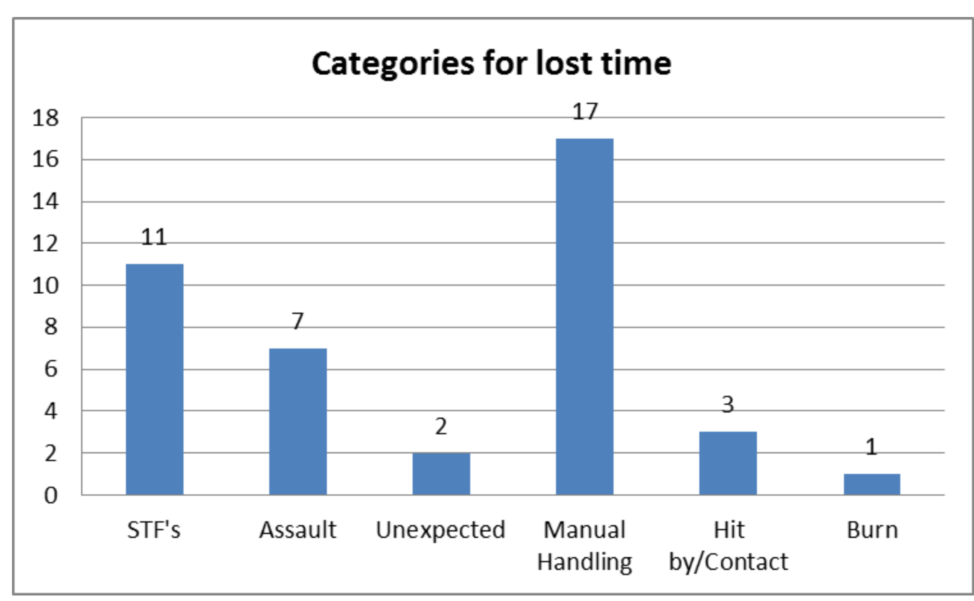
Not all lost time is reportable under RIDDOR. Staff may have under 7 days absent due to a work related injury or ill health.

During April 2017 to March 2018 the Trust lost 1,427 days due to work place incidents.

The graph below identifies the total number of days lost each month from April 2017 to March 2018.



Categories of lost time incidents



Locations where incidents took place were:

- 19 = Ward related – of which Wards B12 and B14 had 3 incidents each
- 5 = Hospital Grounds
- 14 = Departments such as ITU, A&E, SAU, Maternity, Catering
- 2 = Corridor

2.4.3 Sharps Incidents

The Health and Safety Department collate information on sharps incidents reported on DATIX system.

The table below shows the number of incidents reported each month in 2017/18 compared with 2016/17

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016/17	7	9	10	9	8	15	12	16	8	5	7	11
2017/18	8	9	6	12	8	5	12	16	7	9	9	4

117 incidents were reported in 2016/17 compared with 105 in 2017/18. This shows a reduction of 12 incidents and 1 of the incidents was reported to the HSE as a dangerous occurrence.

The table below shows the causes of all incidents recorded relating to sharps

Cause	Number of Incidents
Incorrect disposal	17
Needlestick injury (clean)	5
Needlestick injury (dirty)	69
Sharps box incorrectly labelled	1
Sharps box not sealed	3
Splash	10

This information is reviewed in detail by the Safer Sharps Working Group

The Safer Sharps Working Group meets monthly to discuss topics such as the incident statistics, looking at the type and location of the injury. The group discusses what further can be provided to the Trust – such as training and device safety. Actions coming from the meeting also look at a review of procedures and device procurement, incident data is considered to support procurement.

2.4.4. Non Clinical Manual Handling Incidents

Although there has been an increase with non-patient manual handling incidents, they do remain low.

Comparison of incidents 2016/17 and 2017/18

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016/17	1	2	0	1	3	1	2	1	2	6	2	1
2017/18	4	1	1	5	5	5	3	1	4	2	1	5

Categories reported 2017/18

Category	Number of Incidents
Equipment Broken/Faulty	2
Personal harm moving inanimate load	6
Personal harm whilst using equipment	14
Environment size/layout compromising staff position	2
Insufficient staff for safe technique	2
Inappropriate technique	5
Lack of training	1
Equipment not suitable for the task	5
	37

One incident was reportable to the HSE which involved a member of staff moving equipment that wasn't secured sufficiently. The member of staff sustained bruising to their back and foot and was subsequently absent from work for a period of 88 days.
Training was put in place to prevent further incidents from occurring.

A review of the e-learning and practical sessions for non-clinical manual handling is planned to take place in the 2018/19 H&S agenda.

2.4.5 Fire Incident

On March 23rd 2018, Warrington hospital suffered a fire in the roof area of the Kendrick wing administration block. Upon recognising the signs of fire, staff raised the alarm and the evacuation process started. Staff from active clinics guided patients, and staff from administrative areas all evacuated to a place of safety.

Cheshire fire service received the alarm call and attended. When the fire crews arrived, they found that all persons were accounted for and staff had effectively followed the Trust's emergency evacuation procedure. Almost within two hours of the alarm being raised, the main fire was extinguished and firefighters proceeded damping down and hot spotting.

The following morning Estates and Facilities teams gathered, and quickly a plan of recovery was underway, with temporary power supplies, 'radio' fire alarms and reinstating the buildings heating system. These quick steps were the first in a long line of visits, inspections, audits and appraisals, all determined to bring the hospital back to a working order, enabling staff to provide their necessary services.

Following the fire, the main concern was to ensure that patient care was not adversely impacted. Ophthalmology was the service mostly affected clinically within the Trust.

Corporate services that were affected included finance, coding and clinical audit. Immediate continuity plans were put in place with estates, IT and the managers of the clinical and corporate teams. Successful relocation was put in place across all teams, minimising impact of patients and staff.

The Kendrick Fire Response Group was instated within the Trust to oversee the options and the work required to reinstate Kendrick Wing, and recover all losses through insurance processes, and this work continues.

Cheshire Fire and Rescue Service feedback was sought which was as follows:

Visit 21.05.18 to provide feedback from the fire brigade's perspective on the action taken by the Trust during the fire.

- Overall very good feedback – Physical aspects of fire stoppage were very good and Bronze response worked very well – the Trust provided reports and information required immediately (Asbestos reports)
- Silver & Gold response did not work as well as it could have (Major incident room, single point contact) and so there is learning for the Trust
- Suggested opportunity for joint WHH and Cheshire Fire brigade Bronze, silver, gold exercise. (
- Are to liaise to include all key facts on Fire brigade system – shared nationally (Any fire engine attending fire would have key facts about the hospital(s) displayed on console system)

A report is being compiled to be presented to Health &Safety Committee regarding the fire, to examine actions and shared learning.

2.4.6 Employer Liability and Public Liability Claims

The following show the numbers of claims received by the Trust and the categories.

	16/17	17/18
Employers Liability	**8**	**15**
Slips, trips, falls and collisions	2	5
Exposure to infection, hazardous substance, electricity etc	1	1
Lifting accidents	1	0
Abuse etc of Staff by patients	2	3
Accident caused by some other means	1	4
Other	1	1
Needlestick injury or other incident connected with Sharps	0	1
Public Liability	**3**	**2**
Slips, trips, falls and collisions	3	1
Other	0	1
Totals:	11	17

Number of Non-Clinical Claims Closed 2017/2018

	Discontinued	Settled with Damages	REPUD	Total
Employers Liability	**0**	**8**	**3**	**11**
Slips, trips, falls and collisions	0	1	0	1
Exposure to infection, hazardous substance, electricity etc	0	1	0	1
Lifting accidents	0	1	1	2
Abuse etc of Staff by patients	0	0	1	1
Accident caused by some other means	0	3	1	4
Needlestick injury or other incident connected with Sharps	0	2	0	2
Public Liability	**1**	**2**	**1**	**4**
Slips, trips, falls and collisions	1	0	1	2
Accident caused by some other means	0	1	0	1
Other	0	1	0	1
Totals:	1	10	4	15

Summary of claims closed and settled 2017/18

Claim date	Summary of Allegations	Specialty	Action taken (Investigation)	Total payments
26/08/2015	Accident involving tug	Emergency Medicine	Lack of communication between staff - To ensure there is a clear pathway for moving tugs and cages.	£6,953.00
03/11/2016	Broke door to toilet cubicle fell on claimant	Emergency Medicine	Door repaired To inspect and monitor the area on a regular basis to look for wear and tear and deterioration of equipment	£4,743.00
01/10/2013	Chair collapsed	T&O	Checklist developed - to be completed monthly	£18,407.90
14/04/2015	Chair collapsed	Obstetrics	To carry out monthly checks of all chairs	£8,065.30
05/05/2017	Ceiling tile fell on claimants head	Operations (Estates maintenance and environment issues)	None at time	£3,449.00
20/05/2015	Lifting incident	Domestic and Portering	To ensure all staff are in date with their manual handling training.	£7,631.60
03/07/2016	Fall from chair	Paediatrics and Neonatology	Reiterated to staff, need to adjust chair before using it	£5,520.00

Claim date	Summary of Allegations	Specialty	Action taken (Investigation)	Total payments
22/01/2016	Needle stick injury	Catering	Reinforcement of correct use/disposal procedures re sharps given to staff who have to administer insulin (whilst on duty).	£4,654.00
19/08/2015	Needle stick injury	Obstetrics	reiterated to staff the use of sharps boxes for patients who require them	£3,152.00
23/03/2017	Electric shock	Catering	H&S asked for actions as result of incident	£5,822.00

There are a further 10 cases where liability has been admitted amounting to damages with reserves of £261,250. The Trust pays excess of £10,000 for Employer Liability Claims and £3,000 for Public Liability Claims.

2.5 SUMMARY AND LOOKING FORWARD

2.5.1 Learning and Improvements

- A review of the Trust's Health & Safety Strategy, policies and reporting has been undertaken.
- A review of the Trust's Health and Safety Sub Committee has been undertaken including frequency, terms of reference and assurance reporting.
- There has been a number of Health & Safety improvements put in place including
  - Flooring has been replaced with non-slip flooring in many areas or new flooring to reduce hazard tape and STFs
  - Weekly inspections of corridors to identify damage that could cause injury – raise issues to Estates before incidents occur
  - Gates have been installed on some linen cupboards to hold in bags of dirty linen to stop overflowing onto corridors
  - Heavier matting at entrance doors to prevent tripping and ruffling of carpets
  - Embedded matting at Croft Wing entrance to prevent slip and trips
  - Metal barriers installed at car park near bus stop to stop short cuts across pot hole area where cars park and also around pavement to stop people crossing road in busy areas
  - Asked for beds to be taken to the first floor near to Pathology and Theatre to prevent congestion on ground floor, damage caused by tugs, possible collisions etc
  - Clinical waste wheelie bins not open as much due to daily campaign of inspections – vastly reduced – some areas now have more than one bin due to amount of waste
  - Slips, Trips and Falls – wet floor signage has been placed at front entrances so they can be put in situ immediately to warn of wet floor until mopped up
  - Moved clinical waste bins from Labour Ward to corridor so not visible to patients and visitors
  - Replaced metal foot plate at Store Halton as rotting away. New one now in situ and no incidents should occur

- External walkabouts identify broken flags, obstacles etc to prevent slips and trips, more undertaken at Halton which have identified numerous broken flags
- No timetable of inspections now to Managers therefore ad hoc inspections to see the wards and departments. Increased inspections also have made departments better – good housekeeping
- Constant reminders to Estates regarding barriers around contractors and workmen especially when in the roof spaces. This had seen a massive improvement now and are always in place when workmen are about

2.5.2 Future Development

The priorities over the next 12 months are to:-

- Enter into the RoSPA (Royal Society for Prevention of Accidents) Awards for Health and Safety Accreditation award. This is recognised as the most rigorous and respected health and safety awards scheme in the UK.
- Increase in the number of inspections for Wards and Departments by collaborative working with the Union Representatives.
- Development of an external inspection template.
- Increase safer sharps audits.
- Raise awareness and develop a campaign to be disseminated across the Trust to promote safer user of sharps, correct disposal etc.
- Sharing feedback and learning on non-clinical incidents.
- Provide good practice links in Communications to highlight areas of excellent housekeeping or other areas of outstanding performance in health and safety.
- Review of the RMF audit tool to include a Welfare standard.
- Continue to analysis of lost time incidents looking at trends and themes.
- Ensure level ones have appropriate detail and are completed in time.
- Ensure all RIDDOR incidents have Level 1 investigations and are affectively tracked and reduce the incidents of claims due to ensuring robust risk assessment and training is available.
- Review of incident reports.
- Provide Divisional reports on health and safety management data.
- Promote a topic of the month to ensure outstanding compliance with the legislation.
- Review generic risk assessments to ensure they are appropriate to the needs of the Organisation and effectively implemented.
- Review policies and guidance documents in line with current legislation.
- Produce comprehensive DSE reports for staff and managers to minimise the risk of work related upper limb disorders.
- Continue to develop the extranet pages
- Provide tool box talks on various topics at the Safety Risk Leads Group
- Develop risk assessment training for all levels of staff across the Trust

2.5.3 Conclusion

There is an established pro-active safety management system within the Trust in particularly with audits and inspections. Documentation is now fully standardised and Departments are meeting compliance with the Risk Management Framework.

During the past year health and safety communications have improved for example introduction of a newsletter. There are much better lines of reporting within the Health and Safety Sub Committee providing detailed assurance reports for all Health and Safety legislation the Trust must comply with.

There is a need to improve on the safer sharps agenda. This needs more awareness and training across the Trust and a campaign and additional audits will take place throughout the year.

3 RECOMMENDATIONS

The Board of Directors is asked to discuss and note the information within the annual report.

BOARD OF DIRECTORS

AGENDA REFERENCE:	BM/18/09/87
SUBJECT:	**Director of Infection Prevention and Control Annual Report**
DATE OF MEETING:	26 September 2018
ACTION REQUIRED	**For information and assurance**
AUTHOR(S):	Lesley McKay Associate Director of Infection Prevention and Control
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse
LINK TO STRATEGIC OBJECTIVES:	SO1: To ensure that all care is rated amongst the top quartile in the North West of England for patient safety, clinical outcomes and patient experience
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	BAF1.1: CQC Compliance for Quality BAF1.3: National & Local Mandatory, Operational Targets
STRATEGIC CONTEXT	Healthcare associated infection is one of a number of metrics used to measure Trust performance.
EXECUTIVE SUMMARY	This report outlines the arrangements, activities and achievements of the Trust relating to infection prevention and control for the April 2017 to March 2018 financial year (FY). • Twenty four cases of C. difficile were reported, 19 of which were considered unavoidable by the CCG review panel • PLACE assessment results rated the Trust higher than the national average for cleanliness • Antimicrobial Stewardship has been strengthened by provision of additional ward rounds • Six of the ten Code of Practice criterion are fully compliant. There are minor non-compliant issues within the other 4 criterion • The Trust reported 1 MRSA bacteraemia which was considered unavoidable. Cases of MSSA bacteraemia rose compared to the previous FY • Thirty six cases of E. coli were reported which is an increase of five cases compared to the previous FY • A significant period of reduced staffing resulted in the work plan not being fully achieved. This impacted on the IPC audit and policy review schedule

<table>
<tr><td></td><td colspan="2">This report builds on previous annual reports submitted to the Board to give a whole year account of infection prevention and control activity.</td></tr>
<tr><td>RECOMMENDATION:</td><td colspan="2">Annual Work plan to be delivered including:-

Continue to improve compliance with the Health and Social Care Act (2008) Code of practice on preventing infections and related guidance (2015)
Continue work against the action plans for reduction of healthcare associated infections:-
• Staphylococcus aureus bacteraemia reduction (MRSA/MSSA)
• Clostridium difficile infection reduction
• Gram Negative bloodstream infection reduction
Complete actions following external review.
Establish GNBSI reduction working group
Increase infection control audits to demonstrate compliance with policies and guidelines.
Complete all Policy reviews.
Complete actions listed in the IPC Strategy and redevelop this for the next 3 years</td></tr>
<tr><td rowspan="4">PREVIOUSLY CONSIDERED BY:</td><td>Committee</td><td>Quality Assurance Committee</td></tr>
<tr><td>Agenda Ref.</td><td>QAC/18/07/81</td></tr>
<tr><td>Date of meeting</td><td>3 July 2018</td></tr>
<tr><td>Summary of Outcome</td><td>Noted</td></tr>
<tr><td>FREEDOM OF INFORMATION STATUS (FOIA):</td><td colspan="2">Release Document in Full</td></tr>
<tr><td>FOIA EXEMPTIONS APPLIED:
(if relevant)</td><td colspan="2">None</td></tr>
</table>

BOARD OF DIRECTORS

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1. BACKGROUND/CONTEXT

EXECUTIVE SUMMARY

Organisation

Warrington and Halton Hospitals NHS Foundation Trust is a secondary care organisation providing healthcare services across the towns of Warrington, Runcorn, Widnes and surrounding areas. The Trust operates across two sites, has approximately 600 inpatient beds, an annual budget in the region of £215 million, employs over 4,200 staff and provides access to healthcare for over 500,000 patients as an outpatient and/or inpatient.

The Trust's vision is to ensure be the most clinically and financially successful integrated health care provider in our part of the region. The Trust works to a number of nationally and locally set targets to ensure that service users receive the care they need when they need it and importantly to the highest national quality and safety standards.

Good infection prevention and control practices are essential to ensure that people who use healthcare services receive safe care. Effective prevention and control of infection is part of everyday practice and is embedded at all levels of this organisation.

Activities

This report outlines the arrangements, activities and achievements of the Trust relating to infection prevention and control for 2017/18 financial year (FY).

Infection prevention Action plan for the year

The Infection Prevention and Control Team worked towards delivery of the annual work plan. Pressures and a significant period of reduced staffing had an impact on full achievement of the work plan. The ward/department audit programme was not fully completed and some scheduled policy reviews did not take place. Nil effects were noted in terms of policies not being updated. A separate programme of high impact intervention audits continued and this provided assurance on compliance with clinical procedures.

A robust work plan (appendix 1) has been devised for the 2018/19 FY. The work plan will ensure, in respect of infection prevention and control (IPC), that the Trust has robust governance arrangements; attendance at other relevant committees to support integration of IPC across the organisation; compliance with all mandatory surveillance requirements; monitoring of environmental cleanliness standards; audits of practice; policy/guideline reviews are completed and a programme of education and awareness raising events takes place.

The work plan underpins the 3 year Infection Prevention and Control Strategy developed in 2016 (appendix 2). Progress against both these documents was monitored by the Infection Prevention and Control Sub-Committee.

An external review of the IPC service was commissioned with minor areas identified for action. An action plan has been developed to address the findings.

Progress against Code of Practice compliance

Progress has been made to achieve the requirements of the Health and Social Care Act (2008) Code of Practice on prevention of healthcare associated infections (2015). The Trust is working towards full compliance with the 10 criterion:-

- 6 are fully compliant
- 4 have minor non-compliances

Progress against action plans

Progress has been made against objectives set out in the following action plans:-

- *Staphylococcus aureus* (Meticillin resistant/Meticillin sensitive) bacteraemia reduction
    - 1 hospital onset MRSA bacteraemia case
    - 17 hospital onset MSSA bacteraemia cases

In spite of action taken to reduce these hospital onset bloodstream infections, cases of MSSA bacteraemia increased from 14 in FY 2016/17 to 17. Some of these patients had deep seated infections and were likely to have been incubating the infection prior to admission. MRSA bacteraemia cases rose by 1, compared to the previous FY where no cases were observed.

- Gram Negative Blood Stream Infection (GNBSI) reduction
    - 36 hospital onset cases of Escherichia coli (E. coli)

Measured against the figure from January to December 2016 (as required in the CCG Quality Premium), the number of cases has remained constant. Mandatory reporting commenced for:-

- Klebsiella spp. 12 hospital onset cases
- Pseudomonas aeruginosa 6 hospital onset cases

Work is in place with partners across the health economy to reduce GNBSIs. An internal working group is being set up to drive care improvements to support reductions in hospital onset cases.

- Clostridium difficile infection reduction
    - 24 hospital onset cases

Cases have remained constant compared to the previous FY. These cases were reviewed by the CCG who concluded 19 of the cases were unavoidable; 2 were repeat/relapse cases and 3 cases were avoidable.

This report builds on previous annual reports submitted to the Board to give a whole year account of infection prevention and control activity.

Kimberley Salmon-Jamieson

Chief Nurse

Director of Infection Prevention and Control (DIPC) from September 2017

June 2018

Acknowledgements

Marcia Anthony	Facilities Manager
Natalie Crosby	Matron Intensive care
Carole Farrell	Matron MSK Clinical Business Unit
Julie McGreal	Facilities Manager
Lesley McKay	Associate Director of Infection Prevention and Control
Dr Thamara Nawimana	Consultant Medical Microbiologist/Infection Control Doctor
Dr Zaman Qazzafi	Consultant Medical Microbiologist
Jacqui Ward	Antibiotic Pharmacist

2. KEY ELEMENTS

DESCRIPTION OF INFECTION CONTROL ARRANGEMENTS

Infection Prevention and Control Team

The Infection Prevention and Control Team meet fortnightly. Membership and meeting attendance includes:-

- Consultant Medical Microbiologists:-
    - Dr Zaman Qazzafi (Deputy DIPC)
    - Dr Thamara Nawimana (Infection Control Doctor)

- Associate Director of Infection Prevention and Control:-
    - Lesley McKay

- Infection Prevention and Control Nurses:-
    - Helen McLaren (from May 2017)
    - Karen Smith (until December 2017)
    - Charlene Liptrot (from March 2018)

- Antibiotics Pharmacist:-
    - Jacqui Ward

- Infection Control Administrator:-
    - Amanda Millington (from January 2018)

- Operational Estates Manager
    - Darren Wardley

Infection Control Sub-Committee

The Infection Control Sub-Committee is scheduled to meet bimonthly. Two meetings were deferred due to winter/organisational pressures.

Membership includes:-

- Consultant Medical Microbiologist/Deputy DIPC – Chairman
- Chief Nurse/Director of Infection Prevention and Control – Deputy Chair
- Consultant Microbiologist/Infection Control Doctor
- Associate Director of Infection Prevention and Control
- Infection Prevention and Control Nurse Specialists
- Antibiotics Pharmacist
- Practice Educators (specialist interest in IV device management)
- Associate Director of Nursing Acute Care Services

- Lead Nurses/Matrons from all CBUs
- Lead Allied Health Professional Diagnostics CBU
- Workplace Health and Wellbeing Nurse Manager
- Consultant for Communicable Disease Control/PHE representative
- Facilities Manager
- Estates Operational Manager
- Primary Care Infection Prevention and Control Nurse (3 Boroughs Public Health Infection Control Commissioning Team)

Reporting line to the Trust Board

The links are via:-

- Chief Nurse/Director of Infection Prevention and Control
- Quality and Assurance Committee
- Patient Safety and Clinical Effectiveness Committee

Links to Drugs and Therapeutics Committee

The links are via:-

- Consultant Medical Microbiologist/Infection Control Doctor
- Antibiotics Pharmacist
- Antimicrobial Management Steering Group

Links to Quality and Assurance Committee/Patient Safety and Clinical Effectiveness Committee and Health and Safety Sub-Committee

The links are via:-

- Chief Nurse/Director of Infection Prevention and Control
- Associate Director of Infection Prevention and Control
- Minutes of Infection Control Sub-Committee/high level briefing papers
- Infection prevention and control significant issues reports
- Incident reporting
- Risk register reviews
- Investigation of hospital onset Clostridium difficile toxin positive cases
- Post infection review of hospital onset MRSA/MSSA bacteraemia cases
- Audit of GNBSI cases
- Divisional/departmental Infection Prevention and Control Groups
- Infection Prevention and Control and Sepsis Link Practitioner Group
- Environment Group

DIPC REPORTS TO THE TRUST BOARD (SUMMARY)

Board reports

Reports, which included key performance indicators, HCAI surveillance data, outbreak/incident details and investigation findings for the FY, were submitted to the Quality and Assurance Committee with upward reporting to Trust Board in:-

- May 2017
- July 2017 (Annual Report on previous years activity)
- October 2017
- February 2018
- May 2018

Annual work plan

The Infection Prevention and Control Team work plan covered reporting structure to the Infection Control Sub-Committee and was developed to give assurance that each element of the Code of Practice for prevention of healthcare associated infections (HCAIs), which underpins the Health and Social Care Act (2008) is adhered to and that appropriate evidence of compliance is available. This work plan is underpinned by action plans for key performance indicators and a programme of audit that provides evidence of policy/guideline implementation and compliance.

The Lead Nurses/Matrons/ Lead Allied health Professional for each CBU submit reports at each Infection Control Sub-Committee meeting as a standing agenda item. This allows the Infection Control Sub-Committee to give assurance to the Quality and Assurance Committee and Trust Board that compliance with the Code of practice is maintained and that there is a programme of continued improvement.

The work plan has been redesigned for 2018/19 to provide more in depth detail of activities and priorities for 2018/19 (appendix 1).

Health and Social Care Act (2008) compliance assessment

A compliance assessment against the 10 criteria, specified in the *Health and Social Care Act 2008 Code of Practice for preventions and control of infections and related guidance* (Department of Health 2015), is carried out quarterly.

The Care Quality Commission (CQC) uses this code of practice to judge registered provider compliance with the cleanliness and infection control requirement set out in the regulations. Improvements were noted in the numbers of staff attending mandatory training during the FY.

Compliance with the Code of Practice at the end of March 2018 and areas requiring further improvement are detailed in table 1.

Table 1 – Compliance with the Code of Practice on prevention of HCAIs

	Criterion	*Assessment*	*Action required*
1.	*Systems to manage and monitor the prevention and control of infection*	*Partially compliant*	*Review of IT surveillance systems to detect infections.*
2.	*Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.*	*Partially compliant*	*Upgrades to some hand washing sinks required (design and location).*
3.	*Ensure appropriate antibiotic use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance*	*Partially compliant*	*Implementation of electronic prescribing.* *Implementation of the Sepsis and AMR CQUIN to improve documentation of prescribing decisions*
4.	*Provide suitable accurate information on infections to service users and their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion*	*Compliant*	*Counselling for patients starting antibiotics*
5.	*Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people*	*Compliant*	
6.	*Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection*	*Compliant*	*Overall greater than 85% attendance at Infection Control training*
7.	*Provide or secure adequate isolation facilities*	*Partially compliant*	*Continuous liaison with the Patient Flow Team occurs to optimise use of side rooms for appropriate isolation of patients*
8.	*Secure adequate access to laboratory support as appropriate*	*Compliant*	
9.	*Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections.*	*Compliant*	*Some policies have slipped beyond review date. A recovery plan is in place.*
10.	*Providers have a system in place to manage the occupational health needs of staff in relation to infection*	*Compliant*	

There are 3 HCAI reduction action plans which were reviewed on a quarterly basis. These included:-

MRSA/MSSA bacteraemia reduction action plan

This action plan sets out the work required to reduce the risks of MRSA/MSSA bacteraemia.

The Trust reported 6 MRSA bacteraemia cases (1 hospital onset and 5 community onset). Nil was identified that could have been done differently to prevent the hospital onset case.

The Trust reported 50 MSSA bacteraemia cases (17 hospital onset and 33 community onset). This is an increase of 3 hospital onset cases compared to the previous financial year. Details of investigation findings are included on page 18.

Clostridium difficile reduction action plan

The Clostridium difficile objective for the 2017/18 financial year was 27 cases. The Trust reported a total of 55 cases, 24 of which were hospital onset. This figure remains unchanged from the previous financial year. All 24 cases were reviewed by the CCG. This resulted in 19 cases being assessed as unavoidable, 2 repeat/relapse and 3 avoidable. Details of investigation findings are included on page 15.

The Infection Prevention and Control Team focussed activity on improving management of Clostridium difficile which included:-

- Surveillance of cases/monitoring for increased incidences in defined locations
- Antimicrobial Management Steering Group – Stewardship
- Hand hygiene awareness raising events
- Ward based training for management of infectious diarrhoea, viral gastroenteritis outbreaks and use of personal protective equipment
- Weekly multi-disciplinary team review of *Clostridium difficile* patients
- Promoting improvements to standards of environmental hygiene
- Use of hydrogen peroxide vapour for environmental decontamination

Next year's Clostridium difficile objective has been revised and the threshold reduced to 26 cases.

GNBSI reduction action plan

This action plan was developed in response to the Government's ambition to reduce GNBSIs by 50% by 2021. For the first year the focus has been on reducing E. coli bloodstream infections (BSIs) as they account for approximately 55% of all GNBSIs. Data collection on E. coli BSIs has been in place since 2011.

A 10% reduction target (at CCG level) was set for E. coli BSIs against the baseline year (January to December 2016). For the baseline year the Trust reported a total of 181 E. coli BSIs and 36 of these were hospital onset cases. During the 2017/18 FY the Trust reported a total of 204 E. coli BSIs and 36 of these were hospital onset cases. Overall there has been an increase in cases across the health economy; however Trust onset cases have remained constant.

Reporting of Klebsiella spp. and Pseudomonas aeruginosa BSIs commenced in April 2017. There is no previous data for comparison. Numbers for these BSIs are much lower and for the 2017/18 FY were:

- Klebsiella spp. 12 cases
- Pseudomonas aeruginosa 6 cases

The initial focus of the action plan has been to improve investigation and management of urinary tract infections. The Infection Prevention and Control Team worked closely with the Associate Medical Director for Patient Safety to produce a pathway for investigation and management of urinary tract infection.

For 2018/19, an internal GNBSI reduction action group is being established to address risks from other likely primary focus for infection.

An external review of the IPC service was commissioned by the Chief Nurse on appointment to the DIPC role. The scope of the review was to critically appraise the governance arrangements and structures and make recommendations where required. The review was carried out over 2 days in December 2017. The findings were consistent with already identified strengths and areas for improvement. An action plan was developed in response to the findings and this is monitored by the Infection Prevention and Control Sub-Committee.

Incidents/outbreak reports

A number of incidents occurred which were managed by the Infection Prevention and Control Team. These included:-

Expressed breast milk

A baby was given expressed breast milk (recipient) from another baby's mother (donor). The parents of the recipient were fully informed of the incident and of possible risks. The SOP for safe storage of breast milk was revised and staff education provided to prevent further similar incidents.

Influenza

The Trust saw an unprecedented increase in patients admitted with influenza over the winter months (150 cases). A background rise of influenza both in the Northwest and nationally was noted. In-house testing was introduced to support management of suspected cases.

The situation was communicated effectively within the Trust. Liaison took place with Workplace Health and Wellbeing to purchase additional vaccines and over 200 additional staff members were vaccinated. Three wards were managed with outbreaks of influenza with involvement of Public Health England.

During this time the Infection Prevention and Control Nurses worked over and above expected levels of performance to support the Trust in maximizing bed capacity whilst simultaneously maintaining safe infection prevention and control practice.

Vancomycin resistant enterococcus (VRE)

Ward A5

An increased incidence in VRE was observed for ward A5. Typing of isolates was carried out with results being unique, confirming the cases were not linked. The ward staff were responsive to support from the Infection Prevention and Control Team and additional training on VRE was carried out. Environmental cleanliness was noted to be of a high standard.

Ward A3

An increased incidence of VRE cases was noted on ward A3. Isolates were referred for Typing with the results showing 2 separate incidences of VRE transmission between April and May and August and September. The ward was placed under enhanced surveillance by the Infection Prevention and Control Team. A number of improvement actions were implemented to improve environmental hygiene and equipment decontamination. The ward was decanted and deep cleaning was carried out.

Ward A9

Ward A9 had a cluster of VRE cases in July. Training was provided to staff and the ward placed under enhanced surveillance by the Infection Prevention and Control Team.

Clostridium difficile periods of increased incidence

The Infection Prevention and Control Team developed a robust system for monitoring Clostridium difficile and detecting periods of increased incidence (PII). A PII is defined as two or more new cases (occurring after 48 hours post admission, not relapses) in a 28-day period in a defined location. During the reporting period no periods of increased incidence occurred.

Viral gastroenteritis (Norovirus)

Hospital outbreaks of viral gastroenteritis can have a significant impact on patient care as both patients and staff can be affected. This can lead to ward and sometimes hospital closures. Early recognition of an outbreak and instituting control measures can greatly reduce the adverse operational impact on the Trust.

The Trust carries out in-house testing for viral gastroenteritis pathogens. This assists operational management as suspected outbreaks have been ruled out on the basis of negative test results and areas reopened for patient use. Previously suspected outbreaks would have been managed on clinical symptoms with results only being made available after the outbreak had been declared over (when all symptoms had been settled for 48 hours).

Closure of beds, bays and wards places significant pressure on operational teams. There has not been any hesitation in accepting the Infection Prevention and Control Team's recommendations on bed closures, which has substantially enhanced the overall management of the outbreaks. Outbreaks of diarrhoea and vomiting affecting patients and staff presented a problem on several occasions throughout. Table 2 provides details of the number of reported incidents by month and findings.

Table 2 Viral gastroenteritis incidents

Month	Year	No of wards affected	Closure	Causative organism(s)
Apr	2017	3	1 full 2 partial	Nil identified
May	2017	0		
Jun	2017	3	Partial	Nil identified
Jul	2017	1	Partial	Nil identified
Aug	2017	2	Partial	Nil identified
Sep	2017	4	Partial	Nil identified
Oct	2017	3	3 full 1 partial	Nil identified
Nov	2017	4	2 full 2 partial	Norovirus – 2 wards Nil identified
Dec	2017	1	Partial	Nil identified
Jan	2018	2	full	Norovirus
Feb	2018	0		
Mar	2018	1	Partial	Norovirus

The Infection Prevention and Control Team take a pragmatic and escalatory approach to diarrhea and vomiting outbreak management. This involves closing affected bays and escalating to full ward closures only when appropriate. During the year norovirus was detected on 4 occasions.

Carbapenemase-producing enterobacteriaceae screening

Antimicrobial resistance is viewed as a major threat to public health globally. Of particular concern is the risk posed by Carbapenemase-producing Enterobacteriaceae (CPE) and other Carbapenem-resistant organisms.

The Infection Prevention and Control Team implemented national guidance to isolate and conduct CPE screening for all patients admitted by inter hospital transfer. During the reporting period 500 patients were screened for CPE carriage with nil positives identified.

VRE

Screening for VRE is performed for patients admitted by inter hospital transfer. Additional screening is undertaken when patients are identified with VRE in clinical isolates. Surveillance data identified:-

- VRE detected on rectal screening for 131 patients
- VRE detected from clinical specimens for 79 patients (some patients may have more than 1 clinical site specimen)
    - 66 urine specimens
    - 13 abscess/wound/pus/tissue swabs
    - 1 blood culture specimen

The number of VRE isolates has increased this financial year. All patients were reviewed by the Infection Prevention and Control Team and advice on Infection Control precautions provided.

BUDGET ALLOCATION TO INFECTION CONTROL ACTIVITIES

The budget allocation to infection control includes:-

- Staff - Nursing
    - 1 WTE Nurse band 8b
    - 1 WTE band 7
    - 1.4 WTE Nurses band 6
    - 0.6 WTE Admin and Clerical band 3

- Non-pay expenditure
    - General equipment
    - Stationary
    - Mileage

Revision to the team structure took place in January 2018 to increase administrative support to the Team to a WTE band 4.

HEALTHCARE ASSOCIATED INFECTION STATISTICS

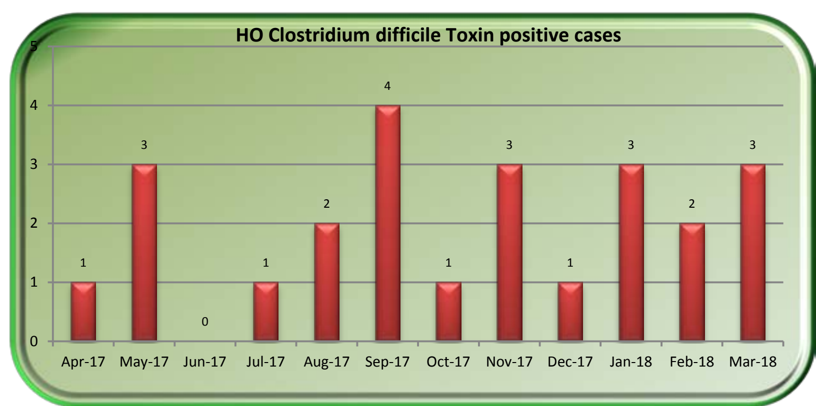
Results of mandatory reporting

The Trust participates in the mandatory reporting of the following healthcare associated infections.

Clostridium difficile (toxin positive)

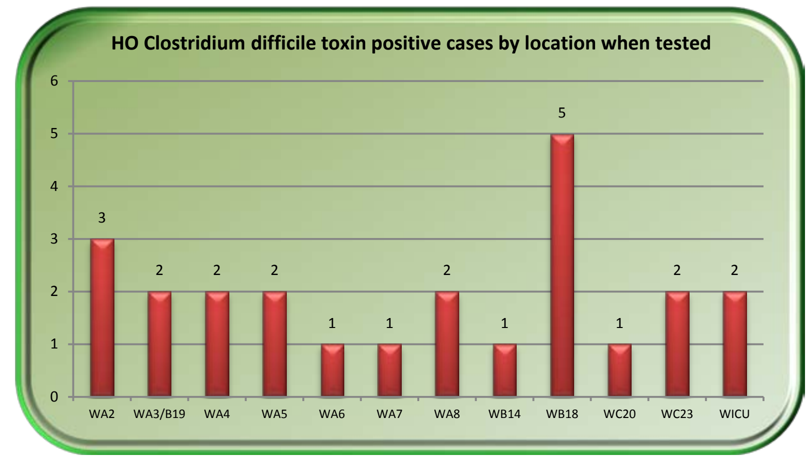
The Trust reported 55 Clostridium difficile toxin positive cases (31 community onset; 24 hospital onset). The number of hospital apportioned cases remains unchanged from the previous financial year. The number of hospital onset cases reported by month is displayed in figure 1.

Figure 1 – Hospital onset (HO) Clostridium difficile cases by month



The distribution of the hospital apportioned cases by location when the sample was taken is displayed in figure 2.

Figure 2 – Clostridium difficile toxin positive cases by location when tested



The location the specimens were obtained from is not necessarily equivalent to where the infection was acquired as patients may have been on the ward/department for less than 48 hours when tested.

All cases underwent root cause analysis. The investigations were completed by Ward Managers or Matrons with input from the patients' consultants. Completed investigations were forwarded to the CCG for review.

The final position was removal of 21 cases (87.5%) from those counted for contractual purposes. This is an improvement from the previous FY where 13 of cases (54%) were removed. Figure 3 depicts the Clostridium difficile toxin positive case review outcomes by month.

Figure 3 – Outcome of CCG review panel decisions by month

2017/18	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Total HAI C difficile	1	3	0	1	2	4	1	3	1	3	2	3	**24**
Not due to lapse in care	1	3	0	1	2	4	0	2	1	2	2	3	**21**
Due to lapses in care	0	0	0	0	0	0	1	1	0	1	0	0	**3**

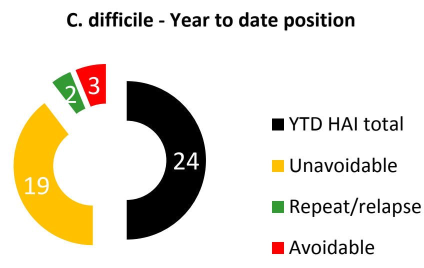
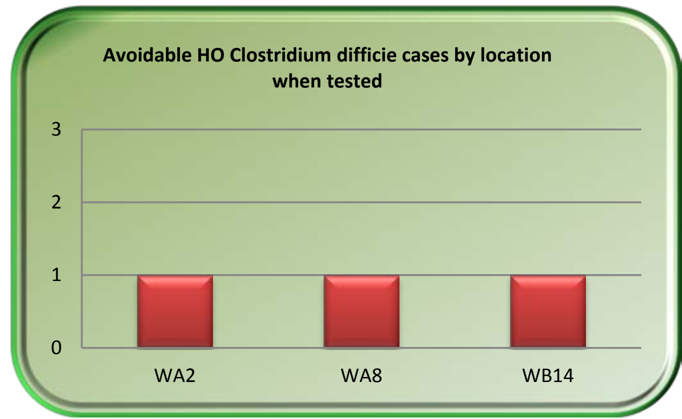


Figure 4 provides adjusted data on the 3 Trust Attributed cases following decisions taken by the CCG review panel.

Figure 4 Avoidable Hospital onset Clostridium difficile toxin positive cases by location



The avoidable cases related to choice of antibiotic prescribing and there were some missed sampling opportunities for one of the cases. Other areas for care improvement emerging from the incident meetings include:-

- microbiological samples are not being received in the laboratory that would support presumptive diagnoses/rationale for antibiotics
- stools not always documented
- isolation not always carried out timely
- Duty of Candour documentation of discussions

There are actions in place to address these findings. A masterclass has been provided to Lead Nurses and Matrons to improve the quality of information in the root cause analysis investigations.

Feedback of investigation findings for shared learning has taken place and additional education provided to areas where the Clostridium difficile policy was not followed.

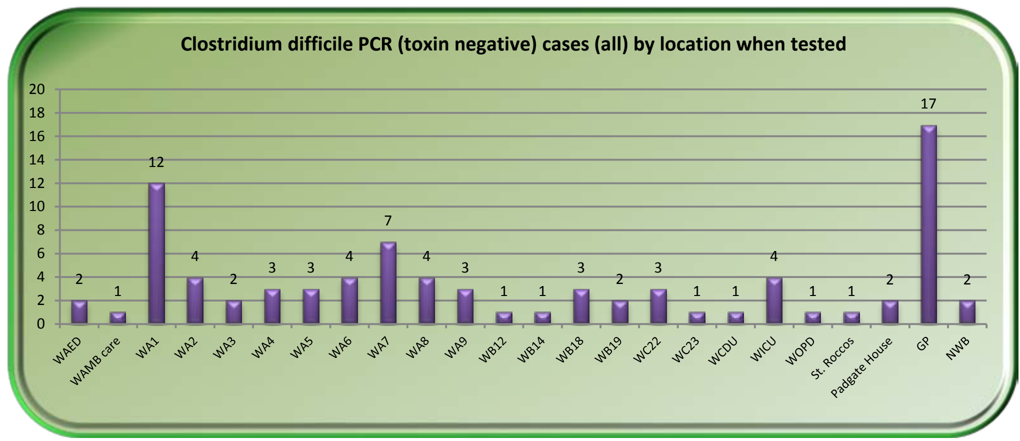
Clostridium difficile (toxin negative/PCR positive)

Diagnostic testing methods for Clostridium difficile infection distinguished between patients who are colonised with Clostridium difficile (PCR positive), and those with Clostridium difficile toxins present which indicates infection is more likely.

The Infection Prevention and Control Team conduct local surveillance on the patients who are Clostridium difficile PCR positive without the presence of toxins. These patients are at a higher risk of developing Clostridium difficile infection than non-colonised patients. Inpatients falling into this category are reviewed by the Infection Prevention and Control Team. Patients exhibiting symptoms are nursed in isolation and treatment advice is provided.

Figure 5 demonstrates the results for all patients (no apportionment) who were Clostridium difficile toxin negative/PCR positive and at the time of testing.

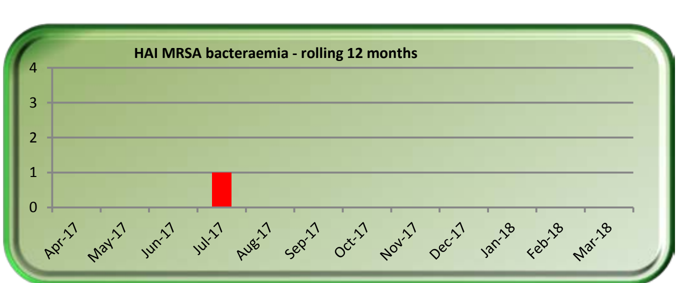
Figure 5 - Clostridium difficile PCR positive/toxin negative cases (all) by location when tested



MRSA bacteraemia

The Trust reported one case of MRSA bacteraemia.

Figure 6 - MRSA bacteraemia case

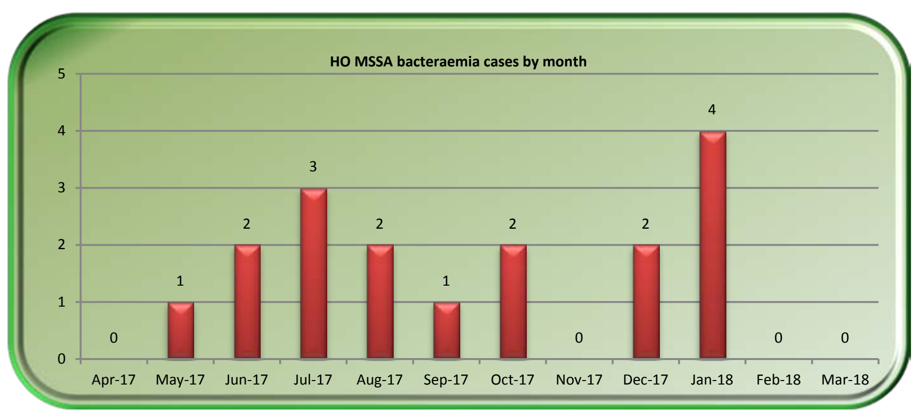


The Trust continues to have a zero tolerance approach to MRSA bacteraemia cases. Nil was identified that could have been done differently to prevent the hospital onset case.

MSSA bacteraemia

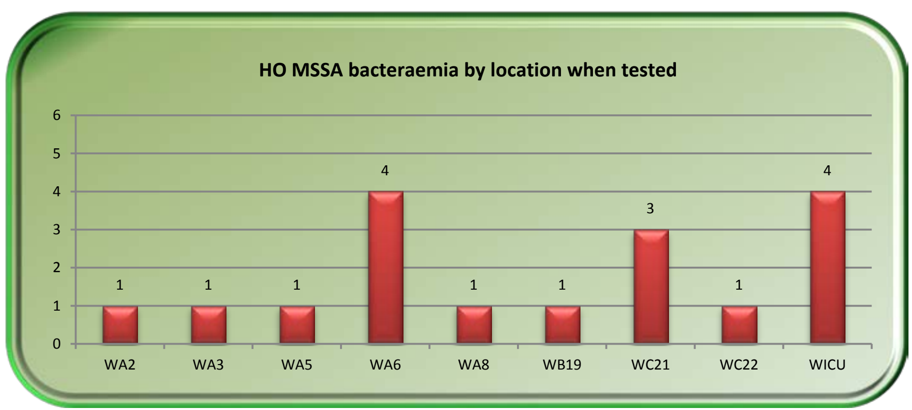
The Department of Health has not set targets for the reduction of MSSA bacteraemia. During the financial year 17 hospital apportioned cases were reported. Figure 7 shows the cases of MSSA bacteraemia identified within the Trust by month.

Figure 7 - MSSA bacteraemia cases by month/source of acquisition



This was an increase of 3 hospital onset cases compared to the previous financial year. Figure 8 shows the patients location at the time the specimen was obtained.

Figure 8 MSSA bacteraemia cases by location detected



The post infection reviews identified a number of different sources for infection including intravenous device, respiratory tract infection, urinary tract infection and some deep seated infections that were likely present prior to admission.

Common themes emerged from the post infection review meetings including timely blood culture sampling on admission and monitoring of invasive devices. Work is in progress with AED to promote timely blood culture sampling on admission.

Glycopeptide resistant enterococci bacteraemia

The Trust reported 1 cases of Glycopeptide resistant enterococci (GRE) bacteraemia. The patient had underlying immunosuppression and was at high risk of this infection. This was a hospital onset case identified on ward A2.

Gram negative bloodstream infections

The Department of Health have introduced a target to reduce gram negative bloodstream infections by 50% by 2021. This is a health economy target linked to the CCG Quality Premium.

E. coli bacteraemia data

Apportionment of previously reported E. coli bacteraemia cases has been retrospectively applied. Data since June 2011 is shown in figure 9.

Figure 9 E. coli bacteraemia June 2011 – March 2018

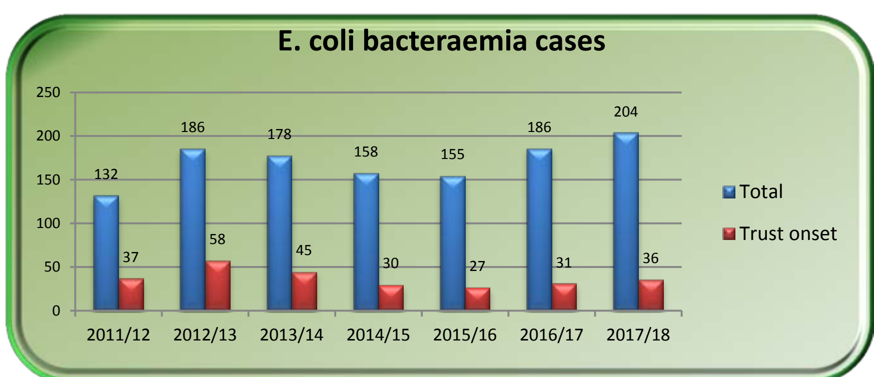
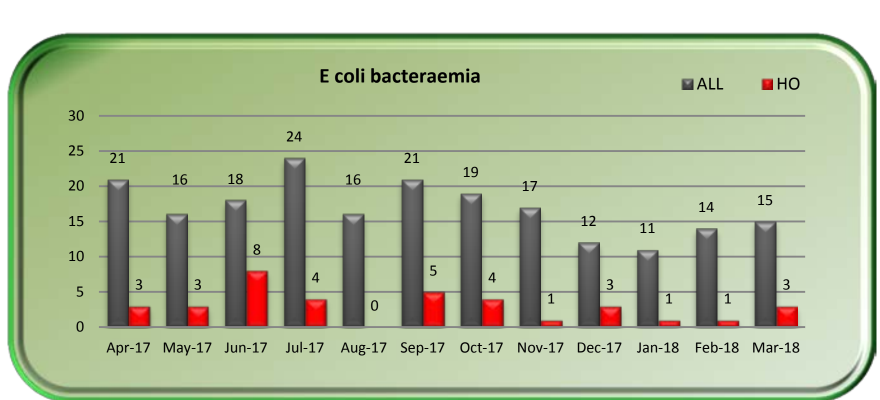


Figure 10 displays the total number of cases (204) reported each month during the FY and the number of hospital onset cases by month.

Figure 10 - E. coli bacteraemia cases 2017/18



The hospital onset E. coli bacteraemia cases by ward when specimen was taken are shown in figure 11.

Figure 11 Hospital onset E.coli bacteraemia cases by ward location when tested

Hospital onset E coli bacteraemia cases

WA1	WA2	WA3	WA4	WA5	WA6	WA7	WA8	WB14	WB18	WB19	WC21	WC22	WICU	HICU
2	1	3	1	2	3	2	5	2	1	1	1	1	5	2

Of the 36 hospital onset cases the source of the bacteraemia was assessed as most likely primary focus being associated with:-

- urinary tract 14 cases
- respiratory tract 8 cases
- Gastrointestinal (not hepatobiliary) 6 cases
- hepatobiliary 4 cases
- Unknown source 3
- Central nervous system 1 case

Reporting of Klebsiella spp. and Pseudomonas aeruginosa bacteraemia was made mandatory from April 2017.

Figure 12 displays the total number of cases reported each month during the FY and the number of hospital onset cases by month.

Figure 12 Klebsiella bacteraemia cases 2017/18

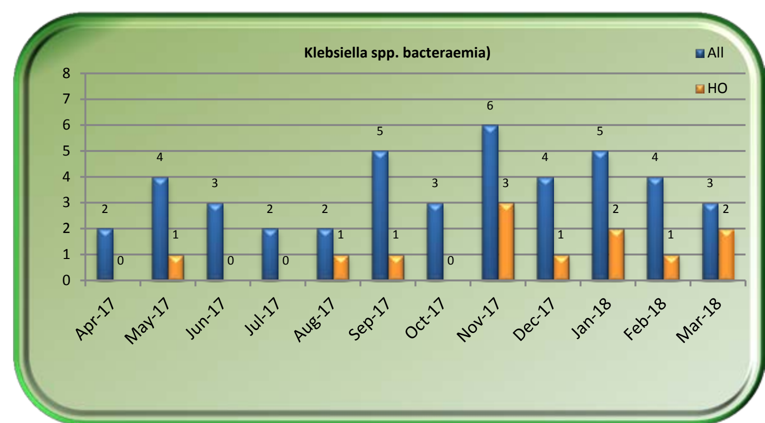
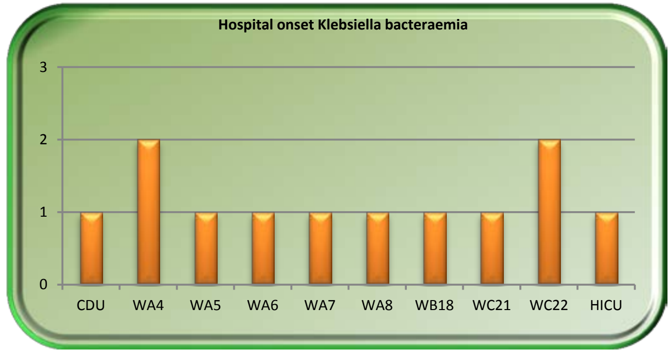


Figure 13 show Hospital onset Klebsiella bacteraemia cases by ward location when tested.

Figure 13 Klebsiella bacteraemia cases by ward loaction when tested



Pseudomonas aeruginosa bacteraemia

Figure 14 displays the total number of cases reported each month during the FY and the number of hospital onset cases by month.

Figure 14 Pseudomonas aeruginosa bacteraemia cases 2017/18

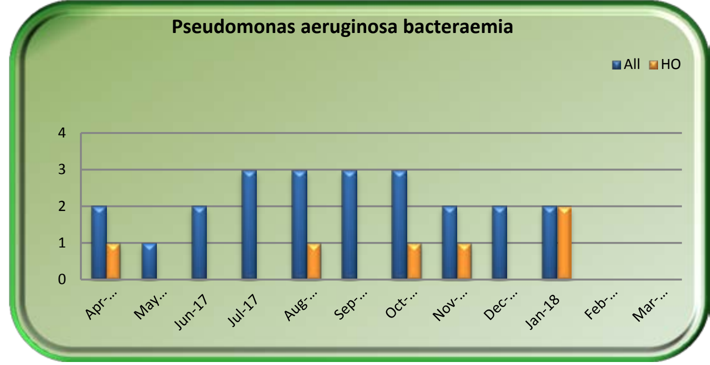
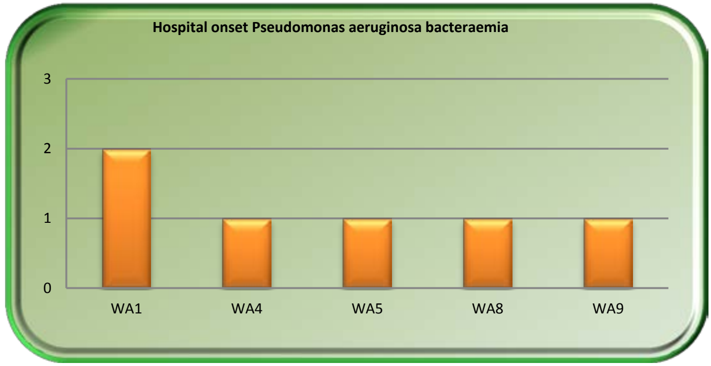


Figure 15 show Hospital onset Pseudomonas aeruginosa bacteraemia cases by ward location when tested.

Figure 15 Pseudomonas aeruginosa bacteraemia cases by ward loaction when tested



MRSA screening

The Trust continues to provide MRSA screening for patients in line with the Department of Health guidance. Just over 26, 500 patients were screened for MRSA.

Work is in progress with the data warehouse team to provide a more robust screening compliance report against the MRSA policy screening requirements. MRSA screening figures are roughly consistent with previous years.

Orthopaedic surgical site infection surveillance

The Trust conducts continuous surveillance on both total hip and knee surgery. This goes further than the mandatory surveillance period of 3 months.

There are 3 classifications for Surgical Site Infection: Superficial infections, those involving the skin or subcutaneous tissue of the incision; deep infection involving the facial and muscle layer of the incision; and organ or space infections, involving any other areas other than the incision opened or manipulated during the procedure.

The surveillance data demonstrates there were 9 reported cases of surgical site infection associated with hip surgery and nil associated with knee surgery. Due to the nature of implant surgery infections can manifest themselves beyond this surveillance period.

Table 3 Hip Surgery surveillance

Type of Surgery	Number of surveillance forms completed	No. of SSI's detected during initial surveillance	Type of SSI Organisms identified
Cemented Uncemented Reverse hybrid Hybrid Revision Resurfacing Bilateral	110 12 96 81 9 6 4	9	1 Superficial incisional with Klebsiella and Proteus mirabilis 1 deep incisional with Enterobacter cloacae 1 joint space with Staphylococcus epidermidis 1 superficial incisional with Staphylococcus aureus 5 patients reported GP prescribed antibiotics (nil microbiology results)
	318		

Table 4 Knee surgery surveillance

Type of Surgery	Number of surveillance forms completed	No. of SSI's detected during initial surveillance	Type of SSI Organisms identified
Cemented Unicompartmental Revision Bilateral	387 26 16 8	0	
Total	437		

The surveillance information collected during 2017/18 indicates Orthopaedic joint replacement infections have remained minimal at 9 cases.

HAND HYGIENE AND ASEPTIC PROTOCOLS

Audits of compliance with the Hand Hygiene Policy are undertaken weekly at ward and department level. An average of 84% of clinical areas was audited with an average compliance rate for the year of 99% (table 6). Peer auditing is in place and a review of the hand hygiene auditing process is planned to provide more robust assurance on auditing and results.

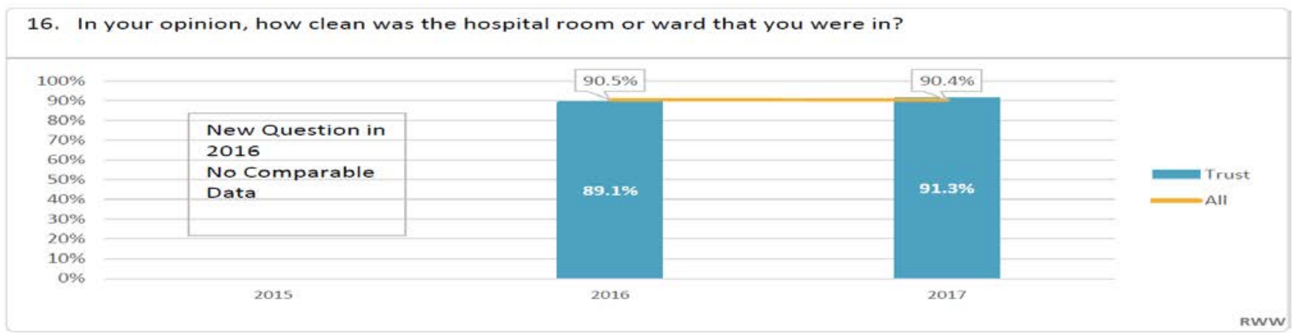
Table 5 Trust wide hand hygiene audit results

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
% areas audited	94%	94%	89%	95%	95%	97%	96%	93%	85%	90%	94%	84%
Compliance	99%	98%	99%	98%	98%	99%	98%	99%	99%	98%	98%	99%

National inpatient survey 2017

Trust scores from the National Inpatient Management Survey 2017 included questions on cleanliness. The results compared to the 2016 survey and nationally are detailed in figure 16.

Figure 16 National inpatient survey results



The Trust has been rated above the national average for patients' perceptions of cleanliness and has improved compared to last year's survey.

DECONTAMINATION

The Decontamination Group was established to provide assurance that the Trust has the appropriate policies and training in place to be compliant with the Health and Social Care Act (2008) and Care Quality Commission standards. Due to executive team staffing changes this group only met twice.

All surgical instruments are decontaminated off site by a company that provides decontamination services for several Trusts within the region. There is a programme of internal and external validation. The Trust is compliant with Department of Health and NHS Estates guidance. The terms of reference have been revised and meetings have been re-established quarterly.

CLEANING SERVICES

MANAGEMENT ARRANGEMENTS

Warrington and Halton Hospitals Domestic team are employed as an in-house service and are part of the Trust Estates and Facilities team. The team is led by an Operational Facilities Manager and on a day to day basis managed by a Domestic and Portering Services Manager on each site.

The Domestic team provide 24 hour, 7 days per week cover, this includes out of hours support by the Portering Team at Halton. The team are also supported by "as and when" staff who cover for vacancies and partially cover for annual leave and sickness.

The Domestic Task Team at Warrington provides a valuable service, dealing with emergency leaks/spills, routine and emergency curtain changes, terminal cleans and any cleaning required following infection outbreaks. They also form the core team progressing deep cleans in clinical areas.

The Trust also uses a Hydrogen Peroxide Fogging machine to assist with decontamination of the environment. This is operated by the Task Team.

BUDGET ALLOCATION

The budget allocation for domestic services for 2017/18 was £3.42m with 143.79 whole time equivalent (WTE) staff employed by the Department.

CLEANING ARRANGEMENTS

The areas that are cleaned in the Trust are broken down into functional areas. Maintaining the required standard of cleanliness is more important in some functional areas than others. In line with the national specifications for cleanliness in the NHS the functional groups are divided into four levels of cleaning intensity, based on the risks associated with inadequate cleaning in that functional area:

Very high risk: Consistently high levels of cleaning are maintained.
Areas include Theatres, ITU and Neonatal

High risk: Outcomes are maintained by regular and frequent cleaning with "spot" cleaning in between. Areas include general wards, public thoroughfares and sterile supplies.

Significant risk: In these areas high levels of cleanliness are required for both hygiene and aesthetic reasons. Outcomes are maintained with regular and frequent cleaning. Significant risk areas include pathology, out-patient departments and mortuaries.

Low Risk: In these areas high levels of cleanliness are maintained for aesthetic and to a lesser extent hygiene reasons. Outcomes are maintained with regular cleaning and "spot" cleaning in between. Low risk areas include office areas, record storage and archives.

MONITORING ARRANGEMENTS

There is a dedicated Monitoring Team within Facilities, who monitor standards of cleanliness within clinical and non-clinical areas at both sites. This team is led by the Facilities Manager (Corporate Services) to ensure there is no conflict of interest. The team are all trained to BICS standard (British Institute of Cleaning Science).

The monitoring of ward kitchens is undertaken by the Catering Department, who monitor cleanliness and food hygiene standards. A schedule is in place to routinely monitor ward kitchens. Any serious breaches of food hygiene are dealt with immediately. An annual inspection of ward kitchens is also carried out by the local Authority's Environmental Health team.

The monitoring programme complies with the Department of Health Specifications, covering domestic cleaning, patient equipment and estates issues. The monitoring frequency is dictated by the risk grading of areas, which are as follows:-

Very High Risk Areas	Theatres, Neonatal Unit, ITU, Endoscopy
High Risk Areas	Wards, Accident & Emergency, Public areas, Pharmacy, Ward Kitchens
Significant Risk Areas	Outpatient Areas
Low Risk Areas	Chapel, Offices

Copies of the monitoring reports are circulated to the Lead Nurses, Matrons, Ward Managers, Domestic and Portering Managers and Estates, to address any remedial action required. If there are any specific areas of concern, this is reviewed and focus is given to address the issue. When necessary, the frequency of monitoring is increased to address any problem areas.

To positively encourage high standards, the Domestic team working on any area which achieves 100%, are presented with a certificate in recognition of the hard work and commitment.

ENVIRONMENTAL HYGIENE GROUP

This group was set up in 2015 and is led by an Infection Control Nurse and is attended by an Estates Manager, Facilities Manager, Associate Director of infection Control, Domestic Manager, Matrons and Ward Housekeepers. The specific requirements of the group are:

- To establish a rolling programme for deep cleaning of inpatient areas
- To establish a rolling programme for use of hydrogen peroxide vapour for decontamination of side rooms
- To ensure roles and responsibilities for cleaning and disinfection of re-usable equipment are made clear
- To ensure mattresses are inspected as per SOP and appropriately disposed of when no longer fit for purpose
- To ensure cleanliness standards in Ward Kitchens are of an acceptable high standard
- To promote water safety by ensuring flushing of underused outlets is carried out in line with the legionella policy and reported centrally to Estates
- To review cleanliness monitoring standards and agree methods
- To ensure Matron involvement in setting expectations of cleanliness standards and monitoring of those standards on a monthly basis

TERMINAL CLEANING

Terminal cleaning is carried out by the Task team on request by a Ward when there is an infection or when a patient has been discharged outside normal working domestic hours and the bed is required quickly. In 2017/18 staff responded to 4,137 terminal clean requests.

Table 6 Terminal cleans

Terminal cleans	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Terminal Cleans 2015/16	278	281	235	254	224	212	236	199	235	208	233	306	**2901**
Terminal cleans 2016/17	222	272	259	307	286	267	289	340	351	292	318	287	**3490**
Terminal cleans 2017/18	217	281	386	346	352	352	349	257	311	419	368	499	**4137**

Table 7 Curtain changes

Curtain changes	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Curtain changes 2015/16	179	188	151	167	124	123	175	114	178	134	157	184	**1874**
Curtain changes 2016/17	144	190	168	202	195	167	177	203	239	195	200	171	**2251**
Curtain changes 2017/18	149	171	262	303	252	252	237	208	235	317	267	308	**2961**

CLEANLINESS SCORES

The 2017/18 cleanliness monitoring scores for clinical areas were as follows:

- Warrington: 95%
- Halton: 97%

Table 8 Cleaning scores Warrington

WARRINGTON	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cleanliness stats 2017/18	92%	94%	98%	96%	96%	94%	94%	94%	96%	93%	95%	97%

Table 9 Cleaning scores Halton

HALTON	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cleanliness Stats 2017/18	100%	98%	95%	97%	97%	97%	97%	96%	97%	97%	97%	97%

PLACE (Patient Led Assessments of the Care Environment)

In 2017 the PLACE assessments were carried out throughout the Trust by a team of patient assessors, Governors and representatives from Warrington and Halton Health Watch. This is facilitated and supported by representatives from the Trust. Results from the assessments are detailed below, along with National averages.

Table 10 Halton Hospital PLACE results

Domain	2017 Place (Halton) %	2017 Place (Organisation) Average %	2017 Place (National) Average %
Cleanliness	99.91%	99.96%	98.38%
Food	88.20%	89.15%	89.68%
Organisation Food	85.82%	86.05%	88.80%
Ward Food	89.77%	90.34%	90.19%
Privacy, Dignity and Wellbeing	82.20%	83.82%	83.68%
Condition, Appearance and Maintenance	93.68%	94.47%	94.02%
Dementia	66.13%	66.93%	76.71%
Disability	75.15%	75.05%	82.56%

The following graph, produced by the Health and Social Care Information Centre, indicates comparison WHH Place scores from 2013 – 2017 for Halton site:

Figure 17 PLACE results Halton site

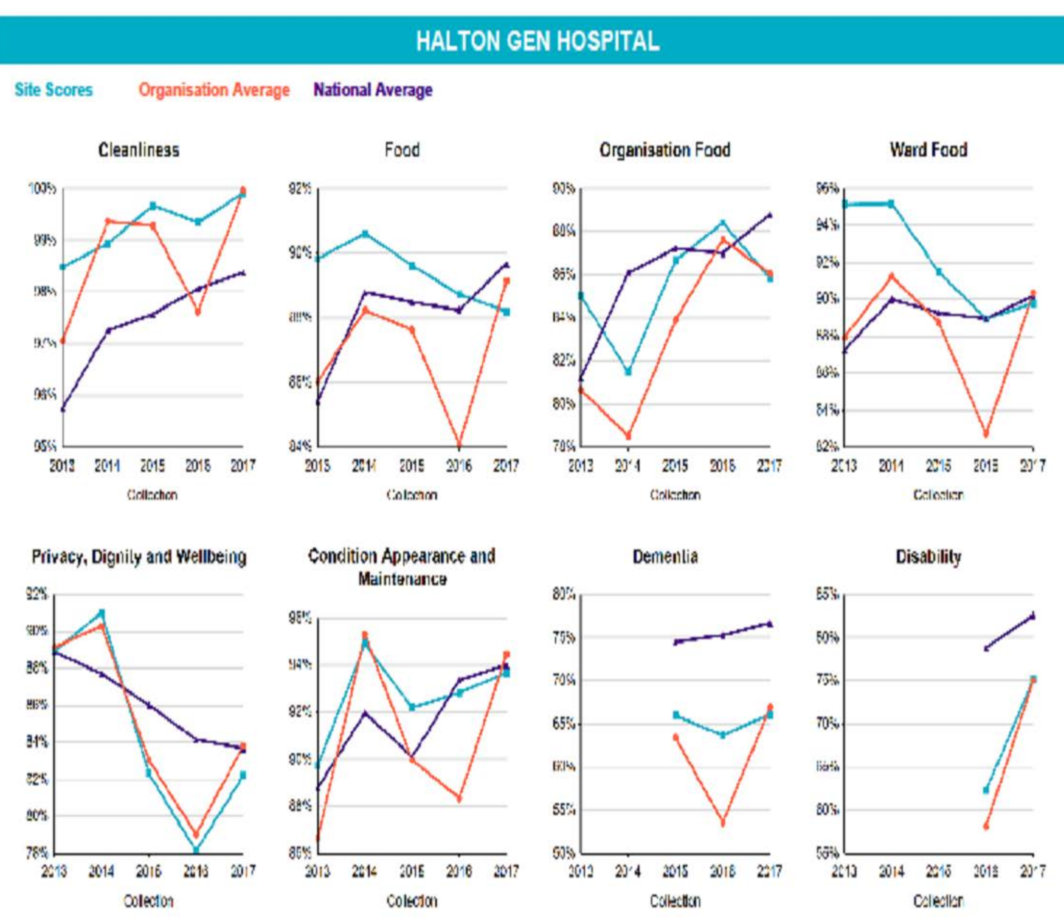


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Table 11 Warrington Hospital PLACE results

Domain	2017 Place % (Warrington)	2017 Place (Organisation) Average %	2017 Place (National) Average %
Cleanliness	99.97%	99.96%	98.38%
Food	89.29%	89.15%	89.68%
Organisation Food	86.09%	86.05%	88.80%
Ward Food	90.43%	90.34%	90.19%
Privacy, Dignity and Wellbeing	84.08%	83.82%	83.68%
Condition, Appearance and Maintenance	94.60%	94.47%	94.02%
Dementia	67.05%	66.93%	76.71%
Disability	75.03%	75.05%	82.56%

The following graph, produced by the Health and Social Care Information Centre, indicates comparison WHH Place from 2013 – 2017 for Warrington site:

Figure 18 PLACE results Warrington site

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Following publication of the PLACE results from the Health and Social Care Information Centre, specific focus was given to the domains that have scored below the national average, with the aim to improve these scores by putting the following measures into place:

- Production of a PLACE Action Plan, circulated to Matrons to address and feedback
- Facilities to monitor progress and submit a monthly report to the Infection Control Sub-Committee
- PLACE issues that require funding, will be included on Risk Registers, including Capital Funding requests
- Monthly reporting and updates to the Patient Experience Group
- Estates and Facilities to work in liaison with the Dementia and Disability Trust Leads re Dementia and Disability standards

CORPORATE REPORTING

A report is submitted by Facilities to the Infection Control Sub-Committee on a bimonthly basis re cleanliness standards scores, number of terminal cleans/curtain changes, process audits re-cleaning hand wash sinks and PPE, ward kitchen monitoring, linen and pest control and waste on a biannual basis.

TRAINING

The Domestic Staff receive specific theoretical and practical cleaning training as part of their induction, which includes infection control elements and this is supported by subsequent refresher training.

Random process audits are also carried out to ensure that staff follow the correct procedure and wear the correct personal protective equipment (PPE) when cleaning hand-wash sinks. Staff competency audits are also carried out to ensure that domestics are working in accordance with their training and the Trust Cleaning Standards Policy and Cleaning manual.

CLINICAL ACCESS/RESPONSIBILITY

The domestic staff are centrally managed by Facilities, however, the Ward Manager and the Housekeeper are able to direct the domestic staff based on each ward regarding day to day priorities. There is also close liaison with the Matrons, who have a specific responsibility for cleanliness standards for their Clinical Business Unit.

Facilities also have a close working relationship with the Ward Housekeepers. The Domestic Task team at Warrington also liaise closely with the Infection Control team and Estates when responding to terminal/deep cleans on the Wards.

There are cleanliness standards notices displayed in Wards, Departments, Public corridors and sanitary areas highlighting the frequency of cleaning in that area and also giving details of who to contact with any issues relating to cleanliness.

INFECTION CONTROL AUDIT

The aim of the audit programme is to measure compliance with Trust polices/guidelines and the care environment. This audit programme contributes to providing assurance that infection risks are effectively managed within the Trust. Due to the 4 month period of reduced staffing within the Infection prevention and Control Team only a limited number of audits were completed during the financial year.

The audits are carried out by the Infection Prevention and Control Nurses using an approved Infection Prevention and Control audit tool. The audit tool has a total of 15 components however these are not all relevant in all areas of the Trust. A rolling programme of audit is in place to cover all in-patient areas. Audits are completed outside of the rolling programme when infection incidents occur.

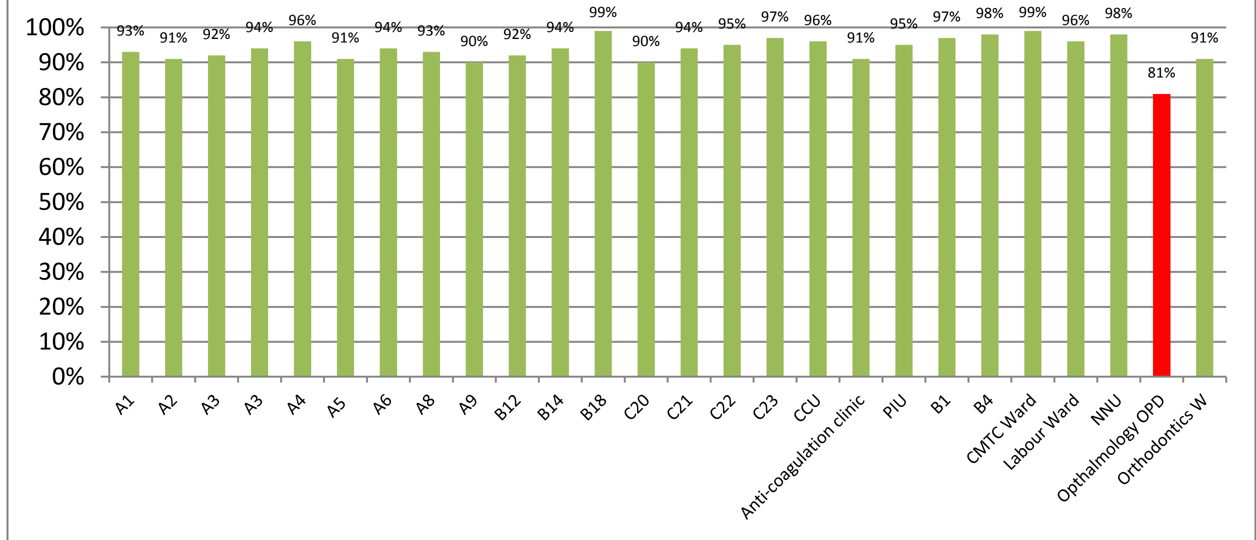
Reports on findings are fed back to the nurse in charge of the clinical area at the time of the audit. This is followed up by a written report within one week of the audit. The manager of the clinical area is responsible for producing an action plan to address areas of non-compliance. The action plan should be added to the Matron's report to the Infection Control Sub-Committee where it will remain for monitoring until all actions are completed.

The compliance results from all audits are compiled to provide an overall compliance score for the Trust of 94%.

Results

A total of 26 inpatient areas were audited. The majority of areas attained above 90% compliance. The exception to this was Ophthalmology OPD (81%). Improvement actions were requested however services have been temporarily relocated following a fire. Results are shown in figure 19.

Figure 19 Infection Control audit results by ward/department



The total percentage compliance for each of the components is detailed in table 12.

Table 12 Audit Summary for each component

	Total
Environment	87%
Ward Kitchens	89%
Handling/Disposal of Linen	96%
Departmental Waste	94%
Safe Handling Disposal of Sharps	94%
Patient Equipment (General)	94%
Patient Equipment (Specialist)	99%
Personal Protective Equipment	91%
Short Term Catheter Management	96%
Enteral Feeding	100%
Care of Peripheral Intravenous Lines	94%
Non-Tunnelled Central Venous Catheters	87%
Isolation Precautions	100%
Hand Hygiene	96%
Overall Compliance	94%

The lowest scoring components were general environment, ward kitchens and care of non-tunnelled central venous catheters. Central venous catheters are only cared for on one ward outside of ICU/CCU. A quality improvement initiative has been requested from the Lead Nurse for this area. Work is in

progress to declutter wards by introduction of the well organised ward (productive ward) scheme. Ward Kitchen audit scores are monitored at the Infection Control Sub-Committee. There is a programme of deep cleaning in place to improve standards.

Other areas of concern identified from the audits include:-

- Waste handling - 6 areas less than 90% compliant
- Safe handling and disposal of sharps – 8 areas less than 90% compliant
- Personal protective equipment – 11 areas less than 90% compliant

Discussion

It is not possible to compare the findings from this year's audit programme with previous years due to the low number of audits completed. The low number of audits completed does give cause for concern, as this has an impact on the ability to provide assurance of policy/guideline compliance and suitability of the care environment.

Concerns have been discussed at the Infection Control Sub-Committee in relation to general ward environments and ward kitchens.

Partnership working with the Health and Safety Team and Workplace Health and Wellbeing is in place to address concerns about sharps safety. This work was instigated in response to an increase in the reported numbers of exposure incidents identified at Infection Control Sub-Committee meetings.

A number of actions have been initiated include combined Matrons and IPCN walkabouts to identify any problems.

Limitations

The Infection Prevention and Control Team staffing was reduced due to a whole time equivalent vacancy for 4 months within the last financial year. This led to a reduction in the number of audits being completed.

Conclusion

Areas that were audited have received their audit results to: confirm good practice and identify where improvement is needed to minimise infection risks and enhance the quality of the patient care environment. The success of the audit programme relies on having robust action plans that are followed through to completion to ensure improvement actions have been taken.

Recommendations

The programme of audit will continue so that assurance on compliance with Trust polices/guidelines and the care environment can be provided. The approaches to targeting audits in areas with hospital apportioned infection will continue.

The Infection Prevention and Control Team will evaluate infection prevention and control auditing tools with other local Trust. This may lead to a change in the auditing tool used.

Discussion has taken place with the Facilities Manager and a strategy to improve standards in ward kitchens requested.

Sharps audit

An external audit of compliance with good practice in relation to sharps management is conducted annually. The sharps bin supplier was invited (October 2017) into the Trust to conduct a Trust wide sharps safety audit. The object of the audit was to establish whether or not sharps are disposed of in a safe manner. The method used was to visit wards and departments and observe existing practices.

Results

One hundred and eleven (112) wards/departments were visited during the audit and four hundred and ninety three (493) sharps containers were reviewed. The sharps containers were mainly supplied by the company conducting the audit. The audit results showed:-

- 0 sharps containers with protruding sharps
- 4 that were not properly assembled
- 1 that was more than three quarters full
- 0 sharps container had the wrong lid on the wrong base
- 0 sharps containers were sited on the floor or at an unsuitable height
- 39 sharps containers were unlabelled whilst in use
- 23 sharps containers had significant inappropriate non sharp contents
- 19 sharps containers did not have the temporary closure in place

The audit recommendations included:-

- Train staff in the assembly of sharps containers
- Train staff to fill in labels at assembly
- Train staff not to put non sharps in sharps containers
- Train staff to put the temporary closure in place when unattended or when moved
- Use a one-brand system
- Re-audit within one year

The audit results demonstrated reasonably good compliance with sharps safety standards. Each area has received a copy of the audit and been asked to improve compliance where standards were not met. The audit has been rescheduled for October 2018.

Side room facilities survey

The Trust is legally required (Department of Health 2015) to provide or secure adequate isolation facilities to minimise the risk of healthcare associated infection transmission. Due to changes in service delivery e.g. change of ward function, availability of resources (side rooms) to isolate patients can change within the Trust.

A trust wide survey was conducted showing that 13 side rooms were being used for non-clinical functions (10 beds on the Warrington site and 3 beds on the Halton site). In addition Daresbury Unit has closed which has resulted in the loss of access to 30 single side rooms all with ensuite facilities.

A number of the side rooms are in areas that are ring fenced for specific patient groups (e.g. stroke and paediatrics). This further reduces the number of side rooms that can be accessed to isolate adult patients with known or suspected infections.

Most of the side rooms being used for alternative functions have retained facilities e.g. hand washing sink, oxygen and suction points. These rooms could easily be converted back to clinical use. The Trust has a recognised risk on the Trust wide/Infection Control Risk Register.

This reduction in side room facilities has resulted in an increased impact on infection control resources to undertake risk assessments and provide advice on prioritisation for side room use when resources are under increased demand. There will be continuous liaison with the Patient Flow and clinical teams to support prioritisation of access to side rooms and the audit will be repeated within 1 year.

Saving Lives/High Impact Interventions

The Divisions have continued a rolling programme of audit to assess compliance with the Department of Health's High Impact Interventions Toolkit. Audit scores are mostly in the region of 90-100%. The results are fed back to the ward teams and the Infection Control Sub-Committee. Action plans are produced, by wards and departments, to correct areas where care improvements are required.

An increased in audits are requested when scores are below accepted standards. Matrons are directed to show the audits drive improvements rather than being seen as a monitoring process.

Antibiotic Prescribing

During the 2017/18 FY, there has been 66 joint Consultant Microbiologist and Antibiotic Pharmacist ward rounds carried out at Warrington hospital. The aim is to carry out 2 antibiotic ward rounds per week; other commitments permitting. One ward round looks at patients on the "target antibiotics":- piperacillin/tazobactam (Tazocin®), meropenem, ciprofloxacin, teicoplanin, cefuroxime, co-amoxiclav and levofloxacin. The use of these antibiotics is closely monitored throughout the Trust as they are either:-

- broad-spectrum antibiotics that should be reserved for more difficult infections that are not responding to first line antibiotics, or
- antibiotics that are more commonly associated with the development of *Clostridium difficile* infection

Consequently we want assurance that these "target antibiotics" are being prescribed as per the Antibiotic Formulary or following the advice of a Consultant Microbiologist and we want to ensure that they are being reviewed in a timely manner and switched to narrower spectrum agents when culture and sensitivity results become available or it is clinically appropriate to do so.

Prior to the introduction of the Anti-microbial Resistance (AMR) CQUIN in 2016 the second ward round primarily focused on wards where there were concerns about compliance with the Trust Antibiotic Formulary (picked up from the quarterly point prevalence audit) or those wards with higher rates of *Clostridium difficile* infection or other healthcare associated infections (HCAIs). However the introduction of the AMR CQUIN in 2016 to try and halt progression of AMR has meant that the focus of this ward round has had to change. Antimicrobial resistance (AMR) has risen alarmingly over the last 40 years and it is thought that inappropriate and overuse of antimicrobials is a key driver. The fact that very few new antimicrobials have come to the market in recent years coupled with an increase in total antibiotic prescribing across England has led NHS England to set Trusts the target of reducing

consumption of two key antibiotics namely piperacillin/tazobactam (Tazocin®) and meropenem. These new targets have meant that extra emphasis and resources have had to be placed on reviewing patients prescribed these 2 antibiotics and we use this ward round to review these patients.

Ward Pharmacists also refer patients for a review on the antibiotic ward round. Common reasons for referral are:-

- Patient is deteriorating despite antibiotics and clinical team have requested a review and have been unable to contact Consultant Microbiologist (CMM) for advice
- Patient is prescribed antibiotics that are non-compliant with the Antibiotic Formulary and clinical team refusing to change antibiotics despite being challenged
- Culture and sensitivity results available to allow rationalisation of antibiotics but not actioned by clinical team
- Patient appears clinically well and is suitable for oral step down or stopping antibiotics but the team with clinical responsibility for the patient are not undertaking this or are requesting CMM advice

Table 13 Total Number of Antibiotics Reviewed

Time period	Number of patients reviewed	Number of antimicrobials reviewed
April 2013 – March 2014	592	770
April 2014 – March 2015	420	579
April 2015 – March 2016	395	545
April 2016 - March 2017	713	829
April 2017 - March 2018	654	905

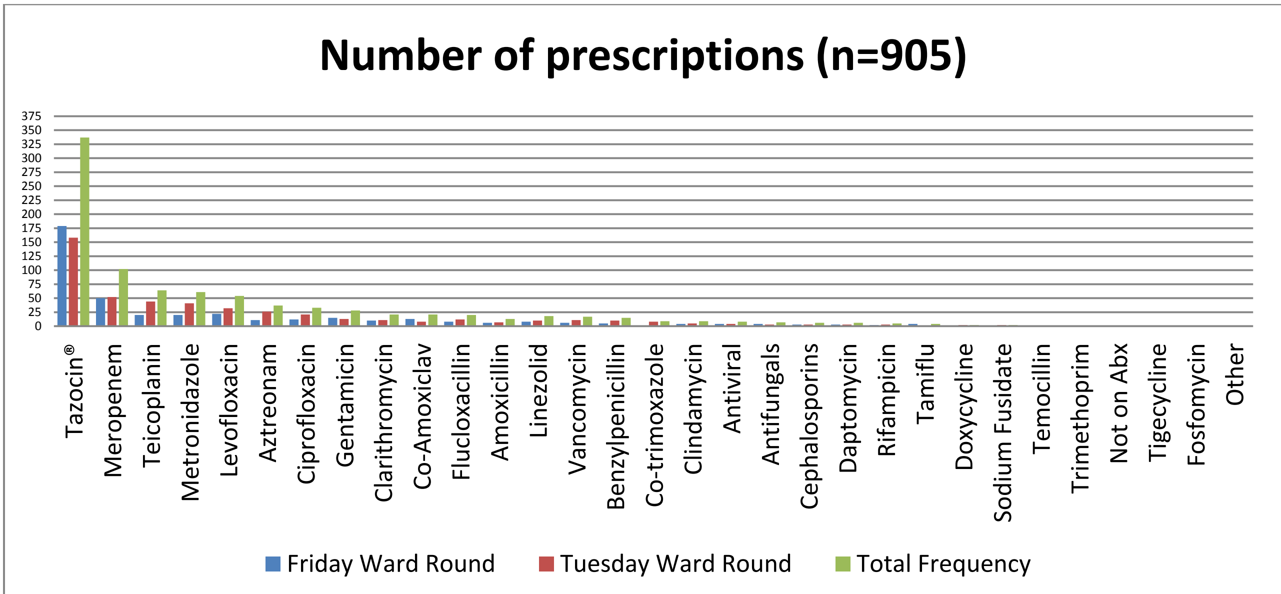
A total of 654 patients and 905 antimicrobials were reviewed between April 2017 and March 2018. These figures show that the appointment of a full-time Antimicrobial Pharmacist into post in August 2016 has had a significant impact on the number of patients who can be reviewed on the joint ward rounds. 492 antibiotics were reviewed on the Tuesday “target” ward round and 413 were reviewed on the Friday ward round which targets specific wards or piperacillin/tazobactam (Tazocin®) and meropenem. In previous years there has been a significant difference in the number of antibiotics reviewed on each ward round due to the different amount of time allocated to each round but each ward round is now allocated a similar amount of Pharmacist and CMM time. Interestingly, fewer patients were reviewed this year than in the previous year however, more antibiotics were reviewed. This can probably be explained by the ongoing National Tazocin® shortage and CQUIN requirement to reduce Tazocin® consumption. This has meant we have had to introduce an “alternative to piperacillin/tazobactam formulary” which includes a number of 2/3 drug combination regimens for the management of different infections that previously would have been treated with a single agent (Tazocin®).

Summary of Antibiotics Reviewed

Figure 20 indicates which antibiotics were reviewed on the ward rounds. 67.5% of the antimicrobials which were reviewed were "target antibiotics," which is similar to the previous year's results (64%). The small percentage increase may reflect the extra effort that is going in to reviewing those patients prescribed piperacillin/tazobactam (Tazocin®) and meropenem in order to help the Trust try and achieve the percentage reduction in use of these antibiotics required by the AMR CQUIN and manage the ongoing National Tazocin® shortage. These 2 antibiotics alone made up 48.5% of all the antibiotics reviewed on the ward rounds.

9 patients were reviewed who were not initially prescribed antibiotics but required intervention due to laboratory reports or microbiology advice was sought by ward doctors when the Consultant Microbiologist was on the ward.

Figure 20 Summary of antibiotics reviewed



Summary of Ward Round Interventions

Of the 905 antibiotics reviewed, 90 antibiotics (10%) were stopped on the ward round and a stop/review date was added to a further 133 prescriptions (15%). 219 antibiotics (25%) were changed to a more appropriate antibiotic – this could be a change in IV antibiotic regimen or an IV to oral step down. Changes were only made if the team looking after the patient could be contacted and the proposed changes were discussed and agreed. The pie chart (Figure 20) below summarises the outcome of the antibiotic reviews in more detail.

Figure 21 Outcome of antibiotic reviews

1%
1%
1%
10%
10%
15%
14%
11%
12%
10%
15%

- Antibiotic Stopped
- Stop/review date added
- No change made
- IV Treatment changed
- IV to oral switch
- Advice Given
- Unable to contact team (message left on Lorenzo)
- Antibiotic already stopped/changed by own team
- Ward Pharmacist follow up
- Awaiting micro results
- Start antibiotics

Summary of Antibiotics Stopped

90 antibiotics (10%) which were reviewed on the ward round were stopped because further antibiotic treatment was considered unnecessary at that point as the patient had already received an appropriate course length, there was no positive microbiology to indicate that that antibiotic was required or there was duplication in antibiotic cover. Antibiotics were stopped only if the team with clinical responsibility for the patient could be contacted and they agreed with the Consultant Microbiologists recommendations. When the team with clinical responsibility for the patient could not be contacted on the ward round no changes were made to the prescriptions at the time of the ward round however a note was left on the patients EPR documenting that a discussion with a Consultant Microbiologist was required. These discussions often occur after the ward round and therefore it is not possible to include the outcome of all these discussions in the data collection.

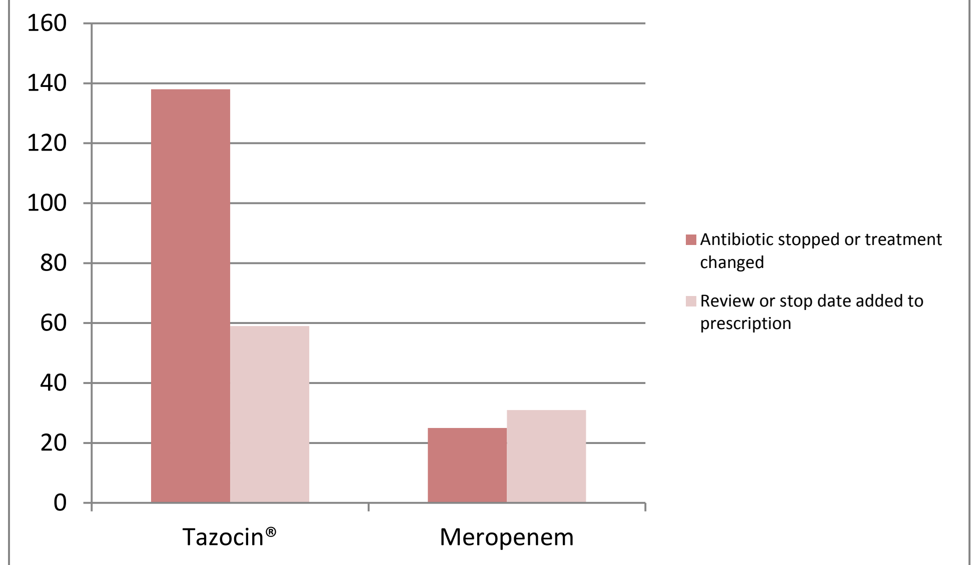
Summary of Piperacillin/tazobactam (Tazocin®) and Meropenem Reviews

Extra effort has gone into reviewing these 2 key antibiotics to help the Trust try and achieve the National AMR CQUIN and manage the National stock shortage of Tazocin®. Graph 2 below shows the outcome of the reviews.

A total of 337 prescriptions for piperacillin/tazobactam (Tazocin®) and 102 Meropenem prescriptions were reviewed over the 12 month period. Following the ward round review we were able to stop/ change treatment for 40% (138) of the prescriptions for piperacillin/tazobactam (Tazocin®) and 25% (25)

of the Meropenem prescriptions. Stop or review dates were added to a further 59 piperacillin/tazobactam (Tazocin®) prescriptions and 31 Meropenem prescriptions.

Figure 22 Summary of Piperacillin/tazobactam (Tazocin®) and Meropenem Reviews



Benefits of the ward round

The joint Consultant Microbiologist and Antibiotic Pharmacist ward rounds are beneficial because they provide a good educational opportunity for the Consultant Microbiologists and pharmacist to educate the junior doctors on antimicrobial resistance and promote prescribing as per the Trusts Antibiotic Formulary.

Before the patient is seen on the ward, the Consultant Microbiologist and Pharmacist review any recent microbiology and blood result's which allows antibiotic treatment to be tailored as appropriate. When reviewing the microbiology we also look for any history of multi-drug resistant organisms which will influence prescribing decisions. The ward rounds ensure that patients are exposed to fewer days of broad spectrum antimicrobial cover and ensure patients are changed to more appropriate antibiotic treatment in a timelier manner. The ward rounds improve patient safety as it can reduce the risks associated with antibiotic treatment particularly those with a narrow therapeutic window.

Cost savings have been made by stopping unnecessary antibiotics, changing antibiotics to more appropriate treatment and adding stop dates to courses of antibiotics.

Nursing time can also be saved by the appropriate stopping of antibiotics, particularly intravenous antibiotics.

The ward rounds also help the Trust to manage antibiotic shortages.

Future developments

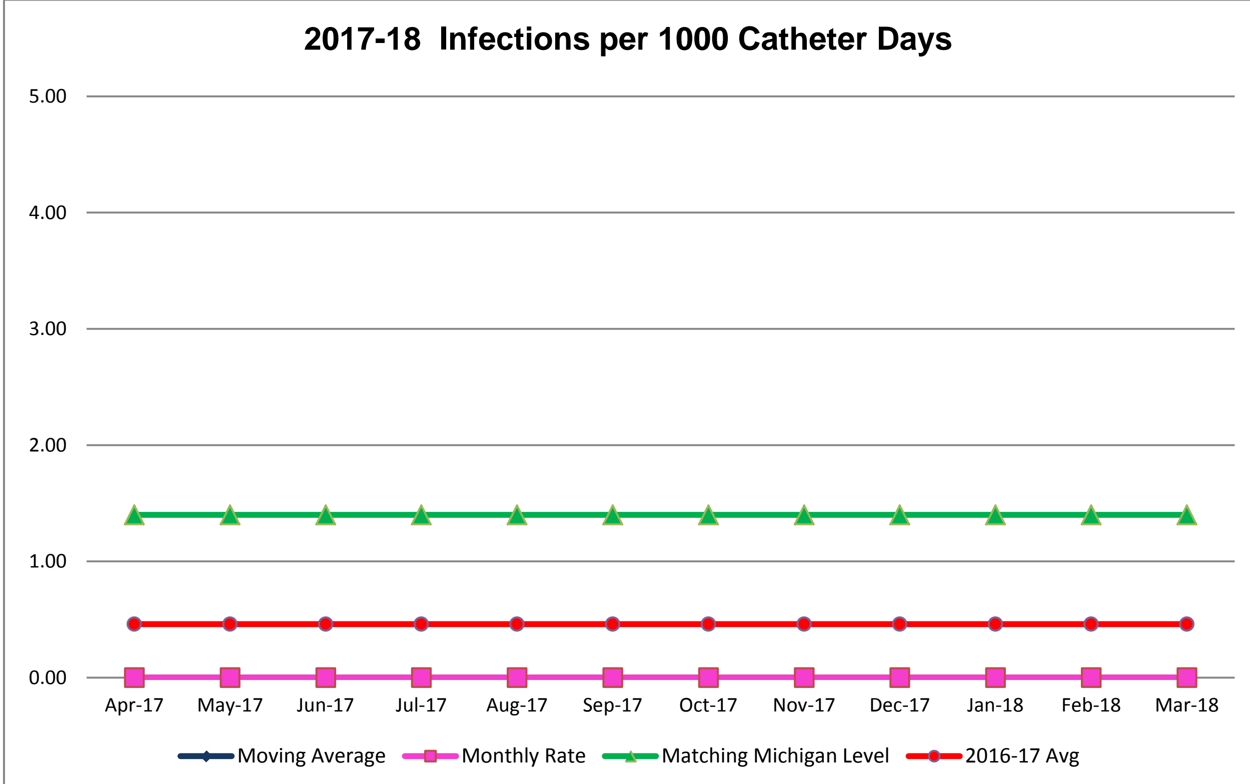
The antimicrobial ward rounds could be expanded so that more patients on antibiotics are reviewed, this is currently limited by the Consultant Microbiologist and Antibiotic Pharmacists other commitments.

At present, we are not able to follow up all patients who are reviewed on the ward round to review their progress unless the ward team contact the microbiologists directly or the ward pharmacists are asked to follow up. With additional staffing resources more patients could be seen and a follow up process introduced. More regular feedback to prescribing teams may also drive further improvements in antimicrobial stewardship within the Trust, but again this would require additional resources.

Matching Michigan

The Trust's ICU is participating in this initiative to reduce the incidence of central venous catheter infections. The data for the 2017/18 financial year is displayed in figure 22.

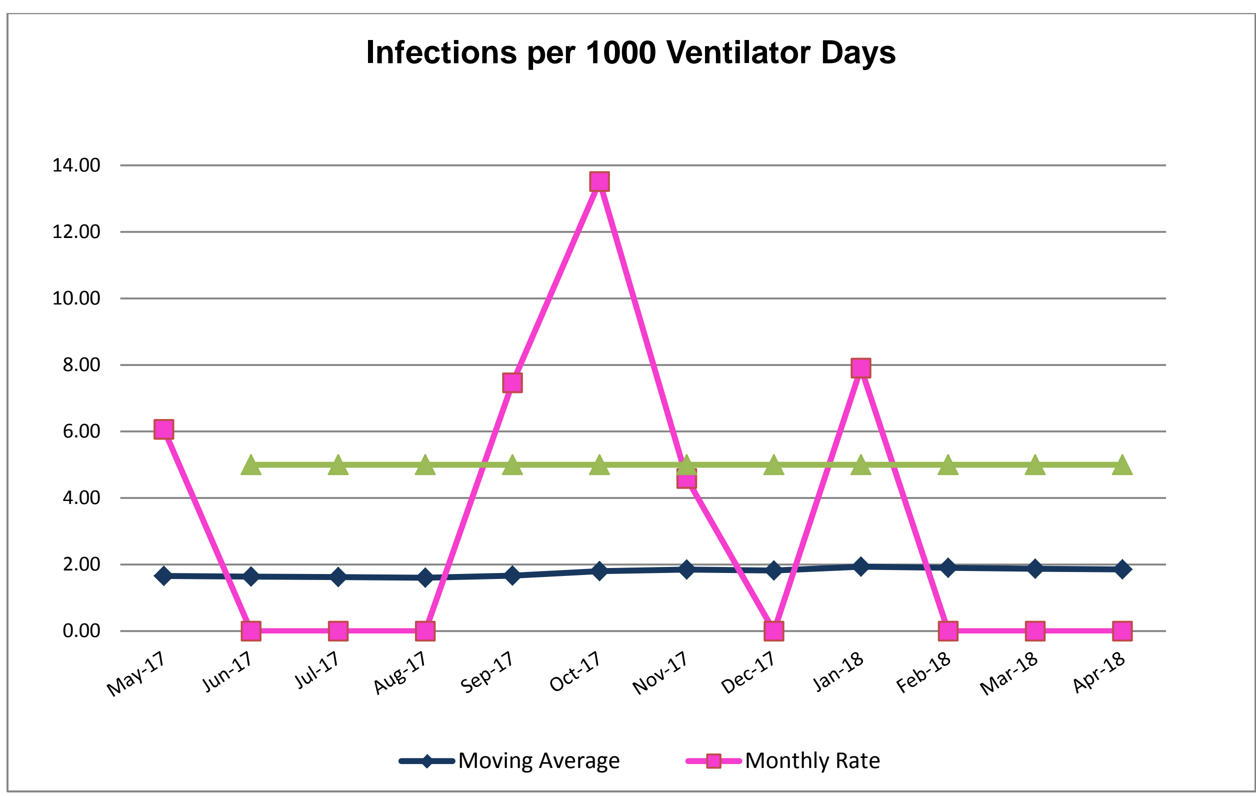
Figure 23 Matching Michigan data



The Trust's overall rate has been consistently below that of Michigan since January 2011.

The ICU also collates data on ventilator associated pneumonias (VAP). This facilitates identification of trends of bacterial pneumonia in ICU patients who are mechanically ventilated. Data for the 2017/18 year is displayed in figure 23.

Figure 24 VAP data



TARGETS AND OUTCOMES

Activities

The Infection Prevention and Control Team has been involved in a number of initiatives within the Trust to promote the importance of infection prevention and control. These include:-

- Antimicrobial Management Steering Group
- Water Safety Group
- Hand hygiene awareness raising events
- On-call service (Medical Microbiology and Infection Control)
- Unannounced spot checks
- Infection prevention and control link staff group
- Environmental hygiene group
- Response to complaints
- Response to litigation
- Response to FOI requests

Updated policies and guidelines

The following documents were revised during the financial year and where appropriate ratified by the Infection Control Sub-Committee:-

- SOP for Filmarray testing stool samples

- Blood culture policy
- SOP for use of HPV equipment
- SOP for mattress inspection and cleaning
- Hand hygiene training booklet
- Hand hygiene training strategy
- Assessing infection risk guidelines
- Multidrug resistant organism guidelines

Information leaflets

- Viral gastroenteritis patient information leaflet

Other documents

- Clostridium difficile – toolkit for case investigation
- MSSA bacteraemia post infection review toolkit
- Assurance framework – Infection prevention and Control Team structure
- Terms of reference - Infection Control Sub-Committee
- Infection Control Sub-Committee Work Plan 2017/8
- Infection Control Strategy 2016 - 2019

Revised and updated infection control policies, procedures and information leaflets are available from the Trust's intranet.

Contribution to other initiatives

Capital Projects

The Infection Prevention and Control Team participated in Estates Safety and Risk Meetings. All areas that have undergone upgrade work have been reviewed and signed off by the Infection Prevention and Control Team prior to re-occupation by patients.

Estates projects

- Frailty assessment unit
- Relocation of C21/CCU
- Upgrade to Butterfly Suite
- Upgrade of Dental Unit
- Relocation of Ophthalmology
- Relocation of diabetic foot clinic

Group documents

- Terms of reference Decontamination Group
- Terms of Reference Infection Control Sub-Committee

External groups

The Infection Prevention and Control Team participated in the following external groups:-

- 5 boroughs Partnership Mental Health Trust Infection Control Committee

- 3 Boroughs Public Health Infection Control Committee
- Public Health Forum (Public health England)
- Health Protection Forum – Warrington Borough Council
- Northwest Antimicrobial resistance Steering Group
- IPC strategic collaborative – NHS England
- Multi-agency C difficile Review meeting

External reviews

- Dynamic mattress decontamination facility

TRAINING ACTIVITIES

The Infection Prevention and Control Team continue to provide a structured annual programme of education. This includes an Infection Control E-Learning package for clinical staff. The following sessions are included in the infection control training plan. Overall attendance at training sessions was 83% across the Trust at the end of the financial year.

Trust corporate induction: All new starters via E-Learning

Mandatory training: All staff

Infection Prevention and Control (and Sepsis) Link Staff

1 day placements/shadowing scheme

- F1 Doctors
- Student Nurses
- Trainee Nursing Associates
- Trainee Assistant Practitioners

Medical Students

- Infection Prevention and Control
- Various infection/microbiology topics

F1/F2 Doctors

- Induction and updates
- Blood culture specimens (indications and technique)
- Antimicrobial prescribing

Consultant Mandatory Infection Prevention and Control Training

Ad hoc clinical based teaching

Single point lessons in response to incidents on:-

- MRSA screening and suppression therapy
- Clostridium difficile management
- Use of personal protective equipment
- Viral gastroenteritis outbreak management
- CPE screening
- Personal protective equipment
- Isolation priorities

Infection prevention and control activities

The Infection Prevention and Control Team have worked hard throughout the year to deliver the annual work plan. This includes provision of clinical advice, education and training, audit, policy development/review, surveillance, and input into complaints, FOI requests and Estates and Facilities issues.

Training attended/ provided by Infection Prevention and Control Team Members

Dr Zaman Qazzafi - Consultant Microbiologist

Apr 17-Mar 18	Grand Round presentations
6/4/17	Year 4 Medical Student Microbiology teaching
6/9/17	Skin and Skin Structure infections - New management paradigms
14/9/17	FY1 doctors teaching – antibiotic stewardship and aseptic technique for collecting blood cultures
25/9/17 & 5/12/17	Regional Microbiology Audit meetings
4/10/17	NHSI Gram Negative Bacteraemia Reduction Initiative meeting – PIN event
21/12/17	NW Mycology Meeting – A regional, national and international fungal update
19/02/18	Presentation to Elderly Care Medical Staff on 'Bacterial Meningitis'
13 and 14/3/18	Consultant Clinical Leadership Programme

Dr Thamara Nawimana – Consultant Microbiologist/Infection Control Doctor

22nd – 25th Apr 17	Attended 27th European Congress of Clinical Microbiology and Infectious Diseases conference in Vienna
5/7/17/17	Participated in clinical audit on effectiveness of antibiotic ward rounds
25/09/17	Attended to Regional Audit meeting on Diabetic foot infection
11/10/17	Presented an audit of the diagnosis & treatment of infective endocarditis
25/09/17	Attended to Regional Audit meeting on Diabetic foot infection

01/12/17	Attended Grand round lecture on Sepsis
21/02/18	Attended Infection prevention & control conference in London

Lesley McKay – Associate Director for Infection Prevention and Control

24/05/17	DIPC Network and DIPC Development programme: speaker presentations, discussion sessions and networking
13/06/17	SYPOL COSHH management system
12th – 13th Sep 17	Effective investigating workshop
28/09/17	NHSE HCAI network meeting
13/12/17	IPS Meeting; presentations and discussions
26/01/18	HMS Coroner role
E. coli bacteraemia collaborative (Health economy group) meetings	
4th and 6th Dec 17	Participation in external review of IPC service

Helen McLaren – Infection Prevention and Control Nurse

4/10/17	NHSI Gram Negative Bacteraemia Reduction Initiative meeting – PIN event

Karen Smith – Infection Prevention and Control Nurse

11th Oct 17	Hydrogen peroxide vapour decontamination training

Jacqui Ward – Antibiotics Pharmacist

Quarterly	North West Antimicrobial Pharmacist Group educational session

CONCLUSION

This has been a very challenging year for the Infection Prevention and Control Team due to the noted increase in influenza cases and reduction in team staffing. It is to their great credit that these issues have been managed alongside a proactive agenda to address Clostridium difficile and bloodstream infections from MRSA/MSSA and E.coli. Concurrently they have maintained attention to a demanding audit, education and training and surveillance work plan.

Assurance on the prevention and control of infections is provided by a matrix approach of updating policies in light of best practice/legislation; robust and regular auditing of policies and practice; spot checks and self-assessment. Although there was a reduction in auditing there was an increased focus to areas where risks were identified, which was appropriate for immediate patient safety concerns.

The assurance framework, which is forwarded to Commissioners each month, demonstrated compliance with the Health and Social Care Act (2008) Code of practice and summarises the Trusts position against key performance indicators. Alongside the high level briefing papers submitted to the Quality

Committee and Board reports, these documents give the Trust Board assurance about infection control activities and outcomes.

Gratitude is extended to the Infection Prevention and Control Team for maintaining their proactive leadership of a challenging and extremely busy agenda.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

The Board is asked to receive the Infection Prevention and Control Annual Report and note the progress made.

To note the revised mandatory reporting requirement and additional actions required.

4. IMPACT ON QPS?

Q = Improvements to quality by reducing cases of healthcare associated infection

P = Training of staff to care for patients with suspected/diagnosed infections

S = Risk of contractual penalties if healthcare associated infection thresholds are exceeded

5. MEASUREMENTS/EVALUATIONS

Progress against the Infection Control Sub-Committee work plan:-

- healthcare associated infection surveillance data
- action plans
- strategy
- education and training

6. TRAJECTORIES/OBJECTIVES AGREED

Nationally set Clostridium difficile threshold of 26 cases

Zero tolerance to avoidable MRSA bacteraemia cases

Reduction target (health economy) for Gram negative bloodstream infections

National Sepsis and AMR CQUIN

7. MONITORING/REPORTING ROUTES

Infection Control Sub-Committee

Quality and Assurance Committee

Patient Safety and Clinical Effectiveness Committee

Trust Board

8. TIMELINES

Financial year 2017/18

9. ASSURANCE COMMITTEE

Infection Control Sub-Committee

10. RECOMMENDATIONS

Annual Work plan to be delivered including:-

Continue to improve compliance with the Health and Social Care Act (2008) Code of practice on preventing infections and related guidance (2015)

Continue work against the action plans for reduction of healthcare associated infections:-

- *Staphylococcus aureus* bacteraemia reduction (MRSA/MSSA)
- Clostridium difficile infection reduction
- Gram Negative bloodstream infection reduction

Complete actions following external review.

Establish GNBSI reduction working group

Increase infection control audits to demonstrate compliance with policies and guidelines.

Complete all Policy reviews.

Complete actions listed in the IPC Strategy and redevelop this for the next 3 years

Kimberley Salmon-Jamieson
Chief Nurse
Director of Infection Prevention and Control (DIPC) from September 2017
June 2018

Appendix 1 ANNUAL WORK PROGRAMME 2018/19

Progress against this action plan will be monitored at the ICSC bimonthly. Updates will be made where additional activities are identified.

GOVERNANCE								
	Target date	**Leads**	**May**	**Jul**	**Sep**	**Nov**	**Jan**	**Mar**
Develop action plan following external review (monitor progress at ICSC)	Apr 2018	ADIPC						
Review of ICSC Terms of Reference and IPCT infrastructure	Apr 2018	Deputy DIPC						
DIPC annual report	May 2018	ADIPC						
Quarterly reports to Quality and Assurance Committee	Quarterly	ADIPC						
Bi-annual DIPC reports to Trust Board	Monthly	ADIPC						
Risk register monthly review	Monthly	ADIPC						
Assurance Framework monthly submission to CCG	Monthly	ADIPC						
HLBP submission to PSCE; QA; and H and S committees	Bimonthly	ADIPC						
RCAs/PIR of HCAI incidents: Monitoring of associated action plans linked to CBU Governance Frameworks and demonstration of learning	Per case	LNs						
Review of action plans for HCAI reduction including GNBSI; C. difficile and Staphylococcus aureus bacteraemia cases	Per case	LNs						
Submission of C. difficile RCA findings to the CCG panel for review to assess for lapses in care	Quarterly	LNs / ADIPC						
Review of revised C. difficile Objective for 2018/19	Apr 2018	ADIPC						
Review of revised MRSA bacteraemia PIR process	Apr 2018	ADIPC						
IPCT team building away day	Sep 2018	ADIPC						
Review of progress against this work plan and the IC strategy	Bimonthly	ADIPC						
Provision of commentary for Trust Quality Account	Apr 2018	ADIPC						
Code of Practice for prevention of HCAIs – compliance assessment	Quarterly	ADIPC						
Revision to ICSC reporting template – to create HLBP	May 2018	ADIPC						
Review of HCAI reduction action plans (Staphylococcus aureus; C. difficile and GNBSI)	Quarterly	ADIPC						
Other Committee attendance/Group provision								
Antimicrobial Stewardship Group	Quarterly	Deputy DIPC						
Bed meetings	Daily	IPCNs						
CCG CDT review panel meetings	Quarterly	ADIPC						
CDT MDT	Weekly	CL						
CCG RCA review meetings	Each case	ADIPC						
Decontamination Group	Quarterly	ICD / ADIPC						
Event planning group	Monthly	ADIPC						
GNBSI operational group – external	Quarterly	CCG						
GNBSI operational group – internal	Quarterly	Deputy DIPC						
HCAI Network PHE	Quarterly	IPCNs						
Health and Safety Sub-committee	Bimonthly	ADIPC						
Health Protection Forum WBC	Quarterly	HMcL						

	Target date	Lead	May	Jul	Sep	Nov	Jan	Mar
ICSC	Bimonthly	IPCT						
Submit HCAI data to Communications team	Monthly	IPCNs						
Annual review of ToRs for ICSC; operational IC group	Annual	Deputy DIPC/ADIPC						
Action plan for next financial year	Annual	ADIPC						
ICU/IPCT meetings	Biannual	Deputy DIPC						
Incident meetings	As required	IPCT						
IPCT meetings	Fortnightly	IPCT						
IPS meetings	Quarterly	IPCNs						
Medical Devices group	TBC	HMcL						
Nursing & Midwifery Forum	Monthly	ADIPC						
Nutritional steering group	Monthly	CL						
NWB ICC	TBC	Deputy DIPC						
Operational IC & Environment Group	Bimonthly	ADIPC						
Patient Safety and Clinical Effectiveness	Bimonthly	ADIPC						
PIR Staphylococcus aureus bacteraemia meetings	Each case	ADIPC						
Quality and Assurance Committee	Bimonthly	ADIPC/DIPC						
Safer sharps group meeting	Monthly	CL						
Theatre IC group	Monthly	HMcL						
Water safety group	Quarterly	ICD / ADIPC						
Workplace Health & Wellbeing Meetings	Biannual	TBC						
Surveillance								
Compliance with mandatory reporting of MRSA; MSSA; C. difficile; GNBSIs (E. coli, Klebsiella and Pseudomonas)	Monthly	IPCNs/ ADIPC						
Mandatory reporting data validation and timely sign off	Monthly	ADIPC						
MSK compliance with Mandatory orthopaedic surveillance	Quarterly	LN MSK						
Zero tolerance to MRSA bacteraemia cases	Monthly	ALL						
CPE admission screening	Monthly	IPCNs						
SSSI	Quarterly	LN DD						
HCAI surveillance reports – weekly to Chief Nurse, Associate Chief Nurses, Lead Nurses and Matrons	Weekly	IPCNs						
Surveillance of HAI alert organisms (MRSA, VRE, CDT etc.)	Daily	IPCNs						
HCAI reporting for Trust dashboards with commentary	Monthly	ADIPC						
HCAI reporting to ICSC dashboards	Bimonthly	ADIPC						
Pseudomonas surveillance in Augmented care area (ICU and NNU)	Fortnightly	IPCNs						
VRE surveillance	Fortnightly	IPCNs						
Complete Quarterly Mandatory Laboratory returns and submit to PHE	Quarterly	Deputy DIPC						
Antibiotic ward rounds daily on ICU and ward B18	Daily	CMMs						

Environmental cleanliness / monitoring								
	Target date	**Lead**	**May**	**Jul**	**Sep**	**Nov**	**Jan**	**Mar**
Environmental cleanliness monitoring	Monthly	Facilities Manager						
Participate in PLACE assessments	May 2018	IPCNs/ LNs						
Matron and IPC Walkabouts	Monthly	Matrons /IPCNs						
Estates PAM assessment	Annual	ADE						
Legionella Assessments and compass flushing reports	TBC	ADE						
Monitor progress with carpet removal and dishwasher installation	Bimonthly	Deputy DIPC						
Isolation facilities audit – side room use	Annual	IPCNs						
Audit								
Audit Programme (IPC led) against standard precautions with reporting to ICSC	Annual	IPCNs						
Revise current audit programme for IPC policies in line with the Quality Metrics programme and review revised publication of HII audits	Sep 2018	IPCNs						
Hand hygiene audits	Weekly	LNs						
MRSA pre-operative screening audit	Quarterly	LN DD						
MRSA screening compliance audits	Monthly	IPCNS						
Support areas requiring improvements identified on the Quality Metrics programme	Monthly	IPCNs						
Policy and Guideline review								
Antibiotic Formulary	May 2018	Deputy DIPC/ABP						
ANTT policy	July 2018	ADIPC						
Cleaning manual	May 2018	Facilities Manager						
Group A Streptococcus Policy	May 2018	ICD/ ADIPC						
Hand Hygiene Policy	Jul 2018	ADIPC						
Infection Control Policy	Jul 2018	ADIPC						
Waste Management Policy	Jul 2018	Facilities Manager						
Operational Policy for the Cohort Ward	May 2018	LN Sp. Medicine						
Mandatory reporting of HCAIs to the DCS	Jul 2018	ADIPC						
Pest Control Policy	Jul 2018	Facilities Manager						
PPE Guidelines	Jul 2018	ADIPC						
Reporting infections (staff and service users)	Jul 2018	ADIPC						
Terminal cleaning guidelines	Sep 2018	ADIPC						
VHF	Sep 2018	ADIPC						
Standard Precautions guidelines	Sep 2018	ADIPC						
Clostridium difficile guidelines	Sep 2018	ADIPC						
Chickenpox guidelines	Sep 2018	ADIPC						
Safe handling and disposal of waste	Sep 2018	ADIPC						
Viral gastroenteritis guidelines	Nov 2018	ADIPC						
Spillage of blood and body fluids	Nov 2018	ADIPC						
Notification of Communicable diseases	Nov 2018	ADIPC						
Influenza Policy	Nov 2018	ADIPC						

	Target date	Lead	May	Jul	Sep	Nov	Jan	Mar
Isolation of immunosuppressed patients	Jan 2019	ADIPC						
Outbreak Policy	Jan 2019	ADIPC						
Closure of rooms wards, departments and premises to new admissions	Mar 2019	ADIPC						
Care of deceased patients	Mar 2019	ADIPC						
Isolation Policy	Mar 2019	ADIPC						
Awareness raising events								
Replacement of hand hygiene sanitiser dispensers at ward entrances	Apr 2018	IPCNS						
Uniform and workwear promotion for Global Hand washing Day	May 2018	IPCNS						
October IC week	Oct 2018	IPCNs						
November Antibiotic Awareness	Nov 2018	IPCNs						
Seasonal flu campaign with WHWB	Dec 2018	WHWB						
Education								
Provide Mandatory training for IPC supporting areas with low compliance figures	Monthly	IPCNS						
Revise E-Learning package for IPC	May 2018	ADIPC						
Develop ANTT E-Learning package and develop competency assessment framework and annual updates	May 2018	ADIPC						
Participate in Grand Round Presentation on UTI pathway and GNBSI reduction	Jun 2018	IPCT						
Provide single point lesson training in response to incidents	As required	IPCNS						

Appendix 2 - Infection Prevention and Control Strategy

Infection Prevention and Control Strategy

2016 -2019

Trust Strategy

The Trust has introduced a framework that takes into account quality, people and sustainability to develop strategies for success. This Infection Prevention and Control strategy is linked to these building blocks and the Trust strategic objectives as detailed below.

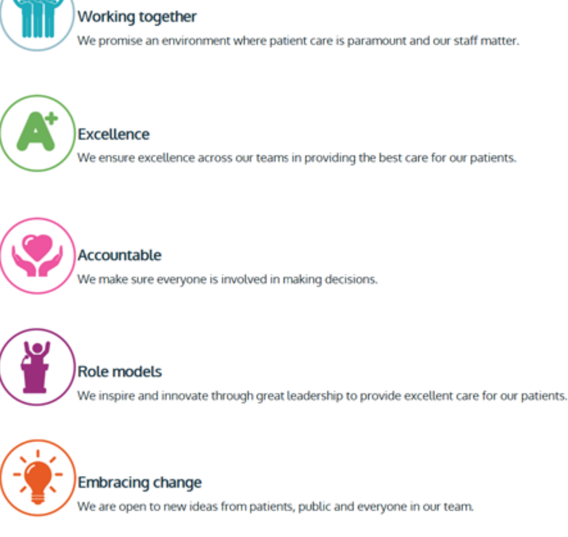
- **Quality**
  - Reduce avoidable harm from preventable healthcare associated infections (HCAIs)
  - Provide a clean and safe environment to improve patients' experiences of the healthcare journey
  - Provide evidence based care
  - Board assurance framework - Care Quality Commission (CQC) compliance for quality
  - 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

- **People**
  - Education of all employees to ensure a competent workforce
  - To have a committed, skilled and highly engaged workforce who feel valued, supported and developed and who work together to care for our patients

- **Sustainability**
  - Compliance with legislation and regulation
  - Board assurance (national and local mandatory operational targets)
  - Liaison with procurement to promote financial viability without compromising quality
  - To deliver well managed, value for money, sustainable services
  - To work with our partners to consolidate and develop sustainable, high quality care as part of a thriving health economy for the future

Trust Values

Warrington and Halton Hospitals NHS Foundation Trust has introduced a set of values and behaviours to shape the delivery of high quality, safe and effective health care for patients. This strategy also takes into account these values.



Infection Prevention and Control Team (IPCT) Values

The Trust recognises that good infection prevention and control is essential to ensure safe care by reducing the risks of acquiring healthcare associated infections to a minimum for patients, staff and visitors.

The IPCT places the patient central to all actions and promotes:-

- high quality care and treatment
- collaborate with all members of our Trust and external partners
- operation within an ethical framework through openness and transparency (Duty of Candour)

Mission Statement

The IPCT mission is to: '***Ensure no patient is harmed by a preventable infection'.***

Infection Prevention and Control Strategy

This strategy has been developed by drawing together existing work streams into an overarching document. This strategy will be reviewed bi-annually to assess progress against **15** key areas.

1. Compliance with legislation/regulation

The CQC judges the Trust on how it complies with the registration requirements for cleanliness and infection control by compliance with the 10 criterion in the *'Code of Practice'* for prevention and control of infections. Table 1 provides information on the current compliance level.

Table 1 – Compliance with the Code of Practice for Prevention of HCAIs

Criterion	***Assessment***
1. Systems to manage and monitor the prevention and control of infection	*Partially compliant*
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections	*Partially compliant*
3. Ensure appropriate antibiotic use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance	*Partially compliant*
4. Provide suitable accurate information on infections to service users and their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion	*Compliant*
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people	*Compliant*
6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection	*Compliant*
7. Provide or secure adequate isolation facilities	*Partially compliant*
8. Secure adequate access to laboratory support as appropriate	*Compliant*
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections	*Compliant*
10. Providers have a system in place to manage the occupational health needs of staff in relation to infection	*Compliant*

❖ ***An Action plan is in place to address areas of partial compliance which is reviewed quarterly***

2. Reduction in avoidable HCAIs

The IPCT members provide a link between the laboratory and clinical teams and provide advice on the appropriate management of patients with known or suspected infections.

The Trust participates in the mandatory:

- enhanced MRSA, MSSA and Escherichia coli bacteraemia and Clostridium difficile infection surveillance scheme
- surgical site infection surveillance - orthopaedic category

❖ **Action plans are in place for the reduction of MSSA/MRSA bacteraemia and Clostridium difficile infection *which are reviewed quarterly***

❖ **A robust process is in place with clinical teams to investigate HCAI incidents and ensure action plans are completed to promote learning**

3. Hand hygiene

Timely and effective hand hygiene is fundamental to preventing transmission of infections.

❖ **Audits will be carried out to assess compliance with Trust Policy**

❖ **Awareness raising events will be carried out to keep this at the forefront of the IPC agenda**

❖ **A review of hand hygiene signage will be carried out**

4. Surveillance

Surveillance on the mandatory reportable HCAIs is conducted monthly and learning from HCAI incidents is shared by:-

- including findings from incident investigations at infection control training sessions
- reports to Divisional Integrated Governance Groups
- review of reports from high profile nationally reported HCAI incidents and conducting gap analysis against Trust processes

There is a focus of activity on mandatory HCAIs. Attention is required to ensure risks are minimised for other HCAIs.

❖ **A review of IT surveillance systems is in progress to enhance surveillance to improve detection of potential outbreaks (NICE QS 61)**

❖ **A programme of surveillance of surgical site infection is required (NICE QS 49)**

5. Education and training

The IPCT provides education and training by a number of different media. This includes a self-directed e-learning package, taught sessions and single point lessons. Feedback on taught training sessions has been provided and revision to slide layout completed.

A plan is in place to review training methods. This will ensure all learning preference styles are considered

- A workbook will be developed to aid learning

❖ **Peer feedback will be requested from training sessions to drive further improvements and Infection Prevention and Control Nurses (IPCNs) will undertake reflection for revalidation purposes**

6. Policies and guidelines

A number of policies and guidelines are in place, as specified by the *Code of Practice* to guide staff on management of patients with known or suspected infections. Some of the policy documents are beyond their review date.

- ❖ **A policy recovery plan is in place to ensure all documents are updated in line with current formatting requirements**

7. Audit

A proactive programme of audit for all ward and departments is in place to assess compliance with infection prevention and control policies, guidelines and Standard Operating Procedures. Managers are asked to complete action plans to address any areas of non-compliance. Additional audits will be undertaken in response to any HCAI incidents/identified clusters of infection.

- ❖ **Progress against the audit programme and action plans will be monitored monthly**

8. Antimicrobial stewardship

The Trust has an Antimicrobial Stewardship Group and has appointed a full time Antibiotics Pharmacist. Work is in place to meet the national Commissioning for Quality and Innovation (CQUIN) for empirical review of antimicrobial treatments and reduction in antibiotic consumption.

- ❖ **Membership of the Antimicrobial Stewardship group is under review following departure of Consultant members**
- ❖ **Discussion is required with the CCG on the reduction in consumption of the main antibiotic used to treat sepsis**
- ❖ **Work is required to meet the requirements of Criterion 3 of the '*Code of Practice*'**
- ❖ **Participation in national antibiotic awareness raising events including education of the public**

9. Clean and safe environment

The cleaning service is provided in-house. Concerns exist in relation to standards of environmental cleanliness and decontamination following known high risk infections. The Trust has a robust programme of inspections and a process in place to feedback findings for action.

- ❖ **Compliance with the current PAS specification for hospital cleanliness will be achieved**
- ❖ **Annual PLACE assessment will be conducted and an action plan generated to address findings**
- ❖ **A bid will be placed for purchase of hydrogen peroxide environmental decontamination equipment**
- ❖ **The Environment Group will be strengthened by Matron level engagement and will review roles and responsibilities for cleaning (Matrons Charter)**
- ❖ **The Decontamination and Water Safety Groups will meet Quarterly and activity will be monitored by the ICSC**

10. Access to isolation facilities

The IPCNs work closely with the Patient Flow Team to optimise side room use. There are competing priorities for these scarce resources.

- ❖ **Audit available isolation facilities**
- ❖ **Work with clinical teams to recover facilities in use as offices**
- ❖ **Continue to work with the Patient Flow Team to prioritise access**

11. Recognition and management of risks

Risks are added to the risk register as they are identified. Actions are in place to address identified risks.

The IPCNs will contribute to responses to complaints, litigation and freedom of information requests as requested.

- **Review Risk Register monthly**

12. Stakeholder engagement and feedback

We actively welcome suggestions to improve our processes to ensure the safety of patients, staff and visitors.

- **360^0 feedback on the IPC service provision**
- **Benchmarking/peer review with other Trusts**
- **Patients will be invited to participate in IPC audits in addition to PLACE assessments**
- **Review of the current IPCT structure will be carried out**

13. Embedding infection prevention and control at all levels of the organisation

Good management and organisational processes are crucial to ensure that excellent standards of infection prevention and control are maintained as part of everyday practice. This requires commitment and active involvement of all employees. It is everyone's responsibility to report and respond to any concern or issue with regards to infection, prevent and control.

- **Addition of an IPC objective to all staff PDRs** (NICE QS113)

14. Trust Board appraisal of infection prevention and control

The Trust Board will be well informed of IPC issues.

- **Monthly high level briefing reports to the Quality Committee**
- **Biannual reports to Trust Board**
- **DIPC Annual report/account of IPC activity**
- **Non-executive and Executive Directors will be invited to participate in walkabouts to review environmental standards of cleanliness**

15. Monitoring and communication of the strategy

The strategy will be monitored by the ICSC bi-annually. Progress updates will be provided to the Quality Committee and the Trust Board (bi-annually). An account of the whole year's activity will be provided by an annual report submitted to the Trust Board.

It is vital that the infection prevention and control process is communicated and embedded throughout the organisation. The IPCT will link with the communication department to ensure key messages are shared with relevant stakeholders. This will include external reporting via the quality contract meeting and internally by existing Trust communication channels.

References

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NICE (2013) Surgical site infection Quality Standard (QS49) https://www.nice.org.uk/guidance/qs49

NICE (2014) Infection prevention and control Quality Standard (QS 61)
https://www.nice.org.uk/guidance/qs61?unlid=150625743201536104842

NICE (2016) Healthcare-associated infections Quality Standard (QS113)
https://www.nice.org.uk/guidance/qs113

BOARD OF DIRECTORS

AGENDA REFERENCE:	BM/18/09/87 b
SUBJECT:	**Infection Prevention and Control**
DATE OF MEETING:	**26 September 2018**
ACTION REQUIRED	**For information and assurance**
AUTHOR(S):	Lesley McKay Associate Chief Nurse and Associate Director of Infection Prevention and Control
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse/ DIPC
LINK TO STRATEGIC OBJECTIVES:	SO1: To ensure that all care is rated amongst the top quartile in the North West of England for patient safety, clinical outcomes and patient experience
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	BAF1.1: CQC Compliance for Quality BAF1.3: National & Local Mandatory, Operational Targets
STRATEGIC CONTEXT	Healthcare associated infection is one of a number of metrics used to measure Trust performance.
EXECUTIVE SUMMARY (KEY ISSUES):	This report provides a summary of infection control activity for Quarter 1(Q1) of the 2018/19 financial year (FY) and highlights the Trust's progress against infection prevention and control key performance indicators. • 7 C. difficile cases in Q1 – all cases were considered unavoidable by the CCG review panel • 1 MRSA bacteraemia case – considered avoidable. The patient likely had this bloodstream infection prior to admission and sampling opportunity was missed in AED • 7 MSSA bacteraemia cases – 3 considered avoidable as associated with peripheral cannula management; 1 related to missed sampling opportunity • 12 E. coli bacteraemia cases – the Trust is above trajectory to meet the reduction target set by NHSI for 2021 • Near miss incident - healthcare worker developed chickenpox, whilst working in a high risk area despite vaccination • Decontamination incident in CMTC theatres. Incident meeting held and appropriate action taken • Ward kitchens require improvements to Estate • The IPCT and Critical Care were finalists in the HSJ Patient Safety Awards for work carried out to

	reduce MSSA bacteraemia cases	
RECOMMENDATION:	The Board is asked to note the contents of the report.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee
	Agenda Ref.	QAC/18/09/105
	Date of meeting	4 September 2018
	Summary of Outcome	Noted
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

SUBJECT	Infection Prevention and Control Q1 report 2018/19

1. BACKGROUND/CONTEXT

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

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

The Secretary of State for Health launched an ambition to reduce gram-negative bloodstream infections (GNBSIs) by 50% by March 2021. The initial focus has been on E. coli bloodstream infections as these organisms represent a large portion (55%) of all GNBSIs.

Breach of licence is considered if the Care Quality Commission reports serious concerns about Trust performance or third parties raise concerns about infection outbreaks.

2. KEY ELEMENTS

CLOSTRIDIUM DIFFICILE

The threshold for 2018/19 has reduced to 26 cases.

The Trust reported 19 cases of *Clostridium difficile* in Q1, 7 of which were hospital onset (appendix 1). These cases are under review and will be assessed for lapses in care by the Clinical Commissioning Group (CCG) review panel in August 2018.

BACTERAEMIAS

Meticillin resistant Staphylococcus aureus (MRSA) bacteraemia

One hospital onset MRSA bacteraemia case was reported in April 2018. This was StEIS reported and a comprehensive internal investigation completed. The investigation identified missed opportunities for blood culture sampling in the Accident and Emergency Department. Action is in place to support timely blood culture sampling.

Meticillin sensitive Staphylococcus aureus MSSA bacteraemia

The Trust reported 12 cases of MSSA bacteraemia in Q1, 7 of which were hospital onset (appendix 1). Post infection reviews are in progress to determine areas for care improvement. Findings from 2 incident reviews have identified the root cause to be cannula associated.

The Trust has recently converted to a different cannula supplier and the changeover was supported by a ward based training programme. However a number of concerns have been raised relating to

insertion difficulties. The cannula supplier is returning to the Trust to support an additional programme of training.

Gram negative bacteraemia (GNBSI)

A GNBSI root cause analysis investigation toolkit has been developed and will be implemented in July 2018 to provide more detailed investigation into cases. This will build on the existing surveillance data gathering tool used to determine likely source of these infections. In addition an internal working group is being set up to review findings and determine priorities for action to support the national reduction target.

Collaborative work continues with community partners to support reduction across the Health Economy. Action plans are in place which focuses on similar themes i.e. antimicrobial stewardship, reduction of urinary and respiratory tract infections, hydration, hygiene and education.

E coli bacteraemia

The Trust reported 54 cases of E. coli bacteraemia in Q1, 12 of which were hospital onset cases (appendix 1). The likely primary source for these cases is predominantly urinary tract infection (n=7); followed by respiratory tract infection (n=3); hepatobiliary (n=1) and 1 case with unknown source.

Klebsiella Spp.

The Trust reported 9 cases of Klebsiella spp. bacteraemia in Q1, 2 of which were hospital onset cases (appendix 1). The likely primary sources for these cases were: 1 intravascular device related and 1 urinary tract infection.

Pseudomonas aeruginosa

The Trust reported 6 cases of Pseudomonas aeruginosa bacteraemia in Q1, 3 of which were hospital onset cases (appendix 1). The likely primary sources for these cases were: 2 respiratory tract infection and 1 urinary tract infection.

OUTBREAKS/INCIDENTS/NEW DEVELOPMENTS

Viral Gastroenteritis

During Q1, one ward (Acute Medical Admissions) reported a suspected viral gastroenteritis outbreak. FilmArray testing was carried out and results were negative allowing the bay to be re-opened promptly.

Chickenpox

A case of Chickenpox was identified in a member of staff working in a high risk area (maternity). The staff member was previously identified as non-immune and had received 2 doses of varicella vaccination. On review the member of staff had not worked during the infectious period and no follow-up action (contact tracing) was required.

Workplace Health and Wellbeing do not routinely check serology for varicella immunity following vaccination. This will be implemented for any staff, employed in rotational posts where this involves allocation to high risk areas.

Decontamination

An incident was reported by CMTC theatres concerning a surgical instrument that may have failed a decontamination process. The instrument holds a disposable long needle. The item was returned after sterilisation with the disposable needle in situ. Assurance could not be provided that the instrument was disassembled prior to decontamination. Action in place as part of surgery includes administration of prophylactic antibiotics and flushing with sterile saline, both would reduce the risk of infection. Duty of Candour has been completed with the patient.

The Decontamination Group has been re-established. A baseline audit tool has been developed to review standards of decontamination across the Trust.

SURVEILLANCE SYSTEMS

The Infection Prevention & Control Team is continuing to explore options to improve surveillance using existing IT systems e.g. Lorenzo and the Trust's Laboratory software. To date no solution has been found. This remains a key area of concern to support the early detection of potential outbreaks. This risk is scored at 16 on the infection control risk register.

INFECTION PREVENTION & CONTROL TRAINING

Attendance at infection control training was previously highlighted as a concern (low compliance across a number of areas <60%). Current reported overall compliance is 85% (to end of May 2018). The Infection Prevention and Control Team have provided a number of additional training sessions to support areas with low compliance. Oversight of attendance continues at the Infection Control Sub-Committee meetings to drive further improvements.

Awareness raising events have been carried out including: hand hygiene (May Global Handwashing Day), change to hand sanitiser signage at ward entrances; focus on peripheral cannula care via the Trust Wide Safety Briefing; single point lessons circulated in response to incidents.

Work is progressing to develop an E-Learning package for ANTT and appoint ward/departmental champions.

INFECTION PREVENTION & CONTROL AUDITS

A programme of audit, to demonstrate compliance with infection control policies and guidelines is in place. The programme of audits has gathered momentum following staffing return to baseline numbers. A total of 10 audits were completed in Q1. Findings are shown in table 1.

Concerns regarding ward kitchens have been discussed at the Trust-Wide Operational Infection Prevention and Control Group meetings. A request has been made to review cleaning standards and to include ward kitchen upgrades in the capital programme.

Concerns regarding enteral feeding standards will be added for discussion at the Nutritional steering Group meetings and areas with low scores have been asked to ensure standards are monitored using High Impact Intervention Audit tools.

Liaison is taking place with the Facilities Manager responsible for providing data on Environmental Standards to provide Trust wide feedback.

Table 1: Infection Prevention and Control Audit Results

Ward	A3	A4	A6	A7	A8	B12	C23	CCU	GUM	NNU
Environment	85%	89%	79%	87%	89%	87%	88%	80%	92%	86%
Ward Kitchens	93%	87%	83%	84%	91%	81%	80%	73%	N/A	80%
Handling/Disposal of Linen	84%	100%	94%	94%	94%	94%	100%	89%	100%	89%
Departmental Waste	100%	100%	94%	95%	95%	100%	89%	100%	75%	94%
Safe Handling Disposal of Sharps	88%	96%	91%	100%	100%	96%	100%	88%	91%	92%
Patient Equipment (General)	100%	93%	86%	89%	91%	100%	92%	97%	100%	93%
Patient Equipment (Specialist)	100%	100%	67%	100%	100%	100%	100%	100%	N/A	100%
Personal Protective Equipment	100%	100%	87%	94%	73%	100%	93%	100%	100%	100%
Short Term Catheter Management	100%	88%	88%	94%	94%	100%	100%	100%	n/a	N/A
Enteral Feeding	N/A	82%	N/A	82%	82%	N/A	N/A	N/A	N/A	N/A
Care of Peripheral Intravenous Lines	100%	82%	82%	100%	100%	100%	100%	100%	n/a	91%
Non-Tunnelled Central Venous Catheters	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Isolation Precautions	100%	100%	100%	100%	100%	100%	100%	100%	n/a	N/A
Hand Hygiene	97%	97%	90%	92%	92%	100%	97%	100%	96%	N/A
Overall Compliance	**95%**	**93%**	**87%**	**94%**	**92%**	**97%**	**95%**	**94%**	**93%**	**92%**

ENVIRONMENTAL HYGIENE

The Environment group has merged with the Trust Wide Operational Infection Prevention And Control Group. Meetings are scheduled to take place monthly. A request has been made to review established hours for cleaning in areas reporting concerns about cleanliness standards.

In addition to the audit programme, the Infection Prevention and Control Nurses co-ordinate walkabouts with Matrons and Domestic Supervisors. These short visits are driving further improvements in standards of environmental hygiene.

INFECTION CONTROL POLICIES

The Cleaning Policy has been revised and a policy introduced for Group A Streptococcal Infections. A recovery plan is in place to ensure all policies reviews are completed.

ANTIMICROBIAL STEWARDSHIP

The quarterly point prevalence audit carried out in May showed 90.6% prescribing compliance with the Trust's Antibiotic Formulary. This equates to 16 patients prescribed antibiotics non-compliant with the Trust formulary.

Membership of the Antimicrobial Stewardship Group is under review. Discussion is in progress to introduce CBU medical leads with responsibility for both antimicrobial stewardship and infection control.

The Trust Antibiotic Formulary has been revised. Access to the policy has been improved by addition of an icon to all desktops.

INNOVATION

The Trust was shortlisted for a Health Service Journal award in the Infection Prevention and Control category. The entry related to work carried out with ICU to reduce MSSA bloodstream infections. Although the entry did not win the award, it was a success to be shortlisted for such a prestigious event and be given an opportunity to showcase the work carried out to effectively reduce these infections.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

Work continues to meet the recommendations of the external review of Infection Prevention and Control.

4. IMPACT ON QPS

Q: The reduction in HCAIs demonstrates a positive impact on the care patients receive.

P: Improved attendance at training assists staff in carrying out their duties.

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

5. MEASUREMENTS/EVALUATIONS

Mandatory reporting of healthcare associated infection (HCAI) to the Public Health England data capture system will continue.

The Infection Prevention and Control Team meet fortnightly to monitor cases of HCAI. Action is implemented in response to increased incidences of HCAIs and infection control related incidents.

The Infection Control Sub-Committee meets bi-monthly (6 times per annum) and discusses HCAI surveillance data and learning from HCAI incidents.

6. TRAJECTORIES/OBJECTIVES AGREED

The Clostridium difficile threshold for 2018/19 is 26 cases.

The zero tolerance to avoidable MRSA bacteraemia cases remains in place.

There is a Department of Health ambition to reduce GNBSIs by 50% by 2021.

7. MONITORING/REPORTING ROUTES

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

- Quality and Assurance Committee
- Health and Safety Sub-Committee

- Patient Safety and Clinical Effectiveness Committee

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

Verbal updates are provided to Trust Board monthly.

An annual report is submitted to Trust Board.

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

8. TIMELINES

- 2018/19 Financial Year

9. ASSURANCE COMMITTEE

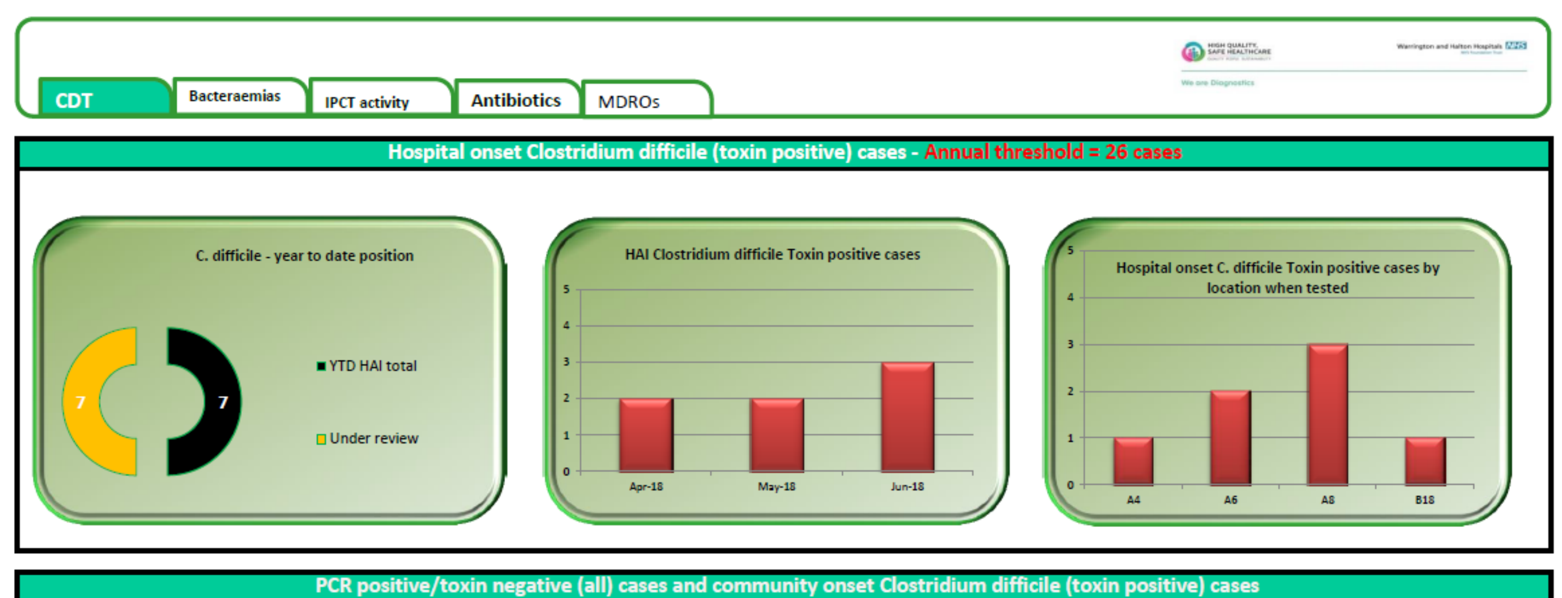
- Infection Control Sub-Committee

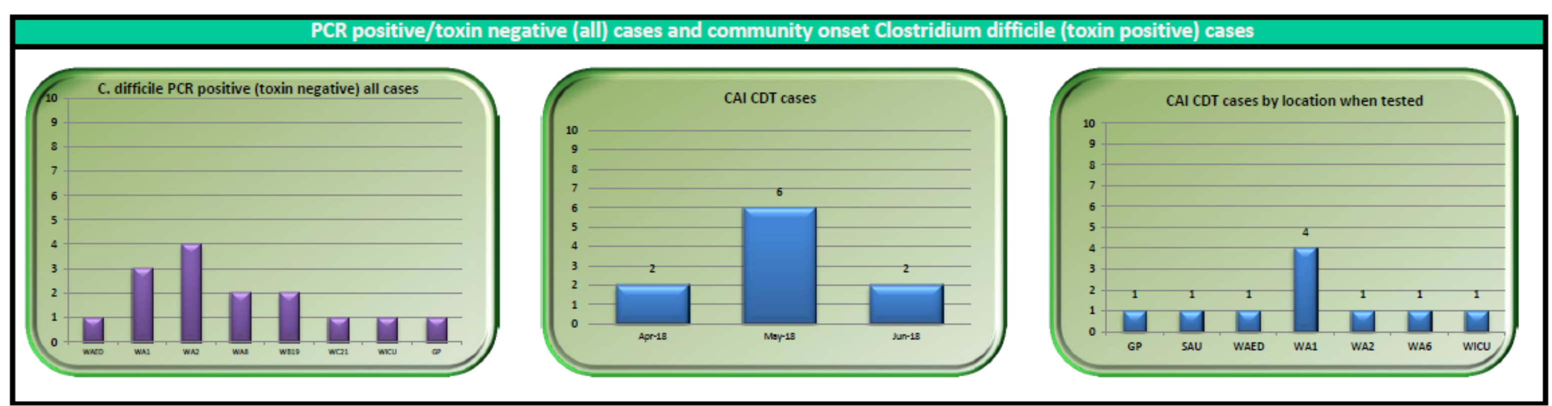
10. RECOMMENDATIONS

Work streams will continue to:-

- Reduce the incidence of Clostridium difficile infection
- Promote Antimicrobial Stewardship
- Partnership working with the Sepsis Nurse to support timely blood culture sampling in AED
- Monitor invasive device management/bacteraemia reduction
- Establish an internal GNBSI reduction group
- Support training in clinical skills for peripheral cannula insertion
- Complete development of the ANTT E-Learning package
- Review infection control surveillance systems
- Support staff training in Infection Prevention and Control
- Promote excellent standards in uniform/workwear
- Review standards for provision of enteral nutrition
- Support assessment of Decontamination standards
- Complete actions set following receipt of the report from the external review including review human resources for the Infection Prevention and Control Team

APPENDIX 1 HEALTHCARE ASSOCIATED INFECTION DATA 2017/18





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CDT | Bacteraemias | IPCT Activity | Antibiotics | MDROs

Hospital onset MRSA bacteraemia data Zero tolerance

MRSA bacteraemia

WA7: 1

MRSA bacteraemia -rolling 12 months

Jul-17, Aug-17, Sep-17, Oct-17, Nov-17, Dec-17, Jan-18, Feb-18, Mar-18, Apr-18, May-18, Jun-18

MSSA bacteraemia data (no thresholds set)

Hospital onset MSSA bacteraemia cases by month

Apr-18, May-18, Jun-18

Hospital onset MSSA bacteraemia by location

WA2, WA4, WA5, WA6, WA9, WICU

MSSA PIR Outcomes

Under Review: 5

Cannula associated: 2

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CDT | Bacteraemias | IPCT Activity | Antibiotics | MDROs

Mandatory GNBSI bacteraemia (total reported)

Mandatory GNBSI - total reported

	E. coli	Klebsiella	P. aeruginosa
Apr-18	17	5	2
May-18	20	2	1
Jun-18	17	2	3

Hospital onset GNBSI cases (all)

Hospital onset GNBSI cases by month

	E. coli	Klebsiella	P. aeruginosa
Apr-18	1	1	1
May-18	6	1	1
Jun-18	5	0	1

Hospital onset E. coli bacteraemia

Hospital onset E. coli bacteraemia

WA2	WA4	WA6	WA7	WA8	WB12	WB14	WC22	WICU
1	1	1	2	2	2	1	1	1

Hospital onset Klebsiella bacteraemia

Hospital onset Klebsiella bacteraemia

WA4	WA6
1	1

Hospital onset Pseudomonas aeruginosa bacteraemia

Hospital onset Pseudomonas aeruginosa bacteraemia

WA5	WB19	WICU
1	1	1

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BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/18/09/88**
SUBJECT:	**CQC Update report**
DATE OF MEETING:	26 September 2018
ACTION REQUIRED	**Review, Discuss and approve**
AUTHOR(S):	Ursula Martin, Director of Governance & Quality
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse
LINK TO STRATEGIC OBJECTIVES:	All
EXECUTIVE SUMMARY (KEY ISSUES):	The following are key issues to highlight within the report: • An update is given regarding progress against the CQC action plan. A significant number of actions have been actioned with 203 actions out of 277 being compliant. • Work continues on the fundamental breaches within the CQC report, with all actions showing progress. A position statement is included within the report.
RECOMMENDATION:	Discuss and note the Report
PREVIOUSLY CONSIDERED BY:	**Committee**: Quality Committee **Date of meeting**: August 2018 **Summary of Outcome**: Quality Committee was assured that progress was being made across the action plan. There was a discussion regarding how assured Quality Committee was that the actions were addressing the issues to ensure the Trust were rated Good.
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None

BOARD OF DIRECTORS

SUBJECT	CQC Update Report	AGENDA REF:	BM/18/09/88

1. BACKGROUND/CONTEXT

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

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

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

2. KEY ELEMENTS

2.1 CQC action plan performance

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

The table below shows the overarching performance as at 19th March 2018

Row Labels	Report completed - Compliant	Report completed - further evidence requested	On Track	Amended date agreed	Action closed- merged with another	Grand Total
However	126	5	4	24	2	161
Must	39	1	5	8		53
Should	38	2	4	19		63
Grand Total	**203**	**8**	**13**	**51**	**2**	**277**

The table above shows that two thirds of our Must Do and Should Do actions are completed and deemed to be compliant. At the most recent Getting to Good, Moving to Outstanding Steering Group, there was consensus that we needed to ensure these actions were expedited. Appendix 1 gives an analysis of Must Do actions that are to be completed.

The following shows compliance at core service level

Row Labels	Amended date agreed	On Track	Report completed - Compliant	Report completed - further evidence requested	Action closed-merged with another	Grand Total
Children and Young People	2		11			13
Critical Care	5	4	31			40
End of Life	2			3		5
Maternity and Gynae	6	4	52	3		65
Medical Care (inc Older People's care)	14	1	27	2	2	46
Outpatients and Diagnostic imaging	7		35			42
Surgery	6	1	24			31
Trustwide	6	2	10			18
Urgent and Emergency Care	3	1	13			17
Grand Total	**51**	**13**	**203**	**8**	**2**	**277**

2.2 Fundamental breach Analysis

Within the Trusts CQC report, there were a number of fundamental breaches listed within the CQC report. Appendix 2 of this report outlines the breaches and position, with actions taken to date. All breaches have actions in place and are being monitored by Executive leads and Getting to Good Workstream.

The position is as follows

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

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RAG status of breaches	Number	Details	To note
RED	2	Regulation 12 – medical devices training Regulation 18 – a) staffing b) APLS training for staff	Regulation 12 – checks in radiology – has moved to Green. Monthly checks remain in place A Trustwide improvement programme in place regarding recording of medical devices training.
AMBER	4	Regulation 11- Consent and Mental Capacity Regulation 12- checks in theatre Halton to prevent Never Events Regulation 15 – premises (radiology, gynae, maternity) Regulation 17 – Governance a) Risk Management b) record keeping c) IG and records being maintained securely	Significant improvement in all areas of these breaches. Awaiting evidence of audits to demonstrate improvement in mental capacity practise and record keeping.
GREEN	3	Regulation 12 – checks of equipment trollies and anaesthetics machines Regulation 13- Safeguarding training Regulation 12 – equipment and checks in radiology	

3 RECOMMENDATIONS

Trust Board are asked to discuss and note the

- CQC action plan progress and update
- The update on Must do actions
- The update on fundamental breaches

Appendix 1 – Analysis of Must Do actions that remain ongoing

Core service	Areas for Review	Actions	Exec Lead	Lead Person	Target date for completion	Target Month for completion	Action Completion Status
Critical Care	The trust must ensure that the formal escalation plan to support staff in managing occupancy levels in critical care is fully implemented.	Ensure that Admission, Discharge and Escalation Policy is audited to show that it is effective	Alex Crowe	Mark Carmichael CBU Manager ABC	31/10/18	Oct	**On Track**
Maternity and Gynae	The hospital must ensure midwifery, nursing and medical support staffing levels and skill mix are sufficient in order for staff to carry out all the tasks required for them to work within their code of practice and meet the needs of the patient. The ward managers and band seven midwives said they did not always have the time to carry out their managerial roles as they were often providing hands on care to patients and were not supernumery on the duty rota.	*Ensure Birth Rate Plus review is undertaken and that a review of staffing models and skill mix is undertaken (ensuring ward managers are supernumerary).* Confirm actions going forward and next steps now Birth Rate Plus has been completed.	Kimberley Salmon-Jamieson	Tracey Cooper Head of Midwifery	30/9/18	Sept	**Amended date agreed**

Core service	Areas for Review	Actions	Exec Lead	Lead Person	Target date for completion	Target Month for completion	Action Completion Status
Maternity and Gynae	The hospital must ensure that the assessment and mitigation of risk and the delivery of safe patient care is in the most appropriate place.	Implementation of MLU Business Case	Kimberley Salmon-Jamieson	Val Doyle CBU Manager Woman's & Children's	30/11/18	Nov	**On Track**
Maternity and Gynae	The hospital must review the impact of the triage system on access and flow and the appropriate assessment of patient safety.	Audit effectiveness of triage system in maternity and gynae. 3 monthly	Kimberley Salmon-Jamieson	Kate Alldred Consultant	30/11/18	Nov	**On Track**
Maternity and Gynae	The hospital must review the safety of the induction bay environment to ensure patient safety is maintained at all times and that the premises are safe to use for the purpose intended.	Ensure a plan is implemented regarding the induction of labour bay following review of the business case	Kimberley Salmon-Jamieson	Val Doyle CBU Manager Woman's & Children's	30/11/18	Nov	**Report completed - further evidence requested**
Maternity and Gynae	The hospital must ensure that all staff receives medical devices training and this is recorded appropriately.	Provide evidence that there is appropriate assurance regarding training in medical devices for staff within maternity and gynae services	Kimberley Salmon-Jamieson	Val Doyle CBU Manager	30/09/18	Sep	**Amended date agreed**

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Core service	Areas for Review	Actions	Exec Lead	Lead Person	Target date for completion	Target Month for completion	Action Completion Status
Maternity and Gynae	Between February 2016 and January 2017, safeguarding (adults) training was completed by 47% of gynaecology nurses in the ward (C20) area. Compliance for gynaecology nurses in the clinic areas was 57%. Medical staff compliance rate was 71%. This was below the trust set a target of 85%.	Ensure that compliance with safeguarding training in Maternity and gynae services is in line with Trust requirements	Kimberley Salmon-Jamieson	Tracey Cooper Head of Midwifery Mustafa Sadiq Clinical Lead Obstetrics	30/09/18	Sep	**Amended date agreed**
Outpatients and Diagnostic imaging	Some rooms were being used both as consulting rooms and treatment rooms; we saw there were no routine infection control procedures followed for cleaning rooms and wiping down treatment couches in between patients in these cases. The trust must ensure all appropriate infection control measures, including	Ensure that there is a review of rooms in outpatients and a Standard Operating Procedure is in place Ensure that infection control processes are being adhered to between patients.	Chris Evans	Jenni Delea CBU Manager Outpatients	30/9/18	Sep	**Amended date agreed**

Core service	Areas for Review	Actions	Exec Lead	Lead Person	Target date for completion	Target Month for completion	Action Completion Status
	environmental cleaning, are observed in all diagnostic and treatment areas, with consistent records						
Trustwide	The trust must ensure that staff receive training on the Mental Capacity Act (2005) and that staff work in accordance with The Act.	Ensure there is an audit undertaken regarding Mental Capacity Act to assess the effectiveness of the training.	Kimberley Salmon-Jamieson	Wendy Turner Lead Nurse Adult Safeguarding	30/09/18	Sep	**Amended date agreed**
Trustwide	The trust must ensure that staff receive training on the Mental Capacity Act (2005) and that staff work in accordance with The Act.	Ensure all staff achieve mandatory training in mental Capacity	Kimberley Salmon-Jamieson	Lead Nurses/CDs CBUs	30/09/18	Sep	**Amended date agreed**
Trustwide	The trust must ensure that staff receive the appropriate level of safeguarding training.	Ensure there are trajectories in place in all areas to ensure full compliance with training on Safeguarding	Kimberley Salmon-Jamieson	John Goodenough	30/09/18	Sep	**Amended date agreed**

Core service	Areas for Review	Actions	Exec Lead	Lead Person	Target date for completion	Target Month for completion	Action Completion Status
Trustwide	The trust must ensure that there are appropriate numbers of staff available to match the dependency of patients on all occasions. The trust must ensure staffing levels are maintained in accordance with national professional standards across wards and theatres.	Repeat the staffing escalation plan audit	Kimberley Salmon-Jamieson	John Goodenough Deputy Chief Nurse/ Rachel Browning Associate Chief Nurse	30/09/18	Sep	**On Track**
Trustwide	The hospital must ensure all necessary staff completes mandatory training	Ensure that all areas of the Trust achieve mandatory training compliance targets.	Michelle Cloney	CBU Managers	30/09/18	Sep	**Amended date agreed**
Urgent and Emergency Care	Reasonable adjustments should be made for appropriate patients including those with a learning disability.	Ensure there is an audit of effectiveness for making reasonable adjustments for patients with a Learning Disability in urgent and emergency care services, following implementation of guidelines and training. Audit within 6 months.	Simon Constable	John Goodenough Deputy Chief Nurse	30/09/18	Sep	**On Track**

Appendix 2 – Fundamental Breach Action Updates

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

Fundamental breach	Action/Progress	Executive Lead	RAG Assessment- May 2018
Regulation 11- Consent and Mental Capacity	Action was put in place at the time of the CQC assessment and after, regarding training and increased surveillance. An audit of MCA and consent is being presented to G2G Steering Group April 2018 to assess current compliance Update May 2018 – audit undertaken December 2017, which showed poor compliance in some areas. Training is being rolled out - Trust still has training gaps, which are being addressed. Spot check audits to be undertaken as part of nursing walkrounds – a further Trustwide audit being undertaken – which is reporting to Getting to Good meeting July 2018 Update June 2018 – audit being presented to G2G meeting August 2018. Training compliance improving Update September 2018 – the Trust re-audit has been completed following the extensive training put in place. This is being discussed at September safeguarding Committee and Getting to Good Steering Group in September. Data is consistent with an overall improvement.	Chief Nurse	
Regulation 12 – medical	A medical devices training database has been purchased, inventories and training needs analysis are underway. Trust Medical Devices Policy has	Chief Nurse	

Fundamental breach	Action/Progress	Executive Lead	RAG Assessment- May 2018
devices training	been approved. Update on paediatrics medical devices to be given to April G2G Steering Group Update May 2018 - this is a Trust wide issue and a workstream is in place. A risk has been escalated to Board re this via Strategic Risk Register. Action plan in place- starting to be implemented. June 2018 – action ongoing. Work commenced regarding inventories, competency assessments and recording training. September 2018 – Significant work is underway with the medical devices improvement plan in situ. Whilst work is underway this remains red as we currently do not have a system that can demonstrate compliance with medical devices training. It is anticipated that this will be in place in		
Regulation 12- checks in theatre Halton to prevent Never Events	We have implemented training, observational audits and are now auditing 100% of WHO checklist completion every month. We are also completing an assurance framework against the new Never Events list published to look at our policies and controls in place. This is being presented to PSESC March 18. Update May 2018– NatSSIPs/LocSSIPS being presented to May Patient Safety and Effectiveness Sub Committee. This is amber/green	Medical Director	

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Fundamental breach	Action/Progress	Executive Lead	RAG Assessment- May 2018
	June 2018 – MIAA audit commenced and LocSSIPs work continuing. September 2018 – MIAA audit to report and following this we can review the assessment of compliance.		
Regulation 12 – checks of equipment trollies and anaesthetics machines	Additional controls were put in place at the time of the inspection and audits are being undertaken – presented at April Getting to Good meeting Update May 2018. Green in theatres (6 months' worth of evidence given, showing 100% compliance) Maternity not showing 100% compliance – increased scrutiny and oversight at Getting to Good meeting June 2018 – maternity agreed as compliant	Chief Nurse	
Regulation 12 – equipment and checks in radiology	1. CR reader in Halton – resolved 2. IRR99 compliance – audit presented at G2G Steering Group March 2018 showing 97% compliance (significant improvement) – not closed as not 100% compliant – further audits being undertaken 3. Ultrasound machines in radiology – resolved Update May 2018 – 1 radiation safety breaches still not 100% compliant	Chief Operating Officer Medical Director (radiation safety	

Fundamental breach	Action/Progress	Executive Lead	RAG Assessment- May 2018
	(warning lights). Other 5 breaches- audits show 100%. Increased scrutiny and oversight at Getting to Good meeting – update to be given at G2G meeting June 2018. June 2018 – Significant improvement in compliance. 1 breach in place re handover forms. Being re-audited and presented to August G2G meeting. Is Red/Amber September 2018 – at the August Getting to Good assurance meeting, the service lead gave assurance that the Trust was fully compliant with the regulation checks highlighted within the CQC report. Monthly checks remain in situ but this has moved from Red to Green since the last update.	lead)	
Regulation 13- Safeguarding training	A review of safeguarding training has been undertaken, with each CBU to report to April G2G meeting a trajectory for compliance Additional training capacity being commissioned Update May 2018 – training compliance showing improvement – need to assess where requires further improvement work. CBUs have been asked to report performance and improvement trajectories to Workforce Committee and to getting to Good Steering Group monthly.	Chief Nurse	

We are WHH

Fundamental breach	Action/Progress	Executive Lead	RAG Assessment- May 2018
	June 2108- Significant improvement – some areas to be yet compliant. September 2108- Further improvement – the Trust is green across all areas of safeguarding training as reported at the previous Getting to Good meeting in August 2018. This has moved from Amber to Green since the last update.		
Regulation 15 – premises (radiology, gynae, maternity)	A review and options appraisal is underway regarding maternity and gynae. Radiology review is also underway. Halton – actions taken at the time and audit reports being presented to Getting to Good Steering Group in April to ensure sustainable actions in place • Treatment couches were not wiped down in between patients in outpatient treatment rooms. • Portable x-ray equipment was found to be covered in a thick layer of dust. • Both phlebotomy chairs in outpatients were broken: one had cracked covering on the armrests and the other had a large tear in the seat covering. • Clinic areas were congested and there was inadequate seating for some areas, with patients needing to stand in corridors whilst waiting. Update May 2018 – need to review environmental work and determine preferred options and mitigations for Induction of Labour and Radiology.	Chief Operating Officer	

We are
WHH

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

Fundamental breach	Action/Progress	Executive Lead	RAG Assessment- May 2018
	preferred option following discussion with nursing team. Need to have training/awareness campaign re information governance, which has been requested by Getting to Good Steering Group. Need to undertake a clinical audit regarding records - storage audit component undertaken. Information governance is amber/red. June 2018 – clinical audit commenced on information governance. September 2018 – this remains amber. Recent CBU changes will have an impact of governance processes and structure at service level – this will be in place by the next update to the Board. In addition a meeting has been convened to assess progress with the information governance breach, following a report received at Quality Committee.		
Regulation 18 – a) staffing b) APLS training for staff	a) Staffing - Acuity and dependency review been undertaken and business case being presented to the Board of Directors for nurse staffing Medical staffing meeting and actions implemented Audit of staffing escalation underway The neonatal unit did not have sufficient numbers of suitably qualified staff. There was no dedicated paediatric pharmacist. A review of neonatal staffing	Chief Nurse/Medical Director	

Fundamental breach	Action/Progress	Executive Lead	RAG Assessment- May 2018
	underway. Paediatric pharmacy provision addressed. b) APLS training – additional capacity for APLS training in paediatrics and critical care and recovery in theatres. An update being presented to April G2G Steering Group Update May 2018 – nurse staffing business case approved – need evidence of implementation plan. Staffing escalation processes have been audited and a survey undertaken- awaiting report, which is being presented to Getting to Good Steering Group in June 2018. Report provided of actions taken to improve medical staffing- need further evidence of effectiveness. Re APLS – clarification of standards raised to CQC as there is some confusion as to the standards assessed. CBUs have been asked to report performance and improvement trajectories to Workforce Committee and to getting to Good Steering Group monthly. June 2018- plans in place for resus training – clarification of training with CQC will take place 11th July.		

Fundamental breach	Action/Progress	Executive Lead	RAG Assessment- May 2018
	Nurse staffing business case – plans in place to implement at every ward level Medical staffing report provided – further evidence required. September 2018 – this remains red rated due to resuscitation training in the Trust and compliance levels.		

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/18/09/89**	
SUBJECT:	Safeguarding Children Annual Report	
DATE OF MEETING:	26th September 2018	
ACTION REQUIRED	The Board of Directors are asked to accept the Safeguarding Children Annual Report and provide challenge where required.	
AUTHOR(S):	John Goodenough, Deputy Chief Nurse	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse	
LINK TO STRATEGIC OBJECTIVES:	All	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	BAF1.1: CQC Compliance for Quality	
	BAF1.3: National & Local Mandatory, Operational Targets	
	BAF2.5: Right People, Right Skills in Workforce	
STRATEGIC CONTEXT	The annual report provides an overview of the safeguarding children activity from across the trust. The report provides assurance that the trust is compliant with section 11 of the Children Act and the government guidance, Working together to Safeguarding Children 2015.	
EXECUTIVE SUMMARY (KEY ISSUES):	The following item contains the Safeguarding Children Annual Report. The safeguarding children annual report builds upon the bi-annual report which was submitted earlier in the year. The report details the outcomes from the objectives set the previous year; safeguarding activity across the trust and the new objectives set for 2018/2019.	
RECOMMENDATION:	Trust Board are asked to receive the Safeguarding Children Annual Report and support the objectives set for 2018/2019.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality + Assurance Committee
	Agenda Ref.	QAC/18/09/103
	Date of meeting	4th September 2018
	Summary of Outcome	Annual report accepted subject to one amendment. The report has been amended and is ready to submit to the Trust Board.
FREEDOM OF INFORMATION	Release Document in Full	

STATUS (FOIA):	
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None

Safeguarding Children Annual Report 2017/2018

Katie Clarke - Named Nurse Safeguarding Children.

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Introduction

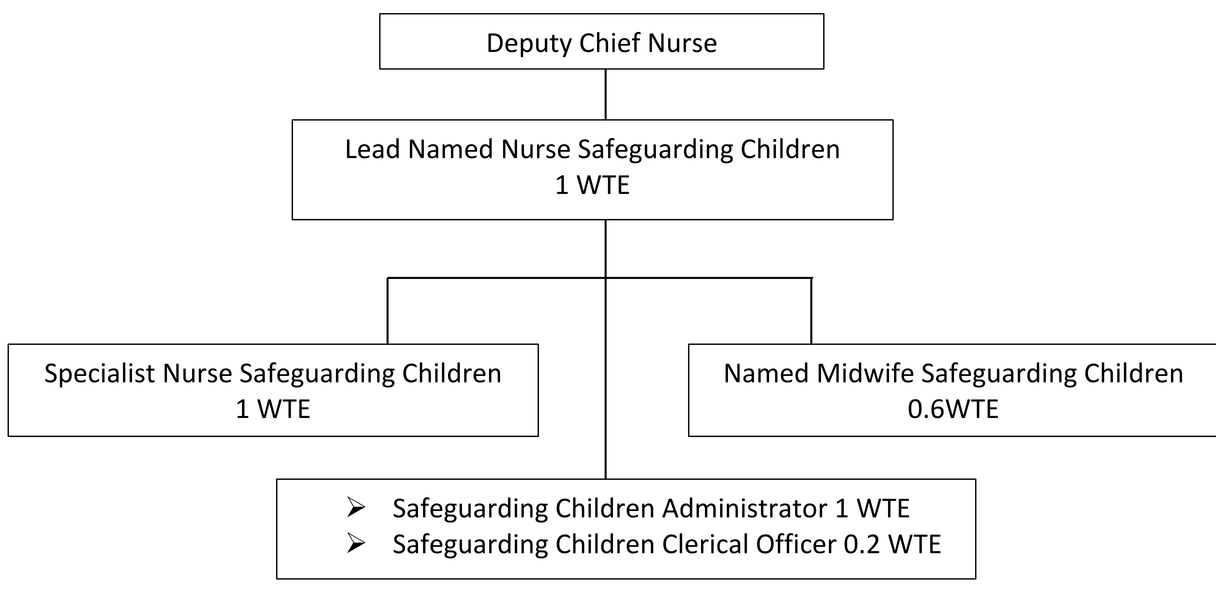
This is the 14th annual report on Safeguarding Children activity within Warrington and Halton Hospitals NHS Foundation Trust (WHHFT). Safeguarding is a core part of our business and a CQC standard. This report gives assurance to the Local Safeguarding Children Boards, Commissioners and the Trust board that the Trust is meeting its obligations to safeguard children.

We don't know exactly how many children in the UK are victims of child abuse. Child abuse is usually hidden from view and children may be too young, too scared or too ashamed to tell anyone about what is happening to them, (NSPCC 2017). The most recent statistic from 2016 suggests there are over 58,000 children identified as needing protection from abuse in the UK and it is estimated that for every child identified as needing protection from abuse, another 8 are suffering abuse. The Department for Education is responsible for child protection in England. It sets out policy, legislation and statutory guidance on how the child protection system should work.

At the local level Local safeguarding children boards (LSCBs) co-ordinate, and ensure the effectiveness of, work to protect and promote the welfare of children. Each local board includes: local authorities, health bodies, the police and others, including the voluntary and independent sectors. The LSCBs are responsible for local child protection policy, procedure and training. All Warrington and Halton Hospitals NHS Foundation Trust employees must be aware of their shared responsibility to safeguard children. This may be when the child or young person is a patient themselves, unborn, a visitor, a patient's child or presenting to an adult service.

The Trust aims to be proactive in fulfilling its Safeguarding function. Effective safeguarding requires robust recruitment and vetting processes for staff and, enough well trained competent staff to identify potential safeguarding situations to enable services to be provided while the child or young person is 'in need' (under Section 17 of the Children act, 1989) or at 'Family support' level (known as Early Help) ideally before the child becomes a 'Child at Risk' (under section 47 of the Children Act).

Safeguarding Children Team Structure



Review of 2017/2018 Objectives

Objective	Outcome	
Safeguarding Children Supervision to be embedded across the trust	Achieved	The Safeguarding Children Supervision Policy was ratified and launched in May. Monthly group sessions are available for all trust staff, currently these sessions are well attended by paediatric and Emergency Care staff. One to one supervision is being accessed by community midwives and specialist paediatric nurses.
Increase awareness of CSE, resulting in increased pre-screening tools completed.	Achieved	CSE screening tools have increased. Analysis of data is captured later in the report
Training compliance to remain above 85% across all levels	Partially achieved	Unfortunately training compliance has fallen below the 85% expected standard. Areas of low compliance have been targeted and compliance is expected to increase.
Develop a joint DNA policy with Bridgewater NHS Health Care	Partially achieved	The policy has been written by WHHFT however it is not yet accepted by Bridgewater NHS.
Strengthen WHHFT relationship with multi-agency partners	Achieved	Achieved - Through training and peer review, multi-agency relationships appears to have been strengthened.
Continue to raise awareness around domestic abuse, increasing the number of referrals.	Partially achieved	Training across the trust has increased, however the number of referrals has decreased. See domestic abuse section within this report

External and Internal Assurance

Hospital CQC inspection

The Trust was inspected by the CQC in March 2017 with an overall grading of requires improvement.
With regards to Safeguarding Children a number of recommendations were made:

- The hospital must ensure that staff receives the appropriate level of safeguarding training, including Safeguarding level 3.
- The hospital should ensure that the mandatory and safeguarding training rates are monitored for medical staff.

Following the inspection the training programme was reviewed and updated to ensure the above recommendations were actioned. A new internal level 3 programme was implemented. Initial feedback from the sessions has been positive and a new programme for 2018/2019 has been developed and is currently being rolled out.

Although the inspection identified some areas for improvement, it also identified some positive work:

"In discussion with us, it was clear that staff were aware of their roles and responsibilities and knew how to raise matters of concern appropriately"

"Staff we spoke with were aware of the safeguarding team and how to access support and advice"

"We observed good safeguarding practice within the maternity service. Compliance rates for nursing and midwifery staff were above the trust target rate"

"We reviewed records and attended a multidisciplinary meeting regarding a patient with special needs. All necessary steps were taken to ensure the patients' mental capacity was assessed and that the patient understood her rights. There was a good trigger plan completed in the records and staff had adhered to these. We observed good input from the safeguarding lead."

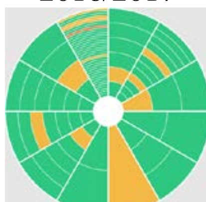
Section 11 Audit

Section 11 (s.11) of the Children Act (2004) places a number of duties on a range of organisations and individuals to ensure that when they go about their day to day business, they do so in a way that takes into account the need to safeguard and promote the welfare of children. It is important to remember that s.11 does not give organisations any new or additional functions, nor does it override their existing functions. Rather, it outlines the need to have in place safe systems and safe processes; for example by ensuring safe recruitment of staff, by providing appropriate training and by having up to date policies which all staff know how to access.

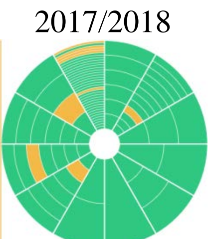
Key agencies such as WHHFT are expected to provide information on arrangements that are in place on a three yearly basis (or as appropriate) using the self-assessment audit tool on the electronic template commissioned by the virtual college. The self-assessment tool was last scrutinised in January 2016 however the Named Nurse for Safeguarding Children reviews the action plan on quarterly basis updating evidence and the action plan where necessary.

Overall the trust is 100% complete and is graded at Level 3 – 98% compliant. This is an increase of 3% on the previous year's figure. The action plan is generated through the electronic system and where there are any issues with completing the action this will be escalated through safeguarding committee.

Section 11 completion



2017/2018



The above charts demonstrate the increase in grade 4 compliance. The below table explains the changes made and details the work undertaken to achieve these changes.

Section	Grade 2016/2017	Grade 2017/2018	Analysis of current position and action needed to improve.
11.1	Grade 3 - 96 %	Grade 4 - 100 %	This grade has increased due to: • increased visibility of the safeguarding Children Team. A survey monkey was circulated and of the 100 responses, 92 people were aware of the team and knew who to contact for support and guidance. • Increased awareness of CSE • Increase awareness of the Early Help Agenda
11.2	Grade 3 - 96 %	Grade 3 - 98 %	Recent hospital CQC inspection identified that staff were aware of their responsibilities in relation to safeguarding children, therefore the grading has increased slightly. 11.2.9 – 'The organisation has an effective allegation policies and systems in pace for professionals and services users, which is compatible with LSCB Procedure and Guidance' is currently graded at level 3 – 75%. Although a new policy has been developed, the policy has only recently been ratified and therefore it will take time to evidence that the policy has been embedded and forms wider part of our culture.
11.3	Grade 3 - 92 %	Grade 4 - 100 %	This grade has increased due to: • Implementation of the safeguarding children supervision policy. • Staff engagement with the supervision process.
11.4	Grade 4 - 100 %	Grade 4 - 100 %	Grade remains the same
11.5	Grade 4 - 100 %	Grade 4 - 100 %	Grade remains the same
11.6	Grade 3 - 75 %	Grade 4 - 100 %	This grade has increased due to: • Reviewed and updated internal paperwork to capture the children's / families wishes and opinions.
11.7	Grade 4 - 100 %	Grade 4 - 100 %	Grade remains the same
11.8	Grade 3 - 96 %	Grade 3 - 96 %	In order for the trust to be 100% compliant, all trust staff must be trained in e safety working practices. WHHFT do not record the number of staff training in this specific subject however it does form part of basic safeguarding training accessed by e-learning. WHHFT focus for training this year has been developed using lessons learnt from case reviews. 2018/2019 training programme will include a session on e-safety and professional boundaries.
11.9	Grade 3 - 96 %	Grade 3 - 96 %	Grade remains the same. A meeting has been scheduled with HR to review this section and re-grade if necessary.
11.10	Grade 4 - 100 %	Grade 4 - 100 %	Grade remains the same
11.11	Grade 3 - 94 %	Grade 3 - 94 %	To increase the grade to 4 the trust need to evidence that they evaluate outcomes from the perspective of the child or young person. A children's forum is being developed which will feed in to this standard once embedded.
11.12	Grade 4 - 100 %	Grade 3 - 97 %	The grading has changed from level 4 to level 3 due to the MCA lead for the trust not having protected study time to keep their knowledge up to date. The MCA lead has changed and this now sits within the safeguarding Adults team agenda.

Key Performance Indicators (KPIs)

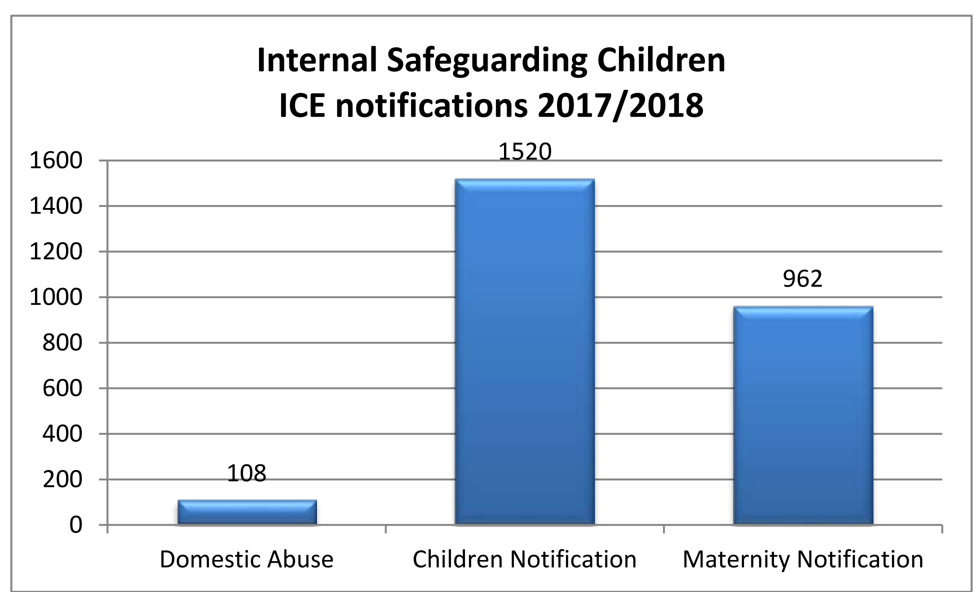
Quarterly key performance indicators are completed and submitted to the designated nurses. The Named Nurse meets with Warrington CCG Designated nurse every 8 weeks for planned supervision. Additional to the supervision the KPIs are reviewed and assurance is provided. An exception report is provided alongside the KPI's. Please see appendix A for detailed list of data requested as part of the KPIs. For 2018/2019 the KPIs have been reviewed and updated.

Safeguarding Activity

Referrals

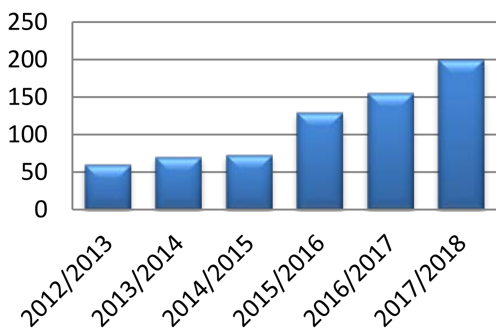
Internal referrals / Notifications

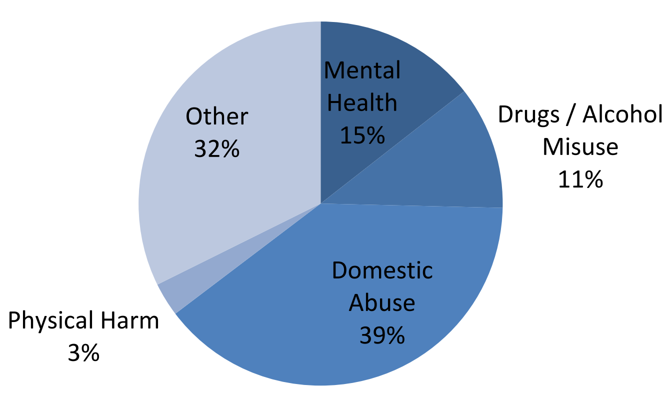
2017/2018 there was a total on 2590 electronic ICE notifications completed asking for further advice from or sharing information with the Safeguarding Children Team. This is a steady increase of 7% from 2423 in 2016/2017. The number of internal notifications has continued to increase year on year. Since the introduction of this process in 2011 there has been a 75% increase in staff utilising the electronic system. This number does not include face to face, telephone or email contacts. The spread of categories remains static with the main reason for contact being on children's notification. The maternity notifications have increased by 20% (167 notifications). The increased notifications have put added pressure on the Named Midwife who only works 3 days per week.



Children's Social Care (CSC) Referrals

The number of referrals to CSC have increased year on year. 2017/2018 saw an increase of 29% (45 referrals) on the previous year. This is a significant increase and it could be suggested that the increase in internal training opportunities has accounted for this. Staff from across WHHFT are recognising children and young people who are vulnerable and at risk resulting in appropriate referrals to external agencies.





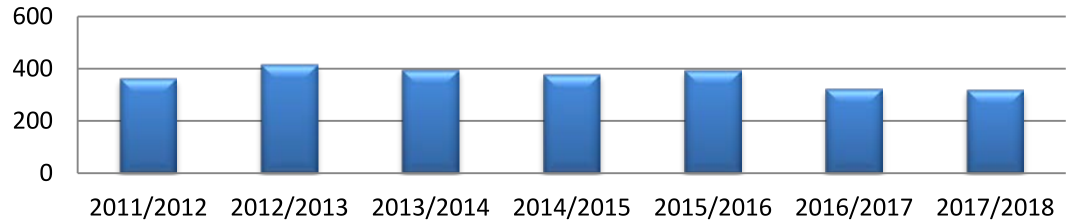
The reasons for referrals have seen a significant increase under the category of 'other'. Previous year was 15% of the referrals. On further review of the data it has been identified that 38 referrals under the category of 'other' have been made due to children not being brought to essential health appointments. Close collaboration between the safeguarding children team and the Ophthalmology / orthoptic teams has contributed to this increase. It is extremely positive that professionals are now recognising that missed health appointments is an indicator or neglect and a multi-agency approach to tackling this issue is required.

Physical harm referrals have reduced from 13 referrals to 6 referrals. This does not reflect the number of child protection medicals completed. The referrals recorded are specifically cases of physical abuse identified by the hospital and not the number of cases where the hospital has been involved with the care.

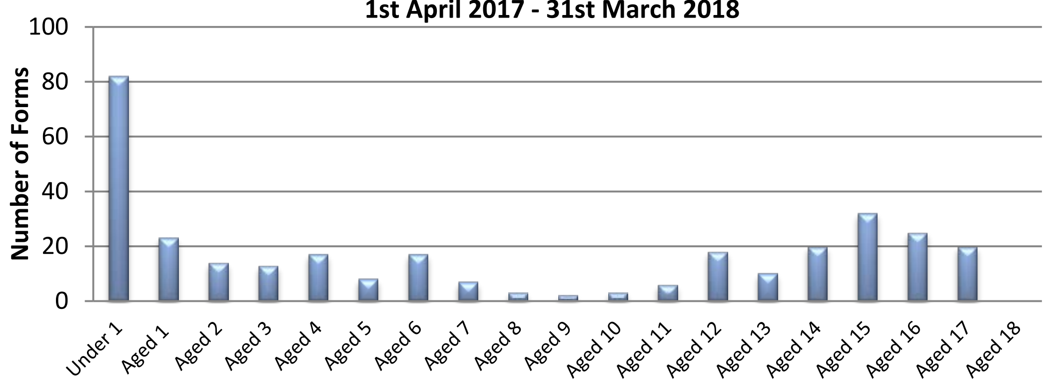
Safeguarding Children Care Pathway

The hospital safeguarding children concerns form was introduced in 2002/3 to monitor compliance with the national standards and to give a measure of performance against Laming recommendations.

The 'Concerns form' is used in the trust to highlight safeguarding children concerns. The form ensure staff are alerted to issues identified for a child and what action plans are in place or completed, It contains a minimum data set for children that have been identified as 'potentially' requiring some level of 'Safeguarding'.
The numbers of concerns forms have remained consistent throughout the years ranging from 300-400. 320 forms were commenced in 2017/2018 which is static on the previous year's figures.



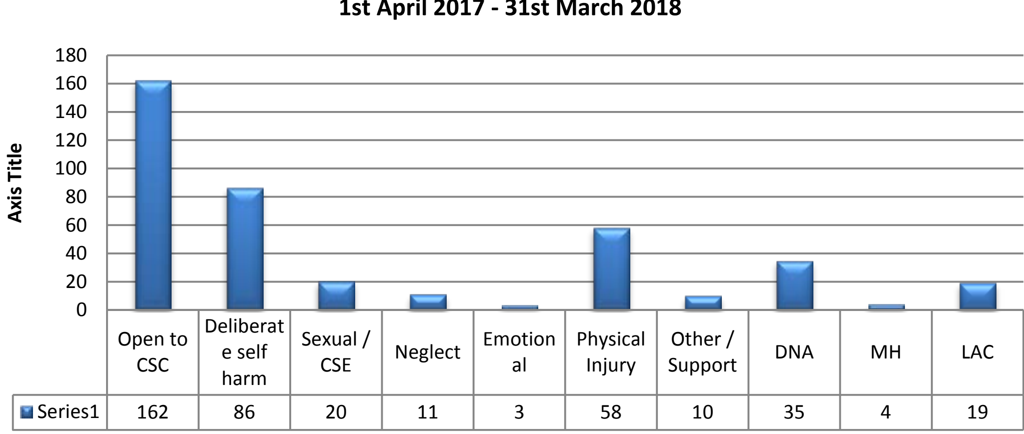
Concerns forms raised versus age of child.
1st April 2017 - 31st March 2018



Similar to previous years there are peaks in the under 1's and over 13 year olds. Analysis of the data identified that 13-18 years old were predominately commenced on concerns forms due to deliberate self-harm. The most common reason for commencing the concerns forms on babies under 1 year old was due to already having an allocated social worker on admission. The number of concerns form commenced due to physical abuse demonstrates how vulnerable this group of children are. Under 2 years old – 30% of concerns forms

commenced due to concerns relating to a physical injury.

An increase of concerns forms commenced on 15 year olds has been evident this year. 63% of the forms were started due to the 15 years attending with some form of deliberate self-harm. The majority of these teenagers will require admission to paediatrics, medical treatment and intervention from the CAMHS (Child Adolescent Mental Health Service). This increase will undoubtedly cause added pressure to the paediatric wards due to time and care required to provide the best service possible for these young people. Listening to these young people requires patience and understanding. Multi-agency working is vital to ensure the young person is provided with the best possible outcome.

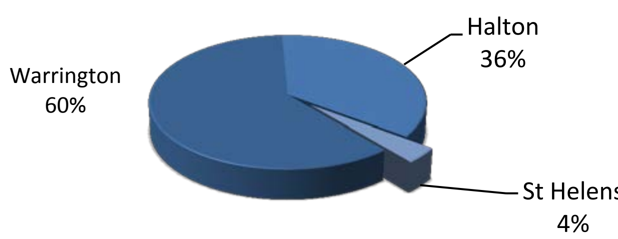


	Open to CSC	Deliberate self harm	Sexual / CSE	Neglect	Emotional	Physical Injury	Other / Support	DNA	MH	LAC
Series1	162	86	20	11	3	58	10	35	4	19

Despite the significant increase in referrals made to CSC regarding children not being brought to medical appointments (DNA), this is not reflected in the number of concerns forms comenced for the same reason. The hospital policy advises practitioners to commence a concerns form when a child has missed three consecutive appointments. It would appear that this practice is not being adhered too and therefore further training is required. An audit of this process has been completed and the findings are shared under the Audit section of this report.

Child Protection Medical

A child protection medical (CPM) assessment should always be considered when there is a suspicion of, or a disclosure of, child abuse and/or neglect involving injury, suspected sexual abuse or serious neglect. The need to consider a medical assessment in these cases arises from section 47 of the Children Act 1989 (and 2004) which places a statutory duty on the Local Authority to make enquiries to enable it to decide whether it should take action to safeguard and promote the welfare of a child. 53 CPM were completed within 2017/2018 which is a slight increase of 4 similar to the increase which was seen last year. During 2016/2017 concerns were raised by partner agencies regarding multi-agency working and quality of CPM reports. A successful multi-agency meeting was held and a new template was developed. This template has been in use throughout 2017/2018 however there have been a few occasions when the template has not been used. This was explored at the time and was identified as a training issue and staff unable to access to the document. Paediatric medical staff training has been updated and the document is now fully accessible on the trust intranet.



The geographical split remains the same to previous years. Halton children are often taken to a neighbouring trust depending on location of residence.

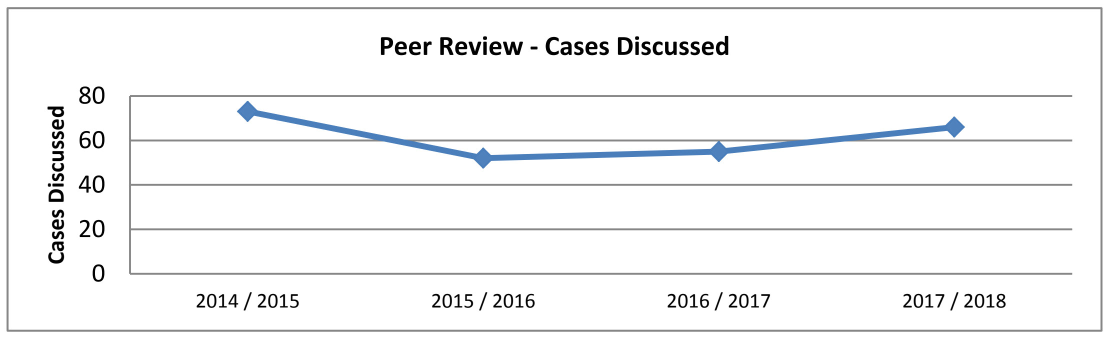
Peer Review

Peer review is the evaluation of work or performance by colleagues in the same field in order to maintain or enhance the quality of the work or performance in that field. The word peer is often defined as a person of equal standing. However, in the context of peer review, it is generally used in a broader sense to refer to people in the same profession who are of the same or higher ranking.

It is a core competency for all clinical staff working with children to undertake regularly documented reviews of practice, including peer review. It is a component of the Clinical Governance Framework and is expected by the judiciary, GMC and professional bodies. 66 cases were discussed as part of the peer review process with attendance from medical staff has been consistent; this is an increase of 11 on last year.

In 2017/2018 the Police, Children's social care and community health have been positive contributors to the Hospital Safeguarding Child Protection Medical Peer Review Meeting. This collaboration has strengthened multi-agency working and relationships providing better outcomes for children.

It was identified early 2018 that there was a gap when monitoring children who required a subsequent rib x-ray as part of their CPM. A decision was made to include these checks as part of the peer review process. Additional to this all child death will be briefly discussed to identify any lessons learnt. This will not replace the Rapid Response Meetings (RRM) held following a child death.



Child Death

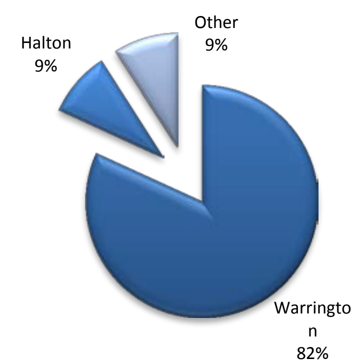
When a child dies unexpectedly it is the responsibility of the designated paediatrician for Sudden Unexpected Deaths in Childhood (SUDIC) to convene a multi-agency meeting. The safeguarding children team support the SUDIC Consultant with this role for all Warrington children regardless of where the death was pronounced.

The Pan Cheshire guidance was reviewed and updated in November 2017. The guidance details a multi-disciplinary approach that will ensure to achieve:

- Sensitive care and support to all affected by the death.
- Preservation of evidence at the place of death.
- Full documentation of all interventions by paramedical and medical staff, including resuscitation prior to the certification of death.
- The completion of a full medical history by medical staff.
- A full review of all the medical records of the deceased.
- A paediatric pathologist (and if necessary a forensic pathologist) investigating the cause of death.
- A multidisciplinary case discussion.

WHHFT were notified of 12 child deaths 2017/2018. Of the 12 cases, 5 of the children were pronounced deceased at WHHFT. 6 RRM (rapid response meeting) were co-ordinated at held at WHHFT. These RRM were held in respect of the 5 children that died at WHHFT and 1 case of a child who died abroad but resided in Warrington. The SUDIC process was followed in all instances and the cases were discussed further at the Cheshire Child Death Overview Panel (CDOP). CDOP produce their own annual report which will provide more details regarding the deaths and any lessons to be learnt. At the point of writing this annual report the CDOP annual report is not available to share.

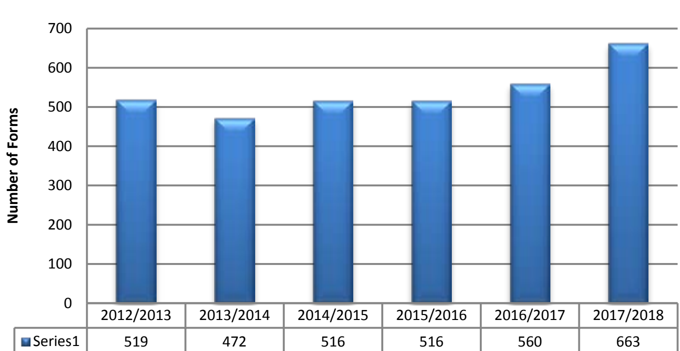
Child Death by Geographical Area 1st April 2016 - 31st March 2017



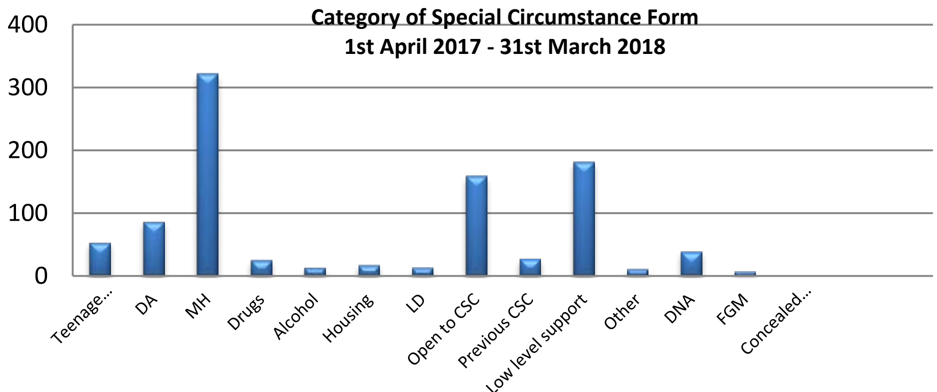
Due to confidentially and ongoing investigations / meetings the causes of deaths cannot be documented within this annual report. It can be noted however that there were no suspicious deaths. Bereavement support is offered to the family and also the staff involved in the incident.

Following relevant multi-agency meetings, feedback and learning is presented internally to the WHHFT Mortality Review Group.

Maternity Pathway



Special circumstance forms (SCF) are commenced when concerns are identified during midwifery care. 2017/2018 saw a 18% increase in number of forms commenced. Families are dealing with more complex issues which impacts on the health and wellbeing of mothers and their unborn babies. Following an audit of maternity records, the SCF were reviewed and updated.



Mental health continues to be the most selected reason for concern (48 %). The perinatal period, as defined in relation to mental illness, spans the time of conception to when the infant reaches the age of one. Perinatal mental illness is relatively common and affects at least 10% of women. The severity of the condition will vary from individual to individual and may have some serious consequences if not identified and managed early and effectively. It is positive that so many women have been identified during the antenatal / postnatal period and commenced on the special circumstance forms. Guidance has been produced to support the midwives when deciding when to commence the specials circumstance forms, within this it details what actions should be taken when there are concerns of perinatal mental health thus ensuring appropriate support is offered at the earliest opportunities.

182 women were identified as needing low level support; this may be in addition to other issues identified however positively this is an increase from the 57 women who were identified the previous year. The safeguarding children level 3 training programme was reviewed and updated to include 'Early Help' which appears to have had a positive effect. Not all cases where low level support was identified required an early help assessment however it is positive that midwives recognised this and was able to support the women and her unborn.

Early Help

In 2017 the Local Authority Warrington Early Help team launched the new 'Early Help Assessment' which has replaced the more commonly known CAF (Common Assessment Framework). The Early Help Assessment is more family and user friendly. Training facilitated by the Early Help Team is being provided to partner agencies. Within WHHFT the priority staff groups identified to attend the training include Community Midwives; Specialist Paediatric Nurses and the Safeguarding Children practitioners. Following the launch of the new document the community midwifery team have embraced the change and since July 2017 they have completed 21 EHA. This is an average of 2.5 assessments being completed which compared to last years data of 1.5 assessments being commenced a month is an improvement. The EHA process can be lengthy with assessments open for a number of months.

Similar to last year's annual repot the LSCB continue to recognise that the Graded Care Profile (GCP) is not being utilised across the region due to various reasons. The tool is completed with the consent of the family during a home visit. The development of services within health has changed impacting on the way hospital based community practitioners are working. In most cases the families attend clinics and children's centres rather than practitioners visiting families therefore making it very difficult to complete the GCP. Community midwives and Paediatric specialist Nurses are continually encouraged to consider the GCP when appropriate. WHHFT completed 2 GCP / Home conditions tool last year

A representative from the early help services continues to attend the Hospital Joint Liaison Meeting where they offer support and advice.

Joint Liaison Meeting

The joint Liaison Meeting was recognised as good practice in the 2016 CQC inspection 'Review of health services for Children Looked After and Safeguarding in Warrington Borough Council'. The report stated:

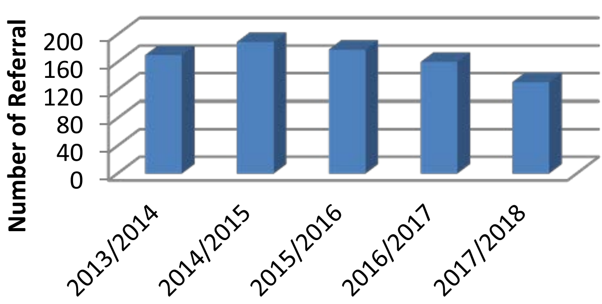
> Good Practice: The joint liaison meeting held at Warrington Hospital has been in place for a number of years. Its role and impact was highly effective in promoting a structured multi-agency approach to safeguarding the health and wellbeing of pregnant women and their unborn babies. A decision-making as well as information sharing group; it included of range of health and social care professionals and enabled proactive sharing of both hard information and soft intelligence.
> As a consequence, casework was secured by a strong early intervention and protection focus, where timely joint response to concerns had effectively prevented escalation of risk. Children's social care readily accepted referrals from the joint liaison meeting where it was highlighted parents were not engaging with the help provided, or where additional targeted support or intervention was required to try and effect change. Practice in this area denotes a high standard of ownership and shared accountabilities for the protection of unborn and new born babies.

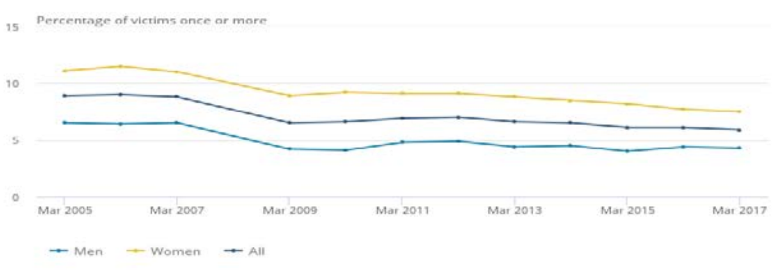
159 cases were discussed at the joint liaison; this is an increase of 37 from the previous year. The agenda is scrutinised before circulation and therefore ensuring that the cases discussed are appropriate. In 2017/2018 the terms of reference; membership and agenda format were reviewed and updated. The meeting continues to thrive.

Domestic Abuse

Referrals

The number of domestic abuse referrals completed has reduced for the third consecutive year. The hospital IDVA remains in post and is providing increased training sessions therefore it was expected that numbers of referrals would in fact increase and not decrease. During MARAC research there have been no cases identified where the Trust has missed a case.

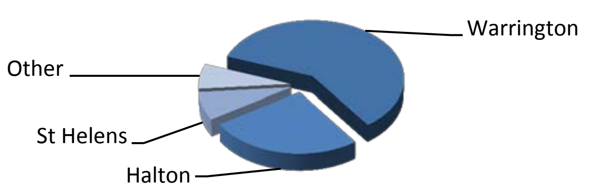




For the year ending March 2017 CSEW, an estimated 1.9 million adults aged 16 to 59 years experienced domestic abuse in the last year, equating to a prevalence rate of approximately 6 in 100 adults.

The trend in the prevalence of domestic abuse has remained fairly stable since the year ending March 2009, but is at its lowest since the year ending March 2005. This would correlate with the decreased numbers of referrals from WHHFT. In comparison to local data, reporting has reduced by 13.3% from 2000 in 2016/17 to 1720 in 2017/18 (Warrington Borough Council). The majority of the referrals continue to be received from the Emergency Department. 9% of the referrals completed were on pregnant victims which is a slight decrease from 11% the previous year. The number of cases where children were in the family has increased from 45% to 58%. A priority for 2017/2018 was to increase referrals through increased awareness raising however this has not been achieved. A new approach to raising awareness will be explored for 2018/2019 and a relaunch of the domestic abuse pathway will be undertaken.

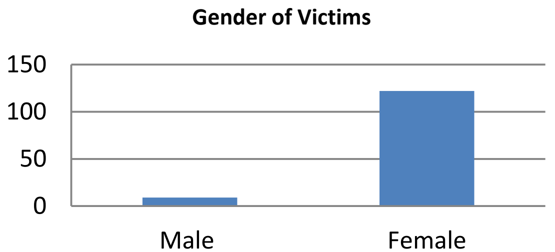
Geographical Area of Domestic Abuse Victims
1st April 2016 - 31st March 2017



The geographical spread remains similar to previous years.

Warrington	78
Halton	34
St Helens	10
Other	9

The gender split in 2017/2018 has decreased significantly. In 2016/2017 the number of male victims accounted for 18% of the referrals made by WHHFT whereas the most recent figure is 7%. There is no clear explanation for this decrease. Training sessions will be reviewed to ensure that focus is not just on women victims and staff are trained to consider male victims also.



Women were more likely to have experienced domestic abuse than men (7.5% compared with 4.3%). This equates to an estimated 1.2 million female victims and 713,000 male victims

Multi-Agency Risk Assessment Conference

A **Multi Agency Risk Assessment Conference** (**MARAC**) is a local, multi-agency victim-focused meeting where information is shared on the highest risk cases of domestic violence and abuse between different statutory and voluntary sector agencies. WHHFT Safeguarding Teams continues to contribute to the MARAC process. The process involved in MARAC includes extensive research on all victims and perpetrators. The amount of work generated from MARACs continues to increase which is causing pressure on the safeguarding teams without additional resources. 68 referrals were risk assessed as HIGH which results in a referral to the appropriate MARAC.

MARAC	MARAC Reports produced.	Cases discussed (Each case will discuss a minimum of 2 people)
Warrington	25	269 (reduction of 58 cases)
Halton	25	219 (reduction of 16 cases)
St Helens	26	462 (increase of 143)

The Lead Named Nurse for Safeguarding Children and the Lead Named Nurse for Safeguarding Adults represents WHHFT on the Warrington MARAC steering group. Relevant information is fed back from the steering group through the WHHFT Safeguarding Committee meeting.

Raising Awareness

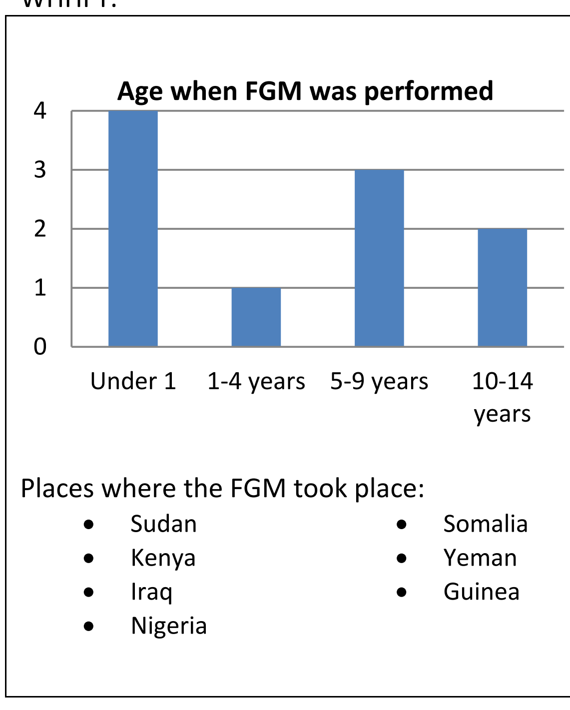
In 2017 The Safeguarding Teams took part The White Ribbon Campaign (domestic abuse). Information packs were distributed across the trust and an information stall was manned at the front of the hospital. The campaign proved to be successful and generated a lot of discussion with visitors / patients and staff.

Female Genital Mutilation (FGM)

Female Genital Mutilation (FGM) is illegal in England and Wales under the FGM Act 2003 ("the 2003 Act"). It is a form of child abuse and violence against women. FGM comprises all procedures involving partial or total removal of the external female genitalia for non-medical reasons. The duty to mandatory report all FGM cases in under 18 years old came in to effect in October 2015.

Between April 2016 and March 2017 there were 9,179 attendances reported at NHS trusts and GP practices where FGM was identified or a procedure for FGM was undertaken. 87 per cent of these attendances were in midwifery or obstetrics services, where this was reported. Data for the treatment area was recorded for six in every ten attendances.

In 2016/2017 there were no cases of FGM identified however in 2017/2018 this figure has increased to 10. The below data has been collected from the victims who have presented at WHHFT.



Places where the FGM took place:

- Sudan
- Kenya
- Iraq
- Nigeria
- Somalia
- Yeman
- Guinea

All notifications of FGM were made by the midwifery teams in 2017/2018. The cases were reviewed by the safeguarding children team and appropriate referrals were made. Of the 10 cases referred 2 remained open for social care assessment due to concerns regarding the newborn female. Feedback from the local authority is that 1 FGM protection order has been put in place following a referral made by WHHFT. The remaining 9 families were aware of the law and were able to demonstrate that they were against FGM. Relevant agencies were notified and this information will remain on the child's records. Agencies will continue to monitor and report any unusual behaviour as the female children involved grow and develop.

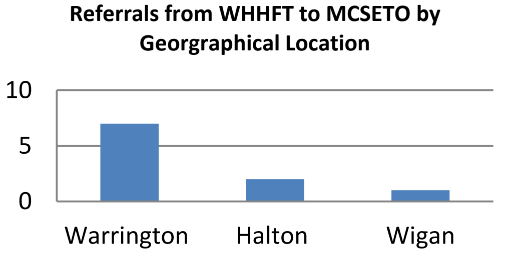
Child Sexual Exploitation (CSE)

CSE continues to be high on the agenda nationally. The pan-Cheshire CSE strategy 2015-2017 remains in place which sets out the commitment of the Cheshire Safeguarding Children's Boards to do everything possible to prevent child sexual exploitation and support victims of this abuse. They recognise that only a proactive, co-ordinated, multi-agency approach will be effective in disrupting child sexual exploitation and prosecuting perpetrators. As a contributor to the board, WHHFT have a responsibility to identify those children and young people at risk of exploitation and our joint responsibility to protect them and safeguard them from further risk of harm. It is also our joint responsibility to prevent children becoming victims of this form of abuse and reassure our communities we can perform our duties effectively. It is the police responsibility to focus on the detection, disruption and prosecution of perpetrators of CSE.

The Safeguarding Children actively contribute to multi-agency meetings, both on a practitioner level and a strategic level. The number of meetings to discuss children and young people has increased, with WHHFT being required to review attendance.

In 2017/2018 the Safeguarding Children Team positively raised awareness of CSE across the trust.

In March 2017 the team took part in the National Awareness Day for CSE. The Safeguarding Children Team manned a CSE stall at the front of the hospital. The number of visitors to the stall was incredible proving the campaign to be a success.
The specialist Nurse for Safeguarding Children presented CSE at the Grand Round.



In 2017/2018 WHHFT staff complied 33 pre-screening tools where they considered CSE. From the 33 pre-screening tools, 10 referrals were made to the relevant agency due to concerns that the child or young person was being exploited. This is 50% increase on referrals made the previous year. Although this is a significant improvement there is still a long way to go to ensure that CSE is embedded across the service.

In 2018/2019 CSE will continue to be a priority. CSE workshops are already being delivered monthly and will continue to do so for a 12 month period. The role of the CSE champions is being reviewed with the intention to re-launch the role and recruit additional champions.

- MCSET – Missing, Children Sexually Exploited, Trafficked (Multi agency meeting where cases of potential CSE are discussed)

Serious Case Review / Multi Agency Case Review

Multi-agency Case Review

In 2017 WHHFT contributed to a WSCB Case review looking at 2 separate but similar cases where concerns had been raised about the effectiveness of multi-agency working. Concerns were related to how partners had worked together to make decisions around investigations into injuries sustained by two young children.

The WSCB produced a 7 minute briefing which gives an overview and the finding of the case.

Following the WSCB report ' Learning from Child O and Child P Case Review' the Safeguarding Children Team reviewed the internal Level 3 safeguarding children training programme and used the lessons learnt to shape the training delivered. To date one sessions has been delivered with a further 4 arranged.

Multi-agency case note audits

The safeguarding children team supported the LSCBs (Warrington and Halton) as contributors to the audit and/or auditors for a number of multi-agency case file audits. These audits would have specific topics that would be reviewed. These topics included

- Child in Need
- CAMHS
- Early Help
- Neglect
- Professional Curiosity

There has been no specific learning from WHHFT from these audits however personal learning from these audits has been shared through the safeguarding children forum meeting. 7 minute briefings produced by WSCB following the audits have been cascaded for further learning.

Training Activity

Due the nature of safeguarding and the expanding agenda, training will always remain high priority.

Safeguarding Children Training

Following the trusts most recent CQC inspection a 'Must do' action for the trust was to ensure that staff receive the appropriate level of safeguarding and MCA training. A report was produced by the Safeguarding Lead Nurses which detailed the current compliance data and explored the training opportunities available to staff along with the issues around achieving compliance of the training.

As demonstrated in the table below, the compliance rating has gradually declined over the year. Compared to the same period last year Quarter 4 has seen the level 3 compliance figures decreased by 10%. The areas where low compliance has been identified have been actioned to ensure that all level 3 staff has training sessions planned and completed by September 2018.

Safeguarding Children	Quarter 4	Quarter 1	Quarter 2	Quarter 3	Quarter 4
	2016/2017	2017/2018			
Level 1	94%	95%	94%	90%	94%
Level 2	85%	87%	87%	84%	84%
Level 3	88%	85%	81%	83%	78%

WHHFT noted the concerns raised following the 2017 CQC inspection in relation to safeguarding training and knowledge across the trust. It was demonstrated within the training report that the Trust have acted on the concerns in order to increase training compliance and knowledge. Innovative ways of delivering training have been explored in order to support staff access to training, as it was evidenced throughout the review that staff had limited access to training opportunities as they were unable to leave the clinical

areas. In order to assess the effectiveness of this training, audits are planned. The audits will be scrutinised by the Trusts joint Safeguarding Committee and the Quality Committee.

Audit Activity – Recommendations

A number of audits have been completed throughout 2017/2018. The findings, learning and recommendations from each audit have been fedback through the most appropriate meeting.
The recommendations from the audits are detailed below:

Child Protection – Physical Harm Concerns Forms / Laming recommendation compliance.

Recommendation	By When	By Who
Create electronic version of the concerns form for completion in Lorenzo.	Oct 2017	Yvonne Blackhurst
Raise awareness / launch of above concerns form	Dec 2017	Yvonne Blackhurst / Anil Gopalakrishna
Invite Social Care and Police to attend Peer Review meeting to share learning from CP medicals	Oct 2017	Katie Clarke
Encourage sharing of outcomes and strategy meeting minutes from social care	Dec 2017	Katie Clarke
Support staff by attending strategy meetings where possible	Oct 2017	Katie Clarke Yvonne Blackhurst
Repeat audit 2017 – 2018	June 2018	Yvonne Blackhurst Katie Clarke

Child Sexual Exploitation – Any missed opportunities?

Quality Improvements	Person Responsible	Achieved by
Support the CSE awareness day	Safeguarding Children Team	March 2018
Provide CSE masterclasses - Monthly sessions from December 2017	Yvonne Blackhurst	December 2018
Encourage staff to attend supervision	Safeguarding Children Team	Monthly
Repeat audit	Yvonne Blackhurst	October 2018

Maternity – Safeguarding Record Keeping

Quality Improvements	Person Responsible	Achieved by
Meet with the senior midwives to discuss the concerns identified	Simone Peters & Katie Clarke	Completed
Review the current safeguarding paperwork and update	Simone Peters & Katie Clarke	March 2018
Disseminate information in relation to domestic abuse	Simone Peters & Katie Clarke	March 2018
Promote Domestic Abuse training	Simone Peters & Katie Clarke	March 2018
Re-audit in 12 months' time.	Simone Peters & Katie Clarke	March 2019

Children not brought to health appointments

The Pan Cheshire section 11 audit states there should be a process for following up children who do not attend an appointment for specialist care. This should be monitored annually to ensure that the policy is being adhered too. 2016/2017 will be the second year this audit is completed. Due to cleansing of data and re-viewing the previous year's audit questions this audit will not be completed until August 2017.

Quality Improvements	Person Responsible	Expected completion
Develop a joint policy with Bridgewater NHS	Katie Clarke	April 2018
Re-launch the completed policy and circulate trust wide	Katie Clarke	May 2018
To review the audit data collection sheet.	Yvonne Blackhurst, Specialist Nurse	June 2018
To complete this audit annually – to comply with section 11 self-assessment tool.	Yvonne Blackhurst, Specialist Nurse	December 2018
To ask outpatients department to consider evening clinics.	Yvonne Blackhurst, Specialist Nurse	May 2018
To explore including paediatric patients in the 'reminder service'	Yvonne Blackhurst, Specialist Nurse	May 2018
To approach public health and education for support in developing a campaign	Katie Clarke	May 2018

2018/2019 Scheduled Audit Plan

Audit Topic	Date of Audit
Child Protection – Physical abuse, Laming Recommendations compliance	May
Maternity – Domestic Abuse screening	June
FGM – Local activity	August
CPIS – Compliance with pathway?	August
CSE – Any missed opportunities?	October
Domestic Abuse – Compliance with pathway?	November
Children not brought to appointments - Compliance with pathway	February

Safeguarding Children Supervision

WHHFT recognises that Safeguarding Children supervision is integral to providing an effective child centred service. Safeguarding children supervision is provided in addition to clinical supervision which it complements but does not replace. The involvement of key health professionals with children, in particular where there may be unresolved safeguarding issues, means that they have a major role in the identification of abuse and neglect. Many of the inquiries into child deaths and serious incidents involving children have demonstrated serious failings in professional practice which have been attributed to lack of effective supervision and support for professionals involved in the care of vulnerable children, including those in the "Looked After System".

In May 2017 WHHFT developed a Safeguarding Children Supervision Policy. All WHHFT practitioners who have regular contact with children and families will have the opportunity for regular, formal safeguarding children supervision by a trained supervisor. All practitioners having irregular contact with children shall have access to ad hoc supervision by a trained supervisor when requested. Urgent supervision may be obtained from the Named Professionals.

Community Midwives and paediatric specialist nurses receive supervision from a trained safeguarding children supervisor. This is in the form of supervision sessions with their supervisor bi-monthly. The frequency of supervision may need to be increased to meet the needs of the practitioner and their caseload.

There are 7 trained safeguarding supervisors within the trust who each hold a case load of community midwives and paediatric specialist nurses. In addition to providing one to one supervision to this staff group, weekly group supervision sessions are provided. Specific areas are targeted for the group sessions, for example Paediatric ward; Neonatal ward; Midwifery service and Emergency Department however any member of staff can attend any session. Initial feedback from the sessions has been positive and Safeguarding Supervisions is beginning to embed across the trust.

To ensure that WHHFT provide effective supervision the nominated supervisors meet on a quarterly basis to offer peer support and share learning.

Following the recent case review referred to earlier in this report, group supervision has been focussed on acceptance and positive response to peer challenge of practice. This topic has generated group discussion demonstrating positive attitudes from staff.

Safeguarding Incidents

DATIX incidents are reviewed on a daily basis. In 2017/2018 52 incident were recorded under the category of safeguarding children. The safeguarding children team will often be asked to review DATIX that fall under a separate category however have an element of safeguarding to it, for example young people absconding from the departments. This figure is not captured in the data below

Issues / trends that have been recognised throughout the last 12 months are shown below with actions taken by the Safeguarding Children Team (this list does not include ALL incidents, however the incidents that have been recognised as regular occurrences):

Issues / trends	Action taken from Safeguarding Children Team
Poor hand over / sharing of information Poor communication	- Education and support. - Reviewed and updated the safeguarding paperwork - The safeguarding children team to explore the option of uploading the safeguarding pathway to LORENZO
Poor documentation	- Education and support - Reviewed and updated the safeguarding paperwork
Staff being victims of verbal abuse from parents / carers.	- Suport offered where needed. - No further support needed in many cases. Security supported at the time of the incidents.
Patients under 18 years old absconded	- No further action was required. Staff dealt with the incident appropriately at the time. Good evidence of multi-agency communication.

Allegations Against Staff

All allegations of abuse of children by those who work with children must be taken seriously. Allegations against any person who works with children, whether in a paid or unpaid capacity, cover a wide range of circumstances.

This procedure should be applied when there is such an allegation or concern that a person who works with children, has:

- Behaved in a way that has harmed a child, or may have harmed a child;
- Possibly committed a criminal offence against or related to a child;
- Behaved towards a child or children in a way that indicates he or she may pose a risk of harm to children.

In December 2017 a change was made to the existing guidance within WHHFT and a standalone policy was developed in line with WSCB and HSCB policies. Within the last twelve months the Safeguarding Children Lead Nurse has provided support and guidance for three potential LADO cases. Of the three cases, one became an open LADO case and joint working was completed with the local authority.

Significant Developments

Child Protection Information Sharing (CPIS)

WHHFT are now live with the CPIS across unscheduled care (Emergency Care, Urgent Care and labour ward). When a child is known to social services and is a Looked After Child or on a Child Protection Plan, basic information about that plan is shared securely with the NHS. If that child attends an NHS unscheduled care setting, such as an emergency department or a minor injury unit:

- the health team is alerted that they are on a plan and has access to the contact details for the social care team
- the social care team is automatically notified that the child has attended, and
- both parties can see details of the child's previous 25 visits to unscheduled care settings in England

This means that health and social care staff have a more complete picture of a child's interactions with health and social care services. This enables them to provide better care and earlier interventions for children who are considered vulnerable and at risk. The CP-IS project is linking the IT systems used across health and social care and helping organisations to change business processes so this basic information can be shared securely between them. The information can only be accessed securely by trained professionals involved in a child's care.

New / Updated policies

- Safeguarding Children - Updated
- Chaperone Policy – New
- Guideline for admission of children to adult wards – New
- Managing Safeguarding Allegations Against Staff & People in position of trust (pipot) policy - New

Objectives for 2017/2018

- Increase number of Domestic Abuse referrals
- Continue to raise awareness of CSE and therefore increasing the number of referrals made
- Implement the Trusts Safeguarding Strategy
- Strengthen the Early Help referral pathways within the trust.
- Review the child death process with the view to developing standalone guidance (it currently sits within the Safeguarding Children Policy)
- Develop a Safeguarding Newsletter

APPENDIX A

Area	Measure	Detail	Threshold
SAFEGUARDING CHILDRENS'S TRAINING	Level 1 Training for all staff	Percentage of Staff who have had training within the past 3 years (to include denominator and numerator)in line with Trust TNA	90%
	Level 2 Training for all relevant staff	Percentage of Staff requiring training who have completed the training within the past 3 years (to include denominator and numerator) in line with Trust TNA	80%
	Level 3 Training for all relevant staff	Percentage of Staff requiring training who have completed the training within the last 3 years (to include denominator and numerator) in line with Trust TNA	80%
	Level 4 Training for all relevant staff	Percentage of Staff requiring training who have completed the training within the last 3 years (to include denominator and numerator) in line with Trust TNA	80%
SPECIFIC SAFEGUARDING TRAINING	Prevent Strategy/Awareness Training	Percentage of overall Staff who have received Prevent Awareness raising in the last 3 years (to include denominator and numerator) Compliance to be monitored each quarter with a trajectory of 90% by year end.	90% year end
	Prevent Strategy/HealthWrap Training	Percentage of overall identified cohort of staff who have received Prevent Wrap training within the past 3 years (to include denominator and numerator) Compliance to be monitored each quarter with a trajectory of 40% be year end. Compliance to be increased (16-17) 70% by year end, (17-18) 90% by year end	40% year end
		Percentage of overall identified cohort of staff who have received Prevent Wrap training in the past 3 years. Compliance to be increased (16-17) to 70% by year end.	70% by year end
		Percentage of overall identified cohort of staff who have received Prevent Wrap training in the past 3 years. Compliance to be increased (17-18) to 90% by year end	90% by year end
	Domestic Abuse Training	Percentage of overall Trust identified cohort of staff who have received Domestic Abuse training in line with policy requirements (to include denominator and numerator)	End of year Count
CHILDREN AND ADULT SAFEGUARDING INTERNAL MONITORING	Safeguarding Policies	Safeguarding Children Policy & Procedures are current, ratified and reviewed in line with Legislation, national and local guidance	
		Management of Allegation Policy and Procedures	
		Prevent Policy to be submitted at Q2	
		Safeguarding Supervision Policy: Children	
	Safeguarding Multi Agency Partnership Working	Multi- Agency Risk Assessment Conferences invited and attended (to include denominator and numerator - 95% attendance) Children	95%
		Total number of contacts made to children's social care services	Count
		Total number of contacts made to Children's social care services in relation to mental health issues	Count
		Total number of contacts made to Children's social care services in relation to alcohol/substance Misuse	Count
		Total number of contacts made to Children's social care services in relation to Domestic Abuse	Count
		Total number of contacts made to children's social care progressing to referral to children's services	Count
		Quality audit on contacts/referrals into children's services (which include Voice of Child being recorded)	Submit Q2
		Number of Child Sexual Exploitation (CSE) referrals made	Count
		Number of MCSEO/CSE strategy meetings attended	Count
		Completion of National Working Group CSE risk template	Embded doc
		Number of children referred/ in service subject to CP plans (CAMHs only)	Count
		(Children) Strategy Meetings invited and attended (to include denominator and numerator - 95% attendance)	95%
SAFEGUARDING ASSURANCE FRAMEWORK	Self Assessment Safeguarding Audit tool Children & Adults	Children Safeguarding annual self-assessment audit (new fields and any changes, amendments and updates to evidence only) tool completed and returned at Q2	Compliance
	Action Plan to support Audit tool compliance	Safeguarding action plan against areas of non compliance (amber& red RAG ratings) against annual audit tool completed in 14/15 &15/ 16 returned quarterly basis	Compliance
		Number of complaints upheld with safeguarding children element	Count
		Number of SUI's reported relating to safeguarding children incidents	Count
		Number of new reviews and actively involved in quarter (Serious Case Reviews, Management Reviews, Domestic Homicide Reviews)	Count

SAFEGUARDING CHILDRENS SUPERVISION	Safeguarding CHILDREN Lead / Named Nurse Quarterly Supervision with CCG Safeguarding Service.	Core offer - 4x one to one sessions per year (Children) with designated professional compliance	100%
	Supervision provided to identified safeguarding specialist staff within the organisation on a quarterly basis by Named Nurse	Number of identified safeguarding specialist staff requiring & receiving supervision on a quarterly basis (Include numerator and denominator) - 100% compliance each quarter	100%
	Supervision - Group supervision / event supervision as per agreed definition e.g. ALTE, SUDI/C	Minimum offer by provider of 4 per year - compliance with this standard 100% by Q4	100%
		Number of Staff Eligible (Provide numerator and denominator)	100%
	Supervision of cases with long term/complex health needs	Number of cases eligible for supervision, numbers achieved in quarter - (Include numerator and denominator reported as percentage)	100%
	Supervision of cases subject to child Protection plan provided in accordance with organisation supervision policy.	Number of cases eligible for supervision / numbers achieved in quarter - (Include numerator and denominator reported as percentage)	100%
	Safeguarding Peer Review / Safeguarding Supervision sessions provided by the Designated Doctor	numbers of peer review child protection medical sessions attended by Named Doctors with safeguarding responsibility	count
		Percentage of safeguarding supervision sessions held with Named Doctor (core offer 4 sessions per year with Designated Doctor)	100%
EARLY HELP	Early help agenda as per NHSE / PH specification	Number of CAFs initiated by a health professional HEALTH VISITOR	Count
		Number of CAFs contributed to by a health professional HEALTH VISITOR	Count
		Number of CAFs led by a health professional HEALTH VISITOR LEAD Professional	Count
		Number of CAFs initiated by a health professional SCHOOL NURSE	Count
		Number of CAFs contributed to by a health professional SCHOOL NURSE	Count
		Number of CAFs led by a health professional (LP) SCHOOL NURSE LEAD Professional	Count
		Number of CAFs/EHAT initiated by a health professional MIDWIFE	Count
		Number of CAFs/EHAT led by a health professional (LP) MIDWIFE	Count
	CAF/EHAT - Measures to be split by CCG/Local Authority	Number of referrals into CAF team (Mental Health Providers)	Count
		Number of referrals to CAMHS for under 18 years old due to self harm related issues / attempted suicide	Count
	Click Here To Insert CCG/LA breakdown	Number of referrals to services for under 18 year olds with a drug / alcohol related issue	Count
		Number of new referrals to MARAC	Count
		Number of CAADA / DASH completed	Count
		Total number of referrals escalated in accordance with escalation policy (Total of Below)	Count
		Total number of CSE Referrals	Count
		Number of referrals to Children's Social Care	Count
		Number of referrals to CSC for CSE	Count
		Number of CSC Referrals for domestic abuse	Count
		Number of CSC Referrals for substance misuse/alcohol misuse	Count
		Number of CSC Referrals for mental health	Count
		Number of CSC Referrals for Other	Count
ATTENDANCE AT MULTI-AGENCY MEETINGS	Number attended	Number:- pre birth invited % attended -MIDWIFE	95%
		Number:- pre birth invited % attended - Health visitor	95%
		Number:- of initial pre school child protection conferences (invited) % attended - HEALTH VISITOR	95%
		Number:- of initial school age child protection conferences (invited) % attended - SCHOOL NURSE	95%
		Number:- of initial child protection conferences (invited) % attended - other (Define in narrative where necessary)	95%
		Number:- of pre school age review conferences (Invited) % attended - HEALTH VISITOR	95%
		Number:- of school age review conferences (Invited) % attended - SCHOOL NURSE	95%
		Number:- of review conferences (Invited) % attended - other (define in narrative where	95%

		necessary)	
		Number:- reports requested/numbers returned for INITIAL CASE CONFERENCE; report % compliance	95%
		Number:- reports requested/numbers returned for REVIEW CASE CONFERENCE; report % compliance	95%
LOST TO SERVICE	Missing/ 'lost' children	Number of children identified as 'missing' or lost to service - OTHER	count
		Evidence of missing/ lost child protocol- SUBMIT Q2	
DOMESTIC ABUSE	Number of Cases	Number of multi-agency referral forms (CART/ESAT & MARAC) completed where an adult presents to A&E as a result of domestic violence and where children live in the household	count
		Numbers of Domestic Abuse AED/Corporate	count
		Numbers of Domestic Abuse (AED/Corporate) cases with WHHT IDVA Support	100%
		Number of Domestic Abuse cases Maternity Services	count
		Number of Domestic Abuse cases (Maternity Services) WHHT IDVA Support	100%
		Number of Domestic Abuse cases where there are children in the home	count
		Number of MARFs submitted where Domestic Abuse is the main concern	count
SEXUAL HEALTH SERVICES		Number of children accessing Sexual Health Services where CSE is flagged	count
		Number of children accessing Sexual Health Services where Pan Cheshire CSE Screening tool is completed	count
		Number of children accessing Sexual Health Services who are referred to relevant agency (CSC/CSE team/CART/ESAT) following completion of Pan Cheshire CSE Screening tool	count
ACCIDENT & EMERGENCY		Number of children attending Accident & Emergency where CSE is flagged	count
		Number of children attending Accident & Emergency where Pan Cheshire CSE Screening tool is completed	count
		Number of children attending Accident & Emergency who are referred to relevant agency (CSC/CSE team/CART/ESAT) following completion of Pan Cheshire CSE Screening tool	count
		Number of children attending Walk in Centres/Unplanned Care settings where CSE is flagged	count
		Number of children attending Walk in Centres/Unplanned Care settings where Pan Cheshire CSE Screening tool is completed	count
		Number of children attending Walk in Centres/Unplanned Care settings who are referred to relevant agency (CSC/CSE team/CART/ESAT) following completion of Pan Cheshire CSE Screening tool	count
FGM	FGM	No of cases identified and reported in line with national guidance 2015	count

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/18/09/90**
SUBJECT:	Q4 2017/18 Mortality Review Findings Report
DATE OF MEETING:	26th September 2018
ACTION REQUIRED	**For Assurance**
AUTHOR(S):	Dr P. Cantrell, Lead Clinician for MortalityG. Sutton, Head of Clinical Effectiveness
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Executive Medical Director/ Deputy CEO
LINK TO STRATEGIC OBJECTIVES:	All
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	BAF1.1: CQC Compliance for Quality
EXECUTIVE SUMMARY (KEY ISSUES):	This briefing paper overviews Trust mortality data and provides local and national context. It also outlines the actions in place to ensure robust oversight and monitoring, through a comprehensive mortality peer review process, as well as improvement plans to reduce Trust mortality rates and the Trust mortality ratio figures.
RECOMMENDATION:	The Trust Board is asked to note the contents of the briefing paper and discuss

PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee
	Agenda Ref.	**QAC/18/07/84**
	Date of meeting	3 July 2018
	Summary of Outcome	**The Committee approved the recommended options within the report.**

FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None

Warrington and Halton Hospitals
NHS Foundation Trust

SUBJECT	Q4 2017/18 Mortality Review Findings Report

1. BACKGROUND/CONTEXT

The importance of reporting mortality statistics at Board level was highlighted in the Francis Report into the failures at the Mid-Staffordshire Trust (February 2010) to which Warrington and Halton Hospitals NHS Foundation Trust provided a full position response reported at Board in September 2010.

The CQC has developed a national framework at the request of the Department of Health which was launched in March 2017. There is a requirement for all Trusts to collect and publish specified information on deaths on a quarterly basis. By the end of Quarter 2 of 2017/18, the Trust is required to have a policy and approach as to how it will publish the data. The Trust has a policy which was ratified at Board in October and is available on the Trust website.

2. KEY ELEMENTS

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

2.1 Structured Judgement Reviews

Particular groups of patients are reviewed at the MRG:

- All deaths of patients subject to care interventions with elective procedures. These will be identified using the electronic patient record which provides a daily update as to patients that have died.
- Patients undergoing an emergency laparotomy.
- SHMI/HSMR outliers identified using the HED system.
- Deaths where learning will inform our existing or planned improvement work, for example if work is planned on improving sepsis care, relevant deaths should be reviewed, as determined by the Trust;
- Death of a patient with mental health needs (this covers Inpatients who are detained under the Mental Health Act) identified via the Trust Patient Safety Manager. If the death may have been due to, or partly due, to problems in care including suspected self-inflicted death it will be investigated as a serious incident.
- Trauma deaths will be reviewed and presented at MRG on a quarterly basis.
- Patients who have died aged between 18 and 55 years.
- Patients who have died with no DNACPR in place.
- Once a quarter, a further sample of other deaths will be selected that do not fit the above identified categories, to ensure we take an overview of where learning and improvement is needed most overall.

- All Coroners' reports received post-inquest will be triangulated with the SJR to enhance the learning.
- Any concern that a member of staff may have in relation to a patient death will be reviewed through the mortality process.
- At the request of the Medical Director or Chief Nurse.

Structured Judgement Reviews are presented to the MRG, an assessment of problems in care is made and any actions or lessons to be learned are sent to the appropriate fora.

2.2 Focused Reviews

We conduct focused reviews where the HED system indicates we are an outlier in a particular diagnosis group, for example Pneumonia. It is important to note that the diagnosis group relates to the condition the patient was being treated for during their stay in hospital and not their cause of death. It is also important to note that excess unexpected deaths does not equate to preventable deaths.

Where we are above our expected number of deaths in a diagnosis group for over three months we will work alongside specialists within the appropriate specialty to perform case note reviews of the patients' stay.

This deep dive provides us with valuable learning as to what is needed to be implemented to ensure we have no further triggers within diagnosis groups. Some aspects of learning are applicable to reduce the likelihood of triggering in the future, such as improved documentation and coding, whereas others are specifically of relevance to that treatment, such as using a dip stick before diagnosing a patient as having a urinary tract infection.

2.3 Mortality Data Analysis

There are three main types of overall data used:

2.3.1 Crude Mortality Rates

This is the percentage/number of deaths against the total number of discharges in a particular timeframe. It needs to be used with caution as it does not take into account complexity of patients.

2.3.2 HSMR (Hospital Standardised Mortality Ratio)

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

Adjustments are made for:

• sex • age • admission method • comorbidities (based on Charlson score)	• month of admission • socio economic deprivation quintile (using Carstairs) • primary diagnosis sub-group

• number of previous emergency admissions • history of previous emergency admissions in the last 12 months	• palliative care • year of discharge

2.3.3 SHMI (Summary Hospital Mortality Indicator)
All observed deaths in hospital and within 30 days of discharge. Adjustments are made only for age, admission method, comorbidities.

Still births, specialist community, mental health and independent sector hospitals, day cases, regular day and night attenders are excluded.

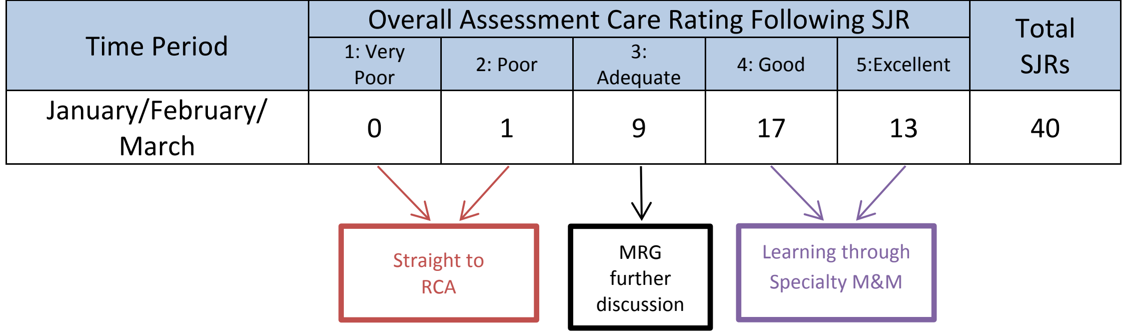
In 2010 the Department of Health endorsed the national review of HSMR commissioned by the NHS Medical Director who committed to implementing SHMI as the single hospital level of mortality indicator to be used across the NHS. Therefore, although we still look at HSMR and the crude mortality rates, it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

3. MEASUREMENTS/EVALUATIONS

3.1 Structured Judgement Reviews

There have been **69** mortalities that have triggered a Structured Judgement Review by a member of MRG. **40** Structured Judgement Reviews that been completed between January 2018 and March 2018.

3.1.1 Dashboard for Structured Judgement Review Ratings



Time Period	Overall Assessment Care Rating Following SJR					Total SJRs
	1: Very Poor	2: Poor	3: Adequate	4: Good	5:Excellent	
January/February/ March	0	1	9	17	13	40

3.1.2 Previous Quarter's RCA Outcome

Summary	Severity Following RCA
Patient admitted to CDU after taking an overdose of Oromorph and Diazepam earlier in the night. Patient had a cardiac arrest on the ward and unfortunately died.	5
Patient was a resident at an organisation under Section of the Mental Health Act. They had numerous attendances at A&E having swallowed foreign objects. They attended A&E with abdominal pain was assessed and discharged back to the secured residence. They were later found by staff following a collapse. Resuscitation was unsuccessful.	5
Safeguarding notification via In-patient on A7 with sepsis. They had severe Alzheimer's disease and bruising noted to thigh by staff nurse. Patient discharged the next day. Brought to UCC as has pain on hoisting and bruising to right thigh Wife says she noted bruising while he was on the ward. An X-ray showed fracture to right neck of femur, there is no clear mechanism or date of injury in this case.	4
The patient attended the Emergency following a fall at home. The patient had hit their head and also had right hip pain. Patient was assessed and referred to T&O with a fractured right neck of femur. The patient was seen by the Locum T&O doctor then moved to Resus and Critical Care bleeped. The patient was assessed by the ITU Registrar and Medical Registrar, patient vomited and had vacant episodes. Cardiac arrest confirmed and CPR commenced. The patient died in ED Resus.	5

3.1.3 Discussion on SJRs Having a Care Rating of 3

- Lack of timely Consultant review of patient: A number of reviews highlighted similar themes where there was either lack of documentation of timely Consultant review or a delayed review by a Consultant. This issue will be addressed through work completed by Head of Clinical Effectiveness and Associate Medical Director for Clinical Effectiveness on 7 Day Services.

- Safety Alert has been issued regarding patients who are admitted as a day case who then need to stay overnight either as a complication of the procedure or due to problems with transport. These patients are now inpatients and require full inpatient clerking. Associate Chief Nurse for Safety has met with senior nursing staff to ensure all patients who become an inpatient, when problems occur, although original admitted as a day case, will be clerked as an inpatient. Nursing staff will inform Doctor that they are required to clerk the patient.

- The issue of inaccurate death certification was raised as part of the 'Cancer of the Rectum & Anus' and 'Cardiac Dysrhythmia' focused reviews. Following review and changes of the processes by the Associate Medical Director for Quality and the Head of Clinical Effectiveness an audit will take place July/August 2018 to assess improvement.

- It was identified that there is no documentation in Lorenzo when Critical Care have reviewed a patient following referral. There has been a discussion in critical care and there is a plan to ensure that all reviews of patients outside the ITU are documented in Lorenzo. There will be an audit undertaken by clinical lead in Critical Care to ensure this is embedded.

- There are two forms in Lorenzo for confirming death. It was agreed that death certification should always be written in Lorenzo using Trust-agreed best practice. The proforma should not be used.

- A patient was admitted who was undergoing chemotherapy at Clatterbridge. The transport was delayed and the chemotherapy was deferred for two days. The patient became even more unwell and discussions with Clatterbridge suggested that chemotherapy should be deferred for a further three days. There was no acute oncology presence in the Trust to have a discussion with the family, who were very concerned that their relative was becoming more ill and not receiving the chemotherapy required. Eventually a DNACPR was put in place and the patient was referred for palliative care. There is a significant problem in the Trust with lack of consistent acute oncology provision and there have been a number of occasions where patients and families have suffered as a result. In this case if acute oncology had assessed the patient they could have assured the family that their relative was too unwell and frail for chemotherapy, avoiding the time taken to arrange transfer of a dying patient for chemotherapy which was not appropriate. **Action :** The Lead Clinician for Mortality is to attend a meeting with the Director of Integrated Quality & Governance, Medical Director and colleagues from Clatterbridge to ensure a more robust process is in place.

3.1.4 Areas of Good Practice

End of Life Care
Excellent examples where the mortality of a patient was anticipated well and conversations with the family initiated. A DNACPR and ceiling of care were put in place alongside anticipatory medications. The patients were moved into a side room with the family present until passing away.

Communication
An excellent example of clinicians involving a patient and their family in discussions regarding the patient's malignant disease. Unfortunately due to the development of a massive pulmonary embolism the patient went into respiratory and cardiac arrest before the Palliative Care team were able to assess the patient. The patient received CPR, but this was unsuccessful.

3.2 Focused Reviews

The below table sets out the focused reviews on mortality outliers that have been planned to be conducted during Quarter 3:

Diagnosis Group	Trigger	Observed deaths/ expected deaths	Date due for completion	Learning Identified
Neoplasms Of Unknown Or Uncertain Behaviour	SHMI	24/13	May 2018	Report due 22/05/18
Liver Disease, alcohol-related	HSMR & SHMI	31/28	June 2018	Report due 19/06/18
Fractured Neck of Femur	SHMI	24/13	June 2018	Report due 19/06/18

3.3 Crude Mortality

- HED data is always three to four months behind, hence, this is the most recent data available.
- Crude mortality should be viewed with caution, as it does not take into account the complexities of the patients, but it is useful to monitor numbers of observed deaths.
- Because of the relative consistency of the relationship between in hospital crude mortality and crude mortality including deaths with 30 days out of hospital, it can give an 'early warning' with regards to mortality including deaths within 30 days out of hospital.

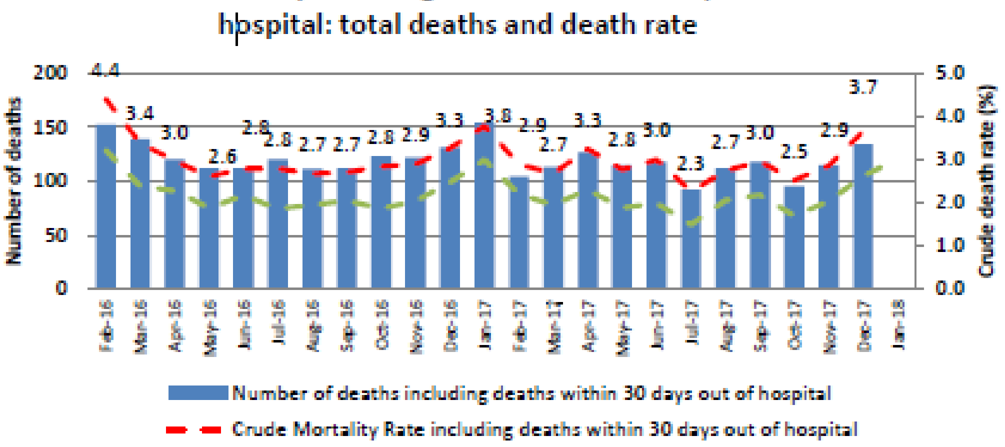


Figure 1: Crude Mortality February 2017 to January 2018

3.4 HSMR

- **We are not a national outlier, with a HSMR of 97.28 for February 2017 – January 2018.**

Quarter 4 HSMR:

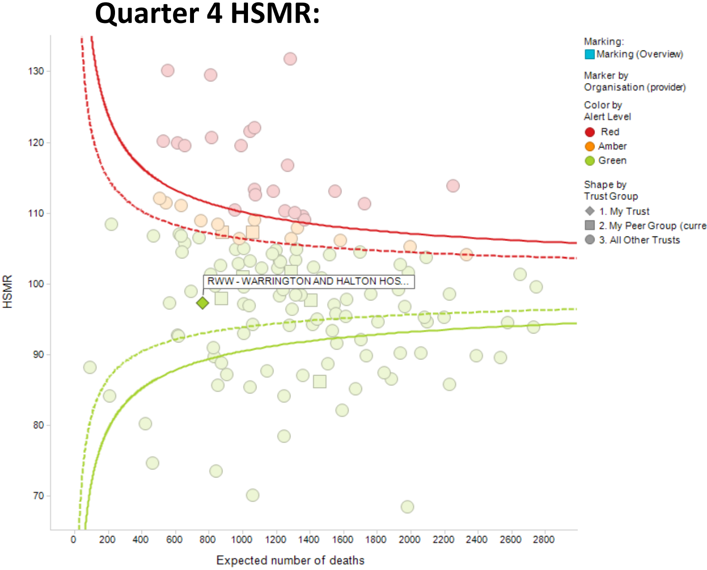


Figure 2: Funnel Plot for HSMR February 2017 to January 2018

The HSMR for the latest month looks quite extreme but this is most likely because data is not yet complete (only 10 deaths are coded for January 2018 to date). We anticipate this figure will change next month when data is more fully coded. (Coding has a large impact on HSMR, because the definition is based on CCS diagnosis groups and so is dependent on this information being completed.)

3.4.1 HSMR by diagnostic grouping

HSMR looks at 56 diagnosis groups which cover approximately 80% of in-hospital deaths nationally. Of these groups, we are showing a statistically significantly high HSMR result in the 12 month period of July 2016 – June 2017 for the following groups:

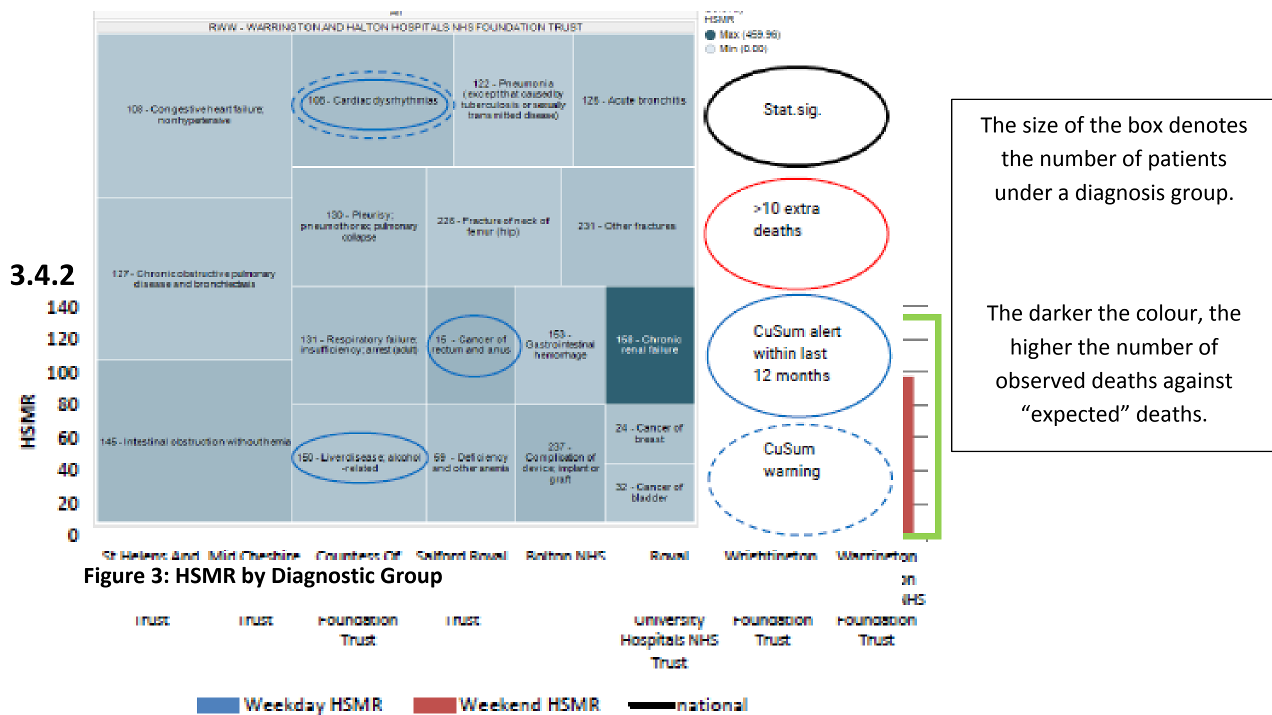


Figure 3: HSMR by Diagnostic Group

3.4.2

Figure 4: Weekend/Weekday HSMR

This graph shows there is very little difference between the weekday and weekend HSMR for Warrington, and neither score is statistically significantly high.

3.5 SHMI

We are a 'green rating' for this indicator, with a SHMI of 104.70 for the period January 2017 to December 2017. We are not an outlier for this indicator.

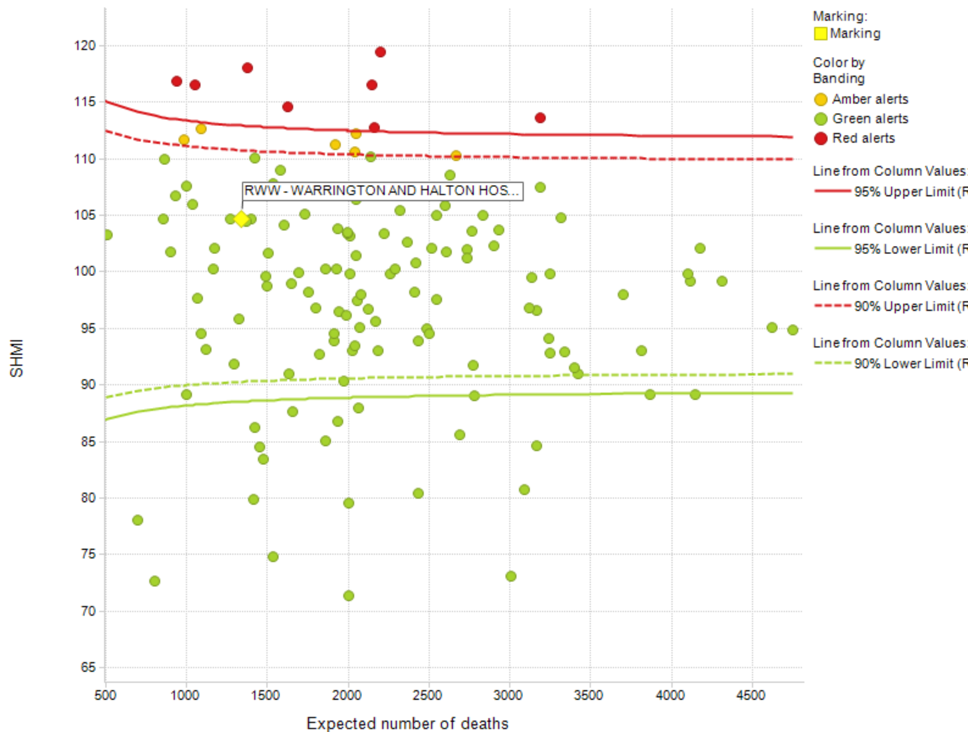


Figure 5: SHMI Funnel Plot (January 2017 -December 2017)

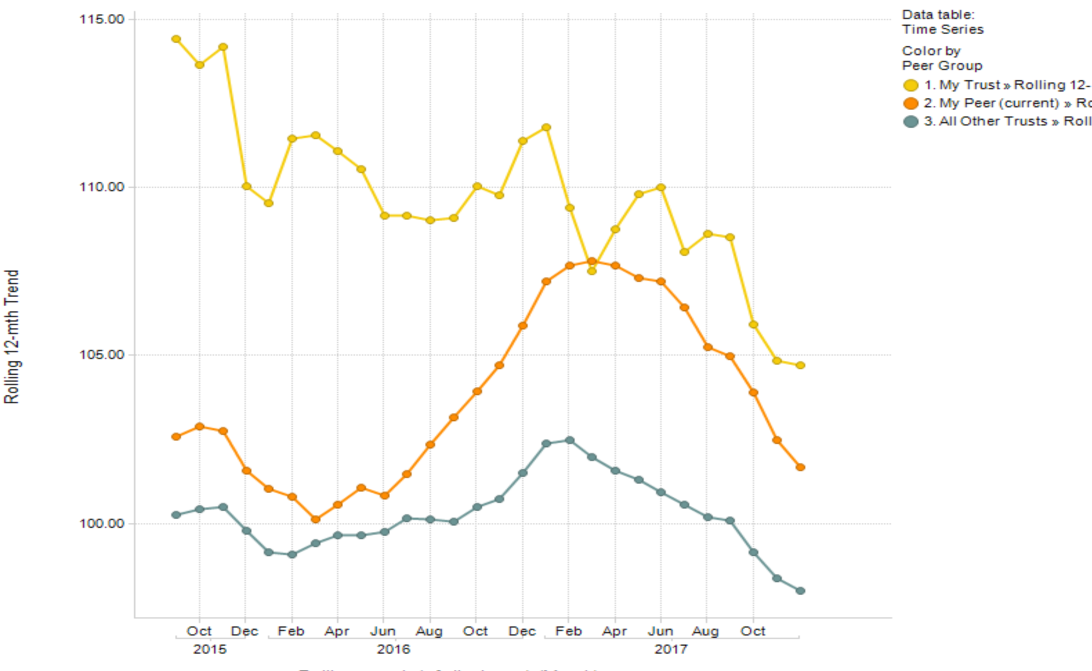


Figure 6: SHMI Trend

Warrington's downward trend continues, and the same can now be seen for peers and all other acute trusts.

The recent downward trend for the peer group can be seen for each of the individual peers, to varying degrees.

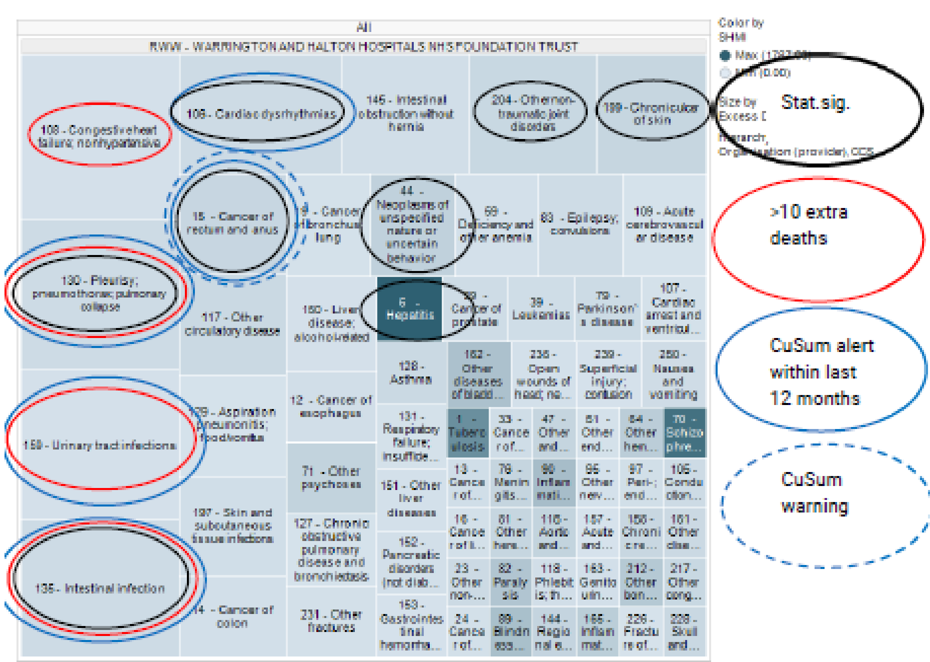


Figure 7: SHMI excess deaths by diagnostic grouping; tree diagram

- CCS groups which are statistically significantly high are ringed black.

3.5.1 Weekend/Weekday SHMI

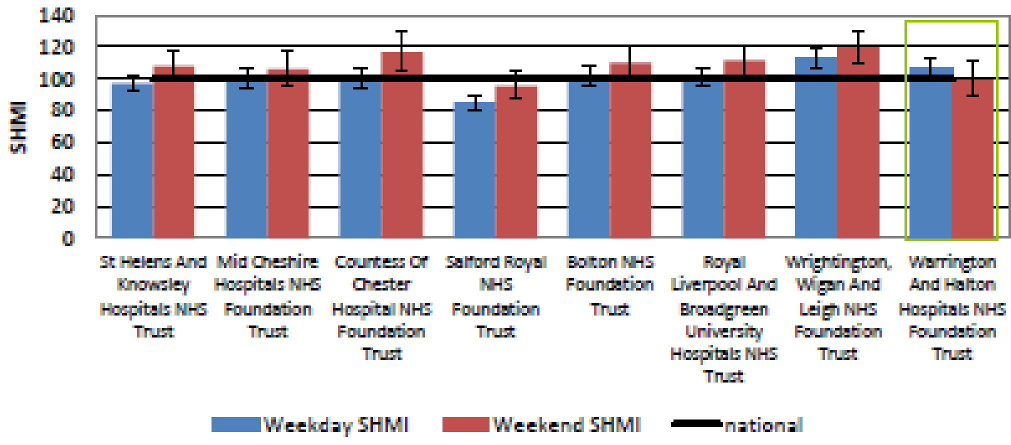


Figure 8: Weekend / weekday SHMI compared to peers

- Weekend SHMI is slightly lower than the weekday SHMI for Warrington, whereas all of its peers have a higher weekend SHMI than weekday.
- Weekday SHMI is statistically significantly high for Warrington, and Wrightington, Wigan and Leigh.
- Weekend SHMI is statistically significantly high for Countess of Chester, Bolton, Royal Liverpool and Broadgreen, and Wrightington, Wigan and Leigh.
- SHMI is statistically significantly low for Salford for weekdays.

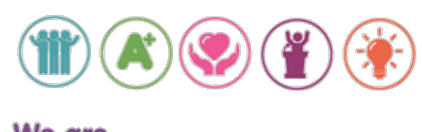
3.6 Summary

- Warrington is not an outlier for SHMI for the last 12 months, both according to the over dispersed model or the early warning Poisson model method also used by HED.
- HSMR is not an outlier for the last 12 months.
- Weekend / weekday mortality is not an issue for Warrington.
- Two members of MRG plan to lead on a focused review into Intestinal Infections.
- Work to date on focused reviews to allow themed learning on areas where we are outliers for mortality, combined with learning from Structured Judgement Reviews has resulted in an improvement in our HSMR and SHMI performance. We plan to continue to improve our existing processes.
- Actions from the focused review into unspecified neoplasms:
  - LG to change the incorrect codes and send an update to PC. This will then mean that we are no longer an outlier and off the HED radar.
  - PDC to raise the issue of documentation at the Medical Group meeting.
  - LG to have cases which show ‘brain tumour’ to be sent to her for clarification.
  - JW will highlight this within AED.

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM 18/09/91**
SUBJECT:	**Flu Programme 2018**
DATE OF MEETING:	26 September 2018
ACTION REQUIRED	Assurance
AUTHOR(S):	Deborah Smith, Deputy Director of HR and OD
EXECUTIVE DIRECTOR SPONSOR:	Michelle Cloney, Director of HR and OD
LINK TO STRATEGIC OBJECTIVES:	SO1: To ensure that all care is rated amongst the top quartile in the North West of England for patient safety, clinical outcomes and patient experience
EXECUTIVE SUMMARY (KEY ISSUES):	This paper provides an update to Trust Board on recent changes to the requirements around the Flu Programme 2018, set out in a joint letter from national clinical and staff side professional leaders including NHS Improvement and NHS England. The letter includes a self-assessment checklist for public assurance via Trust Board by December 2018. This paper sets out a number of requirements the Trust must put in place to comply with the checklist and highlights any areas of non-compliance.
RECOMMENDATION:	Trust Board are asked to: • Note the evaluation of the Flu Programme 2017. • Commit to achieving the ambition of 100% of healthcare workers receiving the vaccine, and any healthcare worker who decides against receiving the vaccine should anonymously mark their reason for doing so. • Agree on a Board Champion for the Flu Campaign 2018. • Approve the proposal for the process of staff opting out of the vaccine. • Commission the formation of a Flu Team. • Note the communications plan set out in the paper. • Note the operational plan to deliver the vaccine, set out in the paper. • Note the progress to date on the best practice

	management checklist.	
PREVIOUSLY CONSIDERED BY:	**Committee**	
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	



BOARD OF DIRECTORS

SUBJECT	Flu Programme 2018	AGENDA REF:	BM 18/09/91

1. BACKGROUND/CONTEXT

This paper provides an update to Trust Board on recent changes to the requirements around the Flu Programme 2018, set out in a joint letter from national clinical and staff side professional leaders including NHS Improvement and NHS England. The letter can be found at appendix 1.

The letter includes a self-assessment checklist for public assurance via Trust Board by December 2018. This paper sets out a number of requirements the Trust must put in place to comply with the checklist and highlights any areas of non-compliance.

2. KEY ELEMENTS

2.1. Flu Programme 2017 Evaluation

The Flu Programme 2017 achieved an uptake level of **85%** of frontline staff against a target of **75%**.

The Programme was very successful. Of particular note was the impact that the visibility of the Occupation Health Team had on the uptake. The whole team committed to vaccinating staff and were able to build on their good reputation across the Trust to achieve the 85% compliance. Vaccinations were available at various times throughout the day and night to accommodate all staff and the team provided targeted mobile clinics on Wards, at training events, and on the corporate induction.

For the first time, the Trust was required to report on staff who did not wish to receive a vaccination. An area to build on for the 2018 is the message to the workforce around opting out of the vaccine. In 2017 the Occupation Health Team did ask staff to complete an anonymous return to set out reasons for opting out. This is a very sensitive topic for some staff and significant challenge was received by the team. This highlights the importance of expectation setting and ownership across senior leaders in the Trust and is important learning for the 2018 Programme.

2.2. Flu Programme 2018

2.2.1. Leadership

A challenging target has been set by national clinical and staff side professional leaders to achieve **100%** uptake for frontline staff. Where staff decline the vaccine, the Trust **must** ask staff to anonymously mark their reason. The Trust **must** report this data monthly throughout the Programme.

The Board are asked to commit to achieving the ambition of 100% of frontline staff receiving the vaccine, and the principle of asking staff to indicate reasons for opt-out.

The Board are also asked to commission the establishment of a **Flu Team** for the period of the Flu Programme 2018. Guidance suggests that a Flu Team is established from senior leaders across staff groups to ensure that there is a consistent message and direction for staff during the Programme. The WHH Flu Team should consist of the Occupational Health Lead Nurse and a senior Leader (Band 8a+) from Nursing, Medical and AHP workforce as well as staff side representatives.

In addition, the **Board are asked** to appoint a **Board Champion** for the Flu Programme 2018. The Board Champion will work with the Occupational Health Team and the wider Flu Team to advocate vaccination to staff and provide leadership to the Programme at the highest level in the organisation.

2.2.2. Communications Plan

The Communications Team are supporting with the campaign for the Flu Programme 2018 and are in the process of finalising the communications plan. The campaign will include myth busters, benefits promotion, senior leaders as advocates, clinic timetables, posters, email, desktop notifications, social media and weekly celebrations of success.

2.2.3. Delivery of the Flu Programme 2018

The Programme delivery plan includes targeting clinical areas and a highly visible presence across the Trust. The aim is to vaccinate over **50% of staff within the first 4 weeks**. The Programme will continue until January 2019 with the option to extend until 31st March 2019 if required. Mobile and drop in clinics will give flexibility of access for staff, as well as out-of-hours provision.

Monthly returns will be submitted to Public Health England which will set out uptake as well as opt-out numbers and reasons.

It is proposed that the opt-out process is lead locally by managers. This will allow close management of the process to prevent duplication of submission. It will also ensure that managers have an overview of the vaccination status in their own areas.

The joint letter from national clinical and staff side professional leaders sets out an **expectation that staff in high risk areas** should inform their Clinical Director/Lead Nurse/Lead AHP of whether they have been vaccinated. The letter sets out that this information should be **held locally** to allow and

overview of safety, including considering changing the deployment of staff where appropriate.

2.3. Best Practice Checklist

The Best Practice Checklist is enclosed with the letter at appendix 1. The Trust is on target to comply with all elements of the checklist, with the **exception** of those set out below:

Quadrivalent (QIV) Flu Vaccine
The letter and checklist set out expectation that the quadrivalent vaccine will be provided to healthcare workers. WHH will be compliant with staff **up to 64 years**. However the guidance issues in February 2018 from NHS England recommended a**djuvanted trivalent vaccine (aTIV) for those over 65 years.** The Trust has therefore ordered and purchased the vaccination QIV for staff up to 65 years and aTIV for staff over 65 years on the guidance from the letter provided as appendix 2. Pharmacy were required to place orders by 29 March 2018. Please note that aTIV vaccination is considered to provide greater protection for the age group identified above.

Peer Vaccinators
The letter and checklist set out expectation that the Trust will utilise peer vaccinators across the workforce. Unfortunately this will not be possible for the Flu Programme 2018 due **concerns raised by the Pharmacy Department** about local storage of the vaccine. Plans are in place to utilise peer vaccinators in 2019.

3. MEASUREMENTS/EVALUATIONS

The final update and opt-out figures will be reported in March 2018. A full evaluation of the Flu Programme 2018 will be conducted in April 2018.

4. RECOMMENDATIONS

Trust Board are asked to:

- Note the evaluation of the Flu Programme 2017.
- Commit to achieving the ambition of 100% of healthcare workers receiving the vaccine, and any healthcare worker who decides against receiving the vaccine should anonymously mark their reason for doing so.
- Agree on a Board Champion for the Flu Campaign 2018.
- Approve the proposal for the process of staff opting out of the vaccine.
- Commission the formation of a Flu Team.
- Note the communications plan set out in the paper.
- Note the operational plan to deliver the vaccine, set out in the paper.
- Note the progress to date on the best practice management checklist.

NHS

Wellington House
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Friday 7 September 2018

To: Chief Executives of NHS Trusts and Foundation Trusts

Dear Colleague

Health care worker flu vaccination

We know you appreciate the importance of all healthcare workers protecting themselves, their patients, their colleagues and their families by being vaccinated against seasonal flu, because the disease can have serious and even fatal consequences, especially for vulnerable patients. Your leadership, supported by the Flu Fighter campaign and the CQUIN has increased take-up of the flu vaccine, with some organisations now vaccinating over 90% of staff. Our ambition is for 100% of healthcare workers with direct patient contact to be vaccinated.

In February, the medical directors of NHS England and NHS Improvement wrote to all Trusts to request that the quadrivalent (QIV) vaccine is made available to all healthcare workers for winter 2018-19 because it offers the broadest protection. This is one of a suite of interventions that can and should be taken to reduce the impact of flu on the NHS.

Today we are writing to ask you to tell us how you plan to ensure that every one of your staff is offered the vaccine and how your organisation will achieve the highest possible level of vaccine coverage this winter.

Healthcare workers with direct patient contact need to be vaccinated because:

a) Recent National Institute for Health and Care Excellence (NICE) guidelines[1] highlight a correlation between lower rates of staff vaccination and increased patient deaths;

b) Up to 50% of confirmed influenza infections are subclinical (i.e. asymptomatic). Unvaccinated, asymptomatic (but nevertheless infected) staff may pass on the virus to vulnerable patients and colleagues;

c) Flu-related staff sickness affects service delivery, impacting on patients and on other staff – recently published evidence suggests a 10% increase in vaccination may be associated with as much as a 10% fall in sickness absence;

d) Patients feel safer and are more likely to get vaccinated when they know NHS staff are vaccinated.

[1] https://www.nice.org.uk/guidance/ng103

In order to ensure your organisation is doing everything possible as an employer to protect patients and staff from seasonal flu we ask that you complete the best practice management checklist for healthcare worker vaccination [appendix 1] and publish a self-assessment against these measures in your trust board papers before the end of 2018.

Where staff are offered the vaccine and decide on the balance of evidence and personal circumstance against having the vaccine, they should be asked to anonymously mark their reason for doing so by completing a form, and you should collate this information to contribute to the development of future vaccination programmes. We have provided an example form [appendix 2] which you may wish to tailor and use locally, though we suggest you use these opt out reasons to support national comparisons.

We specifically want to ensure greatest protection for those patients with specific immune-suppressed conditions, where the outcome of contracting flu may be most harmful. The evidence suggests that in these 'higher-risk' clinical environments more robust steps should be taken to limit the exposure of patients to unvaccinated staff and you should move as quickly as possible to 100% staff vaccination uptake. At a minimum these higher-risk departments include haematology, oncology, bone marrow transplant, neonatal intensive care and special care baby units. Additional areas may be identified locally where there are a high proportion of patients who may be vulnerable, and are receiving close one-to-one to clinical care.

In these higher-risk areas, staff should confirm to their clinical director / head of nursing / head of therapy whether or not they have been vaccinated. This information should be held locally so that trusts can take appropriate steps to maintain the overall safety of the service, including considering changing the deployment of staffing within clinical environments if that is compatible with maintaining the safe operation of the service.

We would strongly recommend working with your recognised professional organisations and trade unions to maximise uptake of the vaccine within your workforce; to identify and minimise any barriers; to discuss and agree which clinical environments and staff should be defined as 'higher-risk'; and to ensure that the anonymous information about reasons for declining the vaccine is managed with full regard for the dignity of the individuals concerned. Medical and nurse director colleagues will need to undertake an appropriate risk assessment and discuss with their staff and trade union representatives how best to respond to situations where clinical staff in designated high risk areas decline vaccination.

It is important that we can track trusts' overall progress towards the 100% ambition. Each trust shall continue to report uptake monthly during the vaccination season via 'ImmForm'. However from this year you are also required to report how many healthcare workers with direct patient contact have been offered the vaccine and opted-out. This information will be published monthly by Public Health England on its website.

By February 2019 we expect each trust to use its public board papers to locally report their performance on overall vaccination uptake rates and numbers of staff declining the vaccinations, to include details of rates within each of the areas you designate as 'higher-risk'. This report should also give details of the actions that you have undertaken to deliver the 100% ambition for coverage this winter. We shall collate this information nationally by

asking trusts to give a breakdown of the number of staff opting out against each of the reasons listed in appendix 2.

You can find advice, guidance and campaign materials to support you to run a successful local flu campaign on the NHS Employers Flu Fighter website www.nhsemployers/flufighter

Finally we are pleased to confirm that NHS England is once again offering the vaccine to social care workers free of charge this year. Independent providers such as GPs, dental and optometry practices, and community pharmacists, should also offer vaccination to staff. There are two parallel letters to primary care and social care outlining these proposals in more detail.

Yours sincerely

- signed jointly by the following national clinical and staff side professional leaders -

Prof Stephen Powis ....National Medical Director, NHS England and on behalf of National Escalation Pressures Panel

Prof Paul Cosford .. Medical Director & Director of Health Protection, Public Health England

Prof Jane Cummings .... Chief Nursing Officer, NHS England

Sara Gorton (Unison).. Co-chair, National Social Partnership Forum

Prof Dame Sue Hill.. Chief Scientific Officer, NHS England

Dame Donna Kinnair. Acting Chief Executive & General Secretary, Royal College of Nursing

Prof Carrie MacEwen .... Chair of the Academy of Medical Royal Colleges

Ruth May... Executive Director of Nursing, NHS Improvement

Dr Kathy Mclean... Executive Medical Director NHS Improvement

Danny Mortimer (NHS Employers)..................... Co-chair, National Social Partnership Forum

Pauline Philip ....National Director of Urgent and Emergency Care

Suzanne Rastrick................................ Chief Allied Health Professions Officer, NHS England

Keith Ridge...Chief Pharmaceutical Officer, NHS England

John Stevens ....Chairman, Academy for Healthcare Science

Gill Walton .... Chief Executive, Royal College of Midwives

Appendix 1 - Healthcare worker flu vaccination best practice management checklist – for public assurance via trust boards by December 2018

A	**Committed leadership** (number in brackets relates to references listed below the table)	**Trust self-assessment**
A1	Board record commitment to achieving the ambition of 100% of front line healthcare workers being vaccinated, and for any healthcare worker who decides on the balance of evidence and personal circumstance against getting the vaccine should anonymously mark their reason for doing so.	
A2	Trust has ordered and provided the quadrivalent (QIV) flu vaccine for healthcare workers (1).	
A3	Board receive an evaluation of the flu programme 2017-18, including data, successes, challenges and lessons learnt (2,6)	
A4	Agree on a board champion for flu campaign (3,6)	
A5	Agree how data on uptake and opt-out will be collected and reported	
A6	All board members receive flu vaccination and publicise this (4,6)	
A7	Flu team formed with representatives from all directorates, staff groups and trade union representatives (3,6)	
A8	Flu team to meet regularly from August 2018 (4)	
B	**Communications plan**	
B1	Rationale for the flu vaccination programme and myth busting to be published – sponsored by senior clinical leaders and trade unions (3,6)	
B2	Drop in clinics and mobile vaccination schedule to be published electronically, on social media and on paper (4)	
B3	Board and senior managers having their vaccinations to be publicised (4)	
B4	Flu vaccination programme and access to vaccination on induction programmes (4)	
B5	Programme to be publicised on screensavers, posters and social media (3, 5,6)	
B6	Weekly feedback on percentage uptake for directorates, teams and professional groups (3,6)	
C	**Flexible accessibility**	
C1	Peer vaccinators, ideally at least one in each clinical area to be identified, trained, released to vaccinate and empowered (3,6)	
C2	Schedule for easy access drop in clinics agreed (3)	
C3	Schedule for 24 hour mobile vaccinations to be agreed (3,6)	
D	**Incentives**	
D1	Board to agree on incentives and how to publicise this (3,6)	
D2	Success to be celebrated weekly (3,6)	

Reference links

1. http://www.nhsemployers.org/-/media/Employers/Documents/Flu/Vaccine-ordering-for-2018-19-influenza-season-06022018.pdf?la=en&hash=74BF83187805F71E9439332132C021EFA3E6F24C
2. http://www.nhsemployers.org/-/media/Employers/Publications/Flu-Fighter/Reviewing-your-campaign-a-flu-fighter-guide.pdf
3. http://www.nhsemployers.org/-/media/Employers/Documents/Flu/Flu-fighter-infographic-final-web-3-Nov.pdf
4. http://www.nhsemployers.org/-/media/Employers/Publications/Flu-Fighter/good-practice-acute-trusts-TH-formatted-10-June.pdf
5. http://www.nhsemployers.org/-/media/Employers/Publications/Flu-Fighter/good-practice-ambulance-trusts-TH-formatted-10-June.pdf
6. https://www.nice.org.uk/guidance/ng103/chapter/Recommendations

Appendix 2 – Example opt out forms for local adaptation and use

Form to be potentially co-branded by NHS organisation and key trade unions

Dear colleague,

Did you know that 7 out of 10 front line NHS staff had the flu vaccine last year, and in some departments more than 9 out of 10 staff were vaccinated?

The flu jab gives our body the information it needs to fight the flu, which stops us from contracting and spreading the virus. For those of us who work in care settings, getting the flu jab is an essential part of our work. In vaccinating ourselves we are protecting the people we care for, and helping to ensure that we are able to provide the safest environment and effective care for patients.

We want everyone to have the jab. The sooner you get it, the more people you can protect. We hope that you will agree to having the vaccine – this really helps to protect patients, you and your family. But, if you choose not to have the flu vaccine, we want to understand your reasons for that by filling in this anonymous form.

Signed

Chief Executive, Medical Director, Director of Nursing, and Trade Union representative

Please tick to confirm that you have chosen not to have the vaccine this year:

☐ I know that I could get flu and have only mild symptoms or none at all; and that because of this I could give flu to a patient. I know that vaccination is likely to reduce the chances of me getting flu and of me passing it to my patients. But I still don't want the vaccine.

Please tick each of the boxes below that apply to your decision not to have the jab.

I DON'T WANT TO BE FLU VACCINATED BECAUSE:

☐ I don't like needles

☐ I don't think I'll get flu

☐ I don't believe the evidence that being vaccinated is beneficial

☐ I'm concerned about possible side effects

☐ I don't know how or where to get vaccinated

☐ It was too inconvenient to get to a place where I could get the vaccination

☐ The times when the vaccination is available are not convenient

☐ Other reason – please tell us here ▸

____

Thank you for completing this form.

NHS England gateway reference: 07648

To:

Heads of Public Health, Heads of Primary Care and SILs

For dissemination to: General Practice and Community Pharmacies

Operations and Information Directorate
NHS England
Quarry House
Quarry Hill
Leeds
LS2 7UE
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5 February 2018

Dear Colleague

Vaccine ordering for 2018-19 influenza season

This letter asks GPs and Community Pharmacists to ensure their influenza vaccine orders for the 2018/19 season use the most effective vaccines for the population.

The clinical evidence available to GP practices and community pharmacists from the Joint Committee on Vaccination and Immunisation (JCVI) and published in the Green book in October (for quadrivalent vaccine) and December (for adjuvanted trivalent vaccine), ahead of orders being placed for 2018/19, is clear that for the 2018-19 winter season, GP practices and Community Pharmacy providers should offer:

- **The adjuvanted trivalent vaccine (aTIV) for all 65s and over**. Given aTIV was only licensed for use in the UK in August 2017, this was not an option for the 2017/18 season. However the JCVI advice is that this is now the best option for 2018/19 for 65+ age group
- **The quadrivalent vaccine (QIV) for 18 – under 65s at risk**. In light of an independent cost-effectiveness study into QIV undertaken by Public Health England and considered by JCVI, the Green Book was updated in October 2017 to provide the advice that QIV is the best option for 18-65 at-risk groups in the 2018/19 season. It is also used for the childhood programme.

While clinicians are professionally responsible for forming their own clinical judgements on whether a particular individual should receive the flu vaccine due to a variety of other factors, use of these more effective vaccines in the 2018/19 season is clearly in the best interests of patients, particularly given the association of flu with increased mortality.

GPs and community pharmacy contractors should review all orders (provisional and firm) for the 2018-19 season and ensure these are in line with the evidence-based clinical view i.e. **65 year olds and over to receive aTIV, and under 65s in at risk groups, including pregnant women, to receive QIV** for the 2018-19 flu season.

Suppliers have confirmed that there will be enough adjuvanted trivalent vaccine and quadrivalent influenza vaccine to meet demand. Orders will need to be placed by **29 March 2018.** If you encounter any difficulties from a manufacturer placing or amending an order, please advise your local NHS England team.

NHS England is able to confirm that that there will be additional funding available in 2018/19, to support use of adjuvanted trivalent vaccine and quadrivalent influenza vaccine.

Attached to this letter is more detailed advice and frequently asked questions.

Yours sincerely

Professor Stephen Powis	**Dr Arvind Madan**	**Professor P Cosford**
National Medical Director	**Director of Primary Care**	**Medical Director**
NHS England	**NHS England**	**Public Health England**

NHS England

Influenza vaccine 2018-19

Advice and FAQs

1. What is the evidence of clinical and cost-effectiveness of seasonal flu vaccines?

The **adjuvanted trivalent inactivated flu vaccine (aTIV),** (Fluad®: Seqirus) was licensed late in 2017 and is available for use in the 2018-19 season. JCVI concluded at its October 2017 meeting that adjuvanted trivalent flu vaccine is more effective and highly cost effective in those aged over 65 years and above compared with the non-adjuvanted or 'normal' influenza vaccines currently used in the UK for this age-group. JCVI agreed that aTIV would be considered the optimal clinical choice for all patients aged 65 years and over. The JCVI specifically considered that the use of the adjuvanted trivalent flu vaccine should be a priority for those aged 75 years and over**,** given that the non-adjuvanted inactivated vaccine has showed no significant effectiveness in this group over recent seasons**.**

JCVI have also reconsidered the use of **quadrivalent influenza vaccines (QIV),** which offer protection against two strains of influenza B rather than one. As influenza B is relatively more common in children than older age groups, the main clinical advantage of these vaccines is in childhood. Because of this, those vaccines centrally purchased for the childhood programme in recent years have been quadrivalent preparations. Further modelling work by PHE suggests that, the health benefits to be gained by the use of quadrivalent vaccines compared to trivalent vaccines, **is more substantial in at risk adults under 65 years of age, including pregnant women**. On average use of quadrivalent over trivalent is likely to lead to reduced activity in terms of GP consultations and hospitalisations, and PHE's work suggests that the overall public health benefit would justify the additional cost of the vaccines compared to trivalent vaccines**.**

2. Where can I get more detail of the clinical evidence and data about the best vaccines to use?

Influenza chapter of the 'Green Book':

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/652682/Greenbook_chapter_19_flu.pdf

Supplemental data from PHE to support the Green book:

https://www.gov.uk/government/publications/flu-vaccination-supporting-data-for-adult-vaccines

3. Is there enough adjuvanted trivalent vaccine (aTIV) and quadrivalent influenza vaccine (QIV) for 2018/19?

Yes.

Seqirus is the only manufacturer of the adjuvanted trivalent influenza vaccine Fluad®. They have confirmed that there will be enough supply for England subject to orders being placed by 5pm Thursday 29th March.

Sanofi Pasteur is producing a quadrivalent influenza vaccine again in 2018/19 and has confirmed they are able to fulfil orders of any size, provided these are made by 5pm Thursday 29th March.

Mylan is also offering a quadrivalent influenza vaccine in 2018/19 and have indicated that they can also take additional orders during February 2018.

It is possible further supplies of quadrivalent from other manufacturers may be confirmed in the coming weeks.

4. I have noted that the only adjuvanted vaccine is trivalent (not quadrivalent). Does this matter?

At the present time there are no adjuvanted quadrivalent vaccines licensed in the UK. JCVI advice covers those vaccines available in the UK. **JCVI is clear that the best vaccine for the over 65s is the currently licensed adjuvanted vaccine, even though it is trivalent.**

Modelling work by PHE suggests that there are relatively small health benefits to be gained by the use of quadrivalent vaccines in the elderly, compared to trivalent vaccines. **The best vaccine for the over 65s is the currently licensed adjuvanted vaccine, even though it is trivalent.**

5. What advice is there on managing multiple vaccines for different patient cohorts safely in practices?

Practices will already be used to handling more than one influenza vaccine for example; live attenuated influenza vaccine for most children but inactivated vaccine for those with egg allergies or immune compromise. The usual procedures for the safe administration of vaccine should be followed. PHE will provide updated advice to address any outstanding issues.

6. I have already ordered my vaccines, do I have to switch?

The advice from JCVI and PHE and clinical evidence base show that use of adjuvanted trivalent vaccine (aTIV) for patients aged 65 and over, and quadrivalent influenza vaccine (QIV) for under 65 at-risk patients, including all pregnant women, is in the best interests of patients.

Clinicians are professionally responsible for forming their own clinical judgements, which take account of the most up to date and reliable scientific evidence, and must act in the interests of patients. This is a contractual and professional duty. Independent expert clinical advice is that adjuvanted trivalent inactivated flu vaccine or quadrivalent vaccines are the clinically preferred choices for the respective patient groups. Use of these vaccines is clearly in the best interests of patients, particularly given the association of flu with increased mortality.

We are asking GPs/community pharmacies to ensure that flu vaccine procurement for 2018/19 is aligned with the clinical evidence-base.. If, after review, orders need to be switched to alternative vaccines, we are asking that this is done promptly, meeting the deadlines for ordering.

If you encounter any difficulties with an individual manufacturer in changing your order to reflect the clinical evidence base, please advise your NHS England local team.

Where despite this advice, a practice/ pharmacy seeks reimbursement for vaccine other than adjuvanted tri-valent and/or QIV NHS England may make enquiries to understand how the evidence of clinical efficacy of aTIV and QIV was taken into account by that practice when deciding to order other vaccines, and how the clinical judgement to use those vaccines was reached. It will wish to be satisfied that such a decision was an exercise of reasonable care and skill as required by the GMS/PMS contracts.

7. What should I do if I want to switch my order?

Contact the supplier(s) you want to switch to. They have guaranteed to extend the order dates (see Q3) and maintain the same prices for that extended period, and will be happy to discuss with you the process of switching your order. You will also need to contact any supplier(s) you have placed a provisional order with; although responsibility sits with you as the purchaser; the provider you are switching to may be able to provide advice on this.

8. I have already ordered my vaccines, will the suppliers of aTIV and QIV be offering competitive prices when I am ordering in January or February?

There are a number of suppliers and Seqirus, Mylan and Sanofi Pasteur have informed us that existing prices and discount structures for their respective products will be held until the ordering windows close. (see Q3 above for precise details, which differ by company).

9. What happens if I miss the deadline for ordering?

Community Pharmacies and GP Practices should make every effort to adjust their orders in line with the evidence base, and within the timeframes specified above. Orders made after the deadlines specified above cannot be guaranteed; but GPs in the position of needing to place a late order should discuss this with the relevant manufacturer directly who will handle this on a case-by-case basis.

10. How are GP practices reimbursed for aTIV and QIV?

There is no change in the process. Practices claim reimbursement through the NHSBA for vaccines used to immunise eligible patients based on the NHS list prices.

11. How are community pharmacies reimbursed for aTIV and QIV

There is no change in the process.

12. What funding is available for holders of vaccine budget and how is this accessed?

NHS England is able to confirm that that there will be additional funding in 2018/9 available, to the body that holds the budget for flu vaccines, either CCG or local NHS England team.

13. What does this mean for CCGs

Where CCGs issue local advice on this topic it should be consistent with the national advice that the new adjuvanted trivalent vaccine for use in those aged 65 years and over, and QIV for at-risk adults under 65 years (including pregnant women) should be used.

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BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/18/09/92**
SUBJECT:	**Emergency Preparedness Resilience and Response (EPRR) Annual Report 2017/18**
DATE OF MEETING:	26 September 2018
ACTION REQUIRED	**For information**
AUTHOR(S):	Keith Preston Interim Emergency Planning Co-ordinator
EXECUTIVE DIRECTOR SPONSOR:	Chris Evans- Chief Operating Officer
LINK TO STRATEGIC OBJECTIVES:	SO1: To ensure that all care is rated amongst the top quartile in the North West of England for patient safety, clinical outcomes and patient experience
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	BAF1.3: National & Local Mandatory, Operational Targets
STRATEGIC CONTEXT	The purpose of the annual report is to:- ▪ Provide an overview of the emergency preparedness arrangements within Warrington and Halton Hospitals NHS Foundation Trust. ▪ Outline the work that has been undertaken in the area during the past 12 months. ▪ Describe our response to incidents which have occurred during 2017-2018. ▪ Summarise our planned work streams and priorities for the year ahead.
EXECUTIVE SUMMARY (KEY ISSUES):	NHS Acute Hospital Trusts are defined as 'Category 1 Responders' by the 2004 Civil Contingencies Act. This carries legal duties to have up to date plans and procedures to underpin the response to a wide range of Major Incidents and Business Continuity challenges. Under the Act, Acute Trusts must show that they can effectively respond to emergencies and business continuity incidents while maintaining services to patients. This work is referred to as Emergency Preparedness, Resilience and Response (EPRR). The range of scenarios is extremely wide and includes

	mass casualty incidents, infectious disease outbreaks, severe weather, criminal/terrorist events, loss of power/ utilities and staff absence. The NHS England EPRR Core Standards are the minimum standards which NHS organisations and providers of NHS funded care must meet. This report reviews incidents and work that has been undertaken in the past twelve months. In recent months the importance of robust emergency planning, preparedness and exercising has been highlighted with the terror attacks in London and Manchester, The Grenfell Tower Fire.
RECOMMENDATION:	The Board is asked to note the work undertaken during 2017-2018 and the planned work programme for 2018-9 in support of the Trust's objectives.
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	

1. BACKGROUND/CONTEXT

All NHS organisations are required to deliver their legal duties and responsibilities for Emergency Preparedness, Resilience and Response (EPRR) set out in The Civil Contingencies Act 2004. As a Category 1 responder under the Act, we have a duty to develop robust plans to prepare and respond effectively to emergencies, to assess risks and develop plans in order to maintain the continuity of our services in the event of a disruption.

This report reviews EPRR work and incidents that have been undertaken in the year. However in recent months the importance of robust emergency planning, preparedness and exercising has been highlighted with the terror attacks in London and a few miles away at Manchester Arena. In addition the tragic Grenfell Tower Fire and Salisbury Novichok poisoning have highlighted the need for sound plans, trained staff and a practiced response.

2. KEY ELEMENTS

PURPOSE

The purpose of the annual report is to:-

- Provide an overview of the emergency preparedness arrangements within Warrington and Halton Hospitals NHS Foundation Trust.
- Outline the work that has been undertaken in the area during the past 12 months.
- Describe our response to incidents which have occurred during 2018-19.
- Summarise our planned work streams and priorities for the year ahead.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

EMERGENCY PREPAREDNESS STRUCTURE

The Trust has a Major Incident Plan in place which is built on the principles of risk assessment, multi-agency co-operation, emergency planning, sharing information and communicating with public. This plan is underpinned by a number of associated business

continuity plans which outline how our critical services will continue to be provided in the event of a disruptive incident.

Lead Officers

- Chris Evans- Chief Operating Officer, is the designated Lead Executive Director with responsibility for Trust Emergency Planning
- Terry Atherton is the Non-Executive Director nominated to support the Acting Chief Operating Officer in this role.
- The Lead Director is supported by Emma Blackwell, Resilience Manager. N.B. Since August 2017 this post has been covered by a part time Interim Emergency Planning Co-ordinator.

Committee Structure

In order to discharge our responsibilities effectively under the Civil Contingencies Act (2004), emergency preparedness arrangements have been embedded into the trust's Committee structure.

The Event Planning Group (EPG), chaired by the Chief Operating Officer is charged with the responsibility of overseeing the development of emergency preparedness arrangements within the Trust. The group meets on a monthly basis and its' membership includes senior managers from all Clinical Business Units and corporate services.

In addition to Emergency Preparedness matters the role of the EPG is to anticipate and plan for forthcoming events which are likely to prevent a challenge to our services and resources and to develop co-ordinated plans in advance. Minutes of the Group's meetings are produced and high level briefing reports are provided to the Quality Committee. Corporate plans, approved at the EPG, are formally ratified at the Quality Committee meetings.

EPRR External Structure:

NHS England Area Team have the lead responsibility for co-ordinating a local health response to an emergency. A Cheshire, Halton and Warrington Local Health Resilience Partnerships (LHRP) exists to deliver National EPRR strategy in the context of local risks. The LHRP brings together the health sector organisations involved in emergency preparedness and strengthen cross-agency working.

The quarterly Strategic LHRP meetings are attended by The Chief Operating Officer or Deputy. The Trust EPRR Co-ordinator attends the Practitioner and task group meetings.

Out of Hours Arrangements:

The Trust operates a Senior Manager On Call l 24/7, 365 day on-call rota and ensures that Senior Managers and Executive Directors are contactable at all times and are able to

respond quickly to a major or serious incident at any time. This structure is supported by specific clinical and departmental on-call rotas which are designed to underpin a response to local service-related operational issues.

4. IMPACT ON QPS

EXERCISES AND TRAINING

The Trust has an ongoing programme of exercises and training events to test and validate emergency plans. Details of all of these events are reported in Appendix 1.

ASSURANCE PROCESS

The Trust is required to undertake an annual self-assessment against the 59 NHS England Core Standards for EPRR. This was last undertaken in September 2017. This included a 'deep dive' into business continuity planning.

The Trust was able to evidence full compliance with 57 of the 59 Core Standards which gave an overall rating of 'Green- Substantial
Compliance level. The two areas identified requiring action were:

a. Attendance of the Accountable Emergency Officer at quarterly Strategic LHRP meetings
b. Enhancements required to the Trust Silver tactical Control room

Both have now been addressed to full compliance standard

The outcomes were presented to the Board in September 2017.

The 2018 EPRR Core Standards Audit has recently been announced and work has been commenced for completion by September 2018.

5. MEASUREMENTS/EVALUATIONS

INCIDENTS & EXERCISES

During 2017-18 the following significant incidents and exercises are of note:

24 Aug 2017 -'Cream fields' Music and Dance festival at Daresbury , Warrington

Numerous patients brought into Emergency Department in Police Custody, suspected of internal concealment illegal drugs.

6 Nov 2017 Warrington Site Electrical Power/Bleep outage

Some short term disruption to internal systems , managed on site with support of Business Continuity Plans

17th Dec 2017 Trust Major Incident Communications Exercise -' Exercise Checker'

A test of effectiveness and efficiency of Trust notification plans. Identified potential for significant low cost improvements utilising an information technology solution

21st Dec 2017 Trust Major Incident- Mass Casualty 'Exercise Concourse'

A test of Emergency Dept. Major Incident Plans and development of a template for further staff training

January 2018 Winter Pressures Capacity Challenge co-ordination

An extended two week period requiring an Executive Led Incident Co-ordination Team working in the Trust Tactical -Silver Control Room . Identified a number of improvements to be made in the Silver Control Room including computers, telephony, recording methods and support equipment

23rd March 2018 Building Fire in the Roof of Kendrick Building

A fire in the roof of the Kendrick building caused smoke and water damage to the Ophthalmology Day case Unit. Staff and patients were safely evacuated with no injuries. The incident was managed on site, Business Continuity Plans were implemented and affected staff and services relocated.

5th June 2018 Trust staff participated in a major incident mass casualty exercise,- Exercise Golden Eagle

Exercise Golden Eagle was an NHSE sponsored Cheshire and Merseyside Major Incident Mass Casualty Exercise, with the aim of testing the NHS England Concept of Operations for Managing Mass Casualties. All Acute Trusts with Trauma Units, and the Aintree Trauma Centre were requested to participate.

The exercise format was the national 'EMERGO' casualty simulation format, using simulated scene attendance, assessment, casualty clearing, initial triage of patients and transport to designated hospitals, in real time. The Trust fully committed to the exercise and the opportunity to brief and train staff, and exercise multiple elements of our Trust Major Incident Plans.

The approach was to work with the actual demands staff and space availability on the day, using real time information from the Lorenzo system, Bed Managers, ED. Theatres and Critical Care . In addition to absorb and treat the simulated patients arriving at the hospital from the exercise scenario. In total there were 40 active Trust participants and 10 'visitor/observers' including The Chief Executive and Deputy.

A total 36 Exercise patients were nominally admitted and treated on the day. Each patient was tracked from arrival in ED through radiology, Surgery, Critical Care and to the wards or discharge . See patient classification table below :

Patient Triage Classification	Number of Casualties
Priority 1 - Immediate life saving care needed	22
Priority 2- Urgent care needed	3
Priority 3- Delayed care needed	11

The exercise was a major undertaking and tested multiple, elements of our Emergency Preparedness. It also served as an excellent staff training opportunity. NHS England have declared that full commitment and participation in the exercise has satisfied the EPRR Core Standard for Acute Trusts to carry out a Live Major Incident Exercise every 3 years.

Debrief reports, comments and actions have been reported to the Events Planning Group for action and opportunities are now being explored to use the exercise format for future Trust training and exercising. Key elements of our Exercise Golden Eagle experience are currently being briefed to all On Call Executives and Senior Managers as part of a rolling programme of Major Incident Management briefings

6. TRAJECTORIES/OBJECTIVES AGREED

WORK UNDERTAKEN IN 2017-18

The following work streams were completed during the year under review:

- Chris Evans has taken over as the Trust Executive Accountable Emergency Officer
- The Trust has participated and contributed fully in all Local Health Resilience Partnership meetings and work streams
- Close liaison has been maintained with partner agencies in planning for local major events i.e. Warrington Neighbourhood Event June 2018 and the annual Creamfields festival
- Membership and terms of reference of the EPG have been reviewed and updated and meeting frequency increased
- Training has been delivered to Key staff in Emergency Preparedness and Incident Management

- The Trust Tactical/Silver Incident Control Room equipment has been significantly enhanced
- Assurance has been provided to NHS England on Trust compliance with the EPRR core standards.

WORK PROGRAMME FOR 2018-19

In 2017-18 the focus was on ensuring the Trust has robust resilience plans in place in the event of any major incident or business continuity incident. To date in 2018-19 the emphasis has been on raising staff awareness, testing plans and identifying and to action areas for improvement.

EPRR is an ongoing cycle of Planning, Training, Testing and Improving. In 2018-19 the emphasis will once again be on reviewing and updating our key Emergency /Major Incident and Business Continuity Plans, acknowledging the experience gained and feedback from testing and exercising.

This will coincide with the return to post of the Trust Resilience Manager, following an extended period of leave .

In addition to this, we will continue to ensure the following work plans are undertaken:-

- Continue as a full and active member of the Local Health Resilience Planning Group
- Update plans and procedures in line with any new National guidance
- Monitor the lessons learned from other incidents in the UK and the evolving security status.
- Review the winter planning arrangements for 2017-18 to identify lessons learnt. Develop a plan for the winter of 2018-19 in conjunction with health partners.
- Participate in multi-agency exercises and training with partner organisations in accordance with priorities identified by the Local Health Resilience Partnership (LHRP).
- Develop specific plans for all bank holiday weekends, the 2018 Cream fields Music Festival, and Christmas and New Year, in order to anticipate and meet potential demand management pressures in the health care system.

7. MONITORING/REPORTING ROUTES

The NHS England led LHRP meets monthly externally and is attended by the Trust Emergency planning lead, the outcomes are fed into the Trust Events Planning Group meeting.

The 2018 NHS EPRR Core Standards Audit will commence in August 2018 for submission to NHS England in September 2018

EPG Minutes are referred to the Trust Operations Board

8. TIMELINES

This report is presented annually to the board in September

9. ASSURANCE COMMITTEE

The Events Planning Group escalates issues to the Trust Operations Board

10. RECOMMENDATIONS

The Board is asked to note the significant EPRR work and achievements undertaken during 2017-18 and the planned work programme for 2018-19 in support of the Trust's objectives.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/18/09/93**	
SUBJECT:	Safe Staffing Report – 6 monthly review	
DATE OF MEETING:	July 2018 – Amended for September Board Meeting.	
ACTION REQUIRED	To discuss, note the contents and actions outlined within the report.	
AUTHOR(S):	Rachael Browning – Associate Chief, Nurse Clinical Effectiveness	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse	
LINK TO STRATEGIC OBJECTIVES:	SO2: To have a committed, skilled and highly engaged workforce who feel valued, supported and developed and who work togther to care for our patients	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	BAF2.2: Nurse Staffing BAF2.5: Right People, Right Skills in Workforce BAF2.1: Engage Staff, Adopt New Working, New Systems	
STRATEGIC CONTEXT		
EXECUTIVE SUMMARY (KEY ISSUES):	This paper details the six monthly review of nurse staffing in line with the commitment requested by the National Quality Board in 2016 and more recently in the Improvement Resource for Adult Inpatient Wards in Acute Hospitals January 2018. • The report provides details of the current nurse staffing workforce data, including numbers of staff in post, turnover of staff and workforce development with the introduction of Nursing Associates in January 2019. • The report represents the review of a two week sample of census data recorded within the SafeCare acuity and dependency system in April 2018. The data shows a deficit of 58.06wte RN's and in the previous 6 monthly Board Staffing Report reported a deficit of 36.78 WTE. This was following the first run of acuity measurement using the SNCT. • The Recruitment and Retention Strategy 2017 remains a priority with actions closely monitored by the Chief Nurse. Innovative recruitment campaigns continue with flexible working opportunities and 'night only' contracts on offer as an example. • Details of staffing incidents are included in the report, along with the introduction of recording 'red flag' as recommended by NICE.	
RECOMMENDATION:	It is recommended that the Board of Directors review and discuss this report.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee
	Agenda Ref.	QAC/18/09/104
	Date of meeting	4 September 2019
	Summary of Outcome	Approved
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None	

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1. Introduction

This paper details the six monthly review of nurse staffing in line with the commitment requested by the National Quality Board (NQB) document, 'Supporting NHS Providers to deliver the right staff, with the right skills, in the right place at the right time – safe and sustainable staffing ' (2016) in response to the Francis Enquiry (2013). The NQB guidance has been further refreshed, broadened and re issued in January 2018 with the provision of 'An Improvement resource for Adult In-patient Wards in Acute Hospitals' which recommendations that Boards should carry out a strategic staffing review at least annually.

The following report is presented as an expectation of the NQB guidance and represents the outcome of reviewing the acuity and dependency data recorded in the Safe Care system for two weeks in April 2018 at WHH.

All Ward Sisters / Charge Nurses, Matrons, Lead Nurses and the Associate Chief Nurse, Clinical Effectiveness participate in the acuity and dependency review process.

2. National context and expectations of the National Quality Board

Boards of Trusts are ultimately responsible for the quality of care they provide, and for the outcomes they achieve. It is well documented that nursing, midwifery and care staff capacity impacts on the ability to deliver a quality experience to our patients and that this has an effect on patient outcomes. Multiple studies have linked low staffing levels to poorer patient experience and outcomes along with increased mortality rates.

The NQB (2016) described three main expectations of NHS Provider Boards to ensure their organisation has the right culture, leadership and skills in place for safe, sustainable and productive staffing. They are also responsible for ensuring proactive, robust and consistent approaches to measurement and continuous improvement, including the use of a local quality framework for staffing that will support safe, effective, caring, responsive and well led care.

Safe, Effective, Caring, Responsive and Well-Led Care		
Measure and Improve - patient outcomes, people productivity and financial sustainability - - report investigate and act on incidents (including red flags) - - patient, carer and staff feedback -		
- Implementation Care Hours per Patient Day (CHPPD) - - develop local quality dashboard for safe sustainable staffing -		
Expectation 1	**Expectation 2**	**Expectation 3**
Right Staff 1.1 evidence-based workforce planning 1.2 professional judgement 1.3 compare staffing with peers	**Right Skills** 2.1 mandatory training, development and education 2.2 working as a multi-professional team 2.3 recruitment and retention	**Right Place and Time** 3.1 productive working and eliminating waste 3.2 efficient deployment and flexibility 3.3 efficient employment and minimising agency

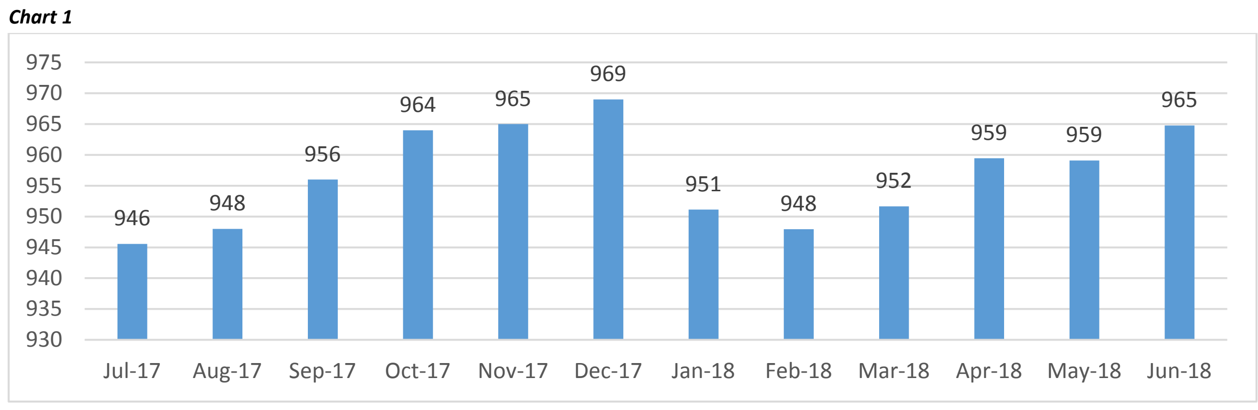
3. Workforce Information - Warrington and Halton Hospitals (WHH)

There is a growing body of evidence which shows that nurse staffing levels makes a difference to patient outcomes (mortality and adverse events) patient experience, quality of care and the efficiency of care delivery. Short staffing compromises care and recurrent short staffing results in increased stress and reduced staff wellbeing, leading to higher sickness and a higher turnover rate as more staff leave.

3.1. Staff in post

Chart 1 below shows the total number of budgeted registered nursing and midwifery staff in post by month since May 2017 to April 2018. January 18 highlights a reduction in nursing staff due to high number of leavers and low number of new recruits. The senior nursing team are undertaking a focused approach for staff retention; including 'itchy feet' senior nurse conversations, offering of ward moves and flexible contracts in order to retain staff.

Chart 1



In March 2018 a review was undertaken on the Registered Nurse (RN) and Health Care Assistants (HCA) across 23 wards at WHH. The purpose of the staffing review was to evaluate the current staffing establishments on the wards across the Trust and identify the correct minimum and safe staffing levels for both RN and HCA. As a result of this review and the development of a subsequent business case, approval was given for a significant financial injection (£3.0m) to staffing budgets of wards in scope of the review.

Chart 2 identifies the number of band 5 vacancies based on the funded establishments against the number of staff in post. Band 5 nursing vacancies reduced from 93 whole time equivalent (wte) in May 2017 to 69wte in March 2018, representing a reduction of 33%. In April 2018 an increase of 20 nursing vacancies has been added to the total, this is reflective of the allocated uplift to staffing numbers in the business case.

Chart 2

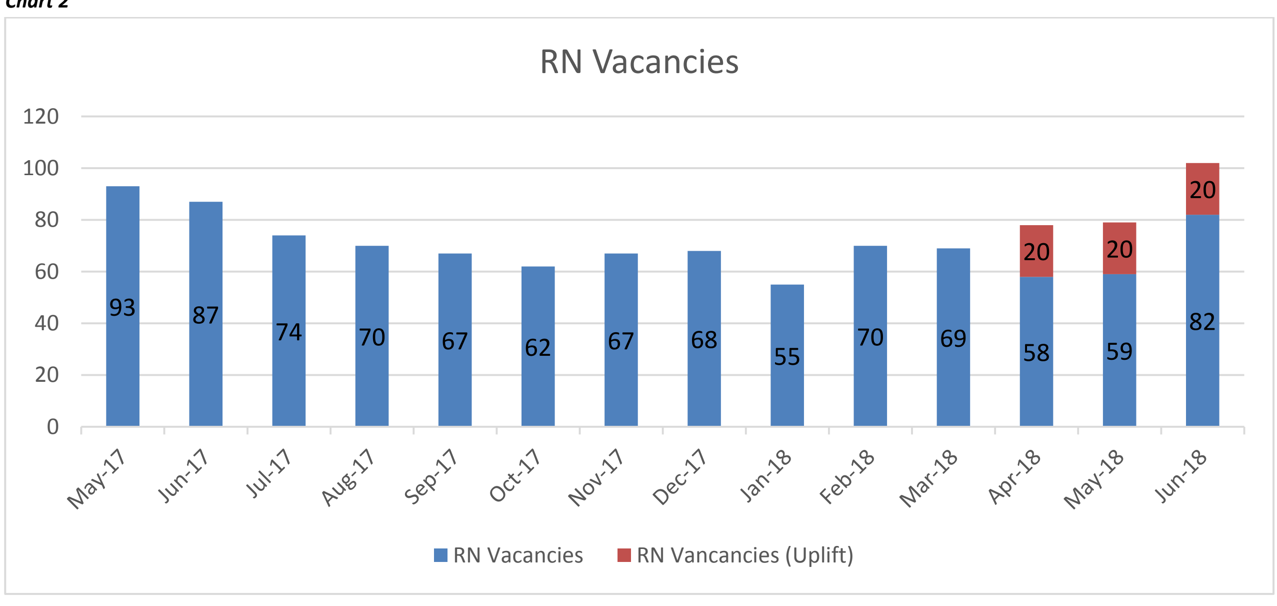
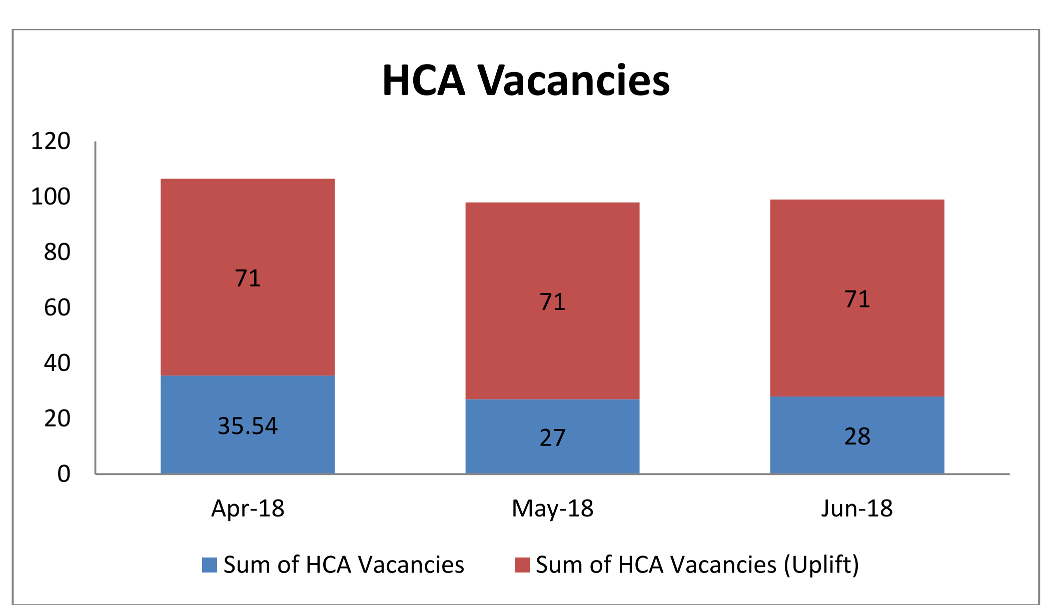


Chart 3 identifies the number of HCA vacancies based on the funded establishments against the number of staff in post. In April 2018 an increase of 71 HCA vacancies has been added to the total, this is reflective of the allocated uplift to staffing numbers in the business case.

Chart 3



3.2. Staff Turnover

Chart 4 illustrates nursing and midwifery turnover which in June 2017 was 12.47% against the national average of 11.79%. An 'exit interview' analysis is to be undertaken in October 2018 order to provide greater insight into the reasons identified for staff leaving and support the trust in its priority to reduce

turnover rates for nursing and midwifery staff. Particular focus will be for those leaving within a 12 month period. Results of which will have an impact on the overall turnover rate.

Chart 4

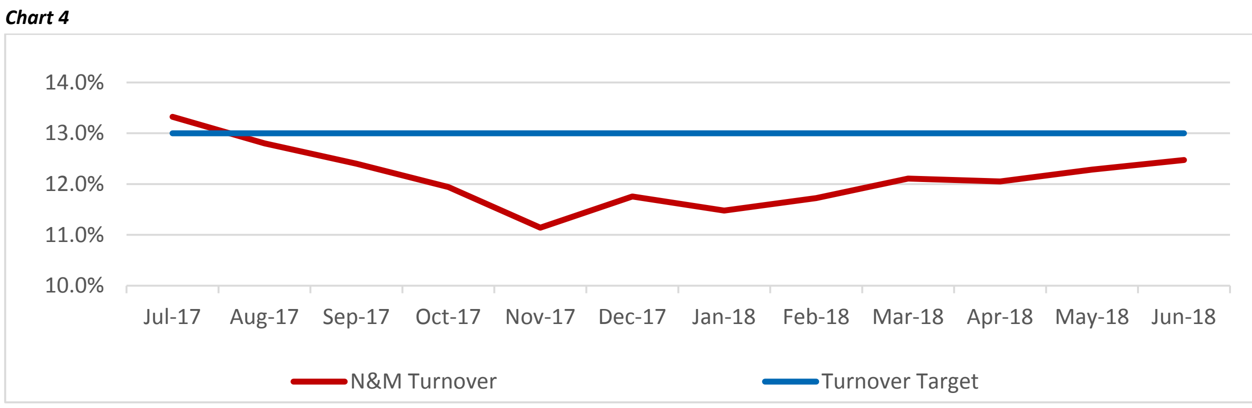
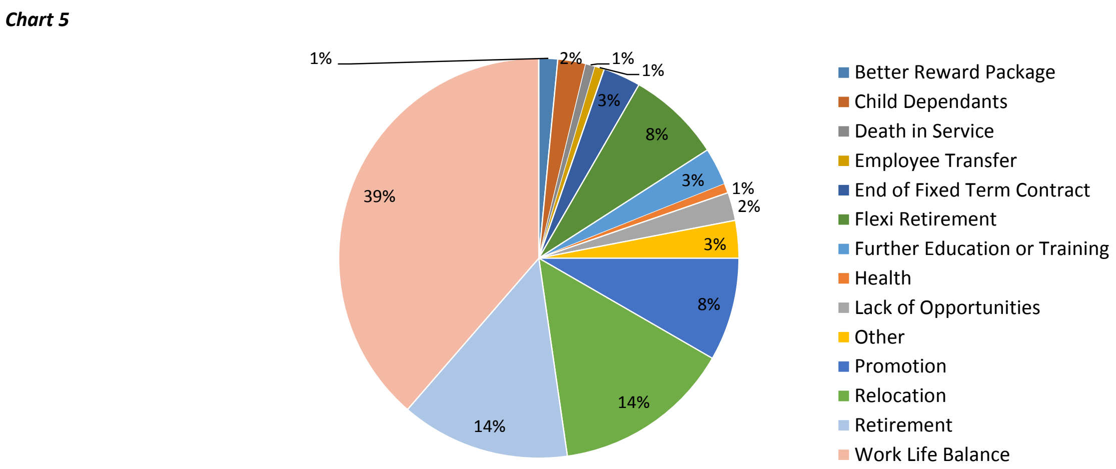


Chart 5 identifies the reasons for nursing and midwifery staff that have left the Trust. It should be noted that this data is only representative for band 5 staff.

Chart 5



Further work is required to improve the quality of the data received regarding staff leavers, as the highest category (35%) is record as ‘other’. Improvements in this field will be a direct result of the exit interview analysis.

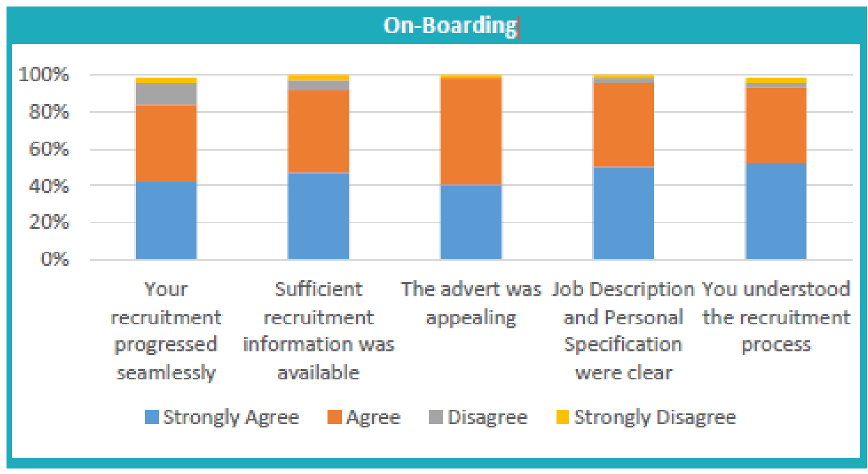
3.3. Recruitment and Retention

The Nursing Recruitment and Retention Strategy continues to be delivered with actions closely monitored by the Chief Nurse and review of the Strategy is planned for November 2018. An innovative recruitment campaign is underway with flexible working plan and night only contracts on offer to future recruits. A number of new approaches have been adopted to support the recruitment campaign, including open days which have resulted in recruiting 43 RNs since the beginning of 2018 and 45 HCAs recruited in May 2018. New recruits will be starting within the Trust throughout August and September 2018.

It should be noted that whilst we are celebrating some success over the last 12 months in managing to recruit this number of qualified nurses in a competitive market, we must be cognisant that the lead in time for some of the staff to commence in post reaches into 2018 and 2019 and continuing attrition rates must also be considered.

As part of the Recruitment and Retention Strategy the Trust has been working hard to review the pre-employment processes 'on boarding'. Chart 6 illustrates the results of the 'on boarding' questionnaire, given to new starters on their induction. This details an overwhelming positive response. Managers are reminded about their responsibility to keep in touch with their successful candidates while the process is under continual review by the recruitment team

Chart 6



3.4. Workforce Development

WHH is currently part of the Nursing Associate national pilot, with 8 Nursing Associates due to complete the programme in January 2019. The Nursing Associate role is a new support role that will sit alongside existing healthcare support workers and fully-qualified registered nurses to deliver hands-on care for patients. It should be noted that this type of post **will not** replace the requirement of registered nurses rather complement the skill mix with early indications showing positives results for patient care and nursing workforce.

The current cohort of Nursing Associates have been allocated to the following wards when they commence with the Trust substantively, these posts are funded from current vacancies at band 2.

Ward	Nursing Associate
A1	2
B4	2
A9	1
CMTC	1
C21	1
Emergency Department	1

As part of this programme they will undertake a preceptorship programme that will mirror that of the RN standards.

4. Evidence Based Strategic Workforce Planning

There must be sufficient and appropriate staffing capacity and capability on inpatient wards to provide safe, high quality care to patients at all times. Nurse staffing levels are determined by using a range of metrics. Warrington and Halton Foundation Trust use four factors as follows;

- Using systematic evidenced based acuity data utilising the Safer Nursing Care Tool (SNCT)
- Benchmarking with Peers for example Care Hours per Patient Days (CHPPD) through the Model Hospital.
- NICE Guidance and 1:8 minimum staffing: patient ratios
- Professional judgement

Each of the above methodologies are used to ensure that we have consistent evidence based approach to determining the required establishments for each ward.

4.1. Evidence Based Acuity Data

The Trust operationally utilises the SafeCare function within the Allocate e-rostering system to collect acuity and dependency data twice daily for all wards. SafeCare uses the same dependency scoring as the Safer Nursing Care Tool (SNCT). This is an evidence based tool that enables nurses to assess patient acuity and dependency, incorporating a staffing multiplier to ensure that nursing establishments reflect patient needs in acuity/dependency terms. The data has previously been manually collated for a two week period twice a year; however we are now able to access the information on a daily basis from the SafeCare module in the electronic system. The data is inputted twice daily. The senior nursing team review the data twice daily to ensure appropriate escalation plans are in place to support staffing decisions to meet the needs of the operational demands so that high quality care can be provided on inpatient wards.

4.2. SafeCare Census Results

It should be noted that the SafeCare tool does not differentiate between qualified and unqualified staff staffing hours and as such requires a very good understanding of the patient groups and nursing requirements. Professional judgment is also an important and essential factor to be considered when making decisions about staffing establishments.

Overall the SafeCare results (summarised in Table 1) show that the acuity of the patients at the time of the survey meant that there was a shortfall of 81.06wte nurses (against the establishments) for the wards. This is based upon the acuity and dependency of the patient group over the two week sampling period (16th to 29th April 2018). Another factor in this figure is that at the time of the census an additional 72 escalation beds were operational in the Trust including Ward C22 who had no establishment of substantive staff. The shortfall against the SafeCare requirements and including the nurse staffing vacancies come to a total of 150.06wte. The successful staffing business case will result in a nurse establishment uplift (described in section 5 of this report) of 93.66wte additional staff. The SafeCare survey results therefore indicate that the uplift is a fair reflection of the requirement. Some of the figures within the table need to be viewed with caution. For example the variance in Acute Medical Unit (AMU) at first glance appears to suggest that they have an excessive amount of nurses in their

establishment; however that is actually a reflection of the fact that the tool is not effective in determining patient acuity in assessment areas. The same principle applies to the Accident and Emergency Department (AED) and a number of those patients transferred to the AMU for assessment therefore are not all recorded in the Safe Care figures.

Included for the first time is an average number of patients deemed as requiring 1 to 1 care (enhanced care, previous referred to as specialing). For the census period overall we had an average of 19 patients per day across our wards who required that extra level of supervision. The nurse staffing business case included a review of enhanced care needs across the wards, and was reflected in the uplift of additional HCA's.

As such the data should be used with caution, triangulated with other safety, experience and quality metrics alongside professional judgement before changes to establishments are made. As such the data is included in the Chief Nurse 6 monthly staffing reviews, along with the other staffing metrics.

An output from the SafeCare live system is shown at **Appendix 1** for reference.

Table 1 – Safecare Census Results 16th – 29th April 2018.

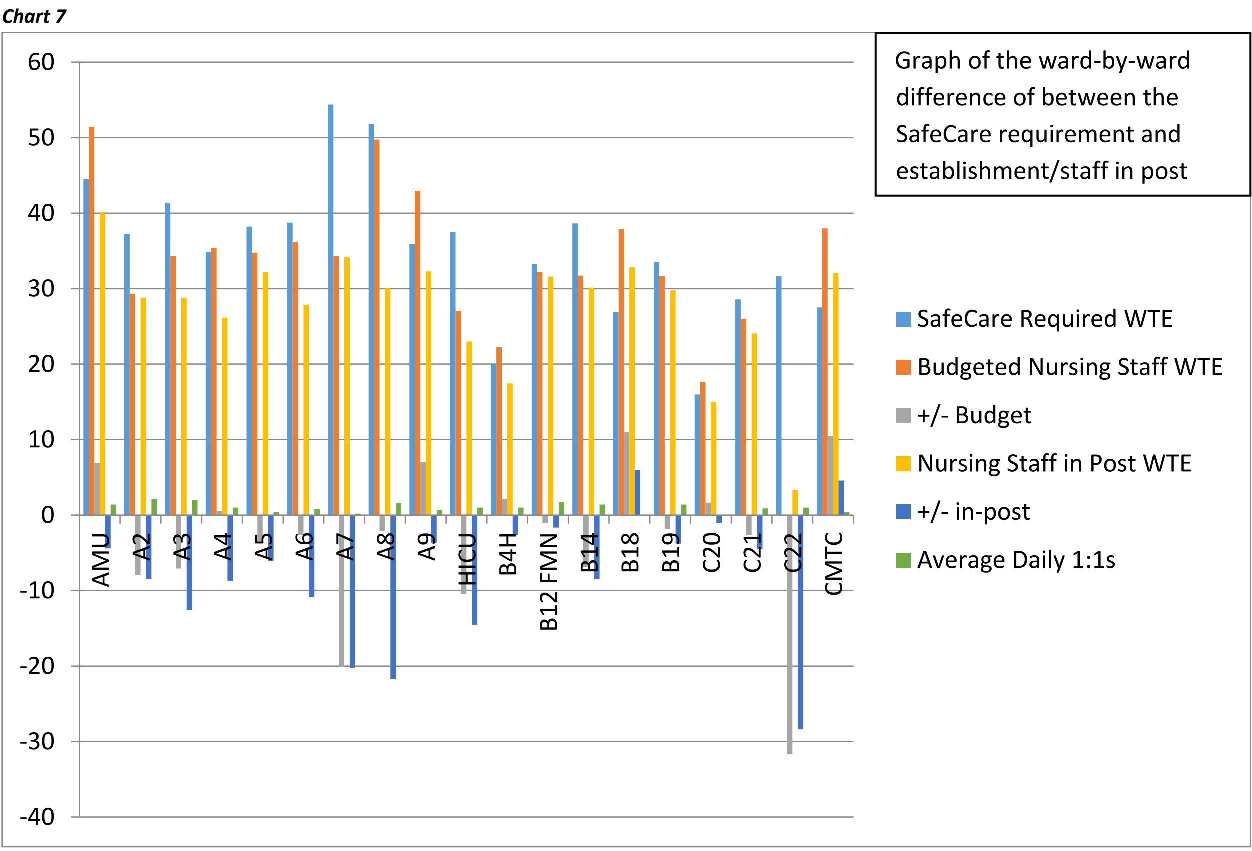
Ward	SafeCare Required WTE Nurses vs Nurses in Post*					
	SafeCare Required WTE	Budgeted Nursing Staff WTE	+/- Budget	Nursing Staff in Post WTE	+/- in-post	Average Daily 1:1s
AMU	44.51	51.42	6.91	40.1	-4.41	1.4
A2	37.24	29.34	-7.9	28.81	-8.43	2.1
A3	41.37	34.29	-7.08	28.78	-12.59	2
A4	34.85	35.39	0.54	26.15	-8.70	1
A5	38.22	34.75	-3.47	32.19	-6.03	0.4
A6	38.74	36.13	-2.61	27.88	-10.86	0.8
A7	54.39	34.29	-20.1	34.18	-20.21	0.2
A8	51.84	49.75	-2.09	30.12	-21.72	1.6
A9	35.95	42.96	7.01	32.28	-3.67	0.7
HICU	37.51	27.07	-10.44	23	-14.51	1
B4H	20.08	22.24	2.16	17.45	-2.63	1
B12 FMN	33.25	32.17	-1.08	31.59	-1.66	1.7
B14	38.63	31.72	-6.91	30.14	-8.49	1.4
B18	26.88	37.87	10.99	32.84	5.96	0
B19	33.56	31.71	-1.85	29.78	-3.78	1.4
C20	15.98	17.63	1.65	14.97	-1.01	0
C21	28.58	25.98	-25.6	24.06	-4.52	0.9
C22	31.68	0	-31.68	3.31	-28.37	1
CMTC	27.5	37.99	10.49	32.07	4.57	0.4
Total	670.76	612.7	-58.06	519.7	-151.06	19

Additional beds/escalation

* Nurses in post information taken from e-rostering system

Chart 7 below shows a comparison of staff in post against the SafeCare data output in WTE.

Chart 7



4.3 NICE Guidance Red Flags

From the 'Safe Staffing for Nursing in Adult Inpatient Wards in Acute Hospitals' NICE guidance, published July 2014, there is a recommendation that Trusts have a mechanism to capture red flag events.

Red flags can be defined as events that prompt immediate response by the registered nurse in charge of the ward on a given shift to ensure there is sufficient staff to meet the needs of patients on the ward. These events are recorded within the SafeCare system, there have been 122 raised in the 2 months (16/4/18 to 13/4/18), these are summarised in the table below. Previous staffing reviews have not recorded any red flags and we are now seeing them recorded and responded to via the system every day. This is the early phase of a new way of working for our staff, we expect these numbers to rise and then we will focus on the timeliness of the response.

Detail on how to define a red flag event can be found in **Appendix 2** for reference

Red Flag	Number
Shortfall in RN Time	82
Missed intentional rounding	18
Less than 2 RNs on shift	16
Delay in providing pain relief	5

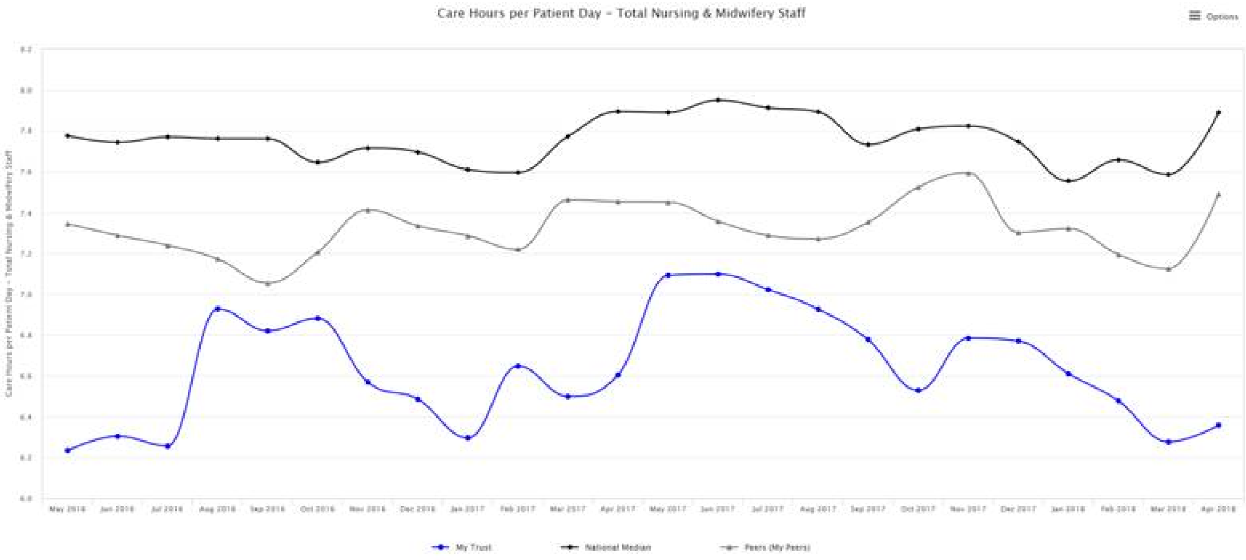
Total	121

4.4. Comparing staffing levels with peers

Care Hours per Patient Day (CHPPD) was developed following Lord Carter's review in February 2016, it has been tested and adopted to provide a single, consistent and nationally comparable way of recording and reporting deployment of staff to provide care on inpatients wards. CHPPD monitoring and tracking can be facilitated alongside e-rostering systems and supports the daily assessment of operational staffing requirements. NHS Improvement (NHSI) Model Hospital portal now makes it possible to compare CHPPD metrics with comparable peer Trusts.

Chart 8 illustrates the reported CHPPD figures for the Trust from May 2016 to April 2018, which were reported as just over 6.6 Care Hours per Patient Day in Jan 2018 and has seen a gradual reduction until April 18 when we have started to see a slight increase. This is in comparison to national median figures of around 7.8 hours over the same period. WHH are currently significantly lower than the national median, which is related to the number of staff vacancies and the significant number of escalation beds that were opened during the winter months, which had an impact on nurse staffing numbers. This position will improve as we continue to make progress in the trust wide Recruitment and Retention Strategy and implement the recommendations of the nurse staffing business case.

Chart 8



Guidance has been recently produced by NHSI (June 2018) for Acute Trust to submit CHPPD data via the Strategic Data Collection Service (SDCS) as part of the monthly nurse staffing return. This is to ensure consistency in recording a reporting staffing staff as CHPPD will become the principle measure of nursing, midwifery and healthcare support staff deployment on inpatient wards. WHH already collect this data and part of the e-rostering system, which is reported monthly on the Trust dashboard and the monthly SDCS staffing return. Chart 9 illustrates this data to July 2018 this will continue to be monitored via the Trust monthly safer staffing report. This data from April 2018 is currently not displayed on the Model Hospital data set

Chart 9

Financial year	Month	Cumulative count over the month of patients at 23:59 each day	CHPPD – Registered Staff	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
2018/19 Total		61248.5	3.9	2.9	6.8

5.0. Establishment Uplift

There is a requirement for an agreed level of contingency for planned and unplanned leave, within the nursing establishments, (this may also referred to as headroom or uplift). Factors included currently within the organisation are long service entitlements in annual leave and alignment with Trust sickness / absence targets along with both mandatory and specific training leave for development. The requirement for this will be greater if there is a higher proportion of part time staff.

It is important that the level of uplift is realistic and reviewed at least annually. In conjunction with the finance team a review has taken place to understand the WHH position against peer organisations in more detail to ensure alignment and parity, particularly with regard to the management of maternity leave which currently does not align with the uplift in establishment. The outcome of the review noted WHH to be both a local and national outlier in regards 'uplift' based at 20% with national recommendations between 22.5% and 25%. As part of the recent financial injection into the nursing staffing budget the establishment uplift, the 23 wards included in the staffing business case have now had their uplift to 23%. The table below illustrated how the 23% uplift has been broken down

	RCN recommended	**Current WHH funded uplift**	**Evidenced WHH actual position**	**Recommended WHH funded uplift**	**Comments**
Annual Leave	17.0%	15.5%	17.0%	17.0%	17% is sufficient to cover an average of 30 days + 8 bank hol per person.
Sickness / absence	4.5%	3.5%	6.4%	4.2%	Sickness cover should be aligned to the organisational sickness absence target.
Study leave	2.0%	1.0%	1.8%	1.8%	The requirement for study leave cover is 1.8% based upon the current mandatory & essential training demands
Parenting leave	1.0%	0.0%	2.5%	0.0%	On average 18 wte are on parenting leave at any one time, equating to 2.5%. It is proposed that parenting leave is managed within baseline
Other leave	0.5%	0.0%	0.5%	0.0%	4,900 hours lost to special leave during 16/17 across all wards areas, this equates to 0.5%. It is proposed that special leave is

					managed within baseline.
Total	**25.0%**	**20.0%**	**28.2%**	**23.0%**	

6. Ward Manager Supervisory Time
There is significant variability in the allocation and usage of supervisory (also known as management) time for Ward Managers on WHH wards. Cognisance should be taken of the Mid Staffordshire Inquiry Report recommendation regarding the supervisory time for Ward Manager roles in order for them to be visible, role models and mentors for patients and staff whilst monitoring and reporting performance throughout their clinical areas.

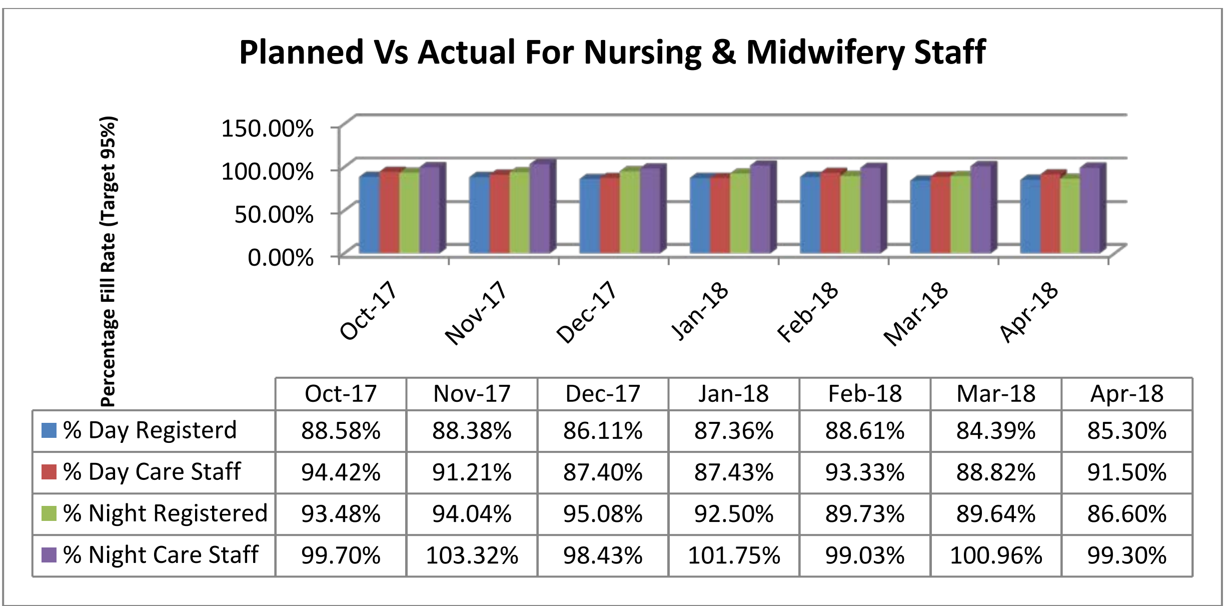
It is clear however that a significant amount of supervisory time which has been allocated in the e-rostering system as management time is being spent by the Ward Managers on the ward caring for patients in order to adequately manage patient acuity due to staffing issues that can be related to sickness/maternity and the requirements for ward establishment reviews. A further audit is to be undertaken on Ward Manager supervisory time in October 2018 so we can better understand the Ward Managers who are not able to perform some of their duties and Ward Manager roles.

7. Monthly Staffing Return
Nursing and Midwifery staffing data is published on a daily basis at entrances to WHH wards along with submission of data on a monthly basis through the Unify system to NHSE, in addition to publication on the Trusts website and reporting to the Board of Directors. A review of the ‘ward staffing boards’ has been undertaken to ensure that staffing levels are displayed on all ward entrances and to support patient understanding of ward staffing. This has resulted in the roll out of new standardised boards with a completion date of September 2018 and example of the new ‘boards’ can been seen in Appendix 3.

The Trust is required to submit a monthly staffing return as part of the Strategic Data Collection Service (SDCS) detailing planned v’s actual staffing fill rates. In line with recommendations from the NQB (2016) the staffing data return is presented to the Board of Directors on a monthly basis highlighting areas where fill rates fall below 90%. Although the 90% standard has not been constantly achieved during the day time there have been mitigating actions taken with senior nurse escalation, and an increase in health care support worker fill rates to support the ward teams. Matrons and Lead Nurses support the Ward Managers with ward risk assessments and staffing plans to ensure safety is maintained.

Chart 10 illustrates Planned versus Actual Staff on Duty as per the monthly staffing return. The data demonstrates consistency across the 6 month period with slight variation seen during seasonal months for example Christmas and Easter.

Chart 10



	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
% Day Registerd	88.58%	88.38%	86.11%	87.36%	88.61%	84.39%	85.30%
% Day Care Staff	94.42%	91.21%	87.40%	87.43%	93.33%	88.82%	91.50%
% Night Registered	93.48%	94.04%	95.08%	92.50%	89.73%	89.64%	86.60%
% Night Care Staff	99.70%	103.32%	98.43%	101.75%	99.03%	100.96%	99.30%

8. Women and Children

8.1. Paediatrics

Nurse staffing levels for Paediatrics are based on Royal College of Nursing (RCN) Standards from the document 'Defining Staffing Levels for Children and Young People's Services: RCN Standards for Clinical Professionals and Service Managers (July 2013)'. This supports assessing acuity with numbers of staff on shift, patient acuity and dependency needs. Paediatrics use an adapted acuity tool and acuity against staffing is monitored at 3 different time points through a 24 hr period on the main ward B11. Further acuity data was collated during a 2 week period during April 16th-29th. The table below indicates the staffing shortfalls over the 2 week period measures acuity and dependency levels against the number of staff rostered for duty on that day.

	0700	1400	2200	Mitigation
Monday 16th April	-0.6 WTE		-0.2 WTE	Band 7 Co –ordinator on 7-4pm
Tuesday 17th	-2 WTE	-1.1 WTE	-0.9 WTE	Ward manager and band 7 on duty during the day
Wed 18TH	-1.4 WTE		-2 WTE	High Acuity overnight
Thurs 19TH	-0.3WTE		-1.6 WTE	
Fri 20TH	- 1.2 WTE			Band 6/7

				co-ordinator on duty
Sat 21ST				
Sun 22ND				
Mon 23RD				
Tue 24TH				
Wed 25TH	-1 WTE	-0.7WTE		Band 6/7 co-ordinator on duty
Thurs 26TH				
Fri 27TH				
Sat 28TH				
Sun 29TH				

During the 2 week monitoring period there are a number of shortfalls identified on the ward at the specific monitoring times however it is important to note that the supernumery coordinator and ward manager are not counted in the staffing numbers. The Paediatric staffing escalation process indicates that at times of high acuity the coordinator and /or ward manager would work clinically on the ward. For any future staffing audits a recommendation has been made to ensure the ward coordinator is included in the overall number of staff rostered. There were a number of shortfalls identified at 2200 hours which were again rectified using the escalation process by moving the support carer from Paediatric A&E to support the ward. Again this has highlighted that HCA's were not included in the staffing assessment numbers and will in future audits. Therefore during the monitoring period the paediatric department was safe and had appropriate escalation processes in place to manage the peaks in activity and acuity. The paediatric department is currently fully established.

8.2. Neonatal Unit (NNU)

Neonatal Unit (NNU) staffing levels are defined by British Association of Perinatal Medicine (BAPM) guidance. BAPM staffing recommendations are assessed at two points during a 24 hour period and recorded on the Badgernet system for the NNU at Warrington and Halton Hospitals. This system is used across the region for all NNU's. An acuity assessment against the BAPM standards utilising the Badgernet system was undertaken over a 2 week period 16th-29th April 2018. There is a robust escalation plan based on BAPM in order to ensure safe quality care delivery is in place on the NNU. Unfortunately during the 2 week monitoring period there were high levels of sickness absence noted which required reliance on temporary staffing accessed via NHSP. The unit as part of the escalation process closed to emergency admissions on 3 occasions during the 2 week audit period. During the two week audit period this occurred on:

- 20th (Night shift)
- 21st (AM)
- 22nd (PM and Night shift)
- 27th (AM&PM

On the 3 occasions when the unit closed to emergency admissions 2 of the closure were related to reduced staffing levels related to sickness absence and the third occasion was due to acuity and

dependency on the unit. The Lead Nurse and Ward Manager are ensuring that sickness absence is being managed in line with trust policy.

Following a number of Datix incident forms relating to staffing levels on the NNU when BAPM agreed levels have not been reached an internal staffing review was undertaken The findings of this review were included in the Trust-wide staffing business case and agreement has been made to uplift the NNU staffing to ensure compliance with commissioned activity and BAPM guidance. The unit are currently in the process of recruiting to these positions and daily staffing assessments are undertaken to ensure appropriate staffing levels are in place on the unit.

8.3 -Midwifery Workforce Position

A recent staffing benchmarking tool for maternity services has been provided by the National Quality Board (2018) - Improvement Resource for Maternity Staffing, which recommends using Birthrate Plus for measuring staffing levels in maternity services.

Staffing levels are based on assessment of clinical risk and the needs of the women and their babies during labour, delivery and the immediate postnatal period. A minimum staffing ratio of 1:1 care for women in established labour has been recommended in Safer Childbirth 2007 and is further supported by NICE, 2015. A two week snapshot of staffing levels to meet acuity was performed between the 16th April to the 29th April 2018. The snapshot showed a ratio of 1:29.

The Birthrate Plus Acuity Tool provides staff with a framework to assess the demands within the Labour Ward and the number of staff required to manage these demands. It uses a classification system based upon clinical indicators during labour, birth and the immediate postnatal period. The tool is able to record the fluctuating workload and can give an early indication when demand is greater to ensure adequate staffing levels are in place.

The two week snapshot has provided data on staffing and acuity. This provides limited data as it only reflects capacity and demand over a short period of time. The 3 month period provided for the NQB tool provides a longer period to assess these aspects in terms of midwife to birth ratios and a longer reporting period is more useful to show trends in activity and acuity. This was done for January to March 2018, when benchmarking against the Improvement Resource for Maternity Staffing by the National Quality Board (2018) tool, which showed a ratio of 1:29 (midwife: birth). It should be noted that The Royal College of Midwives (RCM) recommend a target of 85% staffing levels to meet acuity with clear protocols for escalation. Our acuity tool does show that we escalate to meet acuity demands on a four hourly basis to achieve at least 85% staffing levels. We do have a current escalation policy but this being reviewed to become aligned with a regional escalation policy across Cheshire and Merseyside.

WHH Midwives work flexibly between different areas of the Maternity service to ensure each setting is safe. The previous Birthrate Plus assessment was performed in 2015, and considered the whole of the woman’s childbirth journey and covered all settings. This assessment gave a ratio of 1:29 (midwife: births). Birthrate Plus have just provided us with a draft working on new models of care, which we will be developing over the next few months, but is still based on a ratio of 1:29 (midwife: birth).

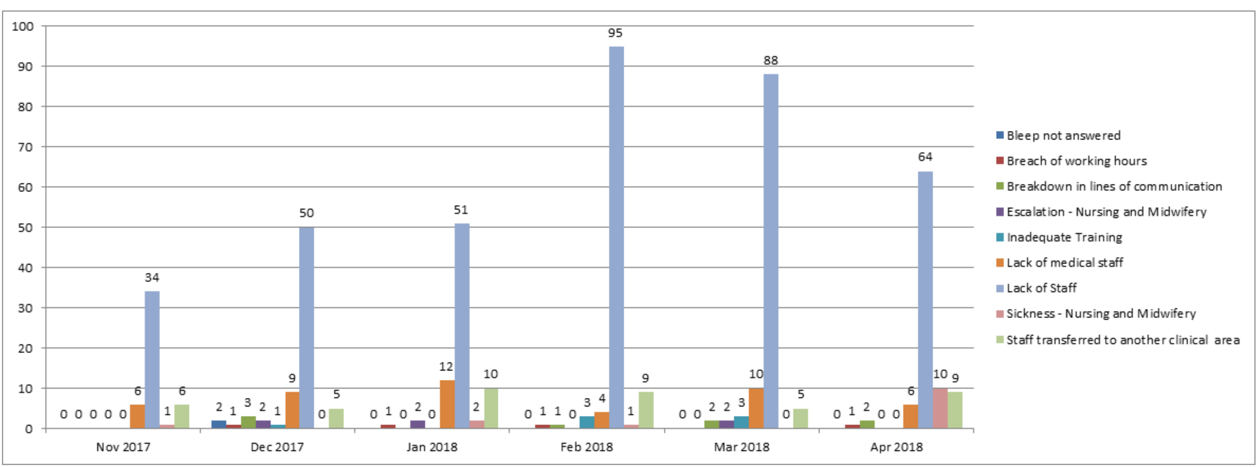
9. Reported Staffing Incidents

In order to ensure effective triangulation of data the following information was gathered from the Trust Datix system to understand staff reporting rationales under the heading of staffing incidents.

'Bleeps not being answered', 'lack of medical staff' and 'staff transfers' are highlighted as the largest reason for completing a Datix within this criterion. This does not distinguish between members of the multi-disciplinary team. All incidents are monitored and actioned within the relevant CBU with detail provided in monthly governance reports. Overarching monitoring of staffing incidents will take place from September 2018 on a monthly basis by the senior nursing team.

Chart 11

Number of staffing incidents from November 2017 to April 2018.



10. Use of Temporary Staffing

NHS Professionals (NHSP) is the preferred supplier of temporary staffing to the Trust. During periods of high demand NHSP have been unable to meet the demand which has resulted in the use of agency staff as per table 2 below.

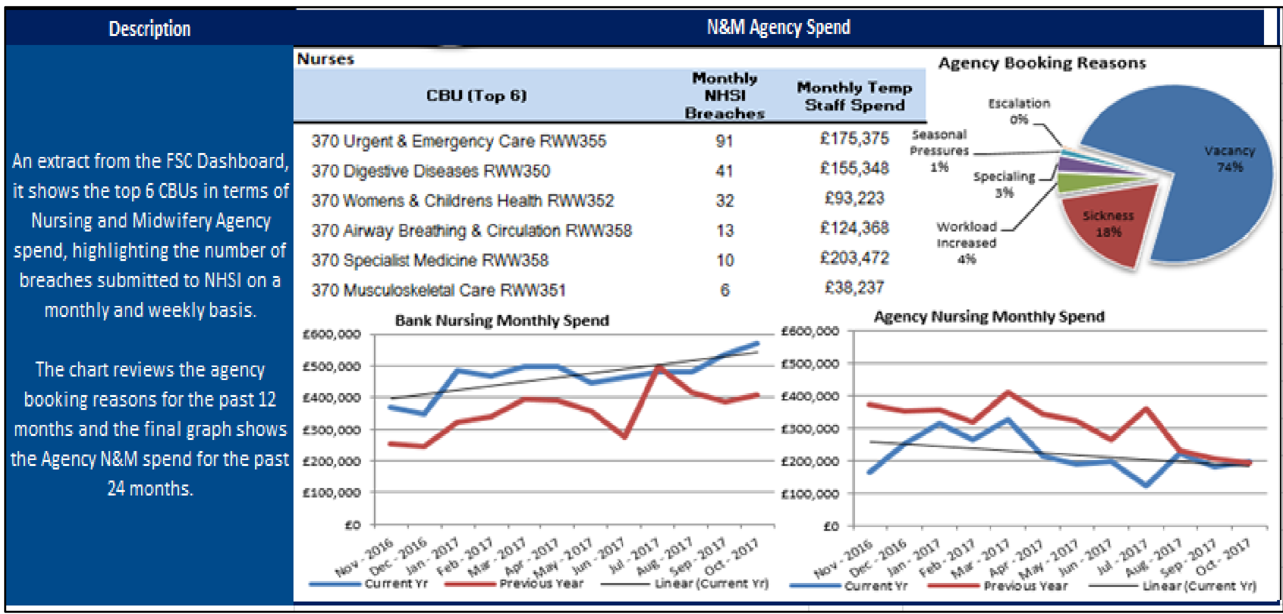
Table 2 Identifies Bank and Agency demand and fill rates over the last 6 months.

Directorate	Bank Filled	Agency Filled	Agency Unfilled	Unfilled	Grand Total
Acute Care Services	648	213	377	325	1563
AIRWAY BREATHING & CIRCUL	1996	357	471	687	3511
Child Health	4				4
DIAGNOSTICS	653	176	301	323	1453
DIGESTIVE DISEASES	2478	1361	424	565	4828
DISCHARGE/PATIENT FLOW	81		1		82
Medicine	1	2	1		4
MUSCULOSKELETAL CARE	804	129	231	278	1442
OUTPATIENTS	16		13	36	65
SPECIALIST MEDICINE	5778	626	1330	2275	10009
Specialist Services	5				5
Specialist Surgery	24				24
Unscheduled Care	139	2	15	96	252
URGENT & EMERGENCY CARE	2691	1127	1205	632	5655
WOMEN'S & CHILDREN'S HEAL	1628	215	195	293	2331
Grand Total	**16946**	**4208**	**4564**	**5510**	**31228**

Mitigation against low fill rates takes place four times a day at the capacity, demand and flow meetings supported by the operational teams.

Chart 12 below shows reduction in usage of agency nursing staff with a reducing trend; however our aim continues to be to reduce our reliance on the temporary workforce overall.

Chart 12



11. Overall Conclusions

The report provides an overview of the current position in the nursing workforce, including data from the evidence based staffing review (SNCT) and comparative benchmarking data from CHPPD. It is acknowledged that we are currently reporting a deficit in the required numbers for nurse staffing of 58.06wte. However, with associated increases in nurse staffing levels and establishment uplifts to 23% following the successful nurse staffing business case, this position is expected to improve going forwards. addressed.

Furthermore the ongoing nursing Recruitment and Retention Strategy continues to be delivered at pace, with a designated Workforce Improvement Lead now in post to support necessary changes. A number of new and innovative approaches have been adopted to support the recruitment campaign, which has resulted in a further 43 RNs and 45 HCAs. A number of the new recruits are due to join the Trust during August 2018, the remaining have start dates for September 2018.

Monitoring arrangements are now in place to review staffing on a daily basis. The number of staff is triangulated with staffing incidents and the recent introduction of 'red flag' events. This provides greater assurance and a transparency to the governance processes to ensure adequate safe staffing levels and well as indicators of safety and effectiveness across the organisation.

12. Recommendations

It is recommended that the Board of Directors note, review and discuss this report.

Appendix 1

Allocate Safe Care "live" output

SPITALS NHS FOUNDATION TRUST

Warrington & Halton Hospitals...
Acute Care Services
HR & OD
Surgery, Women's & Children's
Specialist Medicine
TNA
Coronary Care Unit
A1 Acute Medicine
A2 Acute Medicine
Respiratory Team (H)
Ambulatory Care
Acute Care Team
A&E ENP
C21 Cardiology
C22 Winter Pressure
A&E Department
UCC Runcorn
Respiratory Team (W)
Programme Investigation...
ITU
Catheter Lab
ACT Pool
A7 Respiratory A
B12 Acute Elderly Care
Ward B19 OPAL (PRE A3)
B18 COHORT Ward
Ward A8
B14 Stroke Acute Ward
Ward A3 (PRE A4)
B1 Intermediate Care
Ward A9 (PRE B19 OCT 09)
Maternity Ward
Ward A5 (POST S.R) (W) C23
Warrington Theatres ODP
SAU
Community Midwives
Warrington Theatres Scrub
Warrington Theatres Recovery
Ward B10 & B11
Orthodontics (H)
Labour Suite
Halton Theatres
Ante Natal Clinic
Ward A4 GASTRO (PRE C22)
C20 Ward
Ophthalmic Nursing
Warrington Theatres
Ward B4
Orthopaedic Outpatients
Oral Surgery (W)
Ophthalmic Ward
CMTC Ward
ANDU
Ward A6 (POST S.R) (W)
CMTC Theatres
Specialist Midwives
NIPI Clinic
C20 Clinic
Neonatal Unit

The above chart is an example of the live report that can, with one click, provide detailed information about staff and patients on all of our wards. Wards highlighted in 'Red' have either got a potential challenge (insufficient staff to provide adequate care) or have not submitted the required patient information.

This is reviewed with senior nurses on a three times daily staffing meeting that occur before patient flow meetings. Areas of concern are addressed and risks to patients and staff are minimised as a result.

Appendix 2

Red Flag Events

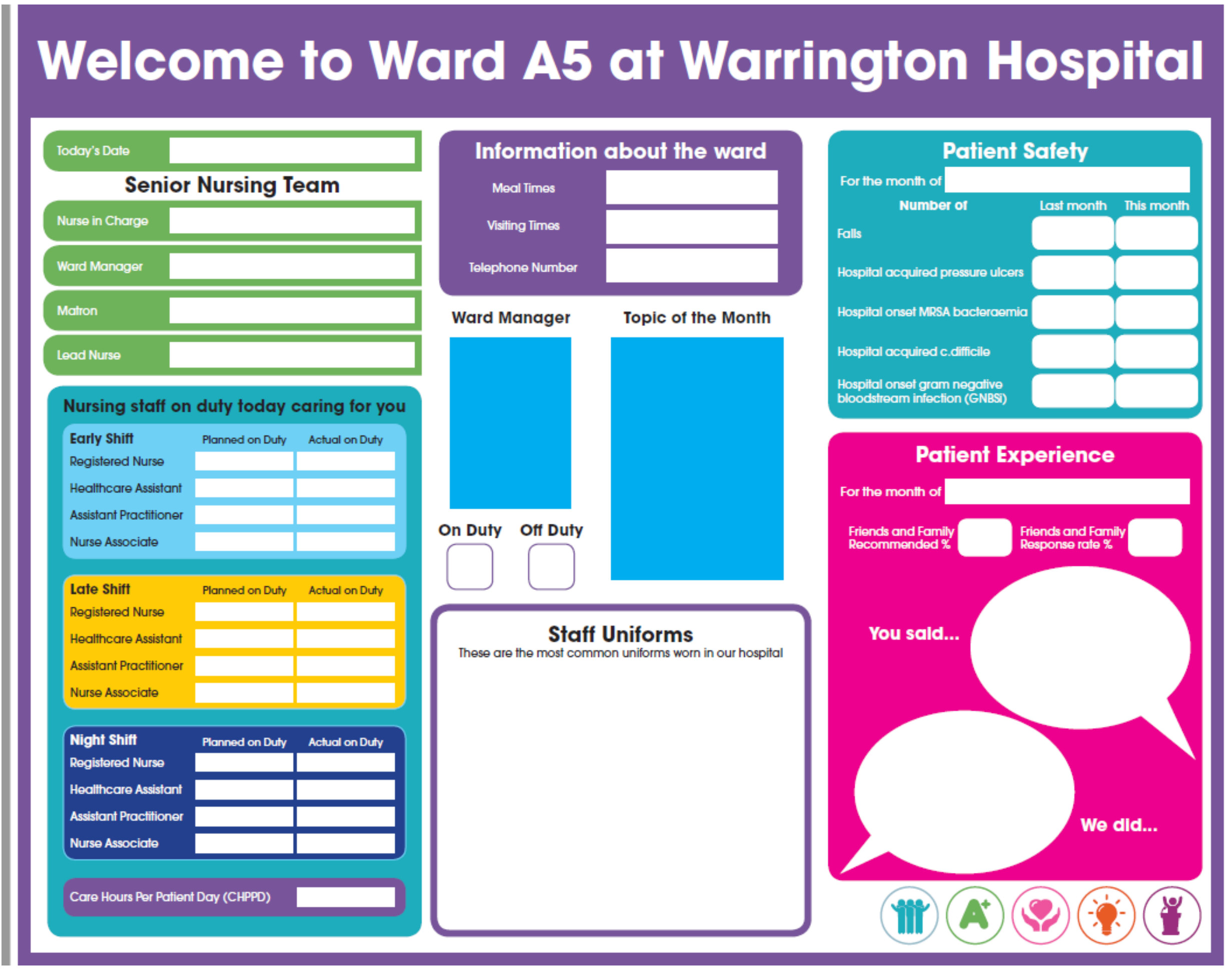
The following are recognised as Red Flag events:

- Unplanned omission in providing patient medications.
- Delay of more than 30 minutes in providing pain relief.
- Patient vital signs not assessed or recorded as outlined in the care plan.
- Delay or omission of regular checks on patients to ensure that their fundamental care needs are met as outlined in the care plan. Carrying out these checks is often referred to as 'intentional rounding' and covers aspects of care such as:
    - Pain: asking patients to describe their level of pain level using the local pain assessment tool.
    - Personal needs: such as scheduling patient visits to the toilet or bathroom to avoid risk of falls and providing hydration.
    - Placement: making sure that the items a patient needs are within easy reach.
    - Positioning: making sure that the patient is comfortable and the risk of pressure ulcers is assessed and minimised.
- A shortfall of more than 8 hours or 25% (whichever is reached first) of registered nurse time available compared with the actual requirement for the shift. For example, if a shift requires 40 hours of registered nurse time, a red flag event would occur if less than 32 hours of registered nurse time is available for that shift. If a shift requires 15 hours of registered nurse time, a red flag event would occur if 11 hours or less of registered nurse time is available for that shift (which is the loss of more than 25% of the required registered nurse time).
- Less than 2 registered nurses present on a ward during any shift.

Red Flags are currently inconsistently recorded in the SafeCare system; however we plan to re-energise and repeat ward level training in January 2018 ensuring that appropriate recording takes place.

Appendix 3

New Ward Entrance Boards



REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/18/09/94**
SUBJECT:	**Medical Appraisal and Revalidation Annual Board Report**
DATE OF MEETING:	26th September 2018
ACTION REQUIRED	**For assurance**
AUTHOR(S):	Lesley Sala/Paula Harris/Andrea Stazicker
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Executive Medical Director/ Deputy CEO
LINK TO STRATEGIC OBJECTIVES:	SO2: To have a committed, skilled and highly engaged workforce who feel valued, supported and developed and who work togther to care for our patients
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	BAF1.1: CQC Compliance for Quality
	BAF1.3: National & Local Mandatory, Operational Targets
	BAF2.5: Right People, Right Skills in Workforce
STRATEGIC CONTEXT	In order to meet the GMC Requirements for Revalidation, every Doctor must participate in an Annual Appraisal, ensuring five Consecutive Appraisals are completed within their Revalidation Cycle and have acquired a 360 Patient/Colleague Feedback Report. Trust Boards are obliged to assure themselves of the medical appraisal and revalidation process through an annual report.
EXECUTIVE SUMMARY (KEY ISSUES):	This Report provides assurances to the Board that our Medical Appraisal System and Processes for monitoring the completion of Annual Appraisals to support GMC Revalidation for the Medical Workforce are robust. In order to meet the GMC Requirements for Revalidation, every Doctor MUST participate in an Annual Appraisal; ensure FIVE Consecutive Appraisals are completed within their Revalidation Cycle and have acquired a 360® Patient/Colleague Feedback Report. This process then informs the GMC directly via GMC Connect which contains the names of every doctor who holds a Registration Number and is licensed to practise in the UK. They identify the Employer – (also

	referred to as the Designated Body) - for whom they have a prescribed connection to an RO - Responsible Officer – (Prof. SAC) and for whom either a Recommendation/Non- Engagement/Deferral for Revalidation is able to be made. All NHS Designated Bodies (Employers) throughout the UK must engage in this system and failure to do so can remove the doctor from the GMC Register and remove their license to practise. The GMC have also made clear the minimum requirements for each Appraisal and relevant Supporting Information. In line with GMC Guidance, the **Supporting Information** 1is collated via **CRMS** – a web-based portal that enables safe and secure data and documentation to be held and when the Appraisal moves to Final Sign-Off, this is further triangulated via **Revalidation Panel Meetings** which are convened and chaired by the RO and relevant colleagues. In summary, our process and systems enable, track and monitor the completion rates via a robust Notification System with a comprehensive Policy to identify the practice and procedure and accountability which has enabled a very successful 6th Year Set of Results that have consistently exceeded the **GMC Target of 80%** • YEAR 1 – 1st MAY 2012 (GO LIVE DATE) – end of April 13 – **99.4%** • YEAR 2 - April 2013 – end of March 2014 - **93%** • YEAR 3 - April 2014 – end of March 2015 - **96%** • YEAR 4 – April 2015 – end of March 2016 - 94% • YEAR 5 - April 2016 - end of March 2017 – 94% ****end of 1st GMC Revalidation Cycle**** YEAR 6 – April 2017 – end of March 2018 - **90%** ****beginning of the 2nd GMC Revalidation Cycle***
RECOMMENDATION:	The Board is asked to note the contents of this report
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None

AGENDA REFERENCE:	**Workforce COMMITTEE** **Medical Appraisal and Revalidation Annual Board Report**
SUBJECT:	**Medical Appraisal and GMC Revalidation**
DATE OF MEETING:	
ACTION REQUIRED	**NONE**
AUTHOR(S):	Lesley Sala/Paula Harris/Andrea Stazicker
EXECUTIVE DIRECTOR	• Prof. Simon Constable – GMC **Responsible Officer** – Deputy CEO • Dr Mohammed Al-Jafari – Deputy Responsible Officer
EXECUTIVE SUMMARY	This Report provides assurances to the Board that our Medical Appraisal System and Processes for monitoring the completion of Annual Appraisals to support GMC Revalidation for the Medical Workforce are robust. In order to meet the GMC Requirements for Revalidation, every Doctor MUST participate in an Annual Appraisal; ensure FIVE Consecutive Appraisals are completed within their Revalidation Cycle and have acquired a 360® Patient/Colleague Feedback Report. This process then informs the GMC directly via **GMC Connect** which contains the names of every doctor who holds a Registration Number and is licensed to practise in the UK. They identify the Employer – (also referred to as the Designated Body) - for whom they have a prescribed connection to an RO - Responsible Officer – (Prof. SAC) and for whom either a Recommendation/Non-Engagement/Deferral for Revalidation is able to be made. All NHS Designated Bodies (Employers) throughout the UK must engage in this system and failure to do so can remove the doctor from the GMC Register and remove their license to practise. The GMC have also made clear the minimum requirements for each Appraisal and relevant Supporting Information. In line with GMC Guidance, the **Supporting Information** [1]is collated via **CRMS** – a web-based portal that enables safe and secure data and documentation to be held and when the Appraisal moves to Final Sign-Off, this is further triangulated via **Revalidation Panel Meetings** which are convened and chaired by the RO and relevant colleagues. In summary, our process and systems enable, track and monitor the completion rates via a robust Notification System with a comprehensive Policy to identify the practice and procedure and accountability which has enabled a very successful 6th Year Set of Results that have consistently exceeded the **GMC Target of 80%** • YEAR 1 – 1st MAY 2012 (GO LIVE DATE) – end of April 13 – **99.4%** • YEAR 2 - April 2013 – end of March 2014 - **93%** • YEAR 3 - April 2014 – end of March 2015 - **96%** • YEAR 4 – April 2015 – end of March 2016 - **94%** • YEAR 5 - April 2016 - end of March 2017 – **94%** ****end of 1st GMC Revalidation Cycle**** ---

[1] Guidance on supporting information for appraisal and revalidation - https://www.gmc-uk.org/registration-and-licensing/managing-your-registration/revalidation/guidance-on-supporting-information-for-appraisal-and-revalidation

	• YEAR 6 – April 2017 – end of March 2018 - **90%** ****beginning of the 2nd GMC Revalidation Cycle***
RECOMMENDATIONS	The purpose of this Report is to brief the Board on the process and progress of Medical Appraisals to support GMC Revalidation and to offer an overview of the annual position for 2017/18. Recommendation: For Discussion For Information For Assurance to Board
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None

SUBJECT	**Medical Appraisal and Revalidation Annual Report 2017/2018**

1. BACKGROUND/CONTEXT

The GMC have strong and effective legal powers designed to maintain the standards the public have a right to expect of doctors. Where any doctor fails to meet those standards, the GMC acts to protect patients from harm - if necessary, by removing the doctor from the Register and removing their right to practise. The introduction of Medical Revalidation across the UK in early December 2012 provided a new way of regulating licensed doctors that seeks to provide extra confidence to patients that their doctors are up to date and fit to practise. Only licensed doctors have to revalidate, usually every five years, by having Annual Appraisals based on the GMC's Core Guidance for doctors, *Good Medical Practice*[2]. The GMC have agreed supplementary guidance with the four health departments of the UK to help doctors understand how they can meet the GMC requirements in the first cycle of Revalidation, which will last from early December 2012 to the end of March 2018. This is in line with the GMC Guidance that was published for all licensed doctors.

The Guidance, which is for Doctors and Responsible Officers, will ensure Doctors are recommended for Revalidation in a consistent way.
In order for a Recommendation to be made, a Doctor **must**, as a minimum:-

- ✓ be ***participating*** in an Annual Appraisal process
- ✓ to ensure ***FIVE consecutive appraisals*** have been completed in preparation for their Revalidation cycle
- ✓ 360® Colleague Feedback
- ✓ 360® Patient Feedback

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

- Evidence of Continuing Professional Development

[2] **GMC – Good Medical Practice 2013– updated 2014**
https://www.gmc-uk.org/-/media/documents/good-medical-practice---english-1215_pdf-51527435.pdf

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

2. KEY ELEMENTS

Below are the identified **10 Steps** to GMC Revalidation that every practising Doctor is required to complete

1. Register on GMC Online
2. Confirm your responsible officer
3. Get a date from the GMC
4. Find out the local appraisal format
5. Gather supporting information
6. Prepare for appraisal
7. Participate in appraisal
8. Sign-off appraisal
9. Repeat steps 5-8 every year
10. Receive your revalidation confirmation from the GMC

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

NONE

4. MEASUREMENTS

NHS Revalidation North – Quarterly/Annual Return Submitted

On the 8th June 2018 – the Trust submitted its AOA – "Annual Organisational Audit" to NHS Revalidation North, which provides a web portal for submission of data as at the end of each Quarter of the Financial Year. The Annual submission of the AOA requests a response on a series of questions within 5 Sections to ascertain and benchmark the quality and delivery of Medical Appraisals to support GMC Revalidation. With a "point in time" set of figures submitted as below. This data allows the GMC to review every Designated Body which then enables NHS Revalidation to provide an **AOA Trust Comparator Report** with Recommendations expected around the **end of July 2018.**

The GMC Target is 80% based on a 20% margin which allows for those Doctors who may have Sickness, Long-Term absence and/or Maternity Leave
Below are the Quarterly Reporting parameters/Definitions for NHS Revalidation North.

2	Number of doctors with whom the designated body has a **prescribed connection**
3	**Number of doctors[1] due to hold an appraisal meeting** in the reporting period Note: This is to include appraisals where the appraisal due date falls in the reporting period or where the appraisal has been re-scheduled from previous reporting periods (for whatever reason). The appraisal due date is 12 months from the date of the last completed annual appraisal or 28 days from the end of the doctor's agreed appraisal month, whichever is the sooner.
3.1	Number of those within #3 above who **held an appraisal meeting** in the reporting period
3.2	Number of those within #3 above who **did not hold an appraisal meeting** in the reporting period **[These to be carried forward to next reporting period]**
	Data entry checker
3.2.1	Number of doctors[1] in 3.2 above for whom **the reason is both understood and accepted by the RO**
3.2.2	Number of doctors[1] in 3.2 above for whom **the reason is either not understood or accepted by the RO**

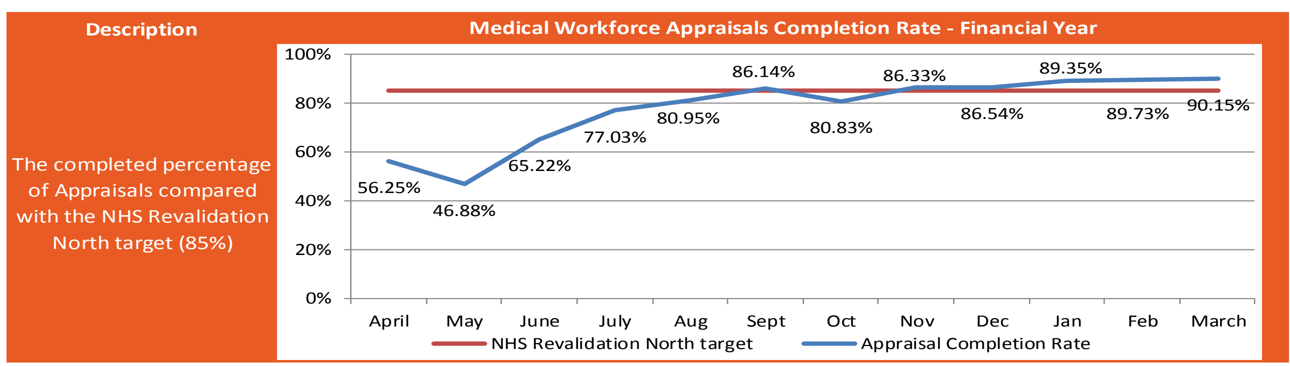
Below are the Timelines for Completion, Tracking and and Notification Periods for Medical Appraisals:

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

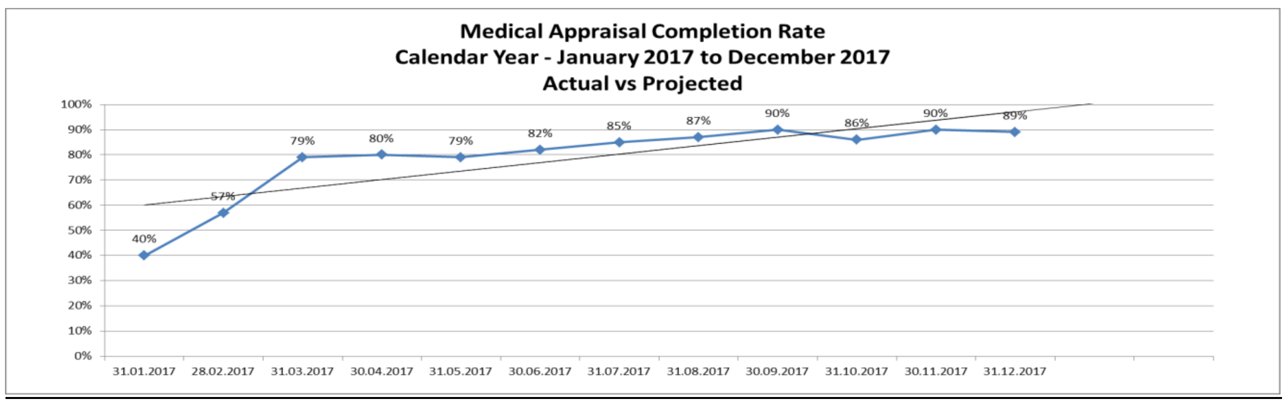
The Medical Education Service have implemented a comprehensive tracking process as we are required to track evidence for **Financial Year** - for reporting purposes to NHS Revalidation North and also the **Calendar Year** to track the "Annual Appraisals for the Revalidaiton Cycle" to include Notification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

- End of Month Completion Rates – for both the Financial Year and the Calendar Year
- End of Month – Exception Reports to the Clincial Directors/Specialty/Stages of Notification
- "In-Month" Compliance Rates – By Specialty
- Monthly delivery of Notification emails and Letters as requried.

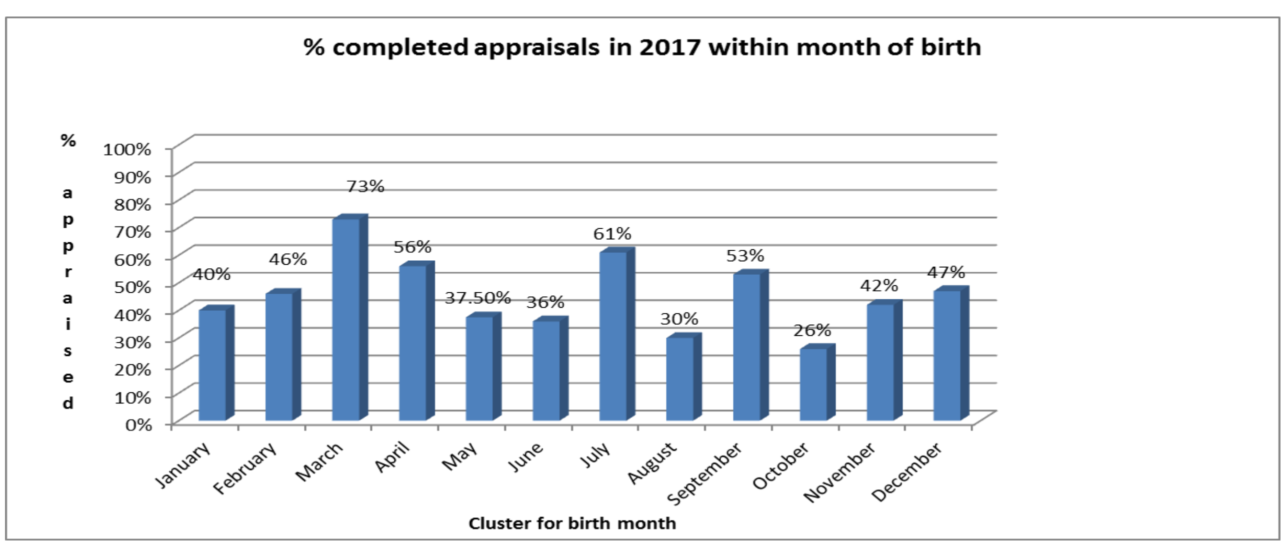
Medical Education Tracker Tools - Financial Year - Apr 17/Mar 18 -Completion Rate = 90.15%



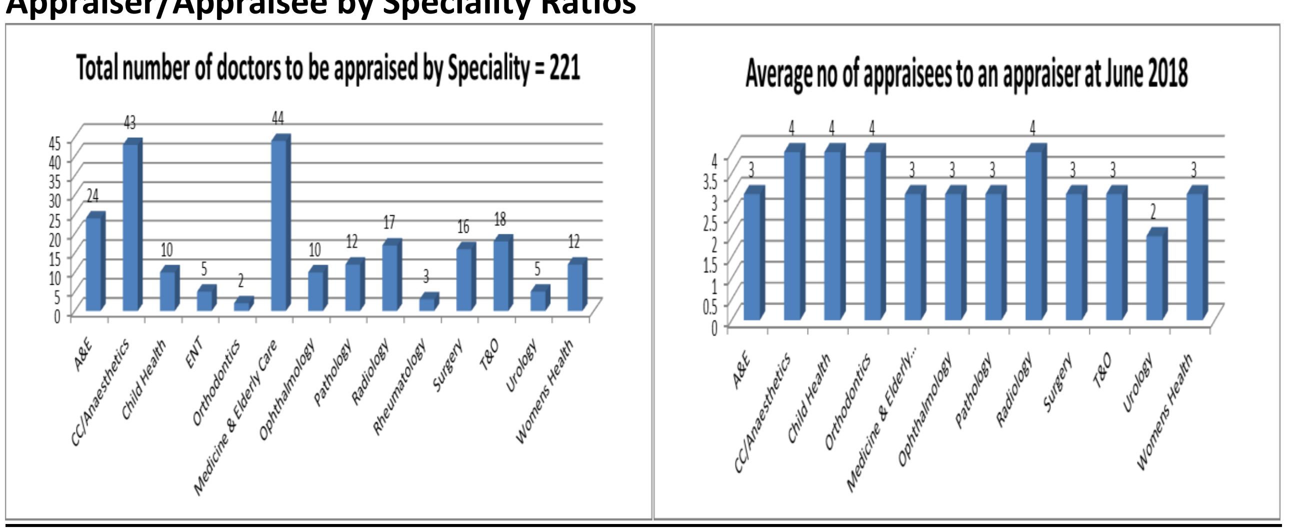
Medical Education Tracker Tool - Calendar Year 2017 Completion Rates = 89%



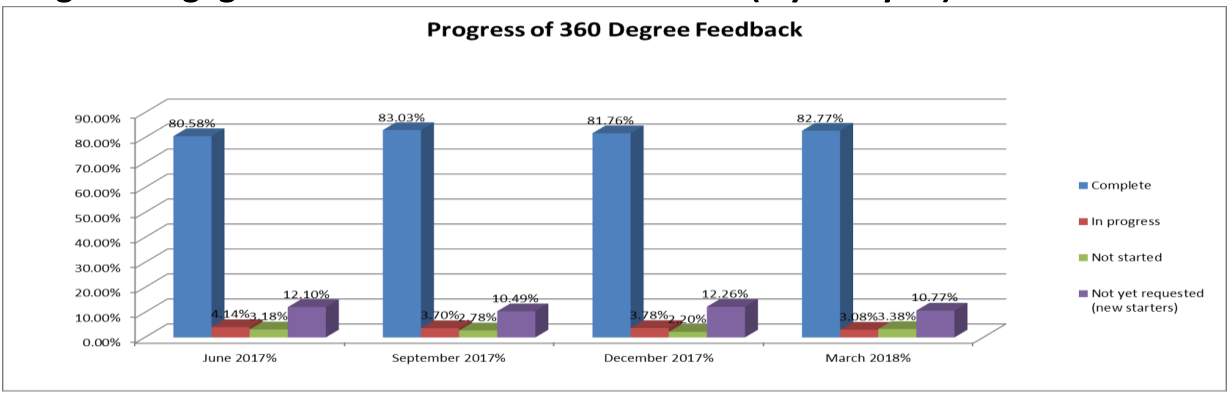
Medical Education Tracker Tool - Calendar Year 2017 Birth Month Compliance Rates



Appraiser/Appraisee by Speciality Ratios



Progress Engagement Tracker – 360© Feedback (5 year cycle)



Medical Appraisal data and in-month completion

Medical Appraisal Specialty Exception Reports sent monthly to Clinical Directors and CBU Managers outlining overdue and incomplete medical appraisals. The report dated 5th June features 1 appraisal still overdue from December 2017, two outstanding/incomplete from February 2018, 3 from March and 9 from April. Reminders, Notifications and (when required) Non-Engagement Letters have been issued.

2017 – 2018 – "5 month comparative analysis" – In-Month Completions

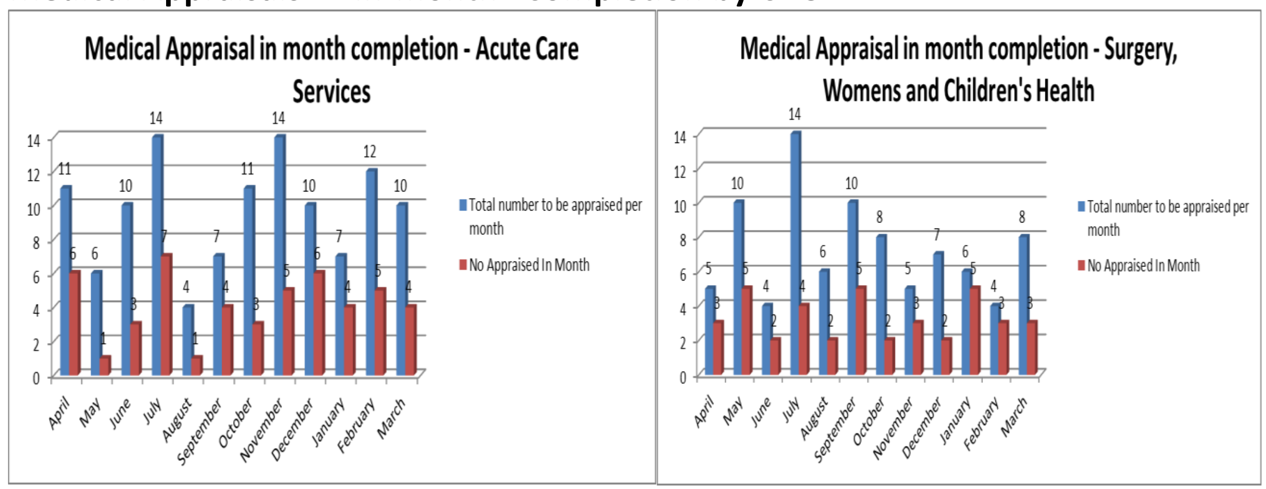
2017

Month of Birth	January	February	March	April	May
Percentage Appraised in month	40%	46%	73%	56%	37.50%
Total number to be appraised per month	15	13	15	16	16
No Appraised In Month	6	6	11	9	6

2018

Month of Birth	January	February	March	April	May
Percentage Appraised in month	69%	50%	39%	63%	58.00%
Total number to be appraised per month	13	16	18	19	19
No Appraised In Month	9	8	7	12	11

Medical Appraisals – "in-month" Completion by CBU



Revalidation Figures - 5 Year Tracker and Financial Year Position

The GMC Connect website identifies *within a 3 month notice period* when a Doctor is due to be revalidated and allows the Trust to discuss and prepare the doctor's documentation required for this process via the Revalidation Panels which are routinely held with the RO/Deputy RO/Clinical Director. As per the table below, the Trust can report ZERO delays/Late Submissions and can demonstrate a robust approach to tracking and monitoring to ensure a doctor is successfully revalidated/deferred.

Financial Year	Deferrals	Reported for Non-Engagement	Revalidate	Total Submissions
2013 - 14	10	0	44	54
2014 - 15	6	0	66	72
2015 - 16	12	0	69	81
2016 - 17	3	0	14	17
2017 - 18	5	1	14	20
Totals	36	1	207	244

5. EVALUATIONS

- As at the 5th June 2018 – there was only **ONE Medical Appraisal OVERDUE** from Dec 2017 and **TWO INCOMPLETE** from February 2018. Reminders and NON-Engagement Notification Letters have been sent in accordance with Trust Policy.
- ALL required submissions were COMPLETED on time for GMC Revalidation decisions by the RO for 2017/18.
- The Appraiser and Appraisee ratios remain consistent at no more than 1:4 and we have also organised "Medical Appraiser Refresher Training". We also encourage "out of specialty" Appraisals with a 3-year turnaround as is considered to be GMC Good Practice.
- The level of engagement is further evidenced by the "in month" completion rates and the mean average for the year had improved on the previous year from 56% to 61%, with the highest in-month completion rate in March 17 at 73%.
- Furthermore, Comparative analysis was undertaken when we identified a slippage in the **Calendar Year In-Month Completion Rates** from the first 5 months in 2017 to the first 5 months in 2018. We concluded that this reduction in engagement was possibly due to the completion of the 1st "Revalidation Cycle" and service pressures and sent robust communications to improve the position and successfully noted the following results:-
    - 2017 – Mean Av. in-month Completion Rate = 50% **(in JAN 2017 = 40%)**
    - 2018 – Mean Av. in-month Completion Rate = **56% (in JAN 2018 = 69%)**

6. TRAJECTORIES/OBJECTIVES AGREED

Key Elements of Current (Notable) Practice – Progress Update

- The Team remain engaged in the **NHS Revalidation North Network** and the Appraisal & Revalidation Administration Network in the NW where we attend Meetings and Conferences, share ideas and receive updates as required.
- **WHH Bi-Monthly ARG Meetings** – Terms of Reference/Minutes/Action Plans/National Updates – Networks/NHS England/maintain up-to-date knowledge – *informs the Education Governance Committee*
  - Collation and upload of a comprehensive "Suite of Reports" (12 month data sets) for every Doctor prior to their Appraisal Meeting.
- Incomplete/Overdue Appraisal Tracker /Revalidation Panels– both shared and discussed to ensure Team/Specialty are engaged and all necessary actions are taken.
- **WHH 9th Bi-Annual Appraiser Forum Meetings -** coordinated to "listen and support the Appraisers" - 14th June 2018 – with Action Notes
- Individual ***Appraiser FEEDBACK Reports*** directly from CRMS are given to each Appraiser to drive quality and expertise in the process and evidence their skills as Appraisers.
- Discussion of subjects such as ***"Quality of Appraisals"*** – ***"In-Month Completion Rates"*** – ***"Documentation required for Sign-Off"*** – ***"Reflections on Complaints, Claims and SUI's***" – ***"WHH Medical Appraiser Survey - Key Findings"***

7. MONITORING/REPORTING ROUTES

- Continue to track both the Calendar Year **(89%)** and Financial Year end data **(90%)**. **– Reports submitted for: Education Governance Committee**
- Continue to deliver Monthly Appraisal Completion (Exception) Reports to each Clinical Lead/Speciality
  - BY CBU/SPECIALTY – to the Clinical Leads and CBU Managers (for information)
  - BY OVERAL TRUST POSITION
  - BY % COMPLETE/INCOMPLETE per month.
  - NHS Revalidation North Figures – Submissions/Recommendations
  - GMC Connect - Recommendations on time or ahead of schedule

- Continue to present the Trust's Annual Organisational Assessment - "AOA" data and Quarterly Submissions to NHS Revalidation North
- Continue to track the - 360© Completion and Progress to ensure every Doctor has a completed Report in line with their GMC Revalidation date. (Underway for the next 5-year Revalidation Cycle.
- Continue to track the ratios of Appraisers to Appraisees – manage all request changes and respond to training needs.
- Annual Review of the WHH Strengthened Medical Appraisal Policy and SOP's - 2017.

8. TIMELINES

- Robust monthly reporting processes are in place
- SUBMITTED - Friday 2nd June 2017 - NHS England Mandatory Return for 2016/17 "**Annual Organisation Audit" – AOA** – **submitted 25th May 2017**
- SUBMITTED - June 2017 - Annual Report to their Board

9. ASSURANCE COMMITTEE (IF RELEVANT)

The Board is asked to note the contents of the Report and to be assured that our systems of monitoring and managing Medical Appraisals to support GMC Revalidation are robust and adhere to NHS England and the GMC Guidance and Practice.

- **GMC Good Practice... "Allocation Process"** - The Trust's total number of Medical Appraisers to **66.**
  - *"A doctor should normally have no more than three consecutive appraisals with the same appraiser and must then have a period of at least three years before being appraised again by the same appraiser... a doctor should not act as an appraiser to a doctor who as acted as their appraiser within the previous 5 years"*
  - ALL Clinical Leads respond and review their Clusters in agreement with the Deputy RO and identify the changes as required.
  - ALL Qualified Physician Associates will be given access to use CRMS to allow then to complete and engage in an annual appraisal; however it should be noted that the quality assurance of these appraisals need not be as stringent as they are not yet **GMC Registered** doctors. Student PAs are exempt from appraisal as they are completing a University portfolio. Their allocated educational supervisors should appraise the PAs.
  - **All Doctors (temp/locum/agency)** with a prescribed connection to the Trust and are employed for **six months or more** are included in the Trust Medical Appraisal and Revalidation process.

10. RECOMMENDATIONS

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

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

- Continuation of current practice for Reporting and Monitoring Systems for WHH to include monthly GMC Revalidation Dashboards for future tracking.

- Annual Review of the following Policies and SOP's:
  - WHH **The Strengthened Medical Appraisal Policy to support GMC Revalidation 2017**
  - **WHH GMC Revalidation Policy 2017**
  - **WHH SOP – Medical Workforce NEW Starter Process 2017**
  - **WHH SOP – Medical Workforce 360© Clinical Feedback Reports Process 2017**
  - **WHH SOP – Medical Practice Information Transfer 2017**
  - **WHH SOP – Revalidation Process 2017**

NO FURTHER ACTIONS ARE REQUIRED

--End of Report--

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/18/09/95**	
SUBJECT:	**Freedom to Speak Up – Biannual Report & Toolkit**	
DATE OF MEETING:	26th September 2018	
AUTHOR(S):	Jane Hurst Deputy Director of Finance (Strategy) and FTSU Guardian	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse	
LINK TO STRATEGIC OBJECTIVES:	SO2: To have a committed, skilled and highly engaged workforce who feel valued, supported and developed and who work togther to care for our patients	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	BAF1.1: CQC Compliance for Quality	
	BAF2.1: Engage Staff, Adopt New Working, New Systems	
	BAF1.2: Health & Safety	
EXECUTIVE SUMMARY (KEY ISSUES):	The purpose of this paper is to update the Trust Board on the activity of the Freedom to Speak Up (FTSU) Team and review the draft self-review toolkit.	
RECOMMENDATION:	The Trust Board is asked to discuss the self-review toolkit and note the progress of Freedom To Speak Up agenda.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Strategic People Committee
	Agenda Ref.	
	Date of meeting	26 September 2018
	Summary of Outcome	TBC
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None	

SUBJECT	Freedom to speak up	AGENDA REF:	BM/18/09/95

1. BACKGROUND/CONTEXT

The purpose of this paper is to update the Trust Board on the activity of the Freedom to Speak Up (FTSU) Team and review the draft self-review toolkit.

2. DISCLOSURES

The first quarter of 2018/19 (April to June) the FTSU team received one disclosure bringing the total since May 17 to 13. In the previous quarter there were no disclosures. The disclosure in quarter 1 related to cultural issues the champion who dealt with the issue facilitated communication between the individuals and the following feedback was collected:-

"I felt listened to and guided. The whole process seemed confidential increasing my confidence in Speaking Up if ever I needed to."

The team also received three other general queries which related to estates which have been passed on and will be monitored for action.

Quarter 1 benchmarking shows that we are not on our own with small numbers of disclosures and the following table indicates similar sized Trusts in the North West.

Table 1: 2018/19 Quarter 1 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	0	0	0	0	0
Bridgewater Community Healthcare NHS FT	4	1	2	2	0
Warrington and Halton Hospitals NHS FT	1	0	0	0	0
Liverpool Heart and Chest Hospital NHS FT	1	0	0	1	0
East Cheshire NHS Trust	3	0	1	0	1
Alder Hey Children's NHS FT	4	1	1	3	0
The Christie NHS FT	4	1	0	3	0
Mid Cheshire Hospitals NHS FT	1	0	1	0	0
The Walton Centre NHS FT	5	0	0	0	0
Liverpool Women's NHS FT	9	0	5	3	1
Southport and Ormskirk Hospital	9	3	3	2	0
Countess of Chester Hospital NHS FT	10	1	9	10	0
Stockport NHS Foundation Trust	10	0	9	1	0
Tameside and Glossop Integrated Care FT	5	0	2	4	2

At the time of writing quarter 2 has not been completed but several disclosures have been received including:-

- an anonymous disclosure relating to bullying which is being managed through HR training as the CBU is known.
- four disclosures by two individuals relating to one ward this is being reviewed through the ward accreditation process under the Deputy Director of Nursing.

It is possible that the increased activity in quarter 2 relates to the increase in communication of the FTSU policy and process undertaken by the team.

3. ACTIVITY OF THE FTSU TEAM APRIL TO AUGUST

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.

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

At the end of July FTSU was the Hot Topic every day for a week this proved very useful and resulted in 7 people stating an interest to get involved and become champions. A summary of the information shared can be found in Appendix 1.

FTSU has been added to the desk top and the wage slip. It has also been updated on Datix. More detail on the planned FTSU activities can be found in our action plan for 2018/19 and is attached in appendix 2. The FTSU team will present at the Grand Round on 12 October and the FTSU Executive Lead Dr Harper from Blackpool Hospital has been invited to come and speak.

The FTSU Guardian has been meeting with relevant Executive Team members, Chair and NED FTSU Lead to complete the FTSU self-review tool kit. The draft document is attached in Appendix 3 for discussion. The document has several attachments for evidence which will

be circulated separately due to size, the draft vision and strategy is attached in Appendix 4. The tool kit reviews of leadership and governance arrangements in relation to FTSU will help boards to identify areas of development and improve.

The Care Quality Commission (CQC) assesses a trust's speaking up culture during inspections under key line of enquiry (KLOE) 3 as part of the well-led question. This toolkit is aligned with the good practice set out in the well-led framework, which contains references to speaking up in KLOE 3 and will be shared with inspectors as part of the CQC's assessment framework for well-led. Completing the self-review tool and developing an improvement action plan will help trusts to evidence their commitment to embedding speaking up and oversight bodies to evaluate how healthy the trust's speaking up culture is.

4. RECOMMENDATIONS

The Trust Board is asked to discuss the self-review toolkit and note the progress of Freedom To Speak Up agenda.

Safety Huddle Hot Topic – FTSU

Monday

What is FTSU?

Speak up – we will listen. Speaking up about any concern you have at work is vitally important. It is essential because it will help us to keep improving our services for all patients and the working environment for our staff.

You may feel worried about raising a concern, and we understand this. But please don't be put off. In accordance with our duty of candour, our Chairman, Chief Executive and the entire Board of Directors are committed to an open and honest culture. We will listen to and investigate what you say and you will always have access to the support you need.

Exec Lead, NED, FTSU Guardian and Champions

Kimberley Salmon-Jamieson ED

Ian Jones NED

Jane Hurst Deputy Director of Finance with team of 5 champions and looking for more frontline champions

Looking for more frontline Champions if you or a member of your team is interested please contact Jane.Hurst@nhs.net or whh.freedomtospeakup@nhs.net We meet once every 4 to 6 weeks for 1 hour to discuss what has been happening.

Tuesday

Who should use it?

Anyone who works (or has worked) in the NHS, or for an independent organisation that provides NHS services can raise concerns. This includes agency workers, temporary workers, students and volunteers. If you require advice as to whether this policy applies to you please contact the FTSU Guardian

What issues can be raised?

You can raise a concern about risk, malpractice or wrongdoing you feel is harming the service we deliver. Just a few examples of this might include (but are by no means restricted to):

- concerns about unsafe patient care
- A criminal offence maybe, has been or is being committed
- unsafe working conditions or other breaches of Health & Safety
- inadequate induction or training for staff
- lack of, or poor response to a reported patient safety incident

- suspicions of fraud can also be reported to our Anti-Fraud Specialist Contact. The Trust's AFS is Karen McArdle. Her contact details are Telephone: 0151 285 4485 / Mobile 07774332881 Email: Karen.McArdle@miaa.nhs.uk

- bullying culture (across a team or organisation rather than individual instances)

- Concerns that someone maybe covering up wrongdoing

What it is not?

Not for moaning about your manager

Not replacement of Trust policies and procedures

Not for estates issues

<u>Wednesday</u>

Key Facts

FTSU is covered under CQC well led review KLOE 3 – Anyone in the Hospital may be asked what do you know about FTSU.

What inspectors may ask Freedom to Speak Up Guardians

How trusts support the role of FTSU Guardian including:

- Evidence that FTSU Guardians can regularly access their boards and CEOs
- Evidence that the FTSU role is appropriately communicated and accessible
- Evidence that the FTSU Guardian has the resources, support and independence to effectively undertake the role

How trusts respond to the concerns raised by their workers – including:

- Is there an appropriate speaking up/whistle-blowing policy
- Evidence that trusts investigate concerns and feedback

Evidence of a positive speaking up culture in the trust including:

- What steps or initiatives have trusts taken to promote speaking up?
- The steps taken by a trust to support minority and vulnerable staff groups to have a voice?
- Are staff who are suspended permitted access to their FTSU Guardian?

Any suggestion to support this can be directed to Jane.Hurst@nhs.net

<u>Thursday</u>

Toolkit released linked to CQC Well Led

Board members have responsibility to ensure:-

- Leaders are knowledgeable about FTSU
- Leaders have a structured approach to FTSU
- Leaders actively shape the speaking up culture

- Leaders are clear about their role and responsibilities
- Leaders are confident that wider concerns are identified and managed
- Leaders receive assurance in a variety of forms
- Leaders engage with all relevant stakeholders
- Leaders are focused on learning and continual improvement

Friday

Cases raised since May 2017 – 13 variety of departments and types of concerns

Nationally over half of disclosures last year related to bullying and harassment

Example of Nurse speaking up regarding staff safety levels resulted in closure of a bay to ensure working within staff staffing levels. Other disclosures having resulted in training and support alongside reviews of staff surveys with Senior managers to improve working conditions.

We compare to other similar size Trusts in number of disclosures but over the last 6 months only 1 (0 in Q4 and 1 in Q1)

Posters have been taken to every ward but when exec do ward walkabout very few know about FTSU – **Need your help to ensure everyone knows about FTSU and how to access it.**

Contact details

Guardian - Jane.Hurst@nhs.net

Champion - Lindsay.Watkinson@nhs.net

Champion - Lisa.Taylor33@nhs.net

Champion - Anne.Browning@nhs.net

Champion - Katie.Armstrong6@nhs.net

Champion - Mark.Ashton1@nhs.net

Chief Executive - Mel.Pickup@nhs.net

Non Executive Lead - Ian.Jones18@nhs.net

Executive Lead - kimberley.salmon-jamieson@nhs.net

FTSU Annual Plan

	Action	Timescale		Responsible
1	Present to Preceptorship Nurses	March / May and on going		Jane
2	Design New posters	July 18		Jane / Candice
3	Add message to Wage Slips	July / Aug 18		Candice
4	Add message to screen saver bi monthly	August and on going		Candice
5	Update telephone number on Weekly news letter	asap		Candice
6	Access Matron meetings	TBC		Jane
7	Access CBU manager meeting	13 July 18		Jane
8	Attend local inductions – Sophie and Carrie Barker	TBC		Jane
9	Attend Equality and Diversity Sub Committee	June 18 and ongoing		Jane / Mark
10	Attend E&D working group	September		Jane
11	Complete Toolkit	September		Jane
12	Get a junior doctor champion	October		Jane and champions
13	Add to ward Accreditation	August		Kimberley
14	Circulate business cards at events	Ongoing		Jane and champions
15	Update intranet pages	September		Candice / Jane
16	Produce information leaflet	September		Candice / Jane
17	Attend HR business partner meeting	July		Jane
18	Review staff survey and arrange pop up sessions	August		Jane
19	Grand Round session	November		Jane and champions
20	Attend HR surgeries	September		Jane and champions
21	Attend new junior doctors induction	September		Mark and Katie
22	Meet with Executive and Non Exec	August / Sept		
23	Attend Nursing and Midwifery Forum	August		Jane
24	Report back to Board on performance and Toolkit	September		Jane
25	Be the Hot topic on safety huddle	July		Jane
26	Incorporate FTSU in disciplinary letters and suspensions as available to everyone	September		Helen (HR)

National Guardian
Freedom to Speak Up

Freedom to Speak Up self-review tool for NHS trusts and foundation trusts

May 2018

How to use this tool

Effective speaking up arrangements help to protect patients and improve the experience of NHS workers. Having a healthy speaking up culture is evidence of a well-led trust.

NHS Improvement and the National Guardian's Office have published a guide setting out expectations of boards in relation to Freedom to Speak Up (FTSU) to help boards create a culture that is responsive to feedback and focused on learning and continual improvement.

This self-review tool accompanying the guide will enable boards to carry out in-depth reviews of leadership and governance arrangements in relation to FTSU and identify areas to develop and improve.

The Care Quality Commission (CQC) assesses a trust's speaking up culture during inspections under key line of enquiry (KLOE) 3 as part of the well-led question. This guide is aligned with the good practice set out in the well-led framework, which contains references to speaking up in KLOE 3 and will be shared with Inspectors as part of the CQC's assessment framework for well-led.

Completing the self-review tool and developing an improvement action plan will help trusts to evidence their commitment to embedding speaking up and help oversight bodies to evaluate how healthy a trust's speaking up culture is.

Self review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
Our expectations			
Leaders are knowledgeable about FTSU			
Senior leaders are knowledgeable and up to date about FTSU and the executive and non-executive leads are aware of guidance from the National Guardian's Office.	Regular reports to Board (at least 2 per annum), Strategic People Committee and Quality Committee. FTSU Summary briefing paper produced for all Board members as part of their mandatory training.		Committee and Board papers received. One to ones with Key members of the Board. Strategic people committee Sept 18.dc TB Report FTSU Mar 18.docx
Senior leaders can readily articulate the trust's FTSU vision and key learning from issues that workers have spoken up about and regularly communicate the value of speaking up.	FTSU Policy is in place and highlights of disclosure are included in regular Board Report. Exec Lead is made aware of all disclosures. We have a		FTSU is discussed at Exec and Deputy Forum, TOB and CBU managers have been made aware.

	draft FTSU vision and a strategy but we aim for FTSU to be embedded in our Trust values New Strategic People Committee is constituted to oversee FTSU in the future.		FREEDOM TO SPEAK UP POLICY JULY 18. Freedom To Speak Up Strategy v2.docx
They can provide evidence that they have a leadership strategy and development programme that emphasises the importance of learning from issues raised by people who speak up.	FTSU is to be included in the People Strategy FTSU included in HR Drop in session. FTSU Awareness is included in Induction for all new starters and volunteers as part of a Values and Behaviours session. Currently, FTSU and managers responsibility in relation to FTSU is referenced in the WHH Growing as a Leader Programme and is	Freedom to Speak Up is championed within our People Strategy due to be re-launched across the organisation in Autumn 2018. 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.	

	included in our HR drop in sessions.		
Senior leaders can describe the part they played in creating and launching the trust's FTSU vision and strategy.	Senior Leaders involved in the launch of FTSU presentations have been delivered at Committees and Board from the start of the process in May 2017 Information has been included it in team brief across the Organisation twice. Placing posters across the organisation. FTSU is included in the Trust Listening into Action Grand Round is booked for the 19th October 2018		FTSU 1st August 18.pptx Freedom to speak up may 17.pptx
Leaders have a structured approach to FTSU			

There is a clear FTSU vision, translated into a robust and realistic strategy that links speaking up with patient safety, staff experience and continuous improvement.	We have a draft vision for FTSU and it is also embedded in our Trust values. There is a clear FTSU action plan for the year. Incorporated into the assessment for ward accreditation and executive ask about FTSU when on CBU / ward walkabout	FTSU to be included in all strategies	
There is an up-to-date speaking up policy that reflects the minimum standards set out by NHS Improvement.	Yes this is on the extranet, updated annually using national examples of best practice	Policy renewal in November FTSU guardians will inform policy review from national best practice exemplars	Reviewed and approved by Audit Committee
The FTSU strategy has been developed using a structured approach in collaboration with a range of stakeholders (including the FTSU Guardian)and it aligns with existing guidance from the National Guardian.	The Draft strategy includes an action plan and regular reporting take place to Board and Strategic People Committee		

Progress against the strategy and compliance with the policy are regularly reviewed using a range of qualitative and quantitative measures.	The Committee and Board papers include a review of number of cases compared to similar sized Trust each quarter.	Feedback activity to be developed by guardian and champions Qualitative and quantitative measure require definition	
Leaders actively shape the speaking up culture			
All senior leaders take an interest in the trust's speaking up culture and are proactive in developing ideas and initiatives to support speaking up.	Regular agenda item on the Board and quarterly meeting with Exec, CEO, Chair and NED. Other evidence in listening to staff include the investment in LIA work and the Trusts quality and safety culture.	Ex walkabouts Ward accred assessment Regular presentations to different group of staf – peoples champions/ TNAs / HCSWs etc etc	
They can evidence that they robustly challenge themselves to improve patient safety, and develop a culture of continuous improvement, openness and honesty.	Quality Committee, Walkabouts – NEDs, ED and Council of Governors		

Senior leaders are visible, approachable and use a variety of methods to seek and act on feedback from workers.	FTSU has been added to Ward visit questions for exec / NED and COG, Perfect Day, Safety Huddle, Team brief, Impact 5 Listening into action		Appendix 1 Hot Topic summary.docx
Senior leaders prioritise speaking up and work in partnership with their FTSU Guardian.	Open door policy to Exec to discuss issues FTSU invited to various forums to speak up		
Senior leaders model speaking up by acknowledging mistakes and making improvements.			
The board can state with confidence that workers know how to speak up; do so with confidence and are treated fairly.	FTSUG works with Comms Team to spread the work including -Posters, Team brief, wage slips, Nurse Preceptorship, Induction, Screen	FTSUG to arrange meeting with staff COG twice a year LIA results to be analysed. Re do FTSU	

	saver Staff survey Executive walkabout checks for FTSU awareness	questionnaire	
Leaders are clear about their role and responsibilities			
The trust has a named executive and a named non-executive director responsible for speaking up and both are clear about their role and responsibility.	Yes and this is in the policy. Executive Lead is Kimberley Salmon-Jamieson Non-Executive Lead is Ian Jones	To be added to the Board Posters to further communicate. This could also be added to organisational structure	
They, along with the chief executive and chair, meet regularly with the FTSU Guardian and provide appropriate advice and support.	Quarterly meetings in the diary	Suggestion to invite Lead Governor twice a year.	
Other senior leaders support the FTSU Guardian as required.	Open Door policy to all Exec for FTSU issues Ask the chief nurse	CBU teams could adopt formal visits to areas offering support re FTSU	

	on line via internet		
Leaders are confident that wider concerns are identified and managed			
Senior leaders have ensured that the FTSU Guardian has ready access to applicable sources of data to enable them to triangulate speaking up issues to proactively identify potential concerns.	FTSU role is undertaken by senior manager who is able to access data across the organisation with close working links to informatics. Quarterly reports to Quality Committee, Strategic People Committee and Board. Chief nurse / medical director triangulation meetings		DRAFT Strategic People Committee Wo PUBLIC Trust Board Cycle of Business 201
The FTSU Guardian has ready access to senior leaders and others to enable them to escalate patient safety issues rapidly, preserving confidence as appropriate.	Open Door policy to Execs, access to NEDs through Board secretary FTSU access to CEO and Chair		

Leaders receive assurance in a variety of forms			
Workers in all areas know, understand and support the FTSU vision, are aware of the policy and have confidence in the speaking up process.	Survey has been undertaken but response was low. FTSU team continue to look at new ways to highlight the policy and process.	Suggested personal letter from Chair asking them to complete pre-printed feedback sheet. Could it be added on annual staff review / PDR	
Steps are taken to identify and remove barriers to speaking up for those in more vulnerable groups, such as Black, Asian or minority ethnic (BAME), workers and agency workers	FTSUG is member of Equality and Diversity Sub- Committee	Use any regional or national learning in this areas – SG committee to promote and E&D committee	
Speak up issues that raise immediate patient safety concerns are quickly escalated	Template completed when disclosure is made states patient safety issues to be immediately raised with Associate Director of Governance / Deputy Director of Nursing Access to ex team always available		

Action is taken to address evidence that workers have been victimised as a result of speaking up, regardless of seniority	No evidence of this to date. Follow up emails sent to individuals to check on them after a couple of months. One individual who disclosed is now a FTSU Champion Guardian promotes confidentially and actively maintains contact with individual to ensure support that this does not occur	Suggested needs an independent route- Michelle to advise	
Lessons learnt are shared widely both within relevant service areas and across the trust	Where issue occur training is put in place to prevent issue occurring again.	Impact of this needs to be monitored / checked needs to be learning briefing also go to quality governors meeting	
The handling of speaking up issues is routinely audited to ensure that the FTSU policy is being implemented	An audit has not been arranged yet	Audit to be built in to the annual audit programme for 2018/19	
FTSU policies and procedures are reviewed and improved using feedback from workers	FTSU policy was reviewed by Audit Committee, JNCC and the FTSU Champions. It is in line with the national guidance	Annual review of the policy	

The board receives a report, at least every six months, from the FTSU Guardian.	Regular FTSU reports to Trust Board – April and September 2018 with additional reports if required		Evidence above
Leaders engage with all relevant stakeholders			
A diverse range of workers' views are sought, heard and acted upon to shape the culture of the organisation in relation to speaking up; these are reflected in the FTSU vision and plan.	FTSU attends a variety of meetings and training sessions and these are outlined in the action plan for the year. The FTSU team undertakes a Survey monkey questionnaire at least once a year. The Trust also shows listening to all staff through Listening into Action work	Consider other staff networks that the FTSU can link into.	
Issues raised via speaking up are part of the performance data discussed openly with commissioners, CQC and NHS Improvement.	FTSUG attending CQC meeting. FTSU on the NHSI agenda (July 18)		
Discussion of FTSU matters regularly takes place in the public section of the board meetings (while	FTSU on Board cycle of business twice a year		

respecting the confidentiality of individuals).			
The trust's annual report contains high level, anonymised data relating to speaking up as well as information on actions the trust is taking to support a positive speaking up culture.	The Trust annual report mentioned FTSU but further detail could be added	Consider further detail in next annual report (Action Board Secretary)	
Reviews and audits are shared externally to support improvement elsewhere.	No action taken to date		
Senior leaders work openly and positively with regional FTSU Guardians and the National Guardian to continually improve the trust's speaking up culture	FTSU Guardian or Champion attends regional and national meeting. Guidance from National Guardian including reports and webinars are discussed between Exec Lead, NED Lead and FTSUG		
Senior leaders encourage their FTSU Guardians to develop bilateral relationships with regulators, inspectors and other local FTSU Guardians	FTSU Guardian or Champion attends regional and national meeting	FTSUG to attend next CQC meeting	
Senior leaders request external improvement support when required.	There has not been a requirement for this linked to		

	FTSU yet.		
Leaders are focused on learning and continual improvement			
Senior leaders use speaking up as an opportunity for learning that can be embedded in future practice to deliver better quality care and improve workers' experience.	As part of our ongoing commitment to being a Learning Organisation, work is currently underway as part of a wider review of Leadership Development to ensure learning from FTSU concerns raised can be fed into development programmes.		
Senior leaders and the FTSU Guardian engage with other trusts to identify best practice.	FTSU Guardian or Champion attends regional and national meeting		
Executive and non-executive leads, and the FTSU Guardian, review all guidance and case review reports from the National Guardian to identify improvement possibilities.	Guidance from National Guardian including reports and webinars are discussed between Exec Lead, NED Lead and FTSUG		
Senior leaders regularly reflect on how they respond to feedback, learn and continually improve and encourage the same throughout the			

organisation.			
The executive lead responsible for FTSU reviews the FTSU strategy annually, using a range of qualitative and quantitative measures, to assess what has been achieved and what hasn't; what the barriers have been and how they can be overcome; and whether the right indicators are being used to measure success.	We have drafted a FTSU strategy, including an action plan which is reviewed annually. We review the quarterly benchmarking of disclosures against similar Trusts		
The FTSU policy and process is reviewed annually to check they are fit for purpose and realistic; up to date; and takes account of feedback from workers who have used them.	FTSU policy is reviewed annual at the Audit Committee and is updated in line with national guidance. Due to go back in November 18		
A sample of cases is quality assured to ensure: • the investigation process is of high quality; that outcomes and recommendations are reasonable and that the impact of change is being measured • workers are thanked for speaking up, are kept up to date though out the investigation		To be arranged with MIAA annual review. Consider letter of thanks from Chair or NED to say thank you on behalf of the Board?	

and are told of the outcome • Investigations are independent, fair and objective; recommendations are designed to promote patient safety and learning; and change will be monitored			
Positive outcomes from speaking up cases are promoted and as a result workers are more confident to speak up.		Team brief and annual review	
Individual responsibilities			
Chief executive and chair			
The chief executive is responsible for appointing the FTSU Guardian.	As per the policy		
The chief executive is accountable for ensuring that FTSU arrangements meet the needs of the workers in their trust.	As per the policy		
The chief executive and chair are responsible for ensuring the annual report contains information about FTSU.	Page 57	More detail is required next year	
The chief executive and chair are responsible for ensuring the trust is engaged with both the regional Guardian network and the National	FTSUG attendance to the regional and National meetings are		

Guardian's Office.	included in the report to Board on FTSU activities		
Both the chief executive and chair are key sources of advice and support for their FTSU Guardian and meet with them regularly.	Quarterly meetings		
Executive lead for FTSU			
Ensuring they are aware of latest guidance from National Guardian's Office.	FTSU Guardian makes sure Executive Lead is aware of new guidance		
Overseeing the creation of the FTSU vision and strategy.	A draft FTSU vision and strategy is being reviewed and FTSU is embedded in the Trust vision and objectives		
Ensuring the FTSU Guardian role has been implemented, using a fair recruitment process in accordance with the example job description and other guidance published by the National Guardian.	As per the policy		

Ensuring that the FTSU Guardian has a suitable amount of ring fenced time and other resources and there is cover for planned and unplanned absence.	Guardian and 5 Champions in place to support. FTSU email address accessible by the champions if the guardian is on leave. Champions details are also on the posters.		
Ensuring that a sample of speaking up cases have been quality assured.		Need to organise an review	
Conducting an annual review of the strategy, policy and process.	FTSU policy is reviewed annual at the Audit Committee and is updated in line with national guidance. Due to go back in November 18		
Operationalising the learning derived from speaking up issues.	FTSU issues will be linked into Ward Accreditations		
Ensuring allegations of detriment are promptly and fairly investigated and acted on.			

Providing the board with a variety of assurance about the effectiveness of the trusts strategy, policy and process.			
Non-executive lead for FTSU			
Ensuring they are aware of latest guidance from National Guardian's Office.	Receive report from FTSUG		
Holding the chief executive, executive FTSU lead and the board to account for implementing the speaking up strategy.			
Robustly challenge the board to reflect on whether it could do more to create a culture responsive to feedback and focused on learning and continual improvement.	On the Board agenda twice a year. Use of this toolkit. Use of Listening into action (LIA)		
Role-modelling high standards of conduct around FTSU.	On the Board agenda twice a year. Time given to FTSUG as required. Included in NED / ED ward walkabouts		
Acting as an alternative source of advice and support for the FTSU Guardian.	As per policy		

Overseeing speaking up concerns regarding board members.	None to date but NED Lead would do this with support from Chair or CE or external support.		
Human resource and organisational development directors			
Ensuring that the FTSU Guardian has the support of HR staff and appropriate access to information to enable them to triangulate intelligence from speaking up issues with other information that may be used as measures of FTSU culture or indicators of barriers to speaking up.	Named HR link for FTSUG Helen Dixon with monthly meetings in place. OD Manager was FTSUG in previous Trust and offers support. HR link to staff survey when a disclosure has specific issue. FTSUG invited to the HR drop in sessions.		
Ensuring that HR culture and practice encourage and support speaking up and that learning in relation to workers' experience is disseminated across the trust.	The HR Team are embedding FTSU into their Staff letters, policies and strategies. They have FTSU posters in their meeting rooms and Occupational health waiting room. FTSU was invited to speak at the workforce committee which resulted in FTSU being hot topic at the Safety huddle,		

	involvement in HR drop in days and raised the FTSU profile		
Ensuring that workers have the right knowledge, skills and capability to speak up and that managers listen well and respond to issues raised effectively.	As per above HR supports the profile of FTSU. When HR is involved in a disclosure monitoring is in place to ensure action is taken and reviewed.		
Medical director and director of nursing			
Ensuring that the FTSU Guardian has appropriate support and advice on patient safety and safeguarding issues.	Director of Nursing is the FTSU Executive lead, safeguarding Executive lead and Governance Executive Lead	Suggest Bi annual review with medical director for triangulation of FTSU information	
Ensuring that effective and, as appropriate, immediate action is taken when potential patient safety issues are highlighted by speaking up.	There is appropriate senior oversight of any patient safety issues and FTSU will raise to Deputy Director of Nursing, Associate Director of Quality or Director of Nursing directly. Monthly meeting with Quality, HR and FTSU to review		Trust Wide Safety Huddle 23 April 2018 medical_cabinet_TOR.docx

	cases. Safety Huddle – Halt moments if something is highlighted through FTSU the Champion know that they can raise with the Safety huddle team or just turn up and tell people.		
Ensuring learning is operationalised within the teams and departments that they oversee.	The Trust has a Learning Framework. Triangulation meeting – ops, quality and HR CMT forum, FY Forum, Junior Doctors Forum	Need to ensure FTSU is linked into this model. Ensure FTSU is on this agenda Ensure FTSU is on these forums COO / MD and CN to be aware	Lessons Learned Framework update.dc

We are WHH

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Freedom To Speak Up Strategy

The Trusts vision for Freedom to speak up is:-

"We consider FTSU in everything we do, all staff will know how to speak up and feel safe doing it. We will become outstanding by listening and learning from our staff."

This document outlines how we will achieve this vision. The Trust has a named Executive Lead, Non-Executive Lead and a Freedom to Speak up Guardian. In addition several champions have been appointed to support the work and spread the word across the Trust.

The Trust has a FTSU policy which is in line with the national guidance and is reviewed annually.

Freedom to Speak up links to the Trust Quality People Sustainability (QPS) Values:

Excellence for our patients – Includes safety, effectiveness and experience

Caring for our staff – About our workforce, how we engage with you and how we develop leadership and help enhance your careers and use your skills

Here for our community – A focus on good governance, financial viability, the profile and perception of the trust and growth.

Our Freedom To Speak Up Strategy

- Provide a clear policy and procedure to raise concerns.
- Increase awareness to all staff regardless of background ensuring everyone know how to raise a concern.
- Ensure Managers and Leaders of the Trust are clear of their roles and responsibilities when handling a concern.
- Provide regular communication to all staff to raise awareness.
- Communicate key findings from cases to Committee and Trust Board including number, overview of themes, benchmarking and update on action plan.
- Seek feedback from those who raise concerns.
- Work with the guidance provided by the national office.

The Freedom To Speak Up Team has produced an action plan to achieve the strategy and is attached.

The following diagram highlights the vision for raising concerns in the NHS as per the Sir Robert Francis QC (2015) Freedom to speak up: an independent report into creating an open and honest reporting culture in the NHS.

1 Identifying that something might be wrong

a. I know that it is right to speak up
b. My organisation is a supportive place to work
c. I am regularly asked for my views
d. I know how to raise concerns and have had training which explained what to do
e. I know that I will not be bullied, victimised or harassed as a result of speaking up

2 Raising a concern

a. My colleagues and managers are approachable and trained in how to receive concerns
b. My organisation has a clear and positive procedure in place
c. I know where to go for support and advice
d. Concerns are taken seriously and clear records are kept
e. Managers always explain what will happen and keep me informed

3 Examining the facts

a. An independent, fair and objective investigation into the facts will take place promptly and without the purpose of finding someone to blame
b. The investigation will be given the necessary resource and scope
c. I am confident that any recommendations made will be based on the facts and designed primarily to promote safety and learning
d. I will be kept informed of developments
e. The process will be kept separate from any disciplinary or performance management action

4 Outcomes and feedback

a. Where there are lessons to be learned they will be identified and acted on
b. I will be satisfied the outcome is fair and reasonable, even if I do not agree with it
c. I will be told what was found out and what action is being taken
d. A plan to monitor the situation will be put in place
e. I feel confident that patients are safe and that my team remains a supportive place to work

5 Reflecting and moving forward

a. I will be thanked for speaking up
b. I will speak up again in future if the need arises
c. I know that my concerns will be taken seriously and actioned as appropriate
d. Lessons learnt will be shared and acted on by me and my colleagues
e. I will advise and support others to speak up in future

1. I feel confident to speak up
2. I feel safe to speak up in future
3. Concerns are investigated
4. Speaking up makes a difference
5. Concerns are well received

Freedom To Speak Up Action Plan 2018/19

	Action	Timescale
1	Present to Preceptorship Nurses	March / May and on going
2	Design New posters	July 18
3	Add message to Wage Slips	July / Aug 18
4	Add message to screen saver bi monthly	August and on going
5	Update telephone number on Weekly news letter	asap
6	Access Matron meetings	TBC
7	Access CBU manager meeting	13 July 18
8	Attend local inductions – Sophie and Carrie Barker	TBC
9	Attend Equality and Diversity Sub Committee	June 18 and ongoing
10	Attend E&D working group	September
11	Complete Toolkit	September
12	Get a junior doctor champion	October
13	Add to ward Accreditation	August
14	Circulate business cards at events	Ongoing
15	Update intranet pages	September
16	Produce information leaflet	September
17	Attend HR business partner meeting	July
18	Review staff survey and arrange pop up sessions	August
19	Grand Round session	November
20	Attend HR surgeries	September
21	Attend new junior doctors induction	September
22	Meet with Executive and Non Exec	August / Sept
23	Attend Nursing and Midwifery Forum	August
24	Report back to Board on performance and Toolkit	September
25	Be the Hot topic on safety huddle	July
26	Incorporate FTSU in disciplinary letters and suspensions as available to everyone	September

Draft

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/18/09/96**
SUBJECT:	**Strategic Partnership Agreement - Memorandum of Understanding between Warrington & Halton NHS Foundation Trust and Warrington & Vale Royal College**
DATE OF MEETING:	26 September 2018
ACTION REQUIRED	**Approval**
AUTHOR(S):	Michelle Cloney, Director of HR & OD
EXECUTIVE DIRECTOR SPONSOR:	Michelle Cloney, Director of HR & OD
LINK TO STRATEGIC OBJECTIVES:	SO4: To work with our partners to consolidate and develop sustainable, high quality care as part of a thriving health economy for the future
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	BAF2.1: Engage Staff, Adopt New Working, New Systems
	BAF2.5: Right People, Right Skills in Workforce
	BAF2.4: Engaging & Involving Workforce
STRATEGIC CONTEXT	The Trust is keen to develop a strategic partnership with local colleges in order to create a career pipeline of potential new recruits through offering learning and education opportunities in the Trust and maximising our offer for apprenticeships, work placements, traineeships and intern ships. Discussions with the college senior leadership team have results in a draft Memorandum of Understanding, with the offer of a place on the Governing Body at WHH for one of the college senior leadership team and reciprocally a place for the Director of HR & OD on the college Board. Inherent in the collaborative strategic partnership is a focus on the learners experience in the workplace and the potential employment pipeline into the Trust. The challenging workforce agenda will therefore focused on: • Improving the skills of the workforce so more people can access jobs from our local population • Giving those without the right skills a second chance to get job ready skills • Building on the successful apprenticeship hub and

	work with businesses to develop higher skilled apprenticeships • Concentrating on supporting graduate level jobs to attract the highest skilled workers • Enabling school leavers to get the qualifications they need to access and create the jobs of the future
EXECUTIVE SUMMARY (KEY ISSUES):	Prior to submission to the Warrington & Vale Royal College Board a working draft MOU was presented to the Executive Team for approval to proceed. The final draft Memorandum of Understanding (MOU) has been approved by Warrington & Vale Royal College Board in July 2018. This draft MOU is therefore brought to Trust Board in order to approve the content and enable membership of the Governing Body to be offered to a member of the senior leadership team and vise versa, the opportunity for the Director HR & OD to join the college Board.
RECOMMENDATION:	Trust Board are asked to: Approve the Strategic Partnership Memorandum of Understanding
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None

Trust Board

SUBJECT	Strategic Partnership Agreement - Memorandum of Understanding between Warrington & Halton NHS Foundation Trust and Warrington & Vale Royal College	AGENDA REF:	BM/18/09/96

1. BACKGROUND/CONTEXT

Discussions with the college senior leadership team have results in a draft Memorandum of Understanding, with the offer of a place on the Governing Body at WHH for one of the college senior leadership team and reciprocally a place for the Director of HR & OD on the college Board.

2. KEY ELEMENTS

The Memorandum of Understanding is intended to support the Trust to create a career pipeline and the college to offer quality educational and learning experience of students seeking healthcare work experiences.

The Strategic Partnership is intended to support a focused on:

- Improving the skills of the workforce so more people can access jobs from our local population
- Giving those without the right skills a second chance to get job ready skills
- Building on the successful apprenticeship hub and work with businesses to develop higher skilled apprenticeships
- Concentrating on supporting graduate level jobs to attract the highest skilled workers
- Enabling school leavers to get the qualifications they need to access and create the jobs of the future

In addition the Strategic Partnership

- Establishment of a Strategic Partnership Group to oversee the MOU and to have the right people in attendance to forge ahead with the monitoring and development of the joint offers
- The Strategic Partnership Group to facilitate the annual review of the MOU
- A reciprocal position on governing boards. A senior leader from the college to become a Trust Governor (Business) and a place on the college governing board for the Director HR & OD from the Trust
- Building communications and marketing available from the college about the learners experience and the workplace experience and employment opportunities within the Trust.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

To discuss and approve the proposed Memorandum of Understanding.

Subject to approval formally offer a place on the Trusts Governing Body and work to encourage a 'young person' representative

4. MONITORING/REPORTING ROUTES

Strategic Partnership Group to be established

5. TIMELINES

Upon formal approval the MOU will be reviewed on an annual basis

6. ASSURANCE COMMITTEE

Strategic People Committee

7. RECOMMENDATIONS

Trust Board are asked to:
Approve the Strategic Partnership Memorandum of Understanding

Appendix A

We are
WHH

Warrington & Halton NHS Foundation Trust and Warrington & Vale Royal College: Memorandum of Understanding

The Agreement
This Memorandum of Understanding (“MOU”) is entered into by Warrington & Halton NHS Foundation Trust (“the Trust”) and Warrington & Vale Royal College (“the College”).

This MOU will be managed collectively by a joint group called the *Strategic Partnership Group* made up of representatives from both organisations.

The MOU commences on 00/00/2018 and has an indefinite duration, subject always to annual review and agreement by both parties to continue with the MOU. The annual review will between both organisations will be facilitated by the Strategic Partnership Group.

Introduction

Warrington & Halton NHS Foundation Trust and Warrington & Vale Royal College will form a strong and co-prosperous partnership that promotes initiatives and opportunities for developing the employability skills and opportunities for College learners and apprentices.

The Trust has an ambition to be ***outstanding for our patients, our communities and each other,*** seeking to deliver this through a strategic framework - Quality, People and Sustainability.

The QPS Framework establishes a set of aims:

- ***Quality***: We will always put our patients first through high quality, safe care and an excellent patient experience.
- ***People***: We will be the best place to work with a diverse, engaged workforce that is fit for the future.
- ***Sustainability***: We will work in partnership to design and provide high quality, financially sustainable services.

Inherent in the collaborative partnership is a focus on the learners experience in the workplace and the potential employment pipeline into the Trust. The challenging workforce agenda will therefore focused on:

- Improving the skills of the workforce so more people can access jobs from our local population
- Giving those without the right skills a second chance to get job ready skills
- Building on the successful apprenticeship hub and work with businesses to develop higher skilled apprenticeships
- Concentrating on supporting graduate level jobs to attract the highest skilled workers
- Enabling school leavers to get the qualifications they need to access and create the jobs of the future

The partnership will develop opportunities that will meet the needs of learners on a range of programmes, enabling them to participate in high quality and realistic work place experiences, including Apprenticeships, Traineeships and Supported Internships.

The College will ensure that learners are prepared for work place experience through promoting the high expectations of the Trust thus ensuring that the Trust has committed and motivated learners in the work place, who could be considered viable candidates for future employment within the Trust on successful completion of their study.

Joint Collaboration

By endorsing the Memorandum of Understanding the Trust will invite a senior leader representative to join the Trust Council of Governors and likewise the College will invite a senior leader to join their Governing Body.

Scope of Work

1. The Trust will use the College as a provider of Apprenticeships at all levels and across all the frameworks on offer.
2. The Trust will provide the opportunity to place Traineeships with a view to developing learner skills so they can progress to an Apprenticeship.
3. The Trust will provide the opportunity to place Supported Interns with a view to working with the College to develop employability as well as personal, social and emotional skills to promote opportunities for employment within the Trust.
4. The Trust will provide the opportunity for learners to undertake work placements within the Trust, which are meaningful and of high quality.
5. The College will work with the Trust to promote wider professional development opportunities to its workforce.
6. The College will work to ensure that all learners participating in employability activities offered by the Trust are fully prepared and supported to ensure that they contribute fully to the working environment.
7. Should funding allow and if sufficient placements are offered by the Trust a job coach will be sourced to support the Trust and co-ordinate those learners who are attending the employers premises on a long term basis, including Traineeships, Supported Internships and long term work placements.
8. The Trust will offer the College the opportunity to participate in the PSA programme delivered by the Trust. The College will identify and select the appropriate learners to participate in the programme, through a rigorous process to ensure commitment and motivation.
9. The Trust and the College will work together in the design and development of curriculum, including the promotion of employability skills and the College Employability Strategy, the design of assessments, guest speakers, mock interviews and educational visits.
10. The College will work to develop communication and marketing materials which promote the Strategic Partnership and promote the Trust as an employer of choice to current and future learners.
11. The College and the Trust will participate in joint career events, open days and learner sessions to promote learning at the College and employment at the Trust.

Resourcing and Monitoring

1. The Trust and the College will work together to develop a detailed plan and timeline to cover the scope of work as detailed above, based on the principles of good value for money.
2. The College and the Trust will meet on a bi-monthly basis at the Strategic Partnership Group to review plans and monitor the progress of sub-groups in delivering against the scope of this Memorandum of Understanding.

General Points

1. This Memorandum of Understanding comes into effect immediately upon signature by authorised representatives of both parties (electronic signature suffices).
2. The operation of this Memorandum of Understanding will be reviewed annually upon the anniversary of the original agreement. It can be amended by mutual consent if necessary, usually at the review date.
3. The Memorandum of Understanding can be terminated by either party, without penalty or need to give reasons, at the review date.

Signed on behalf of Warrington & Halton NHS Trust

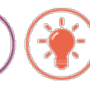
___________________________________ July 2018

Signed on behalf of Warrington and Vale Royal College

____________________________________ July 2018

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/18/08/97**
SUBJECT:	**Guardian Quarterly Report on Safe Working Hours for Junior Doctors in Training**
DATE OF MEETING:	26 September 2018
ACTION REQUIRED	**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.**
AUTHOR(S):	Mark Tighe, Guardian of Safe Working Hours and Mick Curwen, Head of HR Strategic Projects
EXECUTIVE DIRECTOR SPONSOR:	Alex Crowe, Deputy Medical Director
LINK TO STRATEGIC OBJECTIVES:	SO2: To have a committed, skilled and highly engaged workforce who feel valued, supported and developed and who work togther to care for our patients
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	BAF1.2: Health & Safety
	BAF2.1: Engage Staff, Adopt New Working, New Systems
	BAF2.3: Medical Staffing
STRATEGIC CONTEXT	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. This report covers the quarter from April – June 2018.
EXECUTIVE SUMMARY (KEY ISSUES):	The new Junior Doctors Contract has been in place since August 2016, and now all our Foundation Doctors are on this new 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. There has been a significant drop in the number of submitted exception reports (ERs) during the 3 month period. This relates to a reduction in volume and acuity of the workload, compared with the difficult winter period. In addition, the problem areas, such as the medical handover, have been managed well by the directorate. The majority of ERs still relate to juniors working past their allocated hours. The more senior trainees seem to be more concerned with loss of educational and training opportunities, when being asked to cover understaffed areas. This is apparent on one or two of the medical wards (eg. B14 has had rota gaps and sickness leading to understaffing). We have persistent problems with the sign-off meetings between the Educational Supervisors and the trainees, with large numbers of ERs having not been

	completed. This leads to a long delay in our trainees being able to put in claims for time-off in lieu (TOIL) and compensatory payment. We are seeing more requests for time-off in lieu (TOIL), rather than compensatory payment. This is reassuring as it will hopefully prevent them exceeding their recommended maximum hours. I have had a number of useful discussions with ES and trainees in attempts to allow fair resolution of ERs. I have sent numerous emails to our Educational Supervisors and trainees, to remind them of the importance of getting all ERs signed off as quickly as possible.
RECOMMENDATION:	The Board are requested to note the report and progress made with implementing the junior doctor contract and the level of assurance given that the junior doctors are working safely for their own health and wellbeing and the safety of patients. Any concerns that the Board have should be reported back to the Guardian for his attention.
PREVIOUSLY CONSIDERED BY:	**Committee**: **Agenda Ref.**: **Date of meeting**: **Summary of Outcome**:
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None

BOARD OF DIRECTORS

SUBJECT	Guardian Quarterly Report on Safe Working Hours for Junior Doctors in Training covering Q1: 1 April 2018 – 30 June 2018	AGENDA REF:	BM/18/08/97

1. Executive Summary

The New Junior Doctor Contract is well established at WHH. All our rotas remain compliant, and in general the juniors are happy with their allocations. Our Junior Doctors' Forum remains very well attended and enjoys robust discussion. The collaboration of the Medical Director, HR and the Guardian into a single meeting for the JDF seems to work well, 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 a significant reduction in the number of Exception Reports (ER) in the 3 month period (April to June 2018), compared with the difficult times over the winter months. Only 27 new ERs were submitted during this time, with 2 documented as immediate safety concerns (ISC).

The vast majority of ERs still relate to our F1 doctors working past their allocated time, usually on an ad hoc basis, but there has been a cluster from 2/3 areas, which have prompted work schedule reviews.

Six ERs relate to missed educational or training opportunities, mainly from CT or ST grades., but this has improved from the previous 3 months (13 ERs), as acuity has eased on the wards

Most ERs are submitted by juniors working on the medical wards, but this reflects the busier nature of their jobs. I have been impressed with the attempts to resolve the staffing shortages on the acute medical wards, but despite this, the F1s appear to be getting good support and teaching there.

I still have issues with the timeliness of the 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.

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 April 2018 to 30 June 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): 70

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 (2 appointments on the FY2 intake were initially vacant but one was filled on a locum basis).

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 c80 trainees from the Lead Employer and the most recent rotations now include the vast majority of trainees on the new

contract. 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 Q4	No. Exceptions raised Q1	No. exceptions closed	No. exceptions outstanding including those from previous reports
General Medicine – FY1	71(80)	18 (21)	8 (11)	10 (10)
General Surgery – FY1	27 (38)	3 (6)	1	2 (5)
Anaesthetics – SST/JST	1	0	0	0
Medicine - JST	1 (3)	0	0	0
Medicine – ST3	5 (6)	5	0	5
Trauma and Orthopaedics – FY1	1	0	0	0
Obstetrics & Gynaecology JST	1	0	0	0
Paediatrics – Alder Hey – FY1	0	0	0	0
ENT – ST3	0	0	0	0
Emergency Medicine FY2		1	1	0
Total	107 (130)	27 (33)	10 (13)	17 (20)

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 27 exception reports were completed but these cover 33 incidents. The previous quarter was 107 exception reports and 130 incidents which is a significant reduction. This probably reflects the changes which have been made to the FY1 rota in medicine relating to the handover and the ‘winter pressures’ effect has gradually reduced.
2. The 33 incidents were submitted from a total of 13 trainees covering 11 Educational Supervisors, 2 of which do not appear to have yet engaged in the process over this period. There were two exception reports completed, which were classified as an ‘Immediate Safety Concerns’ (ISCs). Both of these related to understaffing on the medical wards, due

to sickness and rota gaps. They were escalated within 48 hours, and were resolved quickly, and to the satisfaction of the trainees, on both occasions.

3. Seventeen (20) exception reports remain open from Q1 and need resolving. It should also be noted that the trainee and Educational Supervisor have met to discuss another 8 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. I have communicated the need to close these ERs to both the trainee and educational supervisors on a number of occasions and covered this issue again at a Grand Round session on 13.7.18. This was a common theme at our recent Regional Guardian meeting, and has proved a difficult problem to correct among many trusts. I will make this a priority at the induction of the new F1s in August. One possible solution is to allow the Guardian access to edit all reports on Allocate, to allow sign-off of delayed reports, but this has not yet been actioned.

Exception reports (response time)				
	Addressed within 48 hours	Addressed within 7 days	Addressed in longer than 7 days	Still open
FY1	2 (5)	0	7	12 (15)
FY2	0	1	0	0
ST3	0	0	0	5

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. 24 (30) Exception Reports were submitted within 14 days and 3 were outside this limit. This is an improvement from Q4 to Q1 of 5% to 89%. 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.

The above table shows that 3 (6) reports (11%) have been addressed by the Educational Supervisor within 7 days, and 7 reports (26%) were addressed in more than 7 days and 17 (20) reports (63%) still remain open. This latter figure is of some concern as the Educational Supervisors should have met to resolve the incidents, although as previously noted, in 8 instances the Educational Supervisor has met with the Trainee but the Exception Report has not been closed off. The exception reports which have been resolved were largely resolved at the 'Initial Stage' but 3 Exception Report have been escalated to 'Level 1 Review Stage'.

Exception reports (type of issue)				
	Hours	**Education**	**Service Support**	**Working**

				Pattern
FY1	14 (20)	3	4	0
FY2	1			0
ST3	2	3	0	0

Clearly the overwhelming number of issues relate to the number of 'hours' 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	3 (6)	0	5	1
FY2	0	0	1	0

The change in outcome to time off in lieu noted in Q4 (61%) has been maintained in Q1 (60%). This is more in line with the national position taken from feedback at Guardian meetings, and is reassuring to us regarding safe working hours. Overtime payments are still quite high at 30% but the number of exception reports with an outcome is relatively low.

Another interesting observation is that there was one Exception Report raised by an FY2 trainee which is the first for over 12 months. In addition, only 5 Exception Reports have been raised by Lead Employer trainees. This trend is not dissimilar to previous reports, and usually relates to lack of educational or training opportunities.

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 has been completed on these doctors and the results are still being analysed.

4. Work Schedule Reviews

There have been two Work Schedule Reviews (WSR) recommended by the Education Supervisors at their initial meeting following submission of an exception report, which have been addressed by the relevant rota managers.

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 which uses the TempRe system for filling shifts.

The tables below show the shifts which were escalated to the Medical bank for filling on the TempRe system 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

Specialty	Requested Shifts	Paid Shifts	Shifts to Agency	Total Hours Requested	Paid Hours
Acute Medicine	142	57	71	1,352	469
Anaesthetic	24	0	0	204	0
Cardiology	4	3	3	32	23
Care of the Elderly	533	275	307	4,152	2,122
Children's	55	14	16	620	156
General Surgery	31	0	0	386	0
Orthopaedic	1,861	60	69	16,963	653
Total	2,650	409	466	23,709	3,421

Locum Bookings (Bank) by Reason

Booking Reason	Requested Shifts	Paid Shifts	Shifts to Agency	Total Hours Requested	Paid Hours
Annual Leave	94	7	7	912	69

Extra	69	25	42	552	191
Maternity / Paternity Leave	13	0	0	159	0
Sickness	13	0	2	162	0
Vacancy	2,461	377	415	21,924	3,162
Total	2,650	409	466	23,709	3,421

1. The above tables show that the main reason, by far, for requesting cover was due to vacancies.
2. Three specialties stand out in terms of requiring cover and these relate to Acute Medicine, Care of the Elderly and Trauma and Orthopaedics with the prime reason known to be other vacancies with the specialties. Not surprisingly, these three specialties also account for the highest use of bank/agency staff.
3. The number of shifts requested to be covered this quarter has risen significantly from 893 shifts to 2650 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**	**c21**	**171.25**	**757**	**757**	**N/K**
General Surgery	**FY1**	**c51**	**408.5**	**544**	**544**	**N/K**
T & O	**FY1**	**c2**	**17**	**89**	**89**	**N/K**
TOTAL	**FY1**	**c74**	**596.75**	**1390**	**1390**	**N/K**
Psychiatry –	**FY2**	**c40**	**316**	**1468**	**1468**	**N/k**

NW Boroughs						
Accident and Emergency	FY2	c30	243.5	352	352	N/K
General Medicine	FY2	c26	205.75	464.5	464.5	N/K
Paediatrics - Alder Hey	FY2	c1	7.5	376	376	N/K
General Surgery/ENT	FY2	c49	391.5	464.5	464.5	N/K
T & O	FY2	c12	94.5	325.15	325.15	N/K
Anaesthetics	FY2	c8	61.5	45	45	N/K
O & G	FY2	c0.5	3.75	352	352	N/K
GP	FY2	c3	22.5	480	360	N/K
Total	**FY2**	**c169**	**1346.5**	**4327.15**	**4207.15**	**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 and trainees on maternity leave 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 been remarkably similar ie, 171 shifts/1364 hours in Q4 compared with 169 shifts/1346.5 hours in Q1. This is undoubtedly due to the ongoing 'winter pressures' efect, where increased activity combined with some gaps in service has increased the need for more shifts to be covered. Whilst working additional hours is voluntary, the trainees have felt some compulsion to work more hours. To what extent this has affected their own health and safety, and those of their patients, is difficult to quantify. However, trainees have their own personal responsibility to only undertake additional hours without exceeding their maximum hours allowed, and if they feel capable of undertaking these. At the Regional Guardians' Meeting, none of the represented trusts were able to quantify the exact number of hours worked by their trainees, in situations where they have opted for extra shifts on top of their rota.
5. The main areas where additional hours/shifts have been worked are general medicine, surgery, psychiatry and AED.

6. A small number of the extra hours worked relate to Exception Reports and these are mostly in general surgery (36.5 hours) at the FY1 level.
7. The volume of locum work does now seem to correspond to the number of Exception Reports which reached an outcome of 'Overtime Payment'. 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

The table below shows the vacancies at **FY1 level only** from **April – June 2018**:

Specialty	Grade	April 18	May 18	Jun 18	Total gaps (average)	Number of shifts uncovered
General Medicine	**FY1**	**1.0**	**1.0**	**1.0**	**1.0**	**65**
General Surgery	**FY1**	**0.4**	**0.4**	**0.4**	**0.4**	**26**
Trauma & Ortho	**FY1**	**0**	**0**	**0**	**0**	**0**
Paediatrics	**FY1**	**0**	**0**	**0**	**0**	**0**
General Psychiatry	**FY1**	**0**	**0**	**0**	**0**	**0**
Total	**FY1**	**1.4**	**1.4**	**1.4**	**1.4**	**91**

NB.

1. One of the trainees is LTFT and works 60% which leaves a gap of 40%
2. There were no trainees who were on maternity leave.
3. The 1.0 wte vacancy in General Medicine was offset by one FY2 trainee working 1.0 wte in an FY1 slot in Respiratory Medicine and another FY2 trainee working 1.0 wte in an FY1 slot in Gastroenterology, both for educational reasons.
4. It does need to be recognized that there were other medical vacancies at different grades which would have had some impact on the resources available on wards and departments which could have contributed to difficulties in some trainees leaving wards on time.
5. 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.

The table below shows the vacancies at **FY2 level only** from **April – June 2018:**

Specialty	Grade	April 18	May 18	June 18	Total gaps (average)	Number of shifts uncovered
GP	FY2	3.0	3.0	3.0	3.0	195
Total FY2	FY1	3.0	3.0	3.0	3.0	195

NB.

1. During this period the three gaps on the rota all coincided to be at GP surgeries and did not affect any of the hospital services. It was not possible to cover any of these gaps.
2. There were no trainees on maternity leave.
3. Although there is not a gap at FY2 level in general surgery there are gaps at other levels and this has been offset by an LAT working at FY2 level in general surgery.

8. Fines

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

9. Qualitative Information

Junior Doctors Forum: The JDF continues to be very well attended, and there is excellent engagement and debate during the meeting. The joint meeting with Medical Director, Guardian and HR appears to be appreciated by the juniors. Hopefully, we can continue to develop this meeting with the new trainees in August.

Education supervisors: whilst there continues to be good engagement from most supervisors, there continues to be significant delays in timing of the review meeting. It is of concern that a number ERs remain outstanding at the current time, and at the Regional meeting, we are all looking at strategies to attempt to sort this problem. I will be meeting with the new doctors in August, and will emphasise the important of early sign-off of ERs.

Exception reports: There has been a significant reduction in the number of Exception Reports over this 3 month period, mainly due to reduced acuity on the wards during this time. There were two Immediate Safety Concerns (ISC) related to reduced staffing (either sickness or rota gaps), and these were sorted quickly.

Compensation for extra duties worked: Our juniors favoured compensation by TOIL, rather than payment. This is more reassuring for us, to ensure none of our trainees are exceeding

their permitted hours. There have been 2 work schedule reviews, following immediate safety concerns, which were useful to correct problems for future F1s in the post.

Allocate training: there have been drop-in sessions available for ES to develop their skills in completion of ER reviews. We will endeavour to repeat these sessions shortly

10. Issues Arising

Our volume of exception reports (ER) have dropped dramatically over this 3 month period. However, it is vital the juniors still engage with the process, to ensure they are working safely within their allocated rotas. Most ERs at WHH still relate to working excess hours at the end of their shift. It is very difficult to monitor individual doctors' hours completely, to ensure they do not breach safe working, as it would be calculated as an average over a full rota

The 2 immediate safety concerns in this 3 month period were addressed and closed rapidly.

We have seen a positive shift in this 3 month period for compensation towards time-off in lieu, rather than supplementary payment, following submission of an Exception Report. This will lead to some reassurance that trainees are not exceeding their maximum safe hours

We do rely heavily on in-house locum cover for outstanding shifts, exaggerated by recent changes to IR35 legislation and agency usage. Whilst coverage of shifts in the surgical specialties is usually manageable, this is more difficult in medicine where the 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 for all Educational Supervisors and Guardian of Safe Working in Allocate have taken place.
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) There may need to be extra recognition of the workload of some of the Educational Supervisors, whose juniors are in the more challenging posts, with PA allocation adjusted accordingly.
5) Continue to try and encourage TOIL as a solution to excess hours rather than compensatory payments, to avoid possible breach in hours and increased costs.
6) Work schedule reviews should continue to be implemented, especially in the medical rota, and medicine/surgery to allow regular attendance at educationally beneficial sessions (formal teaching, theatre, clinics).

12. Summary

Our trust has continued to maintain good engagement of the new 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.

This was an easier 3 month period for the trust, following the severe pressures during the winter months. This has been reflected in the marked reduction in ERs and safety concerns registered on Allocate.

The 2 immediate safety concerns reported by junior doctors all relate to low staffing levels, due to rota gaps or medical sickness. Apart from sporadic occasions, our juniors have been able to attend educational and teaching sessions, without recall to ward duty during this time frame.

Although there is still an issue with sign-off of outstanding ERs, there has been notable improvement in the last 3 months. In addition, 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. This will undoubtedly lead to extra burden on the incumbent doctors, 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 in our trust to date. 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

BOARD OF DIRECTORS

AGENDA REFERENCE:	BM 18/09/98	
SUBJECT:	**Refreshed People Strategy**	
DATE OF MEETING:	September 2018	
ACTION REQUIRED	**Review, Discuss and approve**	
AUTHOR(S):	Michelle Cloney, Director HR & OD and Deborah Smith, Deputy Director HR & OD	
EXECUTIVE DIRECTOR SPONSOR:	Michelle Cloney, Director HR & OD	
LINK TO STRATEGIC OBJECTIVES:	All	
EXECUTIVE SUMMARY (KEY ISSUES):	Following the launch of the new WHH Strategy and a number of national publications on workforce in the NHS, the People Strategy has been refreshed to bring it in line with these changes. This paper includes the draft refreshed People Strategy which was presented to Strategic People Committee (SPC) held on 19 September 2018 for review, discussion, and approval. The SPC approved the document for submission to Trust Board for formal approval. • The Trust People Strategy is presented to the Trust Board of Directors for approval	
RECOMMENDATION:	Discuss and approve the Trust People Strategy	
PREVIOUSLY CONSIDERED BY:	**Committee**	Strategic People Committee
	Date of meeting	19 September 2018
	Summary of Outcome	Approved People Strategy
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None	

BOARD OF DIRECTORS

SUBJECT	Refreshed People Strategy	AGENDA REF:	BM 18/09/98

1. BACKGROUND/CONTEXT

The Trust launched the original People Strategy in autumn 2016. The strategy focused on five key elements: Engagement; Attraction; Retention; Development and Performance. Under this strategy, the Trust has made a number of advances in supporting our workforce.

Following the launch of the new WHH Strategy and a number of national publications on workforce in the NHS, the People Strategy has been refreshed to bring it in line with these changes. The draft strategy can be found at appendix 1.

2. KEY ELEMENTS

2.1 Strategic People Objectives

The refreshed People Strategy is based upon the new WHH Strategy and is designed to ensure delivery of the strategic 'People' objectives set by the Trust Board:

- *To create the conditions to promote wellbeing and enable an engaged workforce to improve patient and staff experience.*
- *To attract and retain a diverse workforce aligned to our culture and values, to ensure that we have the staff with the skills to meet the needs of our population providing excellent and safe care.*
- *To develop a collaborative, compassionate and inclusive culture of collective leadership and organisational learning.*

2.2 National Publications

Health Education England has recently consulted on the first NHS wide Workforce Strategy (Facing the Facts, Shaping the Future). In addition, the National Improvement and Leadership Development Board have launched a framework for developing the NHS Workforce (Developing People, Improving Care). The principles and guidance set out in these documents have been embedded within the refreshed People Strategy.

2.3 Engagement

The refreshed People Strategy has been developed in consultation with staff across the organisation.

Staff feedback and opinion has been taken into consideration via the themes from the 2017 Staff Opinion Survey results, as well as the 'Perfect Day' event held in May 2018.

Expert input has been sought from staff across the HR and OD Directorate and the leaders across the Trust shared their views on delivery of the strategic objectives at the WHH Start of the Year Conference in June 2018.

Strategic People Committee (19 September 2018) received the draft refreshed People Strategy and a presentation on the national, regional and local workforce drivers which helped to shape and inform the content and clarity around how the pledges, priorities, and success measures would support the Trusts strategic People aim …. ***to be the best place to work with a diverse, engaged workforce that is fit for the future.*** SPC members discussed at length the content and appropriateness of each section and agreed for it to proceed to Trust Board for approval.

SPC noted that the People Strategy once approved by Trust Board will be delivered over 3 years, through partnership working between the HR and OD Directorate, Clinical Business Units and Corporate Services colleagues.

The delivery and impact of the strategy will be monitored via the Strategic People Committee, which reports to Trust Board. It is proposed that Strategic People Committee receive a quarterly paper outlining progress against the strategy and impact to date. The paper will include a quantitative measure of success set out in the People Strategy Dashboard.

Trust Board will receive assurance on the delivery of the People Strategy through the Chairs Log presented by the Chair of SPC.

3 RECOMMENDATIONS

Trust Board are asked to approve the Trust People Strategy.

WHH PEOPLE STRATEGY 2018-2021

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Welcome

Welcome to Our People Strategy

Michelle Cloney, Director of HR & OD

I am delighted to welcome you to our People Strategy. This strategy sets out our commitment to make Warrington and Halton Hospitals NHS Foundation Trust (WHH) the best place to work and details how we will support staff to achieve our mission to be outstanding for our patients, our communities and each other.

Across health and social care, organisations are facing a number of workforce challenges. Shortages of clinical staff nationally, an older workforce and changing demand mean that we need to empower our staff to think and work differently.

Health Education England have recently launched the first ever NHS Workforce Strategy (Facing the Facts, Shaping the Future), as well as a framework for developing the NHS Workforce (Developing People, Improving Care). We have embedded these principles within our People Strategy.

It's important to recognise the achievements the Trust has made in the last 18 months, including introducing new roles, rolling out a ward manager development programme and embedding the Trust Values. We've also launched Freedom to Speak Up, via our Freedom to Speak Up Guardian and Champions. Through the Freedom to Speak Up work we are working to ensure that all our staff feel comfortable to raise any concerns and this principle runs throughout this Strategy.

This strategy is our commitment to our staff, to support them in delivering outstanding patient care.

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Foreword

Mel Pickup, Chief Executive Officer

People

We will... **Be the best place to work** with a diverse, engaged workforce that is fit for the future

I am proud to present our People Strategy, which is built on the foundations of our **Q**uality, **P**eople and **S**ustainability Framework (QPS).

This strategy sets out our commitment to the wellbeing, experience and development of our staff. We want to attract and retain a diverse, values-driven and highly skilled workforce, and support them to develop their careers here at WHH.

We have recently refreshed our Trust strategy and have set out our strategic People aim which is …. ***to be the best place to work with a diverse, engaged workforce that is fit for the future***.

We believe that by harnessing the talents of our workforce and creating the conditions for staff to provide excellent care we will be recognised as an outstanding organisation – somewhere where people want to be cared for and somewhere where people want to work.

To that end, we have embarked on an organisation-wide change journey called 'Getting to Good, Moving to Outstanding' – our staff are key to achieving this challenge. Our workforce is our greatest strength, and we know that getting things right for our staff is the best way for us to achieve our mission to be outstanding for our patients, our community and each other.

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What have we achieved?

The Trust launched the original People Strategy in 2016. The strategy focused on five key elements:

- Engagement
- Attraction
- Retention
- Development, and
- Performance.

Under the 2016 People Strategy, the Trust made a number of advances in supporting our workforce, including:

Engagement
70+ People Champions across the Trust
Listening into Action survey reached record levels
Freedom to Speak Up Launched

Attraction
Staffing levels increased by over 200 staff
Increased use of social media to attract staff
Approval to recruit 93 wte more nursing staff

Retention
'We Are WHH' values embedded
New roles introduced into the workforce
Fit to Care Programme rolled out

Development
New induction arrangements
Ward Manager Development Programme
Apprenticeship Programme rolled out

Performance
Enhanced vacancy control systems
New Medical Job Planning process
Centralised Medical Agency process

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Where Are We Now?

We have been able to measure real progress and monitor the impact of our achievements so far.

Setting the context for further ambition ……….

- National Staff Opinion Survey 2017 results indicated Employee Engagement Score 3.74, against a national average of 3.79 and Staff recommendation of the Trust as a place to work or receive treatment 3.62 out of 5
- Vacancies in the Nursing Workforce have reduced from 8.5% in 2016/17 to 6.9% in 2017/18, although vacancies in the Medical Workforce have increased to 12.5%
- Across the workforce there are a number of difficult to fill positions, mirroring the challenges across the NHS
- Employee turnover has reduced from 14% in 2016/17 to 12.7% in 2017/18
- We have achieved our Equality Delivery Systems goals and aim to take this to the next level to ensure that all our staff have the same positive experience and opportunities at work
- We have introduced new roles – Physician Associates and piloted with the University of Chester the Nurse Associates

We have embarked on an exciting new 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.

The launch of a refreshed WHH Strategy, with a redefined 'People Aim' and three 'Strategic Objectives', has given the opportunity to review the People Strategy and to build on our successes, whilst developing a platform for addressing areas which require further attention and renewed focus.

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Our Mission, Vision, Values Aims and Objectives

Our Mission: We will be OUTSTANDING for our patients, our communities and each other

Our Vision: We will be the change we want to see in the world of health and social care

Our Aims/Objectives

Quality	People	Sustainability
EMPOWERING STAFF with the skills they need to make changes		
We will... **Always put our patients first** through high quality, safe care and an excellent patient experience	We will... **Be the best place to work** with a diverse, engaged workforce that is fit for the future	We will... **Work in partnership** to design and provide high quality, financially sustainable services

We will do this by: Continuously improving, exploring new opportunities and technology and being creative and innovative in redesigning and developing all we do.

Our Values

Our People Objectives

WHH Strategic People Objectives

At Warrington and Halton Hospitals NHS Foundation Trust our strategic aim for our workforce is to **be the best place to work, with a diverse, engaged workforce that is fit for the future**. We will achieve this aim through our three strategic People objectives:

We will create the conditions to promote wellbeing and enable an engaged workforce to improve patient and staff experience

We will attract and retain a diverse workforce aligned to our culture and values, to ensure that we have the staff with the skills to deliver excellent patient care

We will develop a collaborative, compassionate and inclusive culture of collective leadership and organisational learning

Our People Strategy sets out what each of these objectives mean for our workforce, how we will deliver them and what success will look like.

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We will create the conditions to promote wellbeing and enable an engaged workforce to improve patient and staff experience

Our People Pledges

Our Pledges	
We will help our staff to be **healthy** and support them if they are unwell	We well help our staff to feel **proud, enthusiastic** and **happy** in work

Our People Priorities

- Increase **mental health** awareness and review our programme of support
- Increase **musculoskeletal wellbeing** awareness and review our programme of support
- Develop our **Fit to Care** Programme
- Create a **coaching culture** where managers recognise staff as individuals
- Develop **high performing** teams where staff can recognise their contribution to the Trust vision
- **Empower** staff to contribute to decision making through Listening into Action

What Does Success Look Like?

- Fewer staff become unwell with mental health and musculoskeletal health related sickness. If they do, staff feel supported through their illness.
- Staff tell us they believe that we value their health and wellbeing
- Staff would recommend WHH as a place to work and receive treatment
- Staff feel engaged in their work, their teams and the Trust

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Our People Pledges

We will attract and retain a diverse workforce aligned to our culture and values, to ensure that we have the staff with the skills to deliver excellent patient care

Our Pledges	
To support our staff to make WHH a **great** and **inclusive** place to work	We will **support** our staff to **develop** new skills and ways of working

Our People Priorities	
• Take a new approach in **attracting candidates** to our Trust • Create new initiatives to improve **employee retention** • Deliver our new **Equality, Diversity and Inclusion** Strategy	• Understand **the workforce we need** to provide outstanding patient care • **Transform** our workforce to ensure it is fit for the future, define clear routes to support the career **development** of staff and establish new roles in the workforce • Introduce a centralised **temporary staffing** model

What Does Success Look Like?

- There are fewer long term vacancies and fewer staff leaving the Trust
- We have achieved the measures within the Equality, Diversity and Inclusion Policy
- We have quality strategic workforce plans in place and are transforming our workforce to deliver them
- All available staff, including bank workers, have completed mandatory training and can access career development opportunities

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We will develop a collaborative, compassionate and inclusive culture of collective leadership and organisational learning

Our People Pledges

Our Pledges	
We will enable staff at all levels in the Trust to **develop** as leaders	We will help our staff feel empowered **to identify improvements** and **put them in place**
Our People Priorities	
• Agree and embed a set of **WHH behaviours**, aligned to our values • Introduce a **WHH Leadership Model**, implement bespoke recruitment processes and leadership development programmes • Develop and embed a **Talent Management** and Succession Planning Framework	• Ensure staff have training in **quality improvement** methodology • Ensure that we benchmark ourselves so that we can **strive for excellence** where there is variation from best practice • Ensure that we promote **research and innovation** within the Trust

What Does Success Look Like?

- Staff are developed and promoted internally and there is increasing competitions for our leadership positions both internally and externally.
- Staff believe in and are displaying the WHH behaviours
- Staff feel supported and valued by their leaders
- All staff have access to Quality Improvement training within the Trust, tailored to their needs
- We have quality improvement plans in place for all areas

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People Strategy Delivery

Delivering the People Strategy

We will deliver our People Pledges over 3 years, through partnership working between the HR and OD Directorate, Clinical Business Units and Corporate Services, and between the Trust and our regional partners. Delivery plans will be produced to underpin each of of the People Pledges. Our progress against our People Pledges will be monitored via the Strategic People Committee, which reports to Trust Board. Key Performance Indicators will be monitored by the Operational People Committee.

Assurance	Trust Board
Strategic Overview	Strategic People Committee
Operational Delivery	Operational People Committee

DRAFT

We are
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Warrington and
Halton Hospitals
NHS Foundation Trust

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/18/09/99**
SUBJECT:	**Board Assurance Framework and Strategic Risk Register report**
DATE OF MEETING:	26th September 2018
ACTION REQUIRED	**Review, Discuss and approve**
AUTHOR(S):	John Culshaw, Head of Corporate Affairs
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Medical Director & Deputy CEO
LINK TO STRATEGIC OBJECTIVES:	All
STRATEGIC CONTEXT	Risk Management is a mechanism for managing exposure to risk that enables the Trust to recognise the events that may result in harm and/or loss. The Trust has a legal and moral duty to patients, visitors and staff to ensure that their safety and wellbeing is not compromised as a result of hospital activities, processes or procedures, as well as regulatory implications.
EXECUTIVE SUMMARY (KEY ISSUES):	Since the last meeting, one new risk has been added to the BAF. *Failure to attend mandatory resuscitation training caused by operational pressures resulting in low compliance rates and risk to patient and staff safety* Also included in the report are notable updates to existing risks
RECOMMENDATION:	Discuss and approve the changes and updates to the Board Assurance Framework and Strategic Risk Register
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None

BOARD OF DIRECTORS

SUBJECT	Board Assurance Framework	AGENDA REF:	BM/18/09/99

1. BACKGROUND/CONTEXT

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

The strategic risk register is outlined in Appendix 1

The following gives notable updates since the strategic risks were last presented to the Board of Directors.

2. KEY ELEMENTS

2.1 New Risks

Since the last meeting one new risk has been added to the register.

Risk	**Risk: Failure to attend mandatory resuscitation training caused by operational pressures resulting in low compliance rates and risk to patient and staff safety**
Controls and Assurances	▪ E-learning was identified for staff to access specific courses. ▪ Review of compliance and staff competencies. ▪ Resuscitation group now meeting quarterly to review figures and TNA ▪ This will remain on the risk register until compliance figures are above 85%, monitored monthly through workforce committee and CQC group. ▪ 230 e mails sent out to Consultant staff requesting resuscitation compliance details. Deadline for response 13th May 2018. ▪ Additional training sessions provided in July and August (early and late to allow all staff to attend) ▪ Flyer produced to provide clarity of requirements for medical staff ▪ Individual correspondence to medical staff from Medical Director ▪ Changes to funding process to support medical staff to attend external courses
Gaps	▪ Low training compliance for specific staff groups. ▪ Level 2 training compliance remains low (53%) in June 2018. Approx. 200 staff were trained in June 2018, however a significant number also had the annual competency expire.
Initial Risk Rating	15 (3x5)
Residual Risk Rating	15 (3x5)

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Actions	Senior Medical Staff Resuscitation Compliance Review – Complete 13 07.2018 Ensure there is appropriate training capacity throughout August 2018 – Complete 23.07.2018 Compliance Gap Analysis Review – Complete 30.07.2018

2.2 Existing Risks – updates

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
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.	i. As a result of the fire in the in the Kendrick Wing a specific risk has been identified: *Failure to meet freeze dates for clinical coding due to the delay in the refurbishment of Clinical Coding Offices* Mitigations to this risk include: • Written to Lead Commissioners to request a two week extension for the next two months. • Agency staff recruited • Overtime offered to existing staff The risk forms part of the Kendrick Fire Group Risk register. **Gaps** • Risk of loss of income due to high levels of uncoded activity. • Increased risk relating to an aged debtor as continuing dispute regarding charges levied by the Trust are being challenged. • Risk of under delivery of CIP due to insufficient schemes identified to deliver the full program and the organisational ability to translate improvement work into financial improvement. • Following recent letter relating to no confidence in the Commissioners and subsequent resignations, there is potential to destabilise the current sustainability and transformational work that is being undertaken. This could have negative effect on the Trust's and Health Economy's financial position due	No impact on risk rating

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WHH

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
		to the potential impact on collaborative schemes. **<u>Assurances & Controls</u>** • Transformation structure being reviewed to strengthened accountability • Trust teams are working within the place based teams to bid for additional STP monies to improve sustainability • Recruited agency staff and additional substantive staff to support clinical coding recovery. Trajectories have been set and are being monitored and are being overachieved. • Regarding the aged debt in dispute, the Commissioners have requested MIAA to undertake due diligence review in to the debtors accounts. Furthermore, regular meetings are taking place between the Trust, CCGs and NHSE to consider future service provision and resolution of financial liabilities. • Continue to work with and support CCG colleagues and maintain attendance from both parties at all collaborative meetings.	
120	Failure to identify and manage patients' risk of sustaining a fall; caused by inadequate risk assessment and implementation of appropriate care plans. This may cause patient harm, has a negative effect on the patient's experience, may prolong their length of stay, and give rise to complaints and claims against the trust.	Two severe harm falls occurred August 2018. **<u>Controls & Assurances</u>** • First wave of the bed replacement programme has been completed • Falls are discussed at the daily Trust-Wide Safety Briefing and themes identified. • Reviewed the current enhanced care process and re-written the policy and process as is currently being piloted on A4 & A7. This pilot is part of the improvement work from the NHSi Falls Collaborative. Enhanced Care Policy to be ratified at PSCESC Sept 2018 • A review of the Trust falls equipment in relation to alarms and sensor pads has taken place and a plan to purchase additional falls equipment is in place. • Reviewed the current falls documentation and revised a number of elements and is currently being piloted on A4 & A7.	No impact on risk rating
122	Failure to provide assurance regarding the	• WRAP Training - Completed - delivered	No impact on risk

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
	Trust's safeguarding agenda being implemented across the Trust due to gaps highlighted during external review may impact on patient safety and cause the Trust to breach regulations.	daily across the Trust. In excess of 1000 staff trained face to face and achieved 85% target • LD Training programme introduced - Delivered daily until the end of July, now fortnightly. • Awaiting delivery of safeguarding adult resource folders for all wards and depts., detailing all aspects of adult safeguarding for wards to access. • Safeguarding Adults Website updated to include additional training resources and videos. • Further MCA Audit completed.	rating
116	Failure to deliver national and local performance targets will result in an impact on patient care, reputation and financial position.	• A performance review group is currently being set up with a view to commencement in September 2018 • An IDT/Frailty business case to be developed by Warrington Together Programme • An NHSi Emergency Care Improvement Programme (ECIP) review was undertaken in July 2018 • Frailty Hub Business Case to be submitted 07.09.2018 for STP Bids; however, IBCF contingency plan in place to support 1 year full funding to allow recruitment to start. • Assurance provided to regional NHSi Director in relation to Elective Care expectations and performance between Sept 2018 - March 2019. • Winter planning sessions commenced in July 2018 which have moved to weekly meeting in Sept 2018. Internal & System plans referencing peer reviews and GIRFT documentation.	No impact on risk rating
115	Failure to provide adequate staffing levels in some specialities and wards, caused by inability to fill vacancies, sickness, resulting in pressure on ward staff, potential impact on patient care and impact on Trust access and financial targets.	• 45 HCAs have been recruited against the Nurse Staffing Business Case, due to start in August/September. • 26 RNs commencing in September 2018 • Daily staffing report which forms part of the bed management reporting framework, underpinned with the staffing escalation process. This was audited in April 2018 with further Audit due October 2018. • Sickness pilot commenced in August 2018 for a period of three months. • Red Flag Events which relate to care	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
		lapses due to staffing are now in place across the Trust and are responded to by the Lead Nurse or Matron on a daily basis. • RCN Recruitment Day taking place on 13th September for trained nurses. • Recruited HCAs & RNs currently on Induction.	
118	Failure to have sufficient anaesthetic cover on critical care, caused by insufficient middle grade/registrar doctors to cover the 2nd and 3rd tier on calls, resulting in potential patient safety issues, operational impact and financial pressures due to locum costs.	• Consultation with existing 12.72 WTE Associate Specialists and Specialty Doctors regarding is planned for a new rota for Critical Care and Maternity. Once consultation complete, a business case for a new critical care staffing model will be developed. • WTE Trainee ACCPS's in place - qualify summer 2020 • Recruitment for 2 WTE ACCPS • 1 Trust grade in place from October 18	No impact on risk rating
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.	• The patients have now all been moved to alternative providers • The Trust is working with Commissioners and other providers on a single service. • The residual risk is reputational and from a regulatory (CQC) perspective	No impact on risk rating
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.	• Medical Devices have been audited at ward and department level and a centrally held inventory is nearly finalised – we have allocated resources for admin support to ensure this is logged electronically on the E-Quip system • A new Medical Devices Safety Group has been established with clinical representation – this will have roles and responsibilities regarding advising on purchasing and procurement of equipment as well as ensuring robust policies, procedures and incident reviews are in place • Training competencies are being put in place for all medical devices in the Trust – aligned to whether they are high risk, medium risk or low risk	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
		• Medical devices has been flagged at the Getting to Good meeting as a risk area for the CQC assessment and an update of the improvement plan in place will be presented to the September meeting.	
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.	Assessment of NICE Guidance against Trust Compliance is ongoing; an action plan has been produced where there are gaps in compliance, both Trustwide and at Specialty level. The Speciality level action plans are monitored at CBU Governance meetings. NICE Guidance compliance is incorporated in Specialty Dashboards. • GIRFT programme looks at clinical variation across specialities and where variation is identified, actions are recommended to rectify these. Performance is monitored at Quality Academy Board.	No impact on risk rating
138	Failure to provide timely information caused by increasing internal and external demands for datasets, implementation of new systems and a lack of skilled staff with capacity to respond. Resulted in a financial impact, external reputation damage and poor management decision making due to lack of quality data.	• Recruited 4 Information analysts as part of business case who are supporting with timely statutory reporting and key Trust work streams including maternity, theatres, delayed discharges, urgent care. • Business Intelligence Development Roadmap produced and priorities will be agreed with key Execs to ensure prioritisation and Trust focused work streams. • Recruited to a Band 8a Business Intelligence Manager, who commenced with the Trust on 03/09/2018. • Recruited to a Band 2 Data Quality Clerk, who commenced with the Trust on 20/08/2018. • Shortlisting for 2 x Band 7 Principal Information Analyst will take place week commencing 10/09/2018; interview 26/09/2018.	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	• Protection Bubble & Windows XP removal: • A report has been created for the IM&T Programme Board the following XP devices/systems using XP have been identified and will be discussed at the September IM&T Programme Board for next steps : o Pathology Masterscan	

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Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
		o Cardiology Cardiac Catheter Lab o Pharmacy Aseptic Room o Radiology PACS o Telephony Paging system • A root caused analysis is being performed on e-outcomes before going to the next IG Sub Committee, IG Manager is chasing. This will go to the IG group in November. • Additional Cyber Security: o Waiting on arrival of the ASA firewalls for remote access , but training required to utilise the product • Phase 2 of the additional cyber security has been completed	

2.3 Risk Management Strategy Updates

The Risk review Group continues to meet monthly with the next meeting due to be held on 8th October 2018.

3 RECOMMENDATIONS

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

Appendix 1- Strategic Risk Register

ID	Risk description	Rating May 2018	Rating June 2018	Rating July 2018	Rating Aug 2018	Rating (current)
88	Failure to implement the requisite GDPR (General Data Protection Regulation) policies, procedures and processes caused by lack of resources resulting in areas of data protection non-compliance	12	12	12	12	12
115	Failure to provide adequate staffing levels in some specialities and wards. Caused by inability to fill vacancies, sickness. Resulting in pressure on ward staff , potential impact on patient care and impact on Trust access and financial targets.	20	20	20	20	20
116	Failure to deliver national and local performance targets will result in an impact on patient care, reputation and financial position.	20	20	20	20	20
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.	16	16	16	16	16
118	Failure to have insufficient anaesthetic cover on critical care, caused by insufficient middle grade/registrar doctors to cover the 2nd and 3rd tier on calls, resulting in potential patient safety issues, operational impact and financial pressures due to locum costs.	16	16	16	16	16
119	Failure to have sufficient assurance in place regarding contractual and governance requirements in Sexual Health Services, resulting in potential	12	12	12	12	12

	patient safety issues, organisational and reputational risk.					
120	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.	16	16	16	16	16
121	Failure to provide assurance regarding complaints handling within the Trust, caused by ineffective systems and processes, resulting in a poor experience for complainants, the Trust not meeting statutory and contractual complaints targets and not having effective systems in place to learn lessons from complaints	12	12	12	12	12
122	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	16	16	16	16	16
123	Failure to prevent harm to patients, caused by lack of timely and quality discharge summaries being sent to primary care, resulting in a lack of appropriate handover of care, with patient safety, operational, financial and reputational consequences.	12	12	12	12	12
125	Failure to maintain an old estate could result in staff and patient safety issues, increased costs and unsuitable accommodation.	15	15	15	15	15
128	Failure to comply with the Thromboprophylaxis	12	12	12	12	12

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	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.					
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.	12	12	12	12	12
133	Failure to successfully engage the Workforce, caused by the potential for a negative working environment 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	12	12	12	12	12
134	Financial Sustainability a) Failure to sustain financial viability, caused by internal and external factors, resulted in 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.	20	20	20	20	20
135	Failure to provide adequate and timely IMT system implementations & systems	20	20	20	20	16

	optimisation caused by either increasing demands and enhanced system functionality which results in pressure on staff; potential in systems being poorly used resulting in poor data quality. Impact on patient access to services, quality of care provided, potential patient harm and financial & performance targets.					
138	Failure to provide timely information caused by increasing internal and external demands for datasets, implementation of new systems and a lack of skilled staff with capacity to respond. Resulted in a financial impact, external reputation damage and poor management decision making due to lack of quality data.	16	16	16	16	16
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	12	12	12	12	12
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	12	12	12	12	12
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.	15	15	15	15	15
153	Failure to attend mandatory resuscitation training caused by operational pressures resulting in low compliance rates and risk to patient and staff safety	15	15	15	15	15

414	Failure to implement best practice information governance and information security policies and procedures caused by lack of resources or ineffective communication of key information governance messages to WHH staff	12	12	12	12	12
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'	12	12	12	12	12
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.	12	12	12	12	12

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/18/09/100**
SUBJECT:	**Risk Management Strategy Annual Report**
DATE OF MEETING:	September 2018
ACTION REQUIRED	**Review, Discuss and approve**
AUTHOR(S):	Ursula Martin, Director of Governance & Quality
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse
LINK TO STRATEGIC OBJECTIVES:	All
EXECUTIVE SUMMARY (KEY ISSUES):	This paper provides an update on the strategic objectives set out in the risk management strategy in order for the Trust to manage risk. There has been considerable amount of work put into the development of a new risk management process. This has included: • A revised Risk Management Strategy with clear objectives • A clear and understandable process has been put in place for all staff to assess, score, manage and escalate risks. • DATIX risk module has been purchased to record, manage and monitor all risk registers. This is currently being embedded throughout the Trust. • The monthly Risk Review Group was set up to review and scrutinise all risk registers on a 12 month rolling programme. The Group is chaired by the Chief Nurse. • Guidance documents have been produced on Risk Management Awareness and DATIX guides for risk • A programme of dates for Risk Management training has been set up for Senior Managers and Ward/Departmental Managers. • An integrated self-assessment tool has been developed which includes all Trust risks e.g. clinical risks, health and safety and this is aligned to the Care Quality Committee regulatory framework. The report gives assurance that the risk management system has been reviewed and there are escalation

	processes in place for risk management. The Trust can also evidence training for staff, and oversight and scrutiny of risk registers. There is a need for further development to strengthen this process and ensure it is fully embedded within the Trust. This will take place during the next 12 months.	
RECOMMENDATION:	Discuss and note the Report	
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Committee
	Date of meeting	August 2018
	Summary of Outcome	Quality Committee was assured that progress was being made as per the initial risk management strategy review
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

Risk Management Strategy Annual Report

Section

1	Introduction
2	Background
3	Risk Management Strategy Objectives
4	Development of the Risk Process
5	Strategic Risk Register
6	CBU/Corporate Services Risk Registers
7	Ward/Department Risk Registers
8	Integrated Self-Assessment Tool
8.1	Pilot of the Self-Assessment Tool
8.2	Overview of Compliance Ratings
8.3	Areas of Partial Compliance
9	Recording of Risks
10	Risk Training
11	Conclusion
12	Appendix 1 – Pilot Report for the Integrated Self-Assessment Tool

1. Introduction

The annual report describes the management of risk throughout the Trust over the last 12 months. Risk management is a critical component of the overall Governance agenda, with the safety of patients and staff being a core value.

This year has seen the implementation of new risk management process including the introduction of a new risk management system and a programme of training.

2. Background

When the CQC inspected the Trust in 2017, they raised concerns regarding risk management systems and how they were being systematically applied in the Trust. There were risks found on the risk register that had been on there for a number of years, some at a high risk grading, with no evidence of having been reviewed or actioned. There were many in consistencies in descriptors and the grading of risks and action plans hadn't been updated. Managers and staff fed back that they found the old system CIRIS problematic. They had no understanding of the system and consequently couldn't manage their risk appropriately.

The CQC raised concerns and determined that the Trust had fundamentally breached Regulation 18 regarding governance, with 'Must do' actions to address the risk management systems within the Trust.

3. Risk Management Strategy and Objectives

The Risk Management Strategy was reviewed with the aim to ensure the Trust had effective processes in place. The revised Strategy was approved by the Quality and Assurance Committee in May 2017.

For risk management to be successful, it was vital that a single approach was to be adopted for the management of risks throughout all levels of the Trust.

The new strategy provides a simply and clear framework for managers to follow.
The key changes were to:

- Develop a clear and understandable process for all staff to assess, score and escalate risk;
- Develop a easy to use IT system regarding Risk Management; system of choice will be Datix;
- Development of training and guidance to support and implement and embed the process throughout the Trust;
- Develop an integrated self-assessment tool which will include all Trust risks e.g. clinical risks, and health and safety, which will be aligned to the Care Quality Commission regulatory framework;
- Review our monitoring and governance systems relating to risk management within the Trust.

4. Development of the Risk Process

A new process was implemented throughout all levels within the Trust. This also included the introduction of DATIX risk module for the recording, monitoring and review of all risk registers.

Identification	**Identification of Risk** Using incidents, complaints, claims, patient feedback, safety inspections, external review, objectives or ad hoc assessments	**Board assesses risks to objectives** Risk identification to be aligned to annual/business planning process
Quantification	**Risks Grading** Using a matrix of 1 to 5 in likelihood & severity giving a maximum score of 25. Risks below 8 – managed locally by Ward/Department Level. Risks of 10 and above – managed at CBU Level. Risks of 15 or above will be escalated to the Risk Review Group and be considered for inclusion on the Strategic Risk Register	
Risk Registers	**Strategic Risk Register** • Those risks mapped against delivery of corporate objectives • Those operational risks either 15 and below deemed to be strategic • Those operational risks deemed to be strategic following cross sectional analysis of impact and likelihood	**Operational Risk Registers** • Risk Registers in place at Ward/Department level • Risk Registers in place at CBU level. • All risks 15 or above will be escalated & considered for inclusion on the Strategic Risk Register at the Risk Review Group

Audit Committee • Annual Governance statement – reviewing systems of internal control • Internal audits of issues linked to strategic risks & monitoring of these action plans	**Quality and Assurance Committee** • Delegated Committee responsible for overseeing risk on behalf of the Board • Monthly review of strategic risk register • Assurance regarding review of divisional risks via Divisional Quality Dashboard reports	**Finance & Sustainability Committee** • Oversees financial risk on behalf of the Trust and report on any additional risk/controls/assurances which will be recorded on the appropriate risk register
Strategic People Committee • Oversees all workforce risks on behalf of the Trust and report on any additional risk/controls/assurances which will be recorded on the appropriate risk register	**Clinical Operations Board** • Monthly review of strategic operational risks • Identification of operational risks and escalation of risk to be recorded on the appropriate risk register	**Risk Review Group** • Monthly report to Quality Committee highlighting exceptions, recommendations for new strategic risks, review of existing strategic risks and an assurance review of a divisional risk register • Rolling review of Divisional Risk Register at the Risk Review Group – at least six monthly review for each CBU
CBU Meetings • Review and discuss all risks at a score of 10 or above • Review and discuss all their services risks from Wards, Departments on a monthly basis. • Any changes must be recorded on the risk register and communicated to all relevant staff		**Ward and Departmental Meetings** • Discuss all the Department's active risks • Risks scored less than 8 managed locally All changes agreed must be recorded on the risk register and communicated to all staff

5. Strategic Risk Register/ Board Assurance Framework

The Strategic Risk Register has been developed and is currently managed on the DATIX system. These are risks mapped against the delivery of corporate objectives and operational risks that are deemed to be strategic.

The risk register is reviewed monthly by the Risk Review Group. The group also reviews any new risks of 15 and above discuss if they should be included on the Strategic Risk Register.

The risk register is also reviewed by the Quality and Assurance Committee, and other strategic committees, prior to reporting to the Board of Directors. The Audit Committee oversees the internal control and has commenced undertaking deep dives of strategic risks.

6. CBU / Corporate Services Risk Registers

Individual meetings have been set up throughout 2017/18 with all CBU Leads, Director of Governance and the Head of Safety and Risk. This is to review the risk registers and transfer to the new Datix system, and ensure all risks are in date, grading is appropriate, controls are in place and gaps in assurances are identified and to ensure each risk has an up to date action plan in place.

At the time of writing this report, below gives the position:

Clinical Business Unit/Corporate Department	Status of risk register on Datix
Airway, Breathing and Circulation	Risk Register completed- ongoing monitoring systems in place.
Urgent and Emergency Care	Risk Register completed- ongoing monitoring systems in place.
Digestive Diseases	11 risk actions outstanding. Work is ongoing and currently being monitored
MSK	Risk Register completed- ongoing monitoring systems in place.
Outpatients and Diagnostics	Risk Register completed- ongoing monitoring systems in place.
Specialist Medicine	4 risk actions outstanding. Work is ongoing and currently being monitored.
Women and Child Health	Risk Register completed- ongoing monitoring systems in place.
Surgery	Risk Register completed- ongoing monitoring systems in place.

Clinical Business Unit/Corporate Department	Status of risk register on Datix
Estates and Facilities	Risk Register completed- ongoing monitoring systems in place.
Human Resources	Risk Register completed- ongoing monitoring systems in place.
Corporate Nursing	Risk Register completed- ongoing monitoring systems in place.
Governance Department	Risk Register completed- ongoing monitoring systems in place.
IT	Risk Register completed- ongoing monitoring systems in place.
Transformation	Risk Register completed- ongoing monitoring systems in place.
Communications	Meeting set up for 27th August 18.
Finance	Meeting set up for 28th August 18.
Pharmacy	2 risk actions outstanding. Work is ongoing and currently being monitored.

7. Ward/Departmental Risk Registers

A programme of training dates has been arranged from August 18 to October 18 to provide Ward/Departmental Managers with the knowledge and understanding to record risks and for them to complete risk registers. The training includes:

- Overview of Risk Management
- Integrated Self-Assessment Tool
- DATIX Risk Module

8. Integrated Self-Assessment Tool

The Integrated Assessment Tool consists of a number of standards each supported by a set of performance criteria and policies and guidance. The standards and criteria have been taken from key legal requirements relating to health, safety and from the CQC fundamental standards. Each standard and performance criteria is designed to be clear, measurable and achievable.

Each Service assesses its level of compliance against each criterion using a simple system identifying, Compliant, Partial Compliant and Non-Compliant. Services are required to outline a brief rationale behind their score, ensuring that they can provide evidence and assurance of their assessment.
Once the Assessment Tool has been completed, Services will be able to identify from their compliance scores the areas where they need to make improvements.

This will then form the basis for completion of risk assessments and risk registers onto DATIX.

The purpose of this tool is to ensure appropriate targets are met by services, and any support required to achieve this is identified.

8.1 Pilot of the Self-Assessment Tool

At the beginning of October, the self-assessment risk management framework was piloted within 13 services within the Trust.

Services who took part in the pilot	
Ward A3	Ward A5
Ward B1	Ward A6
Ward B18	Ward C20
A&E	Urgent Care Centre
Urgent Care Centre	Estates Department
PIU	Pharmacy

Each area was given two weeks to complete the self-assessment and provide any feedback. The assessment for Estates was amended to be more specific to the Department in line with current guidance and legislation.

8.2. Overview of Compliance Ratings

The table below give an overview on compliance ratings within each Department.

Area	Compliant Questions	Partial Compliant Questions	Non - Compliant Questions	Not Applicable Questions	Un-answered Questions	Action Plan Provided	% Compliant Questions	% Partial Compliant Questions	% Non-Compliant Questions	% Not Applicable Questions	% Un-answered Questions
Estates	110	33	11	11	2	Yes	66%	20%	7%	7%	1%
Pharmacy	59	9	0	33	1	Yes	58%	9%	0	32%	1%
Antenatal	89	2	0	10	1	Yes	87%	2%	0	10%	1%
Ward A3	88	5	2	5	2	Yes	86%	5%	2%	5%	2%
Ward A5	89	9	0	2	2	Yes	87%	9%	0	2%	2%
Ward A6	85	11	0	4	2	Yes	83%	11%	0	4%	2%
Ward B1	92	1	0	4	5	No	90%	1%	0	4%	5%
Ward B18	95	1	1	4	1	No	93%	1%	1%	4%	1%
Ward C20	94	0	0	5	3	No	92%	0	0	5%	3%
Ward C22	80	17	0	5	0	Yes	78%	17%	0	5%	0
A&E	89	9	1	2	1	Yes	87%	9%	1%	2%	1%
UCC	79	11	0	9	3	Yes	77%	11%	0	9%	3%
PIU	92	1	1	5	3	Yes	90%	1%	1%	5%	3%

8.3. Areas of Partial Compliance

The table below gives an overview of standards that were not fully met.

Standard 1 – Health and Safety	**Standard 2 – Person Centred Care**
Stress Risk Assessments DSE Working at Height Manual Handling	Mental Capacity Training Patient Feedback Review of Assessments Designing Care and Treatment
Standard 3 – Dignity and Respect	**Standard 4 – Need for Consent**
All departments self-assessed as compliant.	All departments self-assessed as compliant.
Standard 5 – Safe Care and Treatment	**Standard 6 – Safeguarding**
Training Managing Risks	Risk Assessments Mental Capacity Act Training Safeguarding Training Incidents and Complaints
Standard 7 – Nutrition & Hydration	**Standard 8 – Premises and Equipment**
All departments self-assessed as compliant.	All departments self-assessed as compliant.
Standard 9 – Complaints	**Standard 10 – Good Governance**
Monitoring of complaints	All departments self-assessed as compliant.
Standard 11 – Staffing	**Standard 12 – Fit and Proper Persons Employed**
PDR	Recruitment
Standard 13 – Duty of Candour	
Training	.

9. Recording of Risks

The DATIX risk module was designed and built in January 2018. This is now in use to record, manage and review risk registers. This is a simplified system which staff are finding easy to use.

Managers are given direction on how to describe risks using the following wording:

Failure to….. Caused by….. Resulted in…….

This ensures risk descriptors are consistent.

10. Risk Training

A review of risk training has been undertaken and a training needs analysis was completed for staff at all levels.

	Training Requirements			
All staff will receive a local induction on commencement to the area in which they work. The manager is required to communicate all risk assessments in relation to the area of work or advise staff where they can find them.	3 yearly up date	A rolling 12 month programme	2 yearly update	One off training with a rolling programme of dates if required
EXECUTIVES AND NON EXECUTIVES				
Senior Risk Management Training Class Room Based Training – Mandatory			✓	
DATIX Risk Register Training – Mandatory				✓
DEPUTY DIRECTORS & ASSOCIATE DIRECTORS & CLINICAL DIRECTORS				
Senior Risk Management Training Class Room Based Training – Mandatory			✓	
DATIX Risk Register Training – Mandatory				✓
CBU MANAGERS & HEADS OF SERVICE				
Senior Risk Management Class Room Based Training - Mandatory			✓	
DATIX Risk Register Training – Mandatory				✓
LEAD NURSE & MATRON & WARD/DEPARTMENT MANAGERS				
Risk Management Training Class Room Based Training – Mandatory			✓	
DATIX Risk Register Training – Mandatory				✓
Integrated Risk Self-Assessment Tool – Mandatory				✓
ALL STAFF				
DATIX Risk Assessment Training				✓

11. Conclusion

There has been considerable amount of work put into the development of a new risk management process. This has included:

- A revised Risk Management Strategy with clear objectives
- A clear and understandable process has been put in place for all staff to assess, score, manage and escalate risks.
- DATIX risk module has been purchased to record, manage and monitor all risk registers. This is currently being embedded throughout the Trust.
- The monthly Risk Review Group was set up to review and scrutinise all risk registers on a 12 month rolling programme. The Group is chaired by the Chief Nurse.
- Guidance documents have been produced on Risk Management Awareness and DATIX guides for risk
- A programme of dates for Risk Management training has been set up for Senior Managers and Ward/Departmental Managers.
- An integrated self-assessment tool has been developed which includes all Trust risks e.g. clinical risks, health and safety and this is aligned to the Care Quality Committee regulatory framework.

The report gives assurance that the risk management system has been reviewed and there are escalation processes in place for risk management. The Trust can also evidence training for staff, and oversight and scrutiny of risk registers.

There is a need for further development to strengthen this process and ensure it is fully embedded within the Trust. This will take place during the next 12 months.