We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

WHH Board of Directors Meeting – Part 2

Wednesday 26 July 2017
1.00pm – 4:00pm
Trust Conference Room

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NHS Warrington and Halton Hospitals NHS Foundation Trust

Warrington and Halton Hospital NHS Foundation Trust
Agenda for a meeting of the Board of Directors held in public Part 2.

Wednesday 26 July 2017, time 13.00 -4.00pm
Trust Conference Room, Warrington Hospital

REF BM/17	ITEM	PRESENTER	PURPOSE	TIME	
BM/17/07/79	Marc and Clare Littlemore, Surviving Sepsis – a patient's experience of our Intensive Care		Information	1.00	N/A
BM/17/07/80	Welcome, Apologies & Declarations of Interest	Steve McGuirk, Chairman	N/A	1.30	Verbal
BM/17/07/81 Page 4	Minutes of the previous meeting held on 28 June 2017	Steve McGuirk, Chairman	Decision		Encl
BM/17/07/82 Page 13	Actions & Matters Arising - Controlled Drugs Incidences (SC)	Steve McGuirk, Chairman	Assurance		Encl
BM/17/07/83	Chief Executive's Report	Mel Pickup, Chief Executive	Assurance	1.40	Verbal
BM/17/07/84	Chairman's Report	Steve McGuirk, Chairman	Information	1.55	Verbal

Quality People Sustainability

BM/17/07/85	Integrated Performance Dashboard Page 15 Including (b) Nurse Staffing report Page 72 (c) Trust Engagement Dashboard Page 79 and Key Issues Reports for (d) Quality Governance Committee 4.7.2017 (page 86) (e) Finance & Sustainability Committee 19.7.2017 (page 90) (f) Charitable Funds Committee – Chairs Annual Report (page 94)	All Executive Directors Margaret Bamforth, Committee Chair Terry Atherton, Committee Chair Pat McLaren Director Community Engagement + Corp Affairs	Assurance	2.05	Encl

Quality

BM/17/07/86 Page 98	Strategic Risks Monthly update	Chief Nurse Kimberly Salmon-Jamieson	Assurance	2.50	Encl
BM/17/07/87 Page 149	Annual Safeguarding Vulnerable Adults + Children Annual Report	Chief Nurse Kimberly Salmon-Jamieson	Assurance	3.00	Encl
BM/17/07/88 Page 190	6 monthly bi-annual staffing report	Kimberly Salmon-Jamieson Chief Nurse	Assurance	3.10	Encl
BM/17/07/89 Page 225	DIPC Annual Report	Simon Constable Medical Director	Assurance	3.25	Encl

People

BM/17/07/90 Page 285	Annual SIRO Report (deferred from May)	Jason DaCosta Director of IM&T	Information	3.35	Encl

Sustainability

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BM/17/07/91 Pg 311	Quarterly response to Lord Carter	Andrea Chadwick Director of Finance + Commercial Development	Assurance	3.45	Encl
GOVERNANCE					
BM/17/07/92	Any Other Business	Steve McGuirk, Chairman	N/A	3.55	Verbal
	Date of next meeting: Wednesday 30 August 2017				

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D R A F T

NHS Warrington and Halton Hospitals NHS Foundation Trust

Warrington and Halton Hospitals NHS Foundation Trust
Minutes of the Board of Directors meeting held in Public (Part 2) on Wednesday 28 June 2017
Trust Conference Room, Warrington Hospital

Present	
Steve McGuirk (SMcG)	Chairman
Terry Atherton (TA)	Non-Executive Director
Mel Pickup (MP)	Chief Executive
Margaret Bamforth (MB)	Non-Executive Director
Andrea Chadwick (AC)	Director of Finance and Commercial Development
Michelle Cloney (MC)	Interim Director of HR + OD
Simon Constable (SC)	Medical Director + Deputy Chief Executive
Ian Jones (IJ)	Non-Executive Director / Senior Independent Director
Jan Ross (JR)	Acting Chief Operating Officer
Kimberley Salmon-Jamieson (KSJ)	Chief Nurse
Anita Wainwright (AW)	Non-Executive Director
In Attendance	
Lucy Gardner (LC)	Director of Transformation
Pat McLaren (PMcL)	Director of Community Engagement + Corporate Affairs
Jason DaCosta (JDaC)	Director of IM&T
Mark Halliwell (Presentation only)	Chief of Service, Surgery, Women + Children's
Mark Tighe (Presentation only)	Consultant, General Surgery
Julie Burke	Secretary to the Trust Board
Observing	
1 member of the public	

Agenda Ref BM/17/06/	
BM 17/06/	The Board meeting opened with a presentation from the Medical Director, Chief of Service, Surgery, Women and Children's General Surgery Consultant, to provide an overview for the Board on Never Events that had occurred in the Trust, where the Trust sits with other organisations, findings from the reviews that had been carried out to look at qualitative data and any common themes that had been identified. The Trust had reported 3 Never Events in 2016-17, which had been reported through STEIS and as part of investigations, the reasons for these events were discussed in detail and improvement processes put in place. Reasons had included human factors as well as wrong site surgery and medication errors. The Trust had adopted and implemented LOCSiPP (Local) and National NAPSIS (national) standards into its own processes as well as key elements from the WHO checklist. A number of processes have been developed following SUI investigation recommendations, including a Quality Improvement Strategy – site surgery safety interventions, a patient survey for patient safety, a process for each intervention outside of surgery with support for medical leadership and teams to enable concerns to be raised if individuals feel that a process is not been followed correctly. The Board thanked colleagues for the presentation. MH and MT left the Board meeting.
BM 17/06/67	**Welcome, Apologies & Declarations of Interest** The Deputy Chairman opened the meeting, and welcomed those in attendance. Apologies: as above. Declarations of Interest: none declared in respect of agenda items.

BM 17/06/68	**Minutes of the Previous Meeting Held on 31 May 2017** Page 1, Interim HRD present Page 4, 17/05/61(a) 1st bullet point, last sentence to read … NHSI improvement trajectory. Page 6, 17/05/61(b), last bullet point to read … 6 monthly safer staffing report to July Board. With these amendments, the minutes of the meeting held 31 May 2017 were agreed as an accurate record.
BM 17/06/69	**Actions and Matters arising** All actions were reviewed and progress noted since the last meeting.
BM 17/06/70	**Chief Executive Report** The Chief Executive updated the Board on matters that had occurred or progressed since the May Board meeting. - An Independent Chair, Sue Musson had been appointed to the shadow Accountable Care Partnership in Warrington. Sue is a Warrington resident and has held NED and Chair roles in other NHS organisations. - Work had commenced to create a bespoke primary care-led streaming facility adjacent to the Warrington ED following a successful bid of £1m to NHSE to support this. The Board recognised the efforts of the medical records staff in particular to decant all the medical records to enable this work to start as soon as possible. The unit will be operational by October 2017 and is being led by the Acting COO. - The CEO shared with the Board actions that had been taken by the Trust following the recent Grenfell Fire incident to ensure that its building stock was safe. The Trust's Fire Inspection had been signed-off in April 2017 but NHSE requested all Trusts to undertake a formal fire safety inspection/re-inspection. The Fire + Rescue Service identified those sites "at risk", to undertake further priority inspections. WHH was not identified as an "at risk" site following an inspection of its sites on 25 June and this had been reported to NHSE. However, a further full inspection will be carried out when the Cheshire F&RS has completed the inspections of "at risk" sites in the region. - The CEO had attended the first meeting in the municipal calendar of the Warrington Health Scrutiny Committee. Work priorities of the Trust and the CCG for 2017-18 were shared to allow the Scrutiny Committee to develop their Scrutiny calendar to call in any items for scrutiny as appropriate. - Public engagement is underway relating to the transfer of thrombolysis-benefitting patients on a 24/7 basis to Whiston hospital before being repatriated to Warrington for their rehabilitation once stabilised. The next phase of this work will be to create a hyper-acute stroke service concentrated at Whiston. An engagement event is being held on the 6 July, facilitated by local commissioners and the Stroke Association. **<u>Sugar Sweetened Beverages (SSB)</u>** All NHS organisations had received a request to support the SSB initiative to ban/reduce the sales of sugar-sweetened beverages at retail outlets on NHS premises from July 2018. A number of national food and beverage suppliers are supporting this initiative, which includes some of those on Warrington site. **The Board agreed to support this initiative.**

BM 17/06/71	**Chairman's Report** The Chairman had attended the recent successful Dragon Boat Charity Event and congratulated all staff who had taken part to raise funds for the Charity.
BM 17/06/72	**Integrated Performance Report Dashboard (May)** The Director of Finance + Commercial Development introduced the report to provide assurance to the Board in relation to delivery of KPIs across the following areas, Quality; Access and Performance; Workforce; Finance + Sustainability. - Following validation white indicators reported last month (22) had decreased to 9. Indicators remaining white are being reviewed. The relevant Sub Committee will make a future proposal to the Board once the RAG parameters have been agreed and each sub-committee will receive an exception report for both positive and negative progress. - 57 indicators had been approved for the 2017/18 dashboard. This has now increased to 63 due to further granulation. - The Board was asked to note the movement in month in the rag ratings of a number of indicators in Section 2 of the report. The Chief Nurse highlighted areas for the Board to note relating to the Quality KPIs: - 4 Quality indicators rated red, an increase of 1 in month (the indicator was not validated in April). The four are; (1) Duty of Candour (DoC) – some of these incidences had been reported due to the new complaints handling process, SI incidents and mortality reviews. Duty of Candour is now recognised earlier in the pathway and progress monitored through the Quality Bi-Lateral meetings and weekly meetings with the Chief Nurse and Medical Director. - The newly commissioned DATIX reporting system has the functionality to support DoC reporting. - (2) NICE – a process to manage the backlog had been approved through the Quality Committee and KSJ re-assured the Board that the 75% target will be achieved within 6 months. - (3) Mixed Sex Accommodation (MSA) – a new process is in place to manage MSA. Full RCA had been undertaken for the 3 reported breaches, all of which were due to step down from ITU. The maximum number of breaches per month is to be agreed with the CCG. - The Board were asked to note the improvement relating to SEPSIS in-patient screening which had moved from Red to Amber, to 90%. - (4) VTE - Target of 94.10% achieved against target of 95%. In relation to VTE, the Medical Director reported some issues relating to data validation and the recording of risk assessments that had been completed; the 95% standard had been achieved for January, February and March 2017 and work is underway around validating the position for April and May with respect to certain cohorts of patients. SC reassured the Board that risk assessments appear to be being undertaken and that 95% is being achieved for completed risk assessments on admission; the challenge has been about reporting it without time-consuming manual validation. A weekly Task and Finish Group is also monitoring the reduction in the root cause analysis backlog together with the quality of RCAs, which is

	reported through the Patient Safety & Clinical Effectiveness Sub-Committee, with escalation to the Quality Committee as appropriate. The RCAs had not identified any incidences of avoidable harm. In relation to the 12 Controlled Drug Incidents, MB asked about their nature. SC said that he would enquire of the Chief Pharmacist the nature of these incidents and feedback. **SC** The Acting COO highlighted areas for the Board to note relating to Access and Performance KPIs - An increase of 2 red indicators reported relating to ambulance handovers 30-60 and over 60 minutes. This data had not been validated in April due to the Cyber-attack. - 4 hour standard 95% National target – achieved 92.79% in month, which is an improvement on April 91.4% and above the NHSI trajectory of 90.5%. Trajectory will be much more challenging in Q2 which had been discussed in detail at the Financial and Sustainability Committee. JR added that the Trust internal Patient Flow Board (PFB) had been established with each workstream having its own improvement plans with reporting to the A&E Delivery Board on a monthly basis. JR to explore external representation on PFB to support the governance of the newly submitted Delayed Transfer of Care trajectories. - Breast Symptomatic – A Task and Finish Group has been established with Commissioners to support Patient Choice and improve compliance with this target the only breaches recorded are all patient choice issues. - Ambulance handovers – improvement noted for both indicators and the Trust remains one of the better performing Trusts in C&M however further work required to ensure we deliver this target safely. - Discharge summaries – quality of summaries had improved, the 95% target for summaries sent within 24 hours not achieved and there is an improvement plan is in place to improve performance. The 7 day target had been achieved. - Cancelled operations on the day and not offered a date within 28 days – 1 breach in month and an RCA is being undertaken. - Cancelled operations on the day – 22 breaches. Action plan in place to reduce occurrences which is reported through to the Clinical Operations Board (COB). The Interim Director of HR and OD highlighted key points within the People KPIs: - <u>Workforce</u> - 3 indicators rated red, which is an increase in month. - Agency medical spend performance had deteriorated. MC re-assured the Board that this mirrors the national issues relating to the difficulty recruiting to specialist medicine, geriatric and emergency care posts and is not as a result of implementation of the IR35 legislation. This is compounded by the Trust responsibilities relating to HENW and supervision of trainees when recruiting to substantive posts. The Pay Spend and Review Group continue to monitor all pay spend and escalate issues through to the Finance and Sustainability Committee (FSC) as appropriate. - <u>Recruitment</u> - length to recruit to posts had been discussed in depth at the Strategic People Committee (SPC), including the effect in the process when shortlisting is not completed in a timely manner. Drop-out rates following offers of employment had also been discussed and a benchmarking exercise is to be undertaken and findings reported to

	a future SPC. - The recent Nurse Recruitment day had been successful with offers to 50 individuals with an anticipated conversion rate of 50%. - Retention initiatives within Nursing is helping to reduce the number of nursing staff leaving the Trust. - The SPC had received a new People Measures Dashboard which will monitor a number of indicators, including turnover and exit interviews. - Sickness absence – deterioration noted in month but evidence that the Attendance Management Policy is supporting managers to manage sickness absence through to the stage 3 process. - Return to work Interviews – work continuing to ensure managers and staff have appropriate access to occupational health service and utilise phased return to work to support staff. - PDR – steady deterioration noted in compliance since March, each CBU has its own people measures dashboard and is being supported by HR to identify any specific support required against any special measures they may have to improve performance. The Director of Finance and Commercial Development highlighted key points within the Finance Sustainability KPIs - There had been a change to the STF framework to receive STF monies, the 100% monies will be split 70%-30% with 70% remaining for achievement of the financial control total and 30% split as 15% for achievement of A%E target and 15% for primary care streaming. This funding will only be received if the financial plan is delivered. - Financial plan actual position is a deficit of £2.7m, (£0.5m off plan) which poses a significant risk to the Trust's cash position. This had been reported and discussed in depth at the FSC in June. AC had met with both the Acute Care Division and Surgery Women and Children's Division and requested action plans, remedial action plans and areas where additional support may be required. These action plans will be presented to the next FSC in July and any issues escalated to Board as appropriate. - The Trust cash position continues to be monitored and managed on a daily basis. - Better Payment Practice compliance continues to under-perform with YTD 36% against a 95% target due to the cash challenges. - Agency spend – exceeds the NHSI threshold of £1.7m with £1.9m YTD of which £1.1m relates to May. - The Trust has reported and continues to report a Use of Resources score of 3 since October 2016 when the rating was introduced. Further deterioration to the financial position could move the Trust to a Use of Resources score of 4. The Director of Transformation provided an update on the current CIP/transformation performance. - £300k behind plan YTD with £700k CIP and £100k cost avoidance YTD against £1.1m YTD target. - Savings delivered YTD is the same as last year but this year's plan is more challenging. - The FSC had discussed the Transformation programme in detail and supported the rapid decision making process through Executives, FSC and the Quality Committee of current

	uncosted schemes. - HR, OD and Transformation Team are developing a framework to support this work. **The Board noted the report.**
	(b) Nurse Staffing Report The Chief Nurse highlighted key areas for the Board to note in the report which highlights areas where average fill rates fall below 90% of actual versus planned. - KSJ re-assured the Board that where rates fall below 90%, mitigation plans are in place to ensure safe, high quality care is consistently delivered. - Low ratios for health care support workers will form part of the on-going staffing review. The 6 monthly report to Board next month will include the outcomes of the review of fill rates on a shift by shift basis. Future board reports will also include incidences of where harm is reported. **The Board noted the report.**
	(c) Trust Engagement Dashboard The Director of Communications and Corporate Affairs highlighted key areas for the Board to note: - Strong negative sentiment due to 1 patient's interview who had accessed A&E during the Cyber-attack. - Media activity limited due to Purdah and restrictions on what could be published. - Twitter – followers doubled in month and target set to double twitter followers during 2017-18 - Websites – visits to website increased, largely due to the Cyber-attack and people accessing the site for information. - Extranet – good engagement from Junior Doctors to ensure that treatment policies and SOPs are readily available for access at patients' bedside during treatment. - Patient engagement – new provider commissioned, Health Care Communications, which will enable real-time feedback from patients and will sign-post patients to provide their feedback through NHS Choices also. **The Board noted the report.**
	(d) Key Issues Report from June Quality Committee The Key Issues Reports were taken as read and Margaret Bamforth, Chair of Committee highlighted the following: - The Committee receive the Quality Bi-Lateral dashboard to provide a greater level of assurance from Ward to Board reporting. - Improved functionality of QC sub-committees to enable the QC to focus on assurance rather than operational matters. - Quality Improvement Strategy being developed which will be aligned to the Quality Academy. - Annual Report. Amendments to be made to the attendance register for LG + PMcL. **The Board noted the report and the areas of escalation and approved the Committee Chairs Annual Report subject to the above amendment.**
	(e) Key Issues Report from June Strategic People Committee The Key Issues Reports were taken as read and Anita Wainwright, Chair of Committee highlighted the following:

	- The SPC will continue to monitor the delivery of the People Strategy, through the new KPI dashboard and the Operational Plan. - The frequency of this meeting may change following the Governance Review. <u>Annual Report</u> - The Annual Report had been approved by the SPC. <u>Terms of Reference and Cycle of Business</u> - The SPC had approved the ToR and Cycle of Business with the amendment of the Medical Education Governance Annual Report to The Educational Governance Annual Report, and Executive Lead Interim HRD. **The Board noted the report and approved the Committee Chairs Annual Report.**
	(f) Key Issues Report from June 2017 Finance and Sustainability Committee (FSC) The Key Issues Reports were taken as read. Matters within this report had been covered in earlier discussions as part of the finance and CIP discussions. TA re-assured the Board that the Trust's financial position and spend will be closely monitored through the FSC, as will Estates issues (see item BM/17/06/74) and matters escalated to the Board though the Chair's report. **The Board noted the report.**
BM17/06/73	**Annual Complaints Report** The Chief Nurse highlighted key points for the Board to note. The Report is a statutory requirement as part of the Department of Health regulations. - A Complaint Review had been commissioned in 2016 and a comprehensive improvement plan put in place. The management of Complaints remains a risk for the Trust and continues to be monitored and reported to the Quality Committee and Board. - Capacity has been increased within Complaints team with increased scrutiny of complaints with 1 central process for complaint handling. - PALS service had been reviewed and a decrease of 34% (1694 enquiries) had been reported in 2016-17 against 2558 from the previous year. This was in part due to the capacity within the PALS team and subsequent closure of the PALS office. The PALS service is to be extended with a presence on both Halton and Warrington sites. - The PALS enquiries within the report mirror the areas where Complaints had been received. The embedding of the Patient Experience Strategy will support the resolution of more complaints at ward level. - The new centralised system for reporting will include a full E&D profile for collection on all complainants. - The Board were asked to note the cause of complaints, the top 2 indicated a decrease in the number of complaints for those causes. The 3rd highest cause (attitude of staff) had caused concern and KSJ reassured the Board that the newly introduced Ward Manager Programme will support the improvement in this area together with the weekly complaints meeting with herself. - The majority of complaints received related to the Warrington site, with a small number at Halton. The highest number of complaints at CBU level related to Urgent + Emergency Care and Musculoskeletal. - All complainants receive an apology from the Trust whether the complaint is upheld or

	not. - Improvement trajectory in place to conclude complaints over 6 months. - The report shows an increase of 6.7% in formal complaints (430) compared to last year - of 403 with an average of 38 complaints received per month. - In November 2016, it had been identified that there was a backlog of 197 complaints out of a total of 220 awaiting a first response. - At 1 April 2017 there were 234 open complaints with an improvement reported on the number of complaints closed each week, with 40 closed last week. - The Board noted the learning from complaints within the report and the initiatives put in place to improve customer/patient care and patient experience to achieve a satisfactory resolution to complaints received. - The Complaints handling action plan is focussed on local resolution and will form part of the Trust Quality Account next year. - The Trust reported 12.4% of complaints that were converting to the Parliamentary Health Service Ombudsman (PHSO). - KSJ added that Trusts sits comparatively against other Trusts in the economy in relation to complaints received. **The Board discussed and approved the report and were re-assured that the complaints backlog will be cleared by the end of 2017 due to the improvement plan in place.** **The Board recognised the significant work that had been undertaken to reduce the backlog.**
BM/17/06/74	**Strategic Risks** The Chief Nurse highlighted key points for the Board to note: - 2 new risks had been added to the Risk Register since the last report which had been approved at the Quality Committee in June, these related to the Cyber Attack and failure to meet standards of blood administration, both had been rated with risk ratings of 12. - KSJ advised that there had been no SIs as a result of the latter risk. - The report showed updates since the last report, noting that there had been no impact on the risk ratings. - These risks had been reported to Patient Safety and Clinical Effectiveness Committee (PSCE) and escalated to the Quality Committee. TA asked the Board to note the Estates Risk (risk score of 15) which had been discussed at FSC in June and highlighted within the Chair's Issues report. The Acting COO is to prepare a report for the July FSC and any additional risks identified escalated to the Board as appropriate. **The Board discussed, reviewed and approved the Board Assurance Framework and Strategic Risk Register and approved the changes to the strategic risks.**
BM/17/06/75	**Medicines Management Annual Report** The Medical Director highlighted key points for the Board to note: - This report had been presented, discussed and approved at the June Quality Committee. - The Medical Director recognised the work undertaken by the Medicines Management Team to ensure Trust compliance with the published NICE guidance received. The team are also working to support Pharmacy transformation as part of the STP. **The Board noted the report and endorsed its recommendations.**
BM/17/06/76	**NHSI Board Self-Certification Checklist Quarterly Report** The Interim HRD highlighted key points for the Board to note

	- The Pay Spend Review Group (PSRG) had developed a work plan which will be reviewed by the PSRG on 4 July to agree times scales for completion of each area of spend. - The self-certification checklist is submitted weekly to NHSI and reported monthly to the FSC alongside the Pay Spend Dashboard for scrutiny of pay spend with matters for escalation reported to the Board. **The Board reviewed and discussed the report and noted the progress made against the checklist with continued monitoring and scrutiny through the FSC.**
BM/17/06/77	**Emergency Preparedness Annual Report** The Acting Chief Operating Officer highlighted key areas for the Board to note: - The Trust is a Category 1 responder. JR re-assured the Board that the Trust have robust emergency preparedness, business continuity plans and standard operating procedures in place to protect the Trust in the event of a disruption and/or incident - She also reassured the Board that the gap in support due to the Emergency Planning lead taking extended leave will be supported by NHSE, and part time support from other EPRR leads. - The Board noted the major incidents the Trust managed during 2016-17 and the processes for ensuring learning from these events through debrief reports. - The Trust Business Continuity Plans had been updated following the CBU restructure together with CBU level service business continuity plans. - An addition to the report had been learning shared following the recent Manchester incident. In the event of a major incident being declared, NHSE would take over Control of the process through delegated authority processes, as instructed by central government, with the Trust would implementing "Silver Command". - Any issues/learning would be reported through the Emergency Planning Group and FSC. **The Board discussed, reviewed and noted the Emergency Preparedness Annual Report and the planned programme for 2017-18.**
BM 17/06/78	**Changes to the Constitution – Register of Members** The Director of Communications + Corporate Affairs highlighted key areas for the Board to note as a result of the General Data Protection Regulations (GDPR) which become effective in May 2018. The required changes to the constitution involve how the Trust: 1. Communicate privacy information 2. Observe Individual's rights 3. Describe our lawful basis for processing personal data 4. Gain Consent 5. Treat Children. **This approval required Board approval by voting and the motion carried with 11 Voting Members supporting the amendment.** **The Board approved the amendment with a recommendation for formal approval to the Council of Governors in July.**
BM 17/06/79	**Any Other Business** In response to an earlier query relating to the dashboard for Incidents, this was an error within the report and will be rectified for next month's report. **Next Meeting:** Wednesday 26 July 2017, Full Trust Board Meeting, Trust conference Room.

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BOARD OF DIRECTORS ACTION LOG

AGENDA REFERENCE:	BM/17/07/82	SUBJECT:	TRUST BOARD ACTION LOG	DATE OF MEETING	26th July 2017

1. ACTIONS ON AGENDA

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
BM/17/01/09	25 January 2017	DIPC Bi-Annual Report	Future report to Board on operational impact.	Medical Director	26 July 2017			
BM/17/01/12	25 January 2017	Charitable Funds Commission	Board to receive refreshed strategy to maximise income streams as workshop	Director of Community Engagement	26 July 2017	31 January 2017	7.7.2017. Deferred to Part 1 Board on 26 July 2017	

2. ACTIONS COMPLETED AND CLOSED SINCE LAST MEETING

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
BM 17/04/46	26 April 2017	Annual Staff Survey results	Dedicated session to discuss further.	Interim Director of HR & OD	7 July 2017		Discussed at Joint Exec/NED timeout agenda 7 July 2017	

ROLLING TRACKER OF OUTSTANDING ACTIONS

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
BM 17/03/30	29 March 2017	IPR Dashboard	SC to present Learning from Deaths policy to future Board for approval.	Medical Director	30 August 2017			
BM/17/03/34	29 March 2017	Board Annual Cycle of Business	Board to review a draft calendar of meetings for 2018 and use of technology.	Director of Community Engagement +Corp Affairs	6 October 2017		31.3.2017 added to Joint Exec/NED timeout agenda 6 October 2017.	
BM/17/01/08	25 January 2017	Integrated Dashboard - Mortality	Follow-up workshop Learning through Transparency with Board and	Medical Director	6 October 2017		Added to Joint Exec/NED timeout agenda in October	

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			Governors					
BM/17/04/49	26 April 2017	Proposal to change Trust Name	Process to commence to incorporate 'teaching' element into its Brand.	Director of Communications + Corporate Affairs	ASAP		24.5.17. This process has commenced.	

RAG Key

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

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BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/17/07/85 a**
SUBJECT:	**Integrated Performance Dashboard**
DATE OF MEETING:	26th July 2017
ACTION REQUIRED	**For Discussion**
AUTHOR(S):	Marie Garnett – Head of Contracts and Performance
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse Jan Ross – Chief Operating Officer (interim) Michelle Cloney – Director of Human Resources & Organisational Development (interim) Andrea Chadwick - Director of Finance & Commercial Development Simon Constable – Medical Director Lucy Gardner – Director of Transformation
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):	At the end of month 3 the Trust has a financial deficit of £3.1m which is in line with plan. Quality has 1 additional red indicator in June which brings the total to 5. Access and Performance indicators have improved from 7 reds in May to 6 reds in June. This is due to the Total Number of Cancelled Operations on the Day (for non-clinical reason), not offered a date for readmission within 28 days improving from red to green. Workforce indicators have remained static in month

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	and are still reporting the same 3 reds and 3 amber indicators as in May.	
RECOMMENDATION:	The Trust Board is asked to note the contents of this report.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	
FREEDOM OF INFORMATION STATUS (FOIA):	Choose an item.	
FOIA EXEMPTIONS APPLIED: *(if relevant)*	Choose an item.	

SUBJECT	Integrated Performance Dashboard	**AGENDA REF:**	

1. BACKGROUND/CONTEXT

The Integrated Performance Dashboard (Appendix 1) has been produced to provide the Board with assurance in relation to the delivery of all KPI's across the following areas:

- Quality
- Access and Performance
- Workforce
- Finance Sustainability

2. KEY ELEMENTS

The Trust has 63 KPIs on the dashboard.

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

- Red – 18 in May to 17 in June
- Amber – 7 in May to 8 in June
- Green – 29 in May to 29 in June

There are still a number of indicators with no threshold/RAG rating agreed. There were 9 in May and 9 in June. These indicators will be discussed at the relevant Sub Committees in August. If a RAG parameter cannot be set for an indicator an explanation will be provided in the August Board report.

Appendix 2 sets out the RAG ratings for all 63 indicators from April to June 2017.

Quality

Quality KPIs

There are 5 Quality indicators rated red, an increase of 1 in month.

Of the 4 indicators that were red in May 3 have remained red in June as follows:

1. Duty of Candour (DOC) 10 working days target – of the 10 "moderate harm" incidents in June, 33% were completed on target compared to 71.40% in May.
2. Nice Compliance – the Trust achieved 55.26 % in June against a target of 100%, a slight deterioration from 56.13% in May.
3. Mixed Sex Accommodation (MSA) – there is a national zero tolerance approach to MSA breaches. There have been 14 MSA breaches in month compared to 3 in May.

The 2 additional red indicators for June are as follows:

4. Incidents - there has been 1 Never Event in June within the Women's and Children's Clinical Business Unit, therefore this indicator has moved from green to red.
5. Pressure Ulcers – 9 grade 2 pressure ulcers were reported in June compared to 7 in May. Route cause analysis is underway. This indicator has moved in month from green to red.

There is 1 Quality indicator rated amber in month, compared to 2 in May due to the Sepsis CQUIN Inpatient Screening indicator improving from amber to green. The amber indicator is:

1. Staffing Average Fill Rate - Trust performance is 87.51% in June for registered nurse/midwives in the day, against a target of 90%. Plans are in place to ensure the delivery of safe patient care.

Access and Performance KPIs

There are 6 Access and Performance indicators rated red, a decrease of 1 in month; this is due to the Total Number of Cancelled Operations on the Day (for non-clinical reason), not offered a date for readmission within 28 days, indicator improving from red to green. The 6 red indicators are:

1. A&E Waiting Times 4 Hour 95% National Target – the Trust achieved 90.38% in month which is deterioration on May's performance of 92.81%.
2. Breast Symptomatic 14 Days – the Trust achieved 92% in month against a target of 93%. This was an improvement on May's performance of 88.16%.
3. Ambulance Handovers 30 Minutes – The Trust has seen an increase in the number of delayed handovers between 30 and 60 minutes from 126 in May increasing to 171 in June. The challenging time period has been identified as late evening to the early

hours of the morning when medical staffing is reduced. Medical staffing levels are being reviewed to address the issue.

4. Ambulance Handovers 60 Minutes - The Trust has seen an increase in the number of delayed handovers over 60 minutes from 18 in May to 58 in June. The challenging time period has been identified as late evening to the early hours of the morning when medical staffing is reduced. Medical staffing levels are being reviewed to address the issue.
5. Discharge Summaries % Sent Within 24 Hours – the Trust has failed to achieve the target of 95% with performance for June reported at 88.64%. Whilst this is a slight improvement on May's performance 87.76%, the Trust has failed to achieve the overall quarter one target of 95% and will receive a £15k financial penalty from Commissioners.
6. Total Number of Cancelled Operations on the Day (for non-clinical reason). The Trust has a zero tolerance approach to breaches. There were 25 breaches reported in June which was an increase on May's performance of 22. It should be noted that all 25 patients who had a cancelled operation were offered a new date within 28 days in line with the national target.

People

Workforce KPIs

There were 3 Workforce indicators rated red in May and the same 3 indicators have remained red in June. The 3 red indicators are:

1. Recruitment – the time taken to recruit has improved from 78.8 days in May to 72.2 days in June against a Trust target of 65 days.
2. Turnover – In June Trust performance slightly improved to 13.09% compared to 13.29% in May. The Trust target is 7-10%. A number of measures have been put in place to reduce turnover.
3. Agency Medical Spend – the Trust's spend in June is £506k, £64k higher than the same period last year.

There were 3 Workforce indicators rated amber in May and the same 3 indicators have remained amber in June. The 3 amber indicators are:

1. Sickness Absence – performance against this indicator has improved in month from 4.57% in May to 4.46% in June against a target of 4.3%.
2. Return to Work Interviews (RTW) – the Trust achieved 80.11% in month against a target of 85%.
3. PDR Compliance – performance has been steadily deteriorating since March. The Trust's target of 85% has not been met this financial year and performance has dipped further in month to 74.55%.

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

Sustainability

Finance Sustainability KPIs

There are 3 Finance Sustainability indicators rated red, an improvement of 1 in month due to the Financial Position indicator moving from red to amber. The 3 red indicators are:

1. Cash – continues to be a challenge and is under daily monitoring and management. The balance at the end of June was £1.2m.
2. Better Payment Practice Compliance – continues to underperform with year to date performance of 36% against a 95% target due to cash challenges.
3. Agency Spending – has exceeded the NHS Improvement threshold of £2.5m with £2.8m year to date of which £0.9m relates to June. Plans to reduce spending on this expensive resource are required to support financial delivery.

The Finance Report presented at the July finance and Sustainability Committee is attached in Appendix 3.

Whilst the Trust wide cumulative Cost Improvement Plan (CIP) in year position is amber, 7 the Director of Transformation has requested that the RAG parameters be adjusted to more accurately reflect the position.

The current RAG parameters are:

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

The proposed RAG parameters are:

Red:	0-70% of plan delivered YTD
Amber:	70%-90% of plan delivered YTD
Green:	> 90% plan delivered YTD

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 Committee
- Strategic People Committee

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

5. RECOMMENDATIONS

1. The Trust Board is asked to note the contents of this report.
2. Approve a change to the Trust wide cumulative CIP KPI RAG parameters.

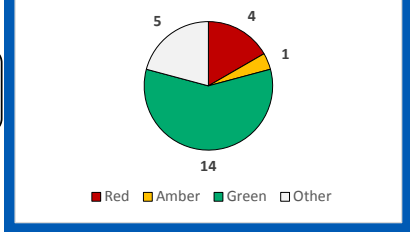
Warrington and Halton Hospitals NHS
NHS Foundation Trust

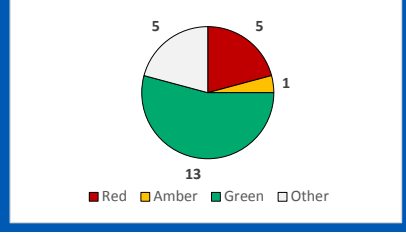
Integrated Dashboard - Board of Directors - June 2017

Appendix 1

Key Points/Actions

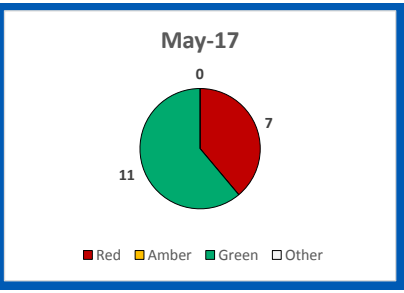
Quality Improvement

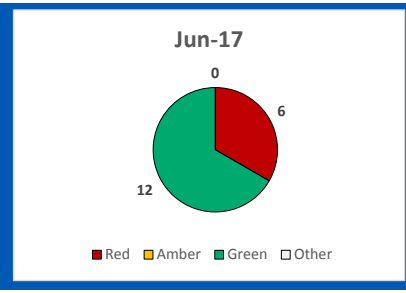




The Trust has had 1 case of MRSA in the month of July; as such this will be reported in the next dashboard. Our HSMR continues a downward trend. All areas monitored in relation to Sepsis achieved or exceeded the target of 90% for June. There have been 9 grade 2 pressure ulcers in month, for which a root cause analysis is underway for each one. There were 2 serious incidents reported in month related to falls, both for Specialist Medicine and both currently under investigation. The overall number of open incidents within the Trust stands at 1024; the Divisions have been asked to review their open incidents. There was 1 Never Event in month, this is currently under investigation and a further update will be provided in future dashboards. There were 10 controlled drugs incidents in month, a breakdown of which has been provided to the Divisions for comment. There has also been an increase in the number of medication reconciliations in month. The decrease in the percentage of VTE assessments being conducted has been due to delays within the coding department; this issue has now been addressed and this cohort of patients will be prioritised for next month. The Trust continues to implement the complaints improvement plan; figures show a reduction in the number of cases in backlog and those over 6 months old.

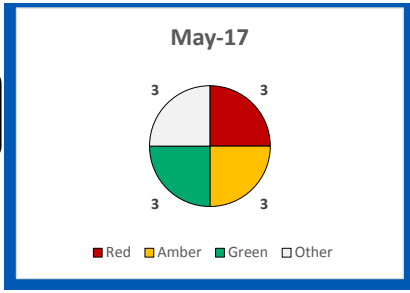
Access & Performance

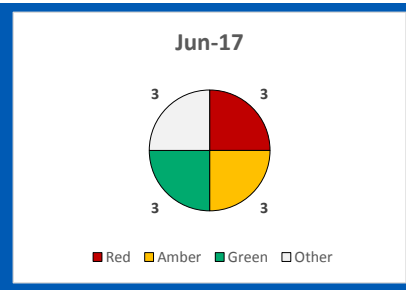




The majority of performance indicators were met for June.
The Trust did not achieve the 95% four hour A&E standard but has met the STP quarterly trajectory. Ambulance handover times remain a challenge and we continue to work with NWAS on an improvement trajectory. Discharge summaries continue to receive focus from each CBU with a view to achieving the improvement trajectories set by the Deputy Medical Director.

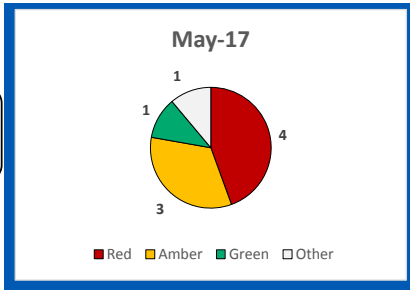
Workforce

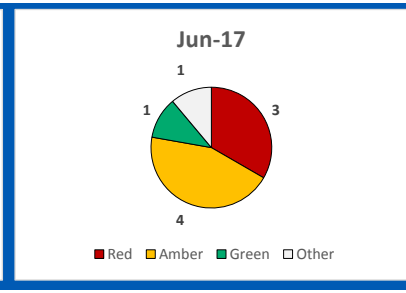




There have been no changes to the status of any of the metrics. The sickness rate has decreased from the previous month but remains as Amber. RTW rates have fallen in month and are below the target of 85% but this could be a timing issue for recording. Turnover rates have fallen again for the 9th month in succession but are still showing Red. Recruitment times have improved both for the time taken from shortlisting to interview and for employment checks. The status remains Red. All elements of Non contracted pay have reduced but agency expenditure remains a concern. Although nurse agency expenditure slightly increased in month, the status is still Green. Medical agency expenditure increased and is Red. Mandatory Training rates have remained stable and are Green. PDR rates have fallen again but remain as Amber. The position of 'high cost agency workers' and 'long term agency usage' has been updated.

Finance





In the month the Trust recorded a deficit of £0.3m which increases the year to date deficit to £3.1m, which is in line with the planned deficit. There are however a number of risks to delivering the control total. Actions plans have been requested from CBUs to mitigate this risk. The cash balance is £1.2m which is in line with the terms and conditions of the working capital loan. The year to date performance against the Better Payment Practice Code is 36% which is 59% lower than the 95% target. The Trust has recorded a Use of Resources Rating of 3 which is in line with the planned rating.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - June 2017

Quality Improvement - Trust Position

Description	Aggregate Position	Trend	Variation

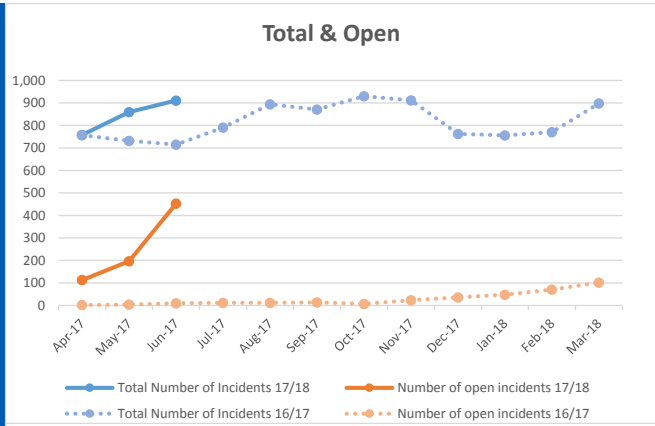
Patient Safety

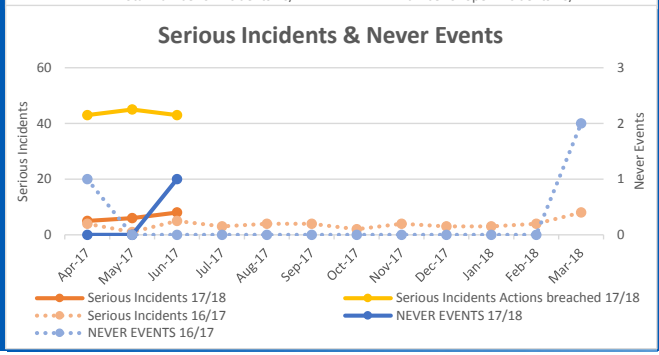
Incidents

Red: 1 or more Never Events
Green: Zero Never Events

Total number of incidents received during the month. Total number of Serious Incidents (SIs) received during the month. Never Events are serious, largely preventable patient safety incidents that should not occur. SI actions breached are the actions from closed serious incidents that are now overdue. Number of open incidents is the total number of incidents that we have awaiting review.

The target for Never Events is a zero tolerance.





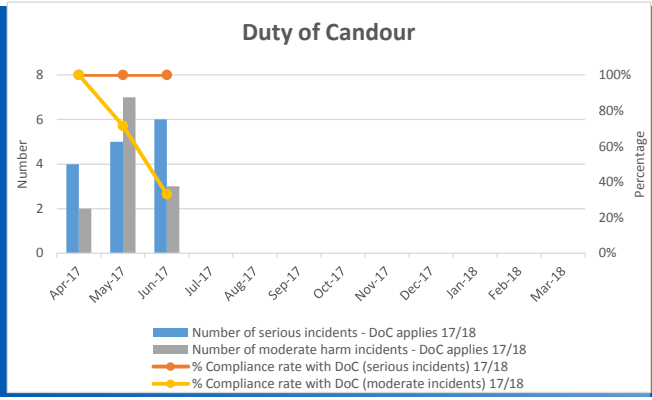
There are currently 43 overall breached actions in relation to Serious Incidents. The divisions are asked to review this data at their Divisional Bi-lateral meetings to set improvement trajectories. Of the 911 Incidents received in June 2017 we received 517 for Acute Care Services, 286 for Surgery and Women & Children's and 108 for Corporate Services. We had 1 Never Event in month for the Womens & Childrens CBU, an investigation is underway. In total there are 1024 open incidents on the Datix system, of which; 758 are for Acute Care Services (oldest date being May 2015), 183 for Surgery and Women & Children's (oldest date being November 2016), 73 for Corporate services (oldest date being May 2016) and 10 Other which are external and under review (oldest date August 2015).

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.

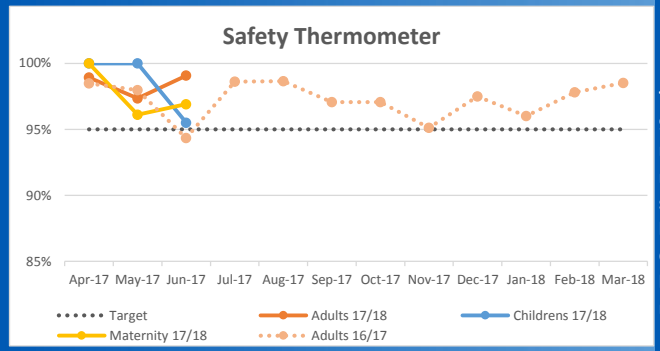
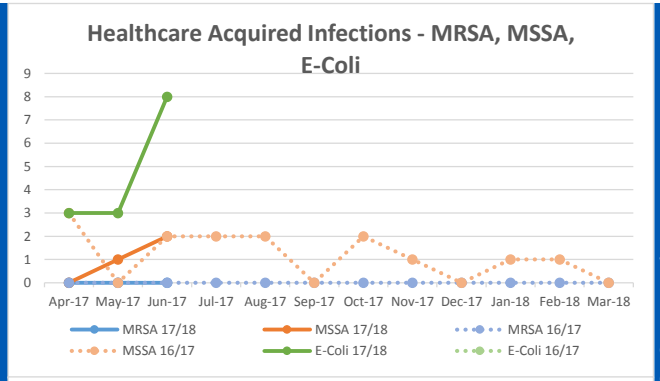
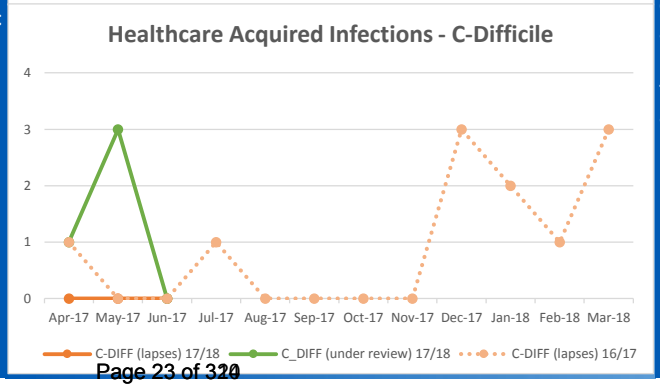


Duty of Candour (DoC) remains a focus of work and improvement. From week commencing 19/6 this has been monitored at the weekly Serious Incident Meeting. Of the 6 Serious Incidents where Duty of Candour applied in June; 2 are for Acute Care Services, 4 for Surgery Women & Children's and 0 for Corporate Services. The divisions now receive a breakdown by CBU of DoC performance and will be asked to look to improve compliance rates. Of the moderate harm still under investigation (1 of which pertains to Pharmacy so is not within the Divisional Split), 1 the relative is in hospital and the other verbal duty of candour has been given but no letter documented.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - June 2017

Quality Improvement - Trust Position

Description	Aggregate Position	Trend	Variation
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%		The overall Harm Free care % is above the target of 95%; Areas of harm caused in the Adult Thermometer related to 1 new pressure ulcer, 1 Fall with harm and 1 new UTI associated with a catheter. Children's services scored below 100% as early warning Score triggers had not been escalated. Maternity scored below 100% due to their scores for the proportion of women that had a PPH of more than 1000mls and proportion of mother and baby separation.
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.	MRSA - National objective is zero tolerance of avoidable MRSA bacteraemia. If breached a £10,000 penalty in respect of each incidence in the relevant month. MSSA - Has no National objective set by public health. Clostridium Difficule (c-diff) due to lapses in care; agreed threshold is <=27 cases per year. E-Coli A national objective has been set to reduce gram negative bloodstream infections (GNBSI) by 50% by March 2021.The focus for 2017/18 will be on Eschericia coli (E. coli) bacteraemia which is one of the largest GNBSI groups. Data reported is for hospital apportioned cases.	 	We have identified a hospital acquired case of MRSA bacteraemia on ward A3 which requires a root cause analysis investigation during July, the outcome will be reported in the August dashboard. A post infection review is underway and a further update will be provided to the next meeting. E-Coli is now being measured, as yet there is no monthly target set and this is to be agreed prior to the next meeting.

Safety Thermometer

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

Healthcare Acquired Infections

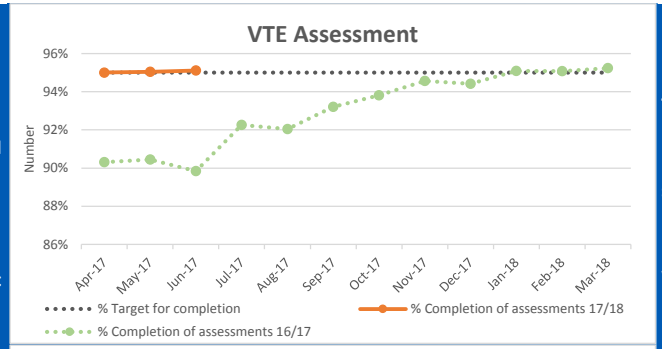
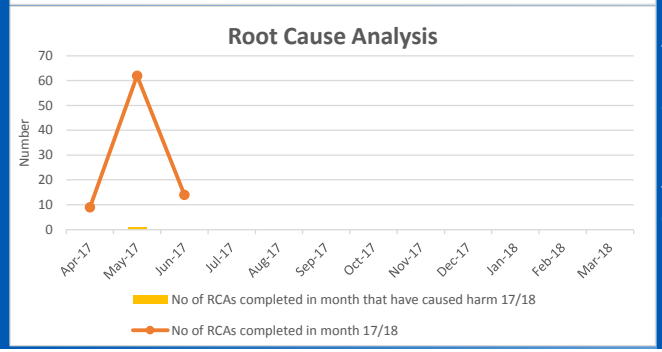
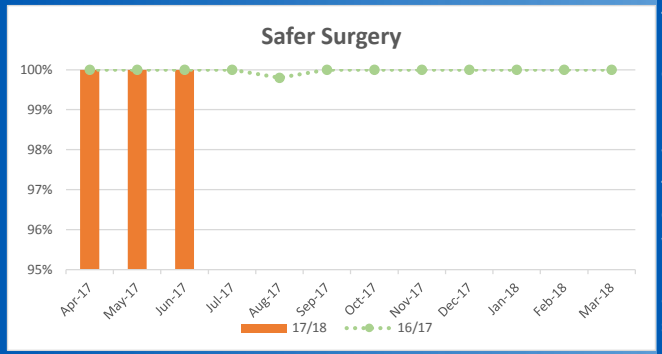
MRSA
Red: More than 5
Amber: 1 to 5
Green: 0

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

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - June 2017

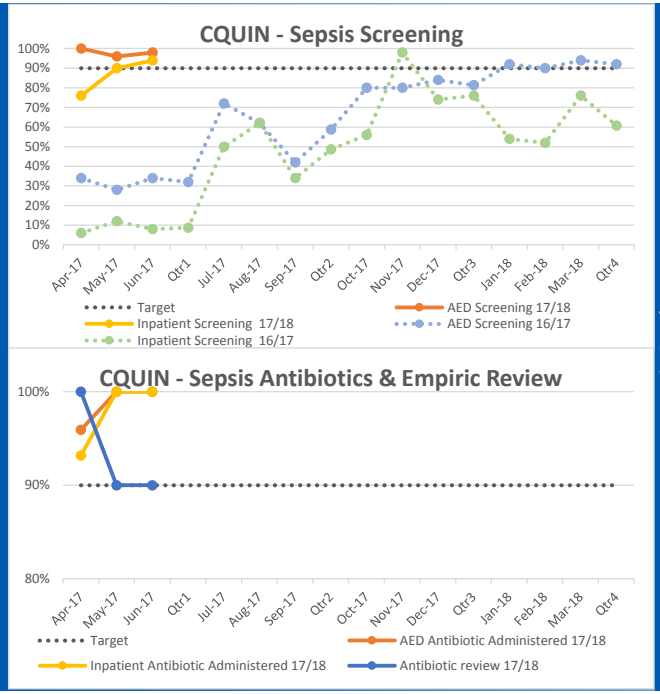
Quality Improvement - Trust Position

	Description	Aggregate Position	Trend	Variation
VTE Assessment Red: <95% Green >=95%	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%. The Trust achieved 95.09% in January, 95.08% in February and 95.23% in March following manual validation of patient level records and data. Technical issues with Lorenzo are being worked through with the relevant teams to ensure accurate VTE data going forward. 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 (risk assessed by harm and occurrence of PE). A revised process has been put in place for April 17 onwards. This has been communicated to Divisions.	 	The VTE risk assessment process has been updated in April 2017. There has been a backlog of RCAs for completion with regard to patients who should have had a VTE risk assessment. There is a programme to undertake these RCAs and clear the backlog of 16/17 and 17/18. At the time of writing this report, this backlog stands at 27 cases. For June 17 there are 15 patients who did not have a VTE assessment, which requires a RCA to be completed. Of the RCA's completed in month there were none which caused harm. There has been a decrease in the overall percentage of assessments completed in month, this is due to a resource issue in the coding department. The VTE nurse has liaised with the department to ensure that the VTE cohort of patients are prioritised for coding.
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%.		Of the Safe Surgery checklists we have continued to see 100% within this area. In relation to improving Safer Surgery across the Trust, we have taken forward the recommendations within the Never Event investigations – which has included observation audits, process review, review of our IT systems to ensure safety elements like laterality is recorded appropriately. We have conducted a safety culture survey across the Trust, which we are going to analyse and decide on focused areas of work. A gap analysis of what LocSSIPs are in place across the Trust (as part of the NAtSSIP work we did last year) . We are reviewing what training we have in place for safer surgery and reviewing our training needs analysis – e.g. training in LocSSIPs, Human Factors etc.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - June 2017

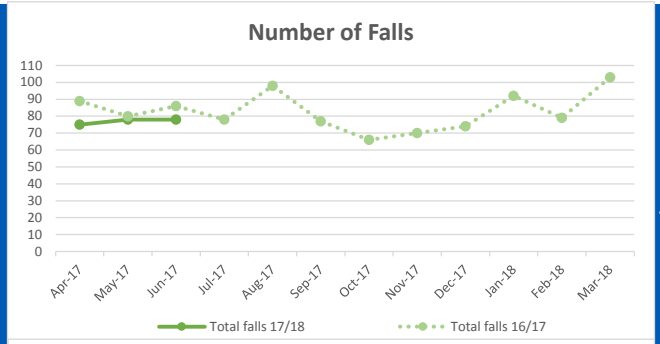
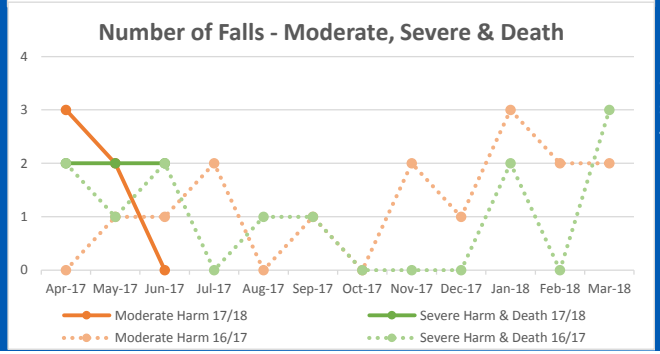
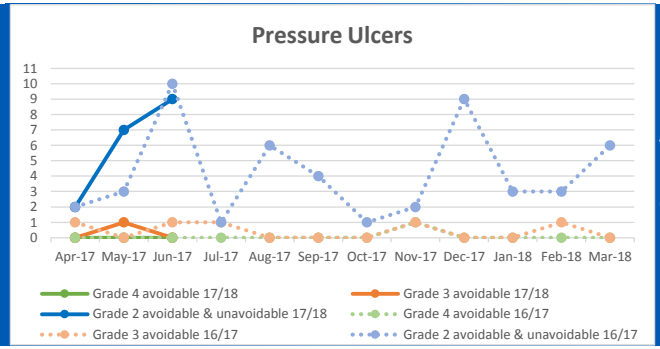
Quality Improvement - Trust Position

	Description	Aggregate Position	Trend	Variation
CQUIN - Sepsis AED Screening Red: Less than 90% Green: 90% or more CQUIN - Sepsis Inpatient Screening Red: Less than 90% Green: 90% or more CQUIN - Sepsis AED Antibiotics Administration Red: Less than 90% CQUIN - Sepsis Inpatient Antibiotics Administration Red: Less than 90% CQUIN - Sepsis Antibiotic Review	**Screening of all eligible patients - acute inpatients. Screening of all eligible patients admitted to emergency areas AED. Inpatient received treatments and empiric review within three days of prescribing antibiotics. Emergency patients received treatment and empiric review within three days of prescribing the antibiotics.**	**The target is to achieve 90%**		**The ongoing work by the Sepsis Nurse Team is demonstrating positive achievements. In June 17 we have achieved 90% or above in all areas.**

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - June 2017

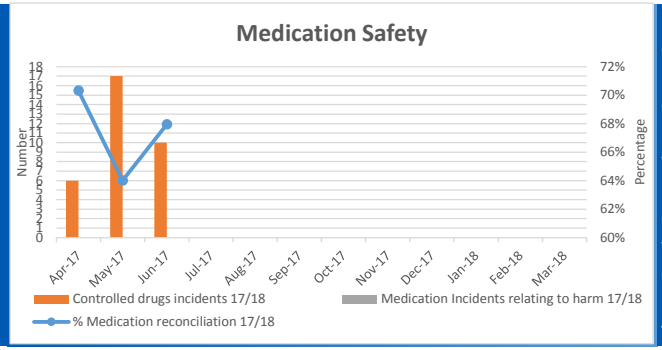
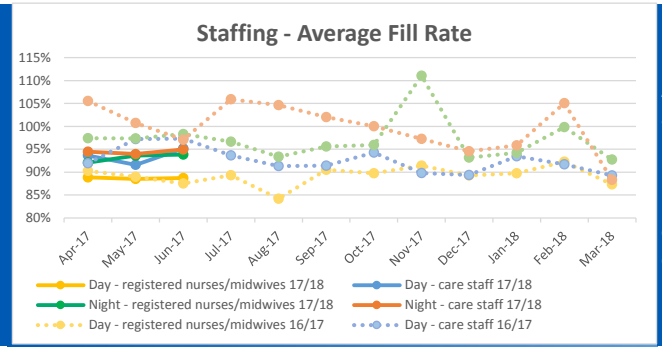
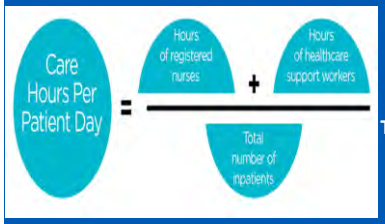
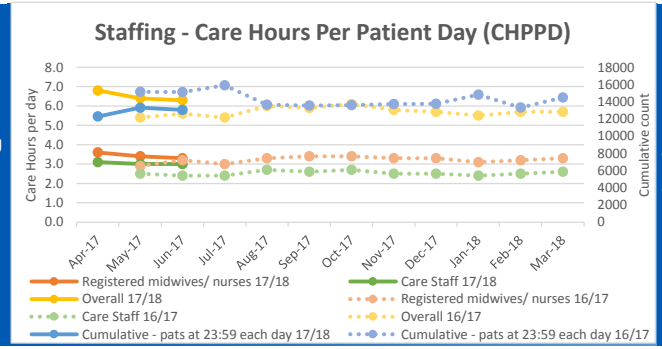
Quality Improvement - Trust Position

	Description	Aggregate Position	Trend	Variation
Total number of Falls & harm levels	Total number of approved falls per month and their relevant harm levels.	10% reduction in falls in 2017/18 using 2015/16 data as a baseline.	 	The 2 serious harm falls (severe and death) were both for Specialist Medicine, are both subject to Level 2 investigation and have been STEIS reported. Since April the number of moderate harm falls has dropped to zero but the overall number of reported falls has been consistently between 75-80 per month. With the recent addition of the Falls Nurse to the Trust we hope to see an improvement in these figures going forward.
Pressure Ulcers Grade 4 Red: 1 or more Grade 3 Red: More than 3 Green: 3 or less Grade 2 Red: More than 6.83	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) Grade 3 hospital acquired (avoidable) Grade 2 hospital acquired (avoidable and unavoidable)		There have been 9 x grade 2 Pressure Ulcers reported for June 17. It should be noted that root cause analysis is underway.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - June 2017

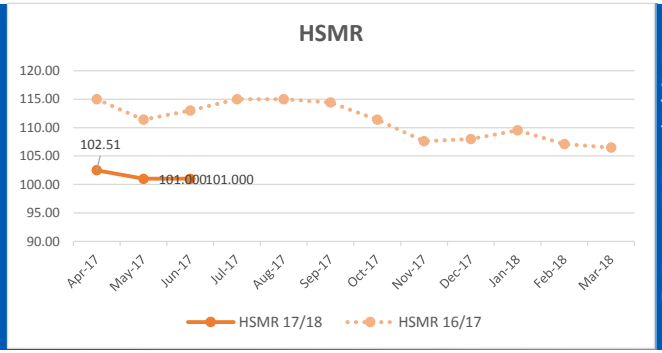
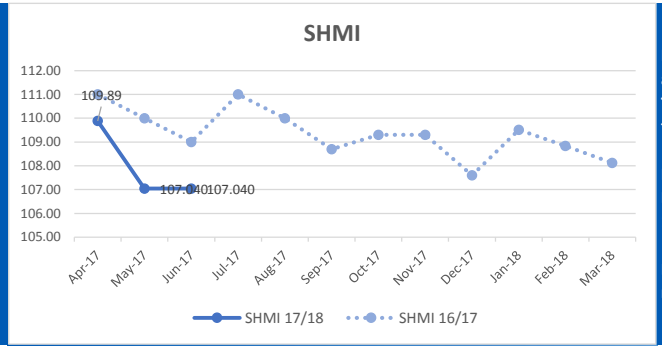
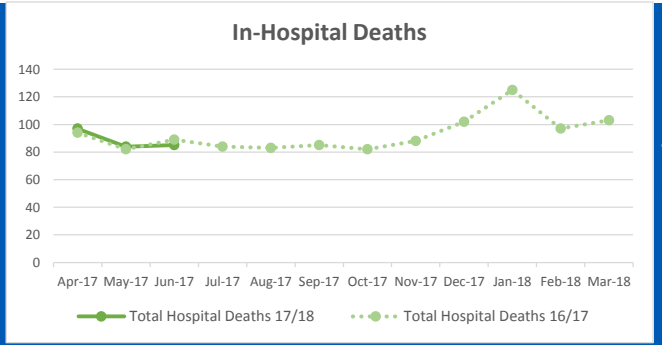
Quality Improvement - Trust Position

	Description	Aggregate Position	Trend	Variation
Medication Safety	Overview of the current position in relation to medication, to include; medication reconciliation, controlled drugs incidents and medication incidents relating to harm.	Targets to be set.		Medication reconciliation is the process of creating the most accurate list possible of all medications a patient is taking. The total number of patients requiring this in June was 1504 (excluding Paediatrics, Maternity and patients with a length of stay <1 day). Of the 1504, 1022 medication reconciliations took place; 258 occurred within 24 hours of admission. There were 10 controlled drugs incidents for the month of June. The Chief Pharmacist is currently reviewing this data and will provide an update for the next dashboard.
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.		Although most areas are above the 90% target 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 at appropriate.
Staffing - Care Hours Per Patient Day (CHPPD)		The data produced excludes CCU, ITU and Paediatrics.		We continue to monitor CHPPD as part of the daily responsive plans regarding care delivery.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - June 2017

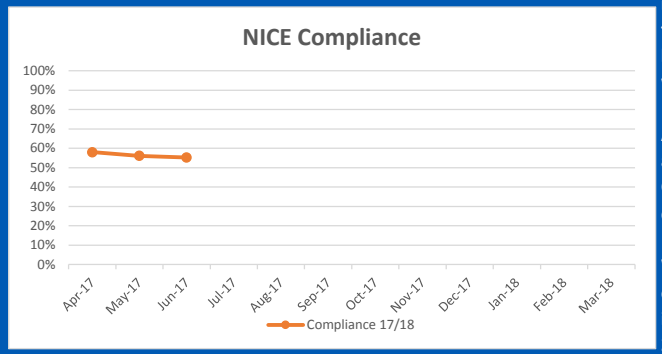
Quality Improvement - Trust Position

Description	Aggregate Position	Trend	Variation
Clinical Effectiveness			
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.**		**In July each year HED receive 'month 13' data , which is not a new month's worth of data, but a 'refresher file' where Trusts have cleaned up their data up to the end of the financial year. In August, we receive 2 months' worth of data (April & May) all in one go, and then the normal pattern of receiving 1 month's new data each month continues. Because of this, in July we will only be able to report mortality data up to the end of March.**
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.**		**In July each year HED receive 'month 13' data , which is not a new month's worth of data, but a 'refresher file' where Trusts have cleaned up their data up to the end of the financial year. In August, we receive 2 months' worth of data (April & May) all in one go, and then the normal pattern of receiving 1 month's new data each month continues. Because of this, in July we will only be able to report mortality data up to the end of March.**
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.**	**No threshold.**		We screen all deaths within the Trust to ascertain if any harm has been caused. For the month of June no harm was identified.

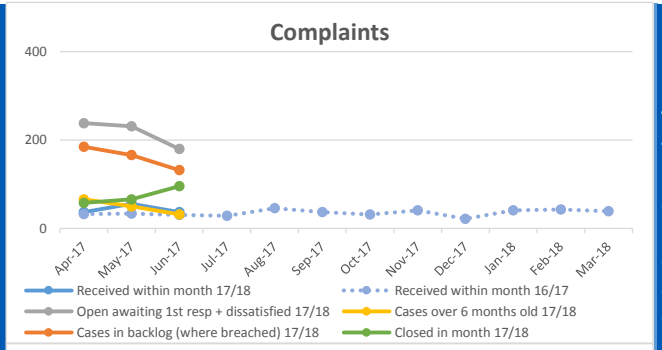
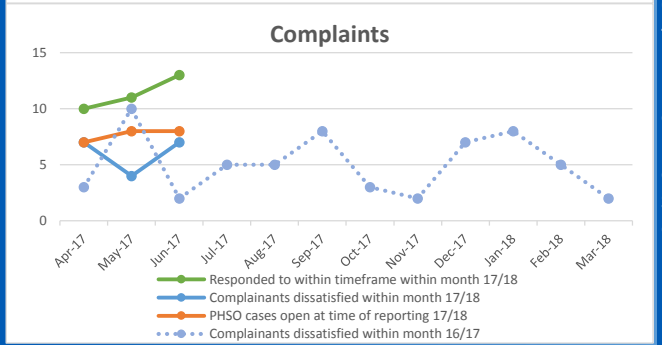
Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - June 2017

Quality Improvement - Trust Position

Description	Aggregate Position	Trend	Variation
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.		Although there has been a slight increase in the number of pieces of NICE Guidance that have moved from “Partial Compliance” to “Full Compliance” there have been a number (10) that have not been assessed within the time periods. Assessment of NICE Guidance compliance and any associated risks will greatly improve when the new Clinical Effectiveness Team is in place and we have a dedicated NICE Guidance Facilitator. Work is ongoing with Clinical Directors to improve compliance with NICE and it is expected that a marked increase in compliance will be in place by October 2017.

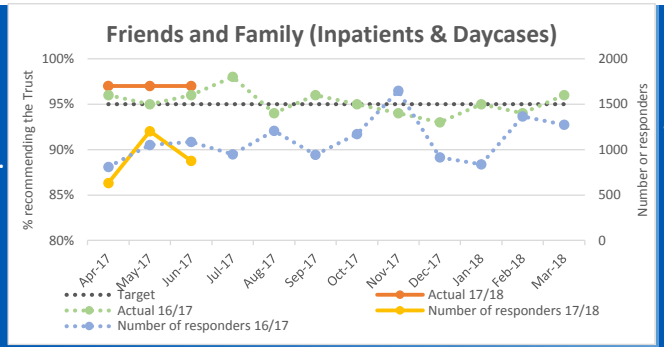
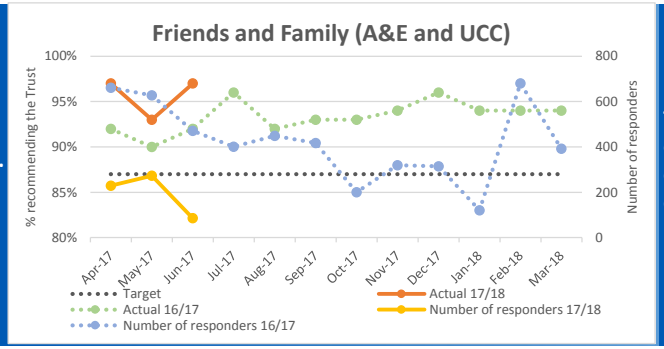
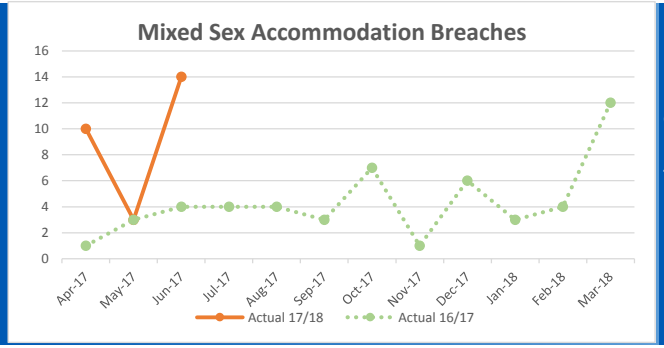
Patient Experience

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.	Targets to be set.	 	The number of complaints received is based on those cases "opened" in month, and not date "first received", in order to ensure a more accurate picture given the historic issues with missed cases. The Trust wide figure will not always match the total cases assigned to ACS or SWC as there are additional complainants assigned to the Corporate Directorate. In month, 6 cases were treated as "high" risk and therefore the subject of a 72hr review. Weekly performance meeting with Divisions and the Chief Nurse / Deputy Director of Governance to monitor complaints performance and to focus areas for improvement. There are currently 180 open complaints, of which; 80 relate to Acute Care Services, 87 relate to Surgery and Women & Children’s and 13 relate to Corporate Services.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - June 2017

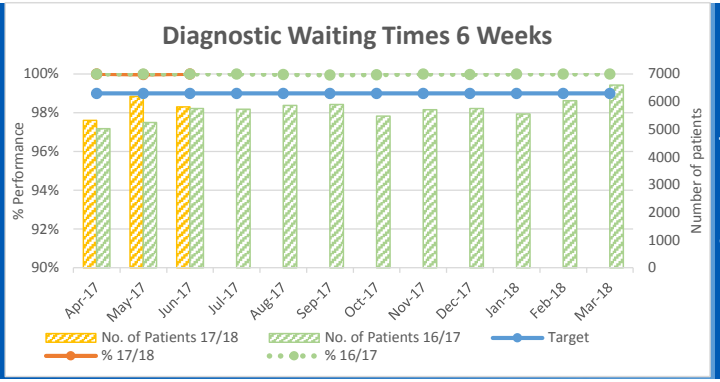
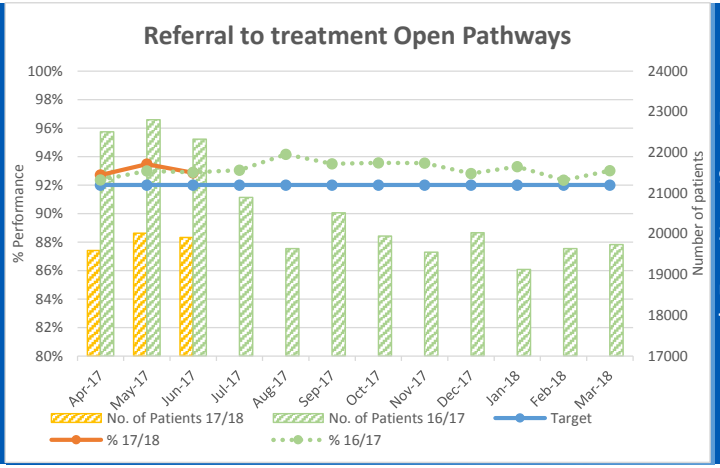
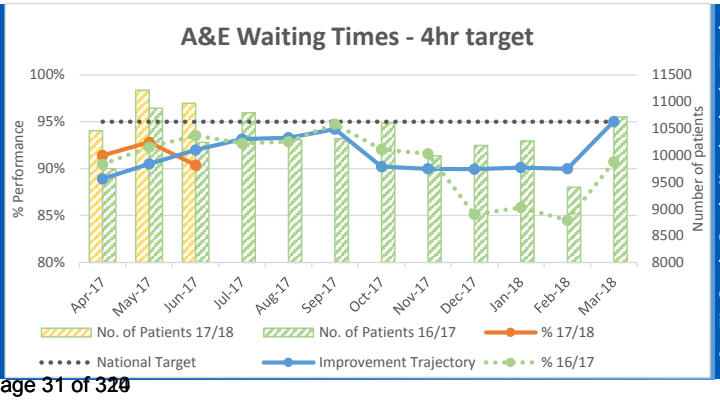
Quality Improvement - Trust Position

	Description	Aggregate Position	Trend	Variation
Friends and Family (Inpatients & Day cases) Red: Less than 95% Green: 95% or more	Percentage of Inpatients and daycase 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%.		We have continued to achieve 97% of our patients recommending the Trust. However, the overall number of responders has decreased in the last month.
Friends and Family (A&E and UCC) Red: Less than 87% Green: 87% or more	Percentage of AED (Accident and Emergency Department) patients recommending the Trust : Patients are asked - How likely are you to recommend our AED to friends and family if they needed similar care or treatment?	The target set is to achieve over 87%.		The target set is to achieve over 87% and 97% of our patients recommend the Trust. However, the overall number of responders has significantly decreased to only 86 responses from 6419 eligible responders.
Mixed Sex Accommodation Breaches Red: 1 or more Green: Zero	We submit data to NHS England in relation to the number of occurrences of unjustified mixing in relation to sleeping accommodation.	There is a target of zero tolerance.		MSA breaches continue to be closely monitored by the operational teams. It should be noted that only Critical Care & Coronary Care step down breaches occur due to capacity challenges within the Trust. The CCG's have now agreed that an Route cause analysis is not required for each MSA breach, they have requested the breach information in the form of a spreadsheet each month.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - June 2017

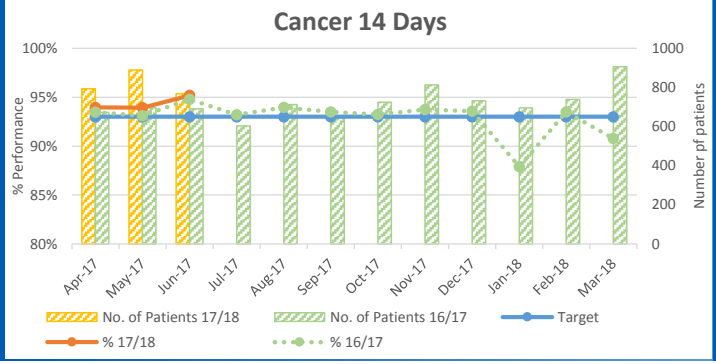
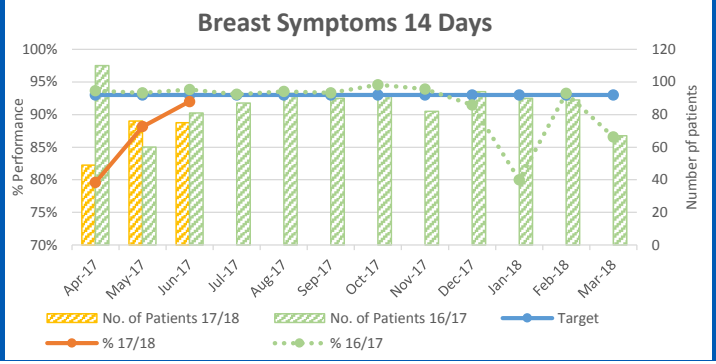
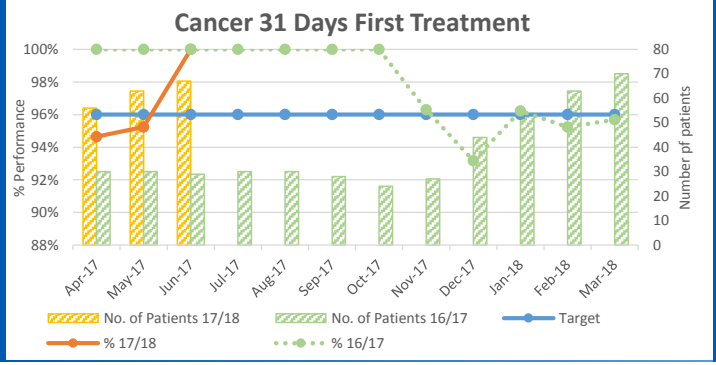
Mandatory Standards - Access & Performance - Trust Position

	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 national target of 99% for Diagnostic waiting times has been achieved with actual performance at 100%. The Trust has also met the STP Improvement trajectory.		There were 4 gynae and 4 pathology breaches at the end of Quarter 1 however despite this the quarter was achieved.
Referral to treatment Open Pathways Red: Less than 92% Green: 92% or	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.	Open pathways continue to perform above the 92% target. The Trust has also met the STP improvement trajectory.		RTT Position for June : 92.86% achieved standard by 172 patients 2 Specialties failed: Urology – 85.36% failed by 104 patients T&O – 84.86% Failed by 196 patients
RTT - Number of patients waiting 52+ weeks Green = 0, otherwise Red				
A&E Waiting Times - National Target Red: Less than 95% Green: 95% or above	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 is not achieving the 95% national 4 hour target but is meeting the STP improvement trajectory.		The Trust achieved Quarter 1 of the agreed improvement trajectory. At week one of the second quarter the Trust delivered 96% for the 1st week in July and just under 93% for the second. We are experiencing a significant peak in ambulance arrivals in the evening and early hours staffing gaps over night. Focus is now on zero tolerance to non admitted breaches, plan commencing week of the 17th July including ENP support later on nights and additional triage support in the evenings.
A&E Waiting Times - STP Trajectory Red: Less than trajectory Green: Trajectory or				

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - June 2017

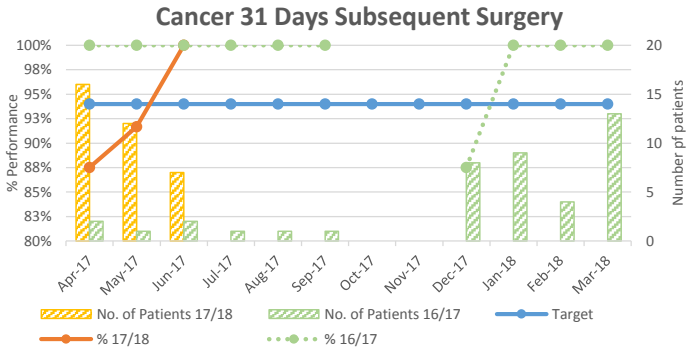
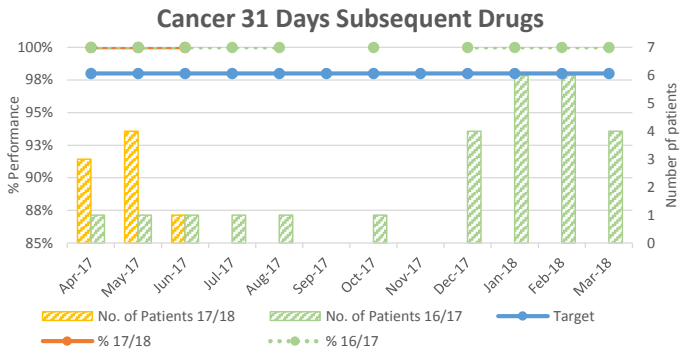
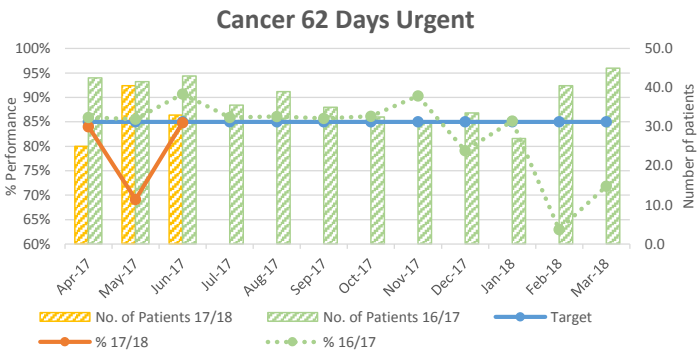
Mandatory Standards - Access & Performance - Trust Position

	Description	Aggregate Position	Trend	Variation
Cancer 14 Days Red: Less than 93% Green: 93% or above	All patients need to receive first appointment for cancer within 14 days of urgent referral. The national target is 93%. This target is measured and reported on a quarterly basis.			Since the introduction of the robust process introduced by the Cancer Management team in January 2017 there have been no breaches of this target.
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.			Following a review of capacity and demand the team are now reducing clinic waiting times down by forward planning and running extra sessions to work towards day 7 for a booking. Thus allowing patients some flexibility in their attendance. Consultant teams have delivered extra sessions through April, May and June to bring the waits down and regular reviews happen weekly to react quickly should there be a spike in referrals.
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.			For the first week in July we continue to achieve this target from Diagnosis To First Treatment . The Trust Achieved Quarter 1.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - June 2017

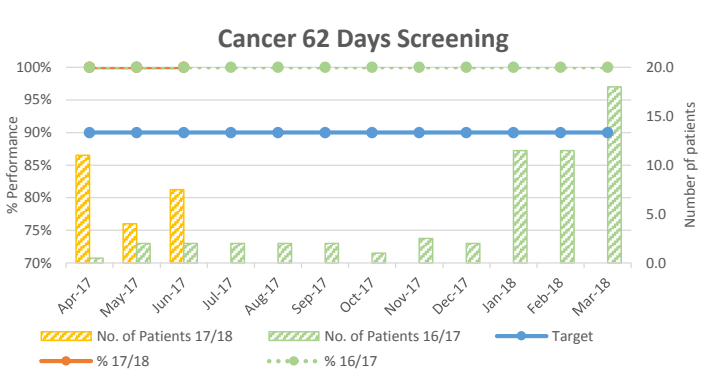
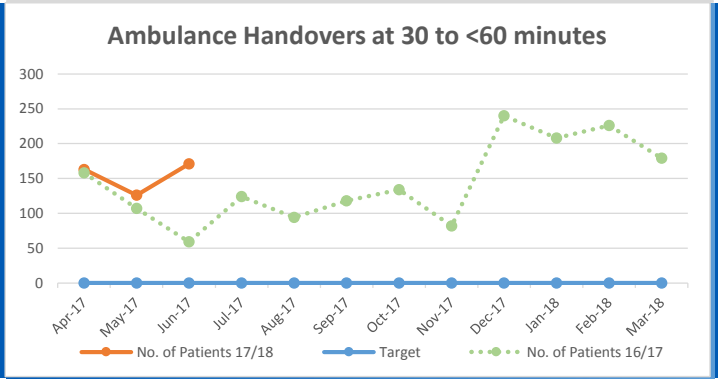
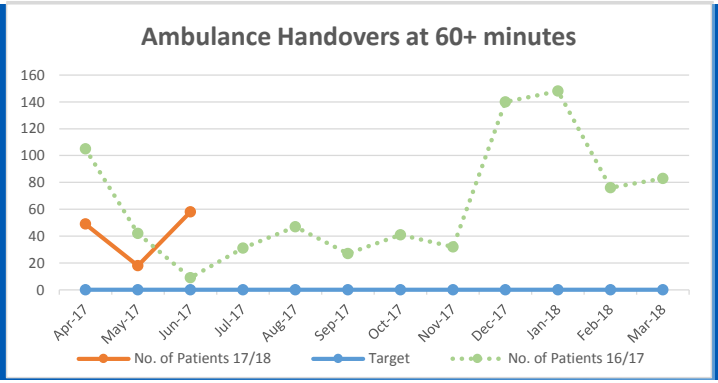
Mandatory Standards - Access & Performance - Trust Position

	Description	Aggregate Position	Trend	Variation
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.			We have achieved 100% for June and continue to be on track in the first two weeks of July.
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.			We achieved Quarter 1, although please note closure is not until 4th August, but internal monitoring assures we continue to be on track.
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 did not achieve 62 day target but is working to recover this position in Quarter 2. The Trust is working with NHSE on the national agenda for cancer to ensure achievement of this target. Failures are not entirely due to our Trust process but are reliant on other Trust's to refer and treat patients within target time. We now have robust mechanisms in place to track patients and ensure referral to tertiary centres by day 38. We have gone back to basics in Quarter 1 tracking patients as at the beginning of April we were tracking over 750 patients, this has now been reduced to 400 which is more manageable. This position does not close till 04/08/2017 and validation remains ongoing with partner organisations.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - June 2017

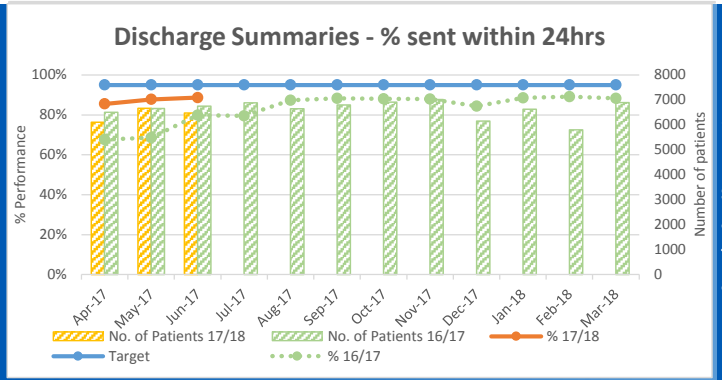
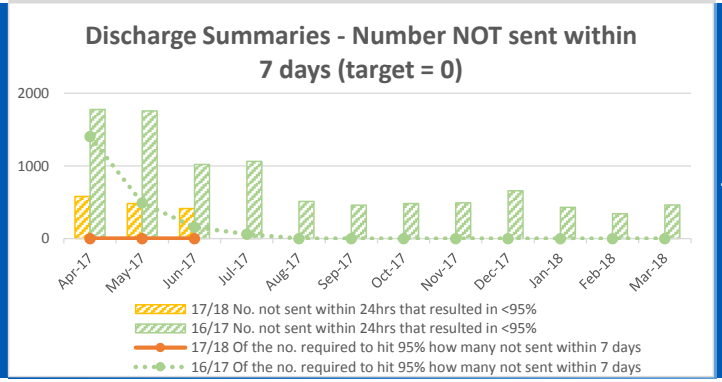
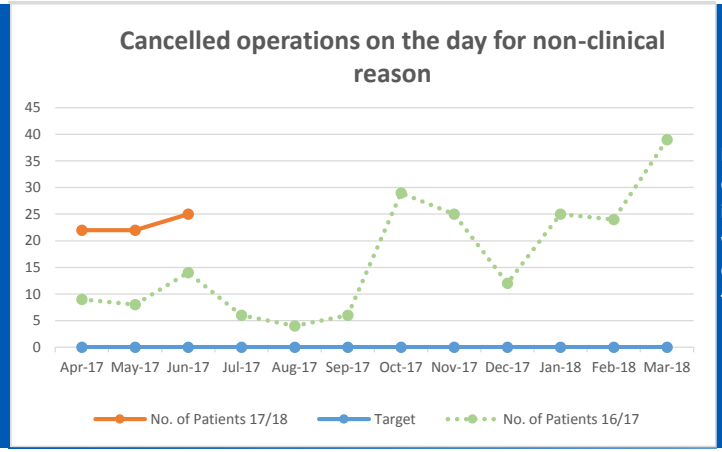
Mandatory Standards - Access & Performance - Trust Position

	Description	Aggregate Position	Trend	Variation
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			We achieved the target for quarter 1 and continue to be on track in July.
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)			The Trust continues to make good progress & works closely with NWAS on an improvement trajectory. The greatest challenge is the high volume of arrivals of ambulances from 21:00pm into the early hours of the morning where medical staffing is limited. We are reviewing staffing arrangements in an attempt to cover if we are successul we expect to see achievement of this target.
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)			The Trust continues to make good progress & works closely with NWAS on an improvement trajectory. The greatest challenge is the high volume of arrivals of ambulances from 21:00pm into the early hours of the morning where medical staffing is limited. We are reviewing staffing arrangements in an attempt to cover if we are successul we expect to see achievement of this target.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - June 2017

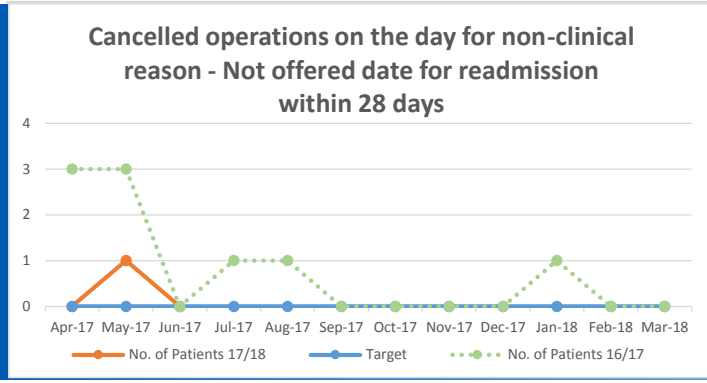
Mandatory Standards - Access & Performance - Trust Position

	Description	Aggregate Position	Trend	Variation
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			Each CBU has data shared daily and improvement trajectories set by the Deputy Medical Director. We have seen significant improvements and a task and finish group has been established to complete the final actions to support achivement.
Discharge Summaries - Number NOT sent within 7 days Red: Above 0 Green: 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			There are no issues with this target.
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			In Quarter 1 there were a number of elective orthopaedic cancellations due insufficent bed capacity. The divisions are working on a bed reconfiguration model to expand the capacity. The division continues to monitor this closely.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - June 2017

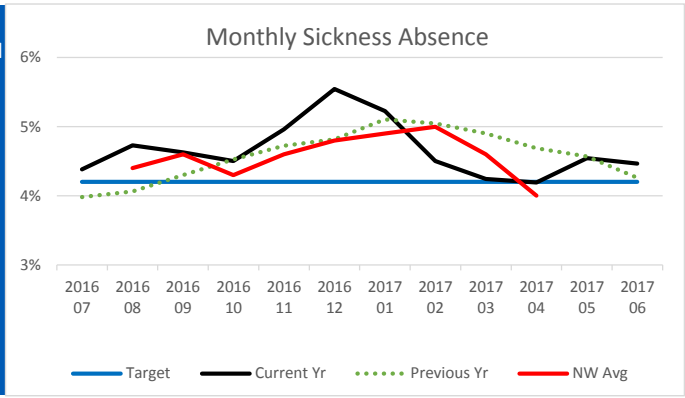
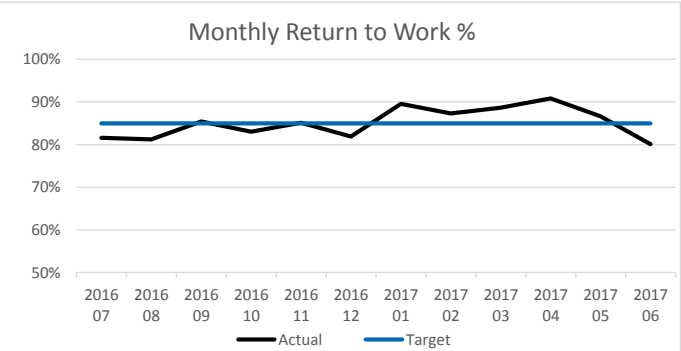
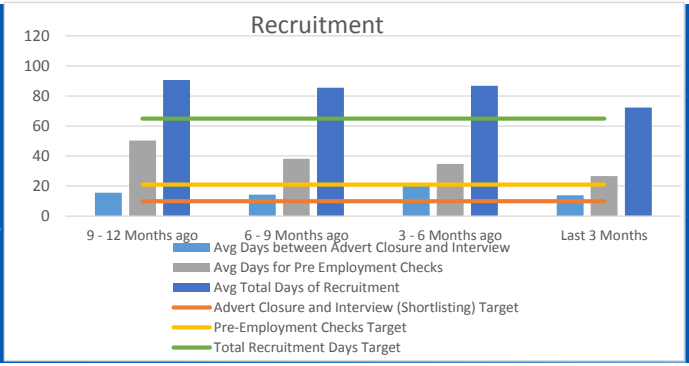
Mandatory Standards - Access & Performance - Trust Position

	Description	Aggregate Position	Trend	Variation
Cancelled Operations on the day for a non-clinical reason - Not offered a date for readmission within 28 days of the cancellation Red: Above zero	All service users who have their operation cancelled on the day or after admission for a non-clinical reason, should be offered a binding date for readmission within 28 days			There were no breaches for Quarter 1.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - June 2017

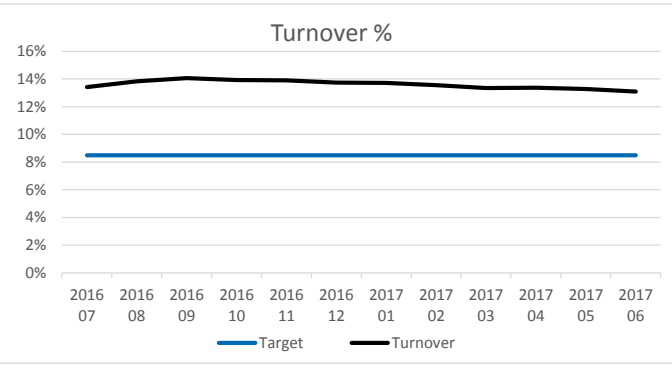
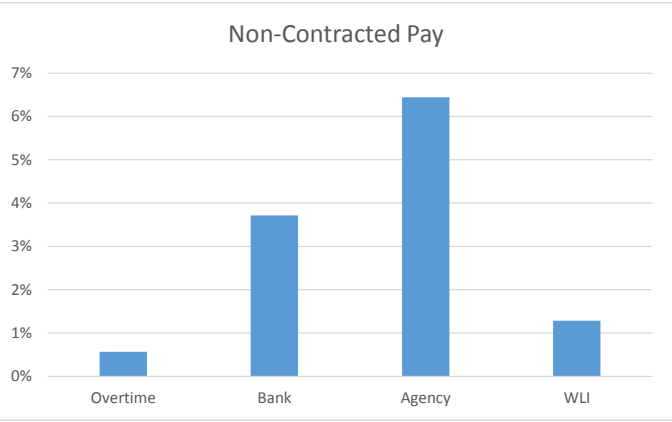
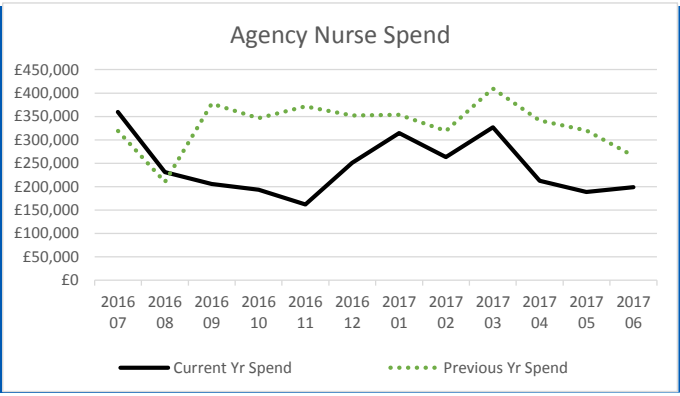
Workforce

	Description	Aggregate Position	Trend	Variation
Sickness Absence Red: Above 4.5% Amber: 4.2% to 4.5% Green: Below 4.2%	Comparing the monthly sickness absence % with the Trust Target (4.2%) previous year, and North West average	Sickness absence for June 2017 decreased from the previous month and was 4.46% but this was higher than the same month last year (4.26%). The cumulative position from April - June is 4.4%. Therefore the trust target of 4.2% is not quite being met. The latest figure(April 2017) for the North West absence performance was 4% (WHH was 4.19%)		Managers are reminded each month about the need for absence being input in a timely manner. The revised Attendance Management Policy was implemented on 1.12.16 and from January 2017 the position is generally better than the same 5 month period in 2016 although June was higher. Sickness for the Divisions is as follows: ACS - June-17 = 4.74% Red SWC - June-17 = 4.74% Red Corporate - June -17 = 3.8% Green Stress remains the number one reason for absence with 24% of all sickness absence due to stress.
Return to Work Red: Below 75% Amber: 75% to 85% Green: Above 85%	A review of the completed monthly return to work interviews.	RTW compliance reduced to 80.11% for June against a target of 85%.		Although the Trust target has apparently not been met, a pattern seems to be emerging that some RTW interview dates seem to be being input after the cut off date for running this report. In previous Board reports it has been reported that the RTW rate has not met the target but when the report has been run again, it is clear that further information is being input, to the extent that the target has been met for the last 5 months. Monitoring at Performance Improvement meetings held by HRBPs and the Director of HR & OD will continue in an effort to increase compliance and improve timely recording.
Recruitment Red: Above Target Green: On or Below Target	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	The average total days to recruit over the 3 month period ending June 2017 has improved from 78.8 days (May) to 72.2 days against a target of 65 days. The position 9 - 12 months ago was 90.6 days.		There is still room for improvement at each of the recruitment stages. However, the time taken from advert closure to interview (13.9 days) has significantly improved from the previously reported position of 17.8 days and the time taken for employment checks has improved from 27.5 days to 26.6 days over the same period. Work is currently being undertaken to combine the ECF and New Starter form to improve the efficiency and a new approval process is being implemented for the Divisions and Corporate areas.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - June 2017

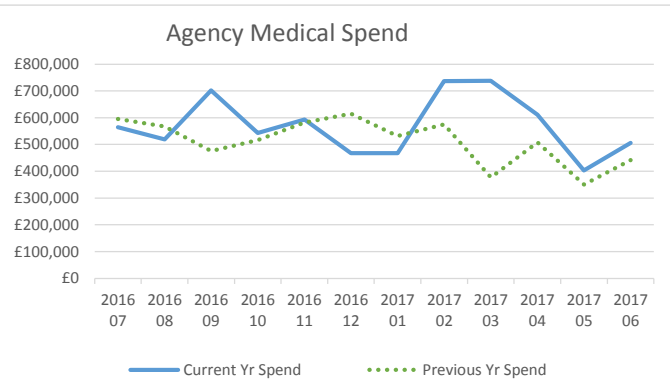
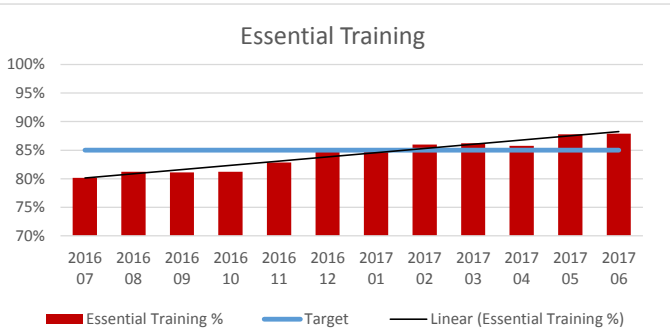
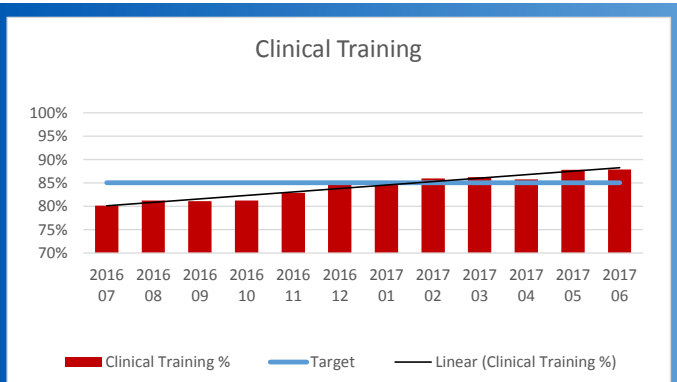
Workforce

	Description	Aggregate Position	Trend	Variation
Turnover Red: Above 12% Amber: 10% to 12% Green: Below 10%	A review of the turnover percentage over the last 12 months	Turnover marginally improved to 13.09% for the period up to June 2017. The status remains as 'red' and the target of 7 - 10% is not being met.		The various measures put in place such as exit/aspiration interviews, on-boarding, improved induction, development opportunities, flexible working etc are gradually having a positive impact on reducing labour turnover. The new Recruitment and Retention Plan for Nursing staff is also supporting this work. This is reflected in the downward trend over the last 9 months. The Trust continues to have more starters (40.8wte) than leavers (37.4 wte) which means that there are 41 more staff working at the trust than 12 months ago.
Non Contracted Pay	A review of the Non-Contacted pay as a percentage of the overall pay bill year to date	Agency spend remains the highest element of Non-Contracted pay, accounting for 6.44% of the Trusts overall pay bill. Bank spend is 3.71% followed by WLI spend at 1.28% and then overtime at 0.57% of the pay bill. Overall Non-Contracted pay now makes up 12%.		All elements of the non-contracted spend have reduced from the previous month. However, the Trust still has a high reliance on non-contracted pay and increasingly so for therapy and medical staff. Agency expenditure is reviewed at FSC and at the Pay Spend and Review Group. This Group is concentrating on examining all spend within the Trust and mapping this against various schemes to identify any gaps. NHSI have set the trust new targets for medical locum/agency expenditure. WLI payments as a proportionate of total spend are at their lowest level for more 12 months.This reflects the reduction implemented in October 2016 and better management of lists.
Agency Nurse Spend Red: Greater than Previous Yr Green: Less then Previous Yr	A review of the monthly spend on Agency Nurses	Agency Nurse spend increased slightly by £10k in June to £199k but was considerably lower than the same month last year (£266k). Overall agency nurse spend is less than the same period in 2016/17		Whilst it is positive that there has been a reduction in agency nursing expenditure, there has been a corresponding increase in bank expenditure. This was to be expected as the trust tries to encourage agency workers to join the bank. Overall it is more cost effective to have staff working through a bank than an agency. The Recruitment and Retention Plan for Nursing continues to be implemented and an Open Day was held on 15.6.17. where 58 nurses were offered posts. C.99 nurses in total have ben appointed and are awaiting clearance or qualification.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - June 2017

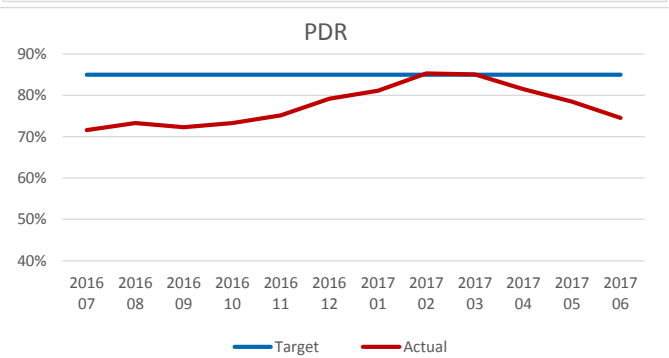
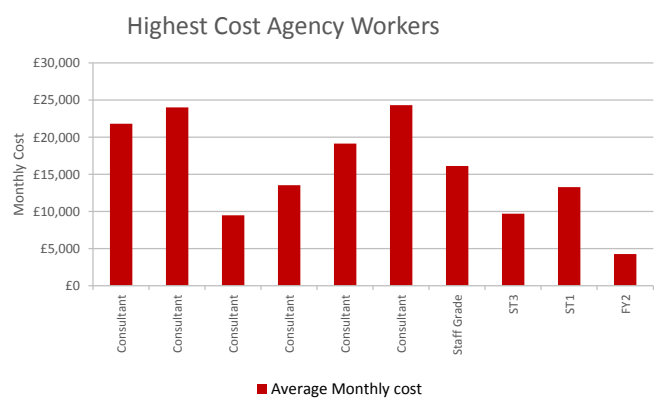
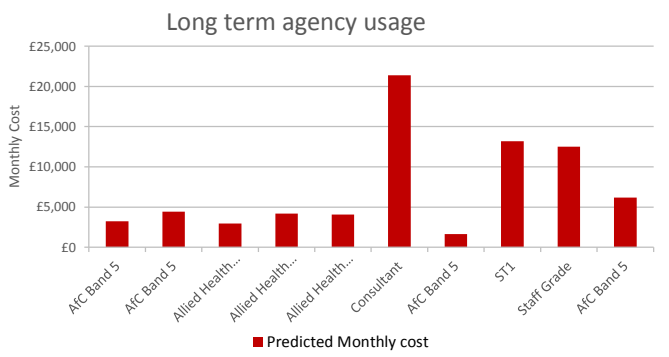
Workforce

	Description	Aggregate Position	Trend	Variation
Agency Medical Spend Red: Greater than Previous Yr Green: Less then	A review of the monthly spend on Agency Locums	Agency Medical spend increased significantly in June to £506k which was a increase of £103k from May and was higher than the same month last year (£442k). Overall agency medical spend is more than the same period in 2016/17		Enforcing the Price Cap rules is continuing to prove difficult and the majority of shifts worked each week breach the Price Cap particularly in Specialist Medicine but these are necessary to maintain patient safety. There continues to be some progress in appointing new consultant staff and persuading some agency medical staff to work through the Trust bank. The Gatenby Sanderson project went live w/c 17.4.17. Two responses were received in relation to the vacancies for Consultants in Respiratory Medicine, both of whom were appointed. There was no response to an advert for Elderly Medicine. Adverts have also appeared for Haematology, Acute Medicine and an Intensivist.
Essential Training Red: Below 70% Amber: 70% to 85% Green: Above 85%	A summary of the Essential Mandatory Training Compliance, this includes: Corporate Induction Dementia Awareness, Fire Safety Health and Safety Moving and Handling	The compliance rate for June was 89.12% and the target of 85% has consistently been met for almost a year.		The HR Business Partners are continuing to highlight the importance of mandatory training at Divisional meetings and at Ward/Departmental meetings. The Trust target has now been met for 11 consecutive months and the last 6 months have been at 89%. At the Performance Improvement meetings, the Director of HR & OD reviews the progress as part of the People Measures pilot. Divisional progress is as follows: ACS June = 90.15% Green SWC June = 87.05% Green Corp June = 90.63% Green
Clinical Training Red: Below 70% Amber: 70% to 85% Green: Above 85%	A summary of the Clinical Mandatory Training Compliance, this includes: Infection Control Resus Safeguarding Procedures (Adults) - Level 1 Safeguarding Procedures (Adults) - Level 2 Safeguarding Procedures (Children) - Level 1 Safeguarding Procedures (Children) - Level 2 Safeguarding Procedures (Children) - Level 3 SEMA	The upward trend continues and the compliance rate for June is 87.87% which is above the trust target of 85%.		The HR Business Partners are continuing to highlight the importance of mandatory training at Divisional meetings and at Ward/Departmental meetings. The Trust target has now been met for 6 consecutive months. At the Performance Improvement meetings, the Director of HR & OD reviews the progress as part of the People Measures pilot. Divisional progress is as follows: ACS June = 87.35% Green SWC June = 86.42% Green Corp June = 91.91% Green

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - June 2017

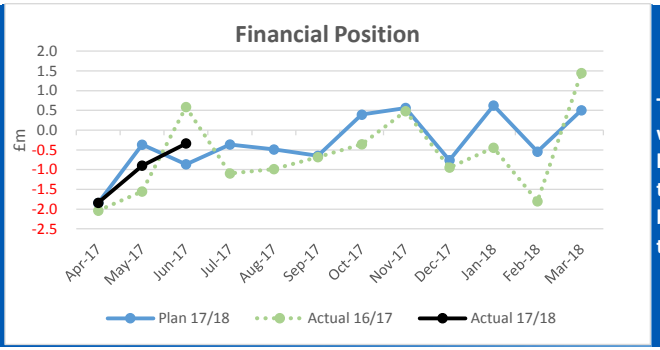
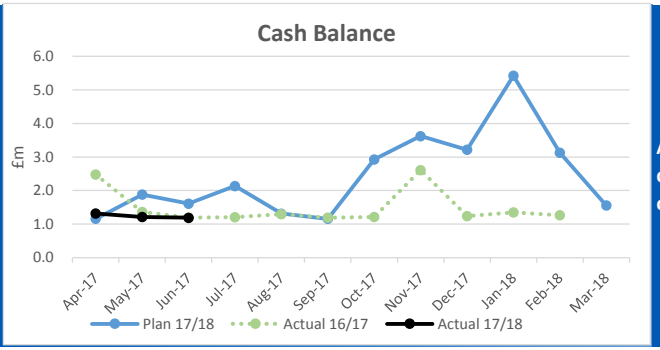
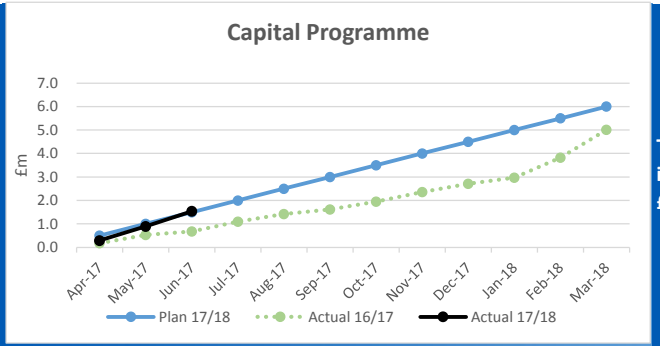
Workforce

	Description	Aggregate Position	Trend	Variation
PDR Red: Below 70% Amber: 70% to 85% Green: Above 85%	A summary of the PDR Compliance rate	The compliance rate for PDRs decreased from 78.47% in May to 74.55% in June. Therefore, the Trust target of 85% is not being met.		From reaching the Trust target in February and sustaining this for March, it is disappointing that there has been a downward trend since then over the subsequent 4 months. Operational pressures are likely to be suggested as the reason for this but the Divisions are keen to reverse this situation and have put plans in place to retrieve the situation. At the Performance Improvement meetings, the Director of HR & OD reviews will re-iterate this message and continue to monitor progress as part of the People Measures pilot. Divisional progress is as follows: ACS June = 71.03% Amber SWC June = 76.48% Amber Corp June = 76.32% Amber
Highest Cost Agency Workers	A summary of the Top 20 highest agency earners over the last 12 months	NHSI have very recently changed the reporting arrangements for the highest earning agency workers. Previously the trust was required to report the Top 20 highest earning agency workers over the last 12 months. Now trusts are required to report the Top 10 highest earning agency workers for the previous week. The Trust uses TempRe for medical/AHP staff and NHSP for nursing staff. For other staff, this is more difficult and relies on more manual systems which are being refined. The graph shows the weekly cost of the top 10 agency earners for the most recently reported position.		All of the highest earners are medical staff. Earnings range from c£4600 - £8400 per week. Efforts are continuing with the medical agencies to try and reduce the rates for the remaining agency workers or to attract them onto the Trust payroll.
Long Term Agency Usage	A summary of agency workers who have been working at the trust every month for over 6 months	NHSI have very recently changed the reporting arrangements for long term agency workers. Previously long term agency workers were defined as working at the trust every month for over 6 months and all staff had to be reported. Now trusts are required to report the Top 10 agency workers who have worked at the trust for a minimum of 3 shifts per week for 6 consecutive weeks.The graph shows the Top 10 agency workers by staff group who have been working at the trust for more than 6 weeks.		3 of the staff are nurses, 3 are doctors, 2 are therapists and 2 are pharmacists. The length of time these staff have worked at the Trust range from 8 - 32 months. In all cases they are covering vacancies and have fixed term contracts which are regularly reviewed dependent upon progress with the filling of substantive posts. Efforts continue to try and persuade these staff to work directly for the Trust.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - June 2017

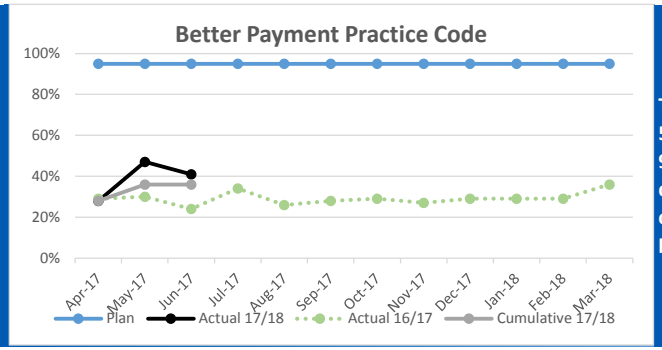
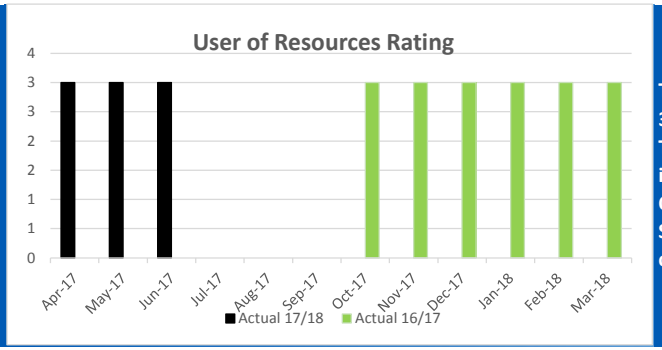
Sustainability & Mandatory Standards - Finance

	Description	Aggregate Position	Trend	Variation
Financial Position Red: Deficit Position Amber: Actual on or better than planned but still in deficit Green: Surplus Position	Surplus or deficit compared to plan	The actual deficit in the month is £0.3m which increases the cumulative deficit to £3.1m.		The cumulative deficit of £3.1m is in line with the planned deficit. There are however a number of risks to delivering the control total. Action plans have been requested from CBUs to mitigate the risk.
Cash Balance Red: Less than 90% or below minimum cash balance per NHSI Amber: Between 90% and 100% of planned cash balance Green: On or better than plan	Cash balance at month end compared to plan	The cash position is £1.2m which equates to circa 2 days operational cash.		A cash balance of £1.2m is required to comply with the terms and conditions of the working capital loan.
Capital Programme Red: Off plan <80% - >110% Amber: Off plan 80-90% or 101 - 110% Green: On plan 90%-100%	Capital expenditure compared to plan. The capital plan has been increased to by £1.0m to £7.0m in respect of the Department of Health funding for the implementation of primary care streaming in A&E.	The actual capital spend in the month is £0.6m which increases the cumulative spend to £1.5m.		The cumulative capital spend of £1.5m is £0.2m below the planned spend of £1.7m.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - June 2017

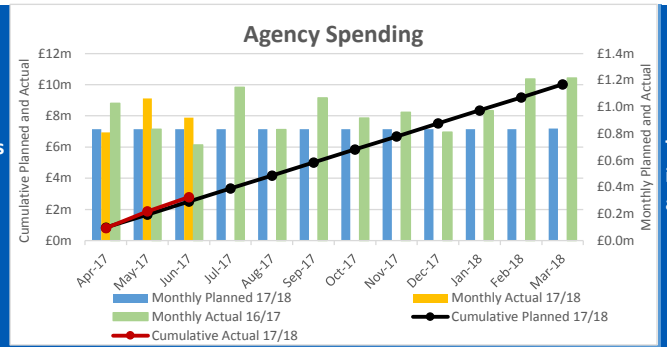
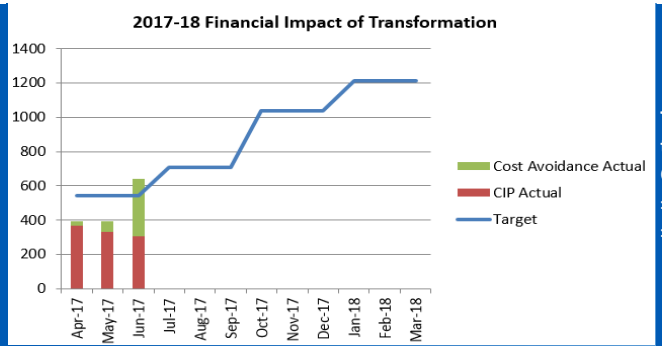
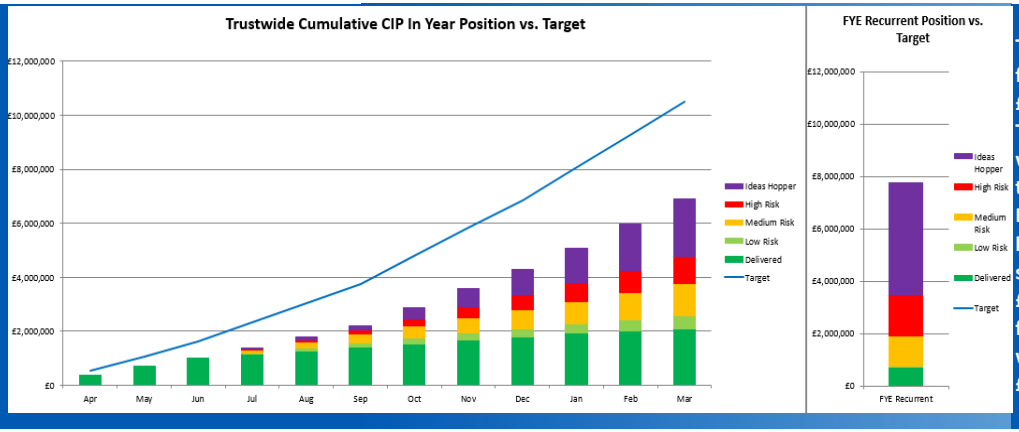
Sustainability & Mandatory Standards - Finance

	Description	Aggregate Position	Trend	Variation
Better Payment Practice Code Red: Cumulative performance below 85% Amber: Cumulative performance between 85% and 95% Green: Cumulative performance 95% or better	Payment of non NHS trade invoices within 30 days of invoice date compared to target.	In month the Trust has paid 41% of suppliers within 30 days which results in a year to date performance of 36%.		The cumulative performance of 36% is 59% below the national standard of 95%. This continues to be a challenge due to the liquidity of the Trust. The cash position is managed on a daily basis.
Use of Resources Rating Red: Use of Resource Rating 4 Amber: Use of Resource Rating 3 Green: Use of Resource Rating 1 and 2	Use of Resources Rating compared to plan.	The current Use of Resources Rating is 3. Capital Servicing Capacity, Liquidity and I&E margin are all scored at 4 (lowest) and Variance to Control Total and Agency Ceiling is scored at 1 (highest).		The current Use of Resources Rating of 3 is in line with the planned rating of 3. The Use of Resource Rating was introduced as an indicator by NHSI in October 2016. Therefore April 2017 - September 2017 will have no comparable previous year data.
Fines and Penalties Red: Greater than zero Green: Zero	Monthly fines and penalties			The Trust has received notification from the commissioners of fines and penalties for month 1. This is currently being reviewed by the Trust. £15k fines and penalties has been included in the financial position.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - June 2017

Sustainability & Mandatory Standards - Finance

	Description	Aggregate Position	Trend	Variation
Agency Spending Red: More than 105% of ceiling Amber: Over 100% but below 105% of ceiling Green: Equal to or less than agency ceiling.	Agency spend compared to agency ceiling	The actual agency spend in the month is £0.9m which increases the cumulative spend to £2.8m.		The cumulative agency spend of £2.8m is £0.3m (12%) above the cumulative agency ceiling of £2.5m.
Cost Improvement Programme - In year performance to date Red: Cumulative CIP savings are less than 50% of planned YTD savings Amber: Cumulative CIP savings are between 50% and 90% of YTD planned savings	Cost savings delivered year to date compared to year to date plan.	CIP savings delivered M3 YTD are £1.m against the M3 target of £1.6m a further £0.4m M3 YTD has been delivered in cost avoidance/income recovery.		The YTD M3 financial impact of transformation activities is £1.4m (£1m CIP & £0.4m cost avoidance) this is £0.2m below the Trust M3 CIP target of £1.6m.
Cost Improvement Programme - Plans in Progress - In Year/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 - In Year & Recurrent forecast vs £10.5m target			The worst case current in year forecast for Trust CIP schemes is £3.5m which is £6.9m below the CIP target of £10.5m. The best case for CIP in year is £6.9m which is still £3.6m below the CIP target. Best case cost avoidance of £1.8m will help mitigate the position but would still leave a bottom line shortfall of £1.7m. Recurrent - The best case forecast for recurrent CIP is £7.8m. The worst case forecast for recurrent CIP is £1.8m.

Appendix 2 – KPI RAG Rating April 2017 – March 2018

	KPI	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
	QUALITY												
1	Incidents												
2	Duty of Candour												
3	Safety Thermometer												
4	Healthcare Acquired Infections												
5	VTE Assessment												
6	Safer Surgery												
7	CQUIN Sepsis AED Screening												
8	CQUIN Sepsis Inpatient Screening												
9	CQUIN Sepsis AED Antibiotics												
10	CQUIN Sepsis Inpatient Antibiotics												
11	CQUIN Sepsis Antibiotic Review												
12	Total Falls & Harm Levels												
13	Pressure Ulcers												
14	Medication Safety												
15	Staffing – Average Fill Rate												
16	Staffing – Care Hours Per Patient Day												
17	Mortality ratio - HSMR												
18	Mortality ratio - SHMI												
19	Total Deaths												
20	NICE Compliance												
21	Complaints												
22	Friends & Family – Inpatients & Day cases												
23	Friends & Family – A&E and UCC												
24	Mixed Sex Accommodation Breaches												
	ACCESS & PERFORMANCE												
25	Diagnostic Waiting Times 6 Weeks												
26	RTT - Open Pathways												
27	RTT – Number Of Patients Waiting 52+ Weeks												

Appendix 2 – KPI RAG Rating April 2017 – March 2018

28	A&E Waiting Times – National Target												
29	A&E Waiting Times – STP Trajectory												
30	Cancer 14 Days												
31	Breast Symptoms 14 Days												
32	Cancer 31 Days First Treatment												
33	Cancer 31 Days Subsequent Surgery												
34	Cancer 31 Days Subsequent Drug												
35	Cancer 62 Days Urgent												
36	Cancer 62 Days Screening												
37	Ambulance Handovers 30 to <60 minutes												
38	Ambulance Handovers at 60 minutes or more												
39	Discharge Summaries - % sent within 24hrs												
40	Discharge Summaries – Number NOT sent within 7 days												
41	Cancelled Operations on the day for a non-clinical reason												
42	Cancelled Operations on the day for a non-clinical reason – Not offered a date for readmission within 28 days of the cancellation												
	WORKFORCE												
43	Sickness Absence												
44	Return to Work												
45	Recruitment												
46	Turnover												
47	Non Contracted Pay												
48	Agency Nurse Spend												
49	Agency Medical Spend												
50	Essential Training												
51	Clinical Training												
52	PDR												
53	Highest Cost Agency Workers												
54	Long Term Usage												
	FINANCE												
55	Financial Position												
56	Cash Balance												

Appendix 2 – KPI RAG Rating April 2017 – March 2018

57	**Capital Programme**												
58	**Better Payment Practice Code**												
59	**Use of Resources Rating**												
60	**Fines and Penalties**												
61	**Agency Spending**												
62	**Cost Improvement Programme – Performance to date**												
63	**Cost Improvement Programme – Plans in Progress**												

Appendix 3

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

FINANCE AND SUSTAINABILITY COMMITTEE

AGENDA REFERENCE:	**FSC/**
SUBJECT:	**Finance Report as at 30 June 2017**
DATE OF MEETING:	19 July 2017
ACTION REQUIRED	**For discussion**
AUTHOR(S):	Steve Barrow, Deputy Director of Finance
EXECUTIVE DIRECTOR	Andrea Chadwick, Director of Finance and Commercial Development
EXECUTIVE SUMMARY	For the period ending 30 June 2017 the Trust has recorded a deficit of £3.1m which is in line with plan, a cash balance of £1.2m and a Use of Resources Rating of 3.
RECOMMENDATIONS	The Committee is asked to note the contents of the report.
FREEDOM OF INFORMATION STATUS (FOIA):	Partial FOIA Exempt
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Section 41 – confidentiality

Appendix 3

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

FINANCE REPORT AS AT 30 JUNE 2017

1. PURPOSE

This report sets out the financial position of the Trust as at 30 June 2017.

2. EXECUTIVE SUMMARY

Year to date performance against key financial indicators is provided in the table below and further supplemented by the dashboard (Appendix A) and schedules (Appendices B to I) attached to this report.

Key financial indicators:

Indicator	Monthly Plan £m	Monthly Actual £m	Monthly Variance £m	YTD Plan £m	YTD Actual £m	YTD Variance £m
Operating income	19.3	19.7	0.4	57.2	57.5	0.3
Operating expenses (1)	(19.8)	(19.7)	0.1	(59.4)	(59.7)	(0.3)
Operating surplus/(deficit)	(0.5)	(0.0)	0.5	(2.2)	(2.2)	0.0
Non-operating expenses	(0.3)	(0.3)	0.0	(0.9)	(0.9)	0.0
Surplus/(deficit)	(0.8)	(0.3)	0.5	(3.1)	(3.1)	0.0
Control total adjustments	0.0	0.0	0.5	0.0	0.0	0.0
Control total	(0.8)	(0.3)	0.5	(3.1)	(3.1)	0.0
Cash balance	-	-	-	1.6	1.2	(0.4)
CIP target	0.5	0.3	(0.2)	1.6	1.0	(0.6)
Capital Expenditure	(0.7)	(0.6)	0.1	(1.7)	(1.5)	0.2

(1) Depreciation and amortisation and restructuring costs are now included in operating expenses (see section 3).

Headlines:

- The monthly position is a deficit of £0.3m which increases the year to date deficit to £3.1m which is in line with plan and delivers a Use of Resources Rating score of 3.
- **In order to deliver position reserves have been utilised which puts the annual plan at risk. A separate presentation setting out the risks and actions will be delivered at the July Finance and Sustainability Committee by the Director of Finance and Chief Operating Officer**.
- The annual cost savings target is £10.5m with planned savings to date of £1.6m. The savings delivered to date position is £1.0m (See agenda item Cost Improvement Report for further details).
- The actual capital expenditure to date is £1.5m which is £0.2m below the planned expenditure of £1.7m (section 4).
- The cash balance is £1.2m which is £0.4 below the planned balance of £1.6m (section 5).
- The Better Payment Practice Code performance based on volume is 41% for the month and 36% for the year to date (section 5).
- The value of aged debt is £5.6m (section 7).
- The value of aged creditors is £12.3m (section 8).

- The Trust has requested a 2017/18 working capital loan of £3.7m to support the planned deficit. The first instalment of £1.6m was been received in April at a 1.5% interest rate (see section 9).
- The Trust has not applied for a capital loan in 2017/18 (section 10).

3. INCOME AND EXPENDITURE (APPENDIX B)

In month the Trust has recorded a deficit of £0.3m which is £0.5m above the planned deficit of £0.8m. This increases the year to date deficit to £3.1m although this is in line with plan.

Operating Income

In month operating income is £0.4m above plan which results in a year to date position to £0.3m above plan. An analysis by income category is summarised in the table below.

Table: Analysis of monthly and year to date income variance by category.

Narrative	Monthly Variance £m	YTD Variance £m
NHS Clinical Income	0.3	0.1
Non NHS Clinical Income	0.0	0.0
Other Operating Income	0.1	0.2
Total Operating Income	**0.4**	**0.3**

Positive variance = above plan, negative variance = below plan.

NHS Clinical Income

In month NHS clinical income is £0.3m above plan which results in a year to date position to £0.1m above plan. The variances by point of delivery are summarised in the table below.

Table: Analysis of monthly and year to date NHS clinical activity and income variances by category.

Narrative	Monthly Variance Activity	Monthly Variance £m	YTD Variance Activity	YTD Variance £m
Elective Spells	(501)	(0.2)	(839)	(0.6)
Elective Excess Bed Days	(76)	0.0	57	0.0
Non Elective Spells	(26)	(0.1)	(116)	0.4
Non Elective Excess Bed Days	(192)	0.0	(68)	0.1
Outpatient Attendances	(850)	(0.1)	(2,949)	(0.3)
Accident & Emergency Attendances	949	0.1	2,419	0.1
Other Activity	-	0.6	-	0.4
Total NHS Clinical Income	**-**	**0.3**	**-**	**0.1**

Positive variance = above plan, negative variance = below plan.

The monthly and year to date income variance by Division is summarised in the following table.

Table: Analysis of monthly and year to date income variances by Division.

Narrative	Monthly Variance £m	YTD Variance £m
Acute Care Services	0.1	0.2
Surgery, Women's and Children	(0.2)	(0.6)
Non divisional	0.4	0.5
Total	**0.3**	**0.1**

Positive variance = above plan, negative variance = below plan.

A year to date analysis of NHS clinical income by category and Division, Clinical Business Unit and specialty is available at Appendices C and D. The main headlines for each division are as follows:

Acute Care Services

The year to date position is £0.2m above plan with an over recovery in Airways, Breathing and Circulation, Diagnostics and Specialist Medicine partially offset by an under recovery in Urgent and Emergency Care.

Surgery, Women's and Children

The year to date position is £0.6m below plan with an under recovery in Musculoskeletal Care, Specialist Surgery and Women's and Children's Health partially offset by an over recovery in Digestive Diseases.

The current activity plan includes £0.9m for spinal activity however NHS England is considering sending all spinal activity to The Walton Centre NHS Foundation Trust. This activity is not part of an agreed contract so there is no notice period. It is important that the cost base is reduced in line with the transfer of activity to minimise the financial loss to the Trust.

Fines and Penalties

Fines and penalties can be levied by commissioners for the non achievement of any national or local targets. However this excludes national standards relating to:

- A&E 4 hour performance
- Referral to Treatment Times (RTT)
- 62 Day Cancer Waits

The Trust has agreed performance improvement trajectories for these standards and will secure a proportion of the Sustainability and Transformational Funding (STF) provided the A&E 4 hour performance trajectory is achieved. This approach ensures that Trusts meeting the eligibility criteria for the STF monies will not face a "double jeopardy" whereby Trusts may incur contract fines or penalties as well as losing access to funding.

The year to date financial position includes £0.02m for fines or penalties relating to the non-achievement of applicable national or local targets specifically discharge summaries issued within 24 hours. In order to minimise and ideally negate any fine or penalty, lead executive directors have been assigned to each contract target to ensure greater focus on compliance. No funding has been set aside to cover the incurrence of fines and penalties so non achievement of any target is a risk to delivery of the Trust's control total.

Commissioning for Quality and Innovation (CQUIN)

The Trust is able to earn £4.5m for the delivery of CQUIN schemes and has assumed 100% of this income in this year's financial plan. £1.7m of funding is earned by achievement of the 2016/17 control total and supporting engagement with STPs, with the balance of £2.8m earned by achievement of national indicators.

CQUIN schemes have been agreed and assigned to a lead director to support the delivery of all schemes. In addition, investment of £0.4m has been provided to support the management and therefore delivery of the CQUIN programme. Monthly monitoring will be undertaken to identify schemes that require remedial action recovery plans to ensure compliance thereby minimising the level of financial risk. The agreed schemes, annual values and estimated year to date penalties are summarised in the table below:

Table: CQUIN schemes, annual values and estimated year to date penalties

Scheme	**Annual value £000**	**YTD Penalty £000**
Improvement of health and wellbeing of NHS staff	438	37
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)	438	8
Supporting proactive and safe discharge	438	0
Improving services for people with mental health needs who present to A&E	438	0
Offering advice and guidance	438	0
NHS E-Referrals	438	0
Preventing ill health by risky behaviours (alcohol and tobacco)	0	0
Breast screening programme clerical staff development (health promotion role)	21	0
Dental	33	0
Hospital Pharmacy Transformation and Medicines Optimisation	34	0
Nationally standardised dose banding for adult intravenous	51	0
Total	**2,767**	**45**

CQUIN schemes are there to promote high quality health and services, therefore commissioners have been approached to request that any penalty is reinvested back into the service to contribute towards the achievement of these targets.

Non NHS Clinical Income

In month and year to date non NHS clinical income is on plan.

Other Operating Income

Sustainability and Transformational Funding (STF)

The value of the 2017/18 STF monies available to the Trust from the general fund is £7.0m. Access to the monies is based on the ability to meet the control total (provided Trusts have agreed the control total) and performance against the A&E standard.

The funding is split across the following criteria:

- Delivery of the financial control total (70%)
- Delivery of the A&E 4 hour performance trajectory (15%)
- Progress on the key milestones for the implementation of A&E Streaming, signed off by NHSI (15%)

The funding is allocated after quarter end based on performance but rather than weighted equally across quarters funding is phased as follows:

- Quarter 1 (15%)
- Quarter 2 (20%)
- Quarter 3 (30%)
- Quarter 4 (35%)

Therefore the amount due in each quarter against each standard is summarised in the table below.

Table: analysis of fund by category by quarter.

Category	Quarter 1 £000	Quarter 2 £000	Quarter 3 £000	Quarter 4 £000	Total £000
Financial	738	984	1,476	1,722	4,920
A&E 4 hour	158	211	316	369	1,054
A&E Streaming	158	211	316	369	1,054
Total	**1,054**	**1,406**	**2,109**	**2,460**	**7,029**

The same principles that were applied in 2016/17 will continue in 2017/18 in that the financial control totals are a binary on/off switch to secure funding. In other words if the financial control total is not achieved then no funding is allocated for the A&E access standards.

There are no tolerances relating to either the delivery of financial or A&E access standards. However there is the opportunity to recover missed payments in later quarters.

Financial – this will operate on a cumulative basis so a Trust that misses the year to date control total for a quarter is able to recover the funding in futures quarter.

A&E Access standard – this will operate on a quarterly basis so a Trust that misses the access standard is unable to recover the funding in a future quarter.

In month other operating income is £0.1m above plan which increases the year to date position to £0.2m above plan. The other operating income includes the share of funding relating to the Sustainability and Transformation funding which is £0.4m in month and £1.1m year to date. The actual income for the month assumes that the Sustainability & Transformation funding will be received in full as the control total for the period has been delivered and the A&E access standards have been achieved.

Operating Expenses

In month operating expenses are £0.1m below plan which reduces the year to date position to £0.3m above plan. An analysis by expense type is summarised in the table below.

Table: Analysis of monthly and year to date income variance by category.

Narrative	Monthly Variance £m	YTD Variance £m
Pay	0.0	(0.6)
Drugs	0.0	0.2
Clinical Supplies and Services	0.0	(0.1)
Non Clinical Supplies	0.0	0.1
Depreciation	0.1	0.1
Total Operating Expenses	**0.1**	**(0.3)**

Positive variance = below plan, negative variance = above plan.

Pay

In month pay costs are £13.9m which is in line with plan. The year to date pay costs are £42.3m which is £0.6m above plan.

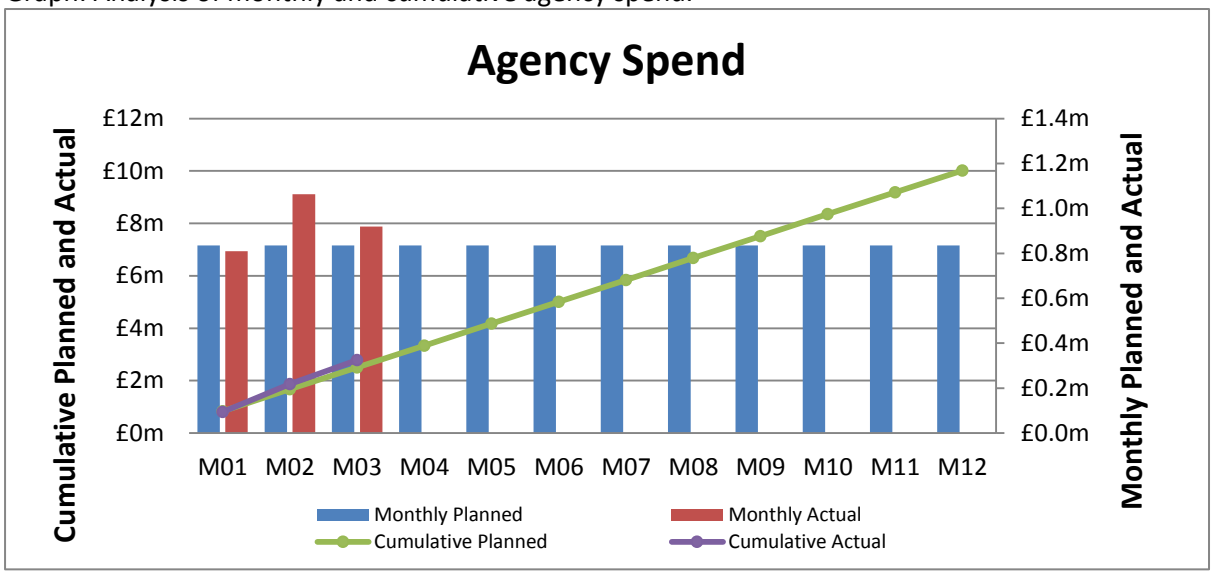
The pay spend includes the continued cost of temporary staffing including Bank, Agency costs, Waiting List Initiatives and additional hours paid at both plain time and enhanced rates. To date the actual expenditure is £5.6m which equates to £22.4m per annum. Reduction in temporary spend is a key feature of the cost savings target so it is vital that these costs are minimised as much as possible.

Agency

The annual plan submitted to NHSI includes an annual locum and agency spend ceiling across all staff groups of £10.0m. Included in this ceiling is the requirement to reduce 2016/17 spend on locum and medical agency by £0.9m.

The monthly locum and agency spend is £0.9m which increases the year to date spend to £2.8m. The ceiling for the year to date is £2.5m so the actual spend to date is £0.3m above the ceiling. The year to date agency spend compared to the planned spend is summarised in the following table.

Graph: Analysis of monthly and cumulative agency spend.



The Use of Resources Risk Rating includes an agency ceiling metric so agency expenditure above the annual ceiling may adversely affect the overall rating depending on performance in the other metrics.

Drugs

In month drugs costs are £1.4m which is in line with plan. The year to date drugs costs are £4.2m which is £0.2m below plan. The position includes excluded PbR drugs which are funded by commissioners, with the additional income shown against other income within NHS clinical income.

Clinical Supplies and Services

In month clinical supplies and services costs are £1.5m which is in line with plan. The year to date clinical supplies and services costs are £4.8m which is £0.1m above plan. This year to date overspend mainly relates to the underachievement against the cost savings target. The over spend on pathology and radiology relates to consumables and maintenance contracts and payments to Platform 7 for patient activity (although these costs are being offset by additional income).

Non Clinical Supplies

In month non clinical supplies costs are £2.4m which is in line with plan. The year to date non clinical supplies costs are £7.2m which is £0.1m below plan. This year to date underspend mainly relates to reduced levels of expenditure on building and engineering works, printing and stationery, computer maintenance and course fees.

Depreciation and Amortisation

In order to align with the format of reporting adopted by NHSI (for planning and monitoring) and Department of Health (for annual accounts), depreciation and amortisation is now included in operating expenses and forms part of the operating surplus / deficit.

In month depreciation and amortisation costs are £0.4m which is £0.1m below plan. The year to date depreciation and amortisation costs are £1.3m which is £0.1m below plan.

Divisional Performance (net divisional income and expenditure)

Across all clinical and corporate divisions there was an in month over spend of £0.7m which increases the year to date overspend to £1.9m as summarised in the following table.

Table: Analysis of monthly and year to date divisional financial positions.

Division	Monthly Budget £m	Monthly Actual £m	Monthly Variance £m	YTD Budget £m	YTD Actual £m	YTD Variance £m
Acute Care	6.6	7.2	(0.6)	20.0	21.6	(1.6)
Surgery, Women's & Children's	7.1	7.2	(0.1)	21.0	21.3	(0.3)
Outpatients	0.3	0.3	0.0	0.9	0.9	0.0
Corporate	4.0	4.0	0.0	12.1	12.1	0.0
Total	**18.0**	**18.7**	**(0.7)**	**54.0**	**55.9**	**(1.9)**

Positive variance = below plan, negative variance = above plan.

An analysis of the monthly and year to date income and expenditure position by each division is included in the dashboard attached at Appendix A and an analysis by each Clinical Business Unit and Corporate Division is attached at Appendix E. The headlines for each division are:

Acute Care Division

The year to date net divisional income and expenditure position is an over spend of £1.4m. The year to date clinical income is over recovered by £0.2m and the expenditure position is overspent by £1.6m.

All Clinical Business Units within the Division are overspent. The main reasons for the overspend are £0.4m shortfall against the cost savings target, £0.2m on staffing escalation beds on Daresbury and Ward A4, £0.5m covering nursing vacancies and one to one nursing and £0.3m in Diagnostics for referred tests and WLI's.

Surgery, Women's and Children's Division

The year to date net divisional income and expenditure position is an over spend of £0.9m. The year to date clinical income is £0.6m below plan and the expenditure position is overspent by £0.3m.

Women's and Children's Health and Specialist Surgery are overspent although this is partially offset by underspends in Musculoskeletal Care, Digestive Diseases and Administration. The year to date over spend is mainly due to agency expenditure in Urology and an additional qualified nurse working

in paediatric A&E at night. This is partly being offset by vacancies particularly within the Therapy Teams and nurse vacancies.

Outpatients

The division is on plan both in month and year to date.

Corporate Divisions

Year to date corporate divisions are breakeven with overspends in Human Resources, Nursing and Governance, Estates & Facilities and Trust Executive offset by underspends in Pharmacy and IM&T.

It is vital that all managers take corrective action where necessary to reduce costs and remain within the allocated resources.

Reserves

The Trust started the year with reserves of £24.5m including £10.8m related to high cost drugs that are funded non recurrently on a monthly basis dependent upon the spend. The remaining balance of £13.7m covers both committed reserves (£12.0m) and uncommitted reserves (£1.7m).

Committed Reserves - to date £6.4m has been transferred to divisions to fund agreed cost pressures. The balance of the pay inflation reserve of £1.1m has been transferred from committed reserves to the uncommitted reserve leaving a balance of £4.5m in the committed reserve.

Uncommitted Reserves – to date £0.1m has been transferred to divisions to fund agreed developments. The transfer of the pay inflation reserve of £1.1m takes the balance remaining in the uncommitted reserve to £2.7m of which £1.7m has been ring fenced for quarter 1 issues leaving a revised balance of £1.0m.

The current position is summarised in the following table.

Table: Analysis of committed and uncommitted reserves (excluding high cost drugs reserve).

Narrative	Committed £m	Uncommitted £m	Total £m
Annual Position			
Balance as at 1 April	12.0	1.7	13.7
Transferred to Divisions (April to May)	(6.4)	0.0	(6.4)
Balance as at 31 May	**5.6**	**1.7**	**7.3**
Transfer balance of the pay inflation reserve from committed to uncommitted reserves	(1.1)	1.1	0.0
Transfer to Divisions (June)			
- PBR midwife, RTT & falls practitioner business cases	0.0	(0.1)	(0.1)
Total			
Balance as at 30 June	4.5	2.7	7.2
Commitments	(4.5)	(1.7)	(6.2)
Reserve Balance Available	**0.0**	**1.0**	**1.0**

Non Operating Income and Expenses

Non operating income and expenses now excluded depreciation and amortisation and restructuring costs.

In month non operating income and expenses are £0.3m which is on plan. The year to date expenses is £0.9m which is on plan.

Use of Resources Rating

The Use of Resources Rating is used to measure and assess financial performance. This is calculated on a cumulative basis and the year to date position and performance results in an overall Use of Resources Rating of 3. The actual score against each metric summarised in the following table.

Table: Use of Resources Rating

Metric	Score
Capital Servicing Capacity	4
Liquidity (days)	4
I&E margin	4
Variance from control total	1
Agency spend	2
Overall Rating	**3**

4. CAPITAL

The Trust has secured capital funding of £1.0m from the Department of Health for the implementation of primary care streaming into A&E. This increases the 2017/18 capital programme to £7.0m. In month the actual spend is £0.6m which increases the year to date expenditure to £1.5m. This is £0.2m below the planned spend to date of £1.7m as summarised in the following table.

Table: Analysis of performance against the revised capital programme.

Category	Annual Budget £m	Budget to date £m	Spend to date £m	Variance to date £m
Estates	2.9	0.7	0.4	0.3
IM&T	1.4	0.3	0.1	0.2
Medical Equipment	2.3	0.6	1.0	(0.4)
Contingency	0.4	0.1	0.0	0.1
Total	**7.0**	**1.7**	**1.5**	**0.2**

Positive variance = below plan, negative variance = above plan.

5. CASH FLOW (APPENDIX F)

The cash balance as at 30 June was £1.2m, in line with the terms and conditions of the working capital loan.

Table: Summary of the monthly cash movement.

Cash balance movement	**£m**
Balance as at 1 June	1.2
In month surplus / (deficit)	0.0
Non cash flows in operating surplus	0.4
Increase / (decrease) in working capital	0.3
Capital expenditure	(0.6)
Other movements	(0.1)
Balance as at 30 June	**1.2**

The operating performance continues to have an adverse effect on the amount of cash available to the Trust. At 30 June the value of aged creditors stands at £12.3m, although this is partially covered by the value of aged debtors at £5.6m.

The current cash balance of £1.2m equates to circa 2 days operational cash. Active management of the working balances continues in order to maintain a cash balance sufficient to pay creditors (see section 8 for further details). Performance against the Non NHS Better Payment Practice Code (BPPC) based on volume is 41% in the month and 36% year to date.

The cash flow movement for the year is detailed in Appendix G. The following table summarises the short term cash flow anticipated over the next 3 months which reflects the requirement to hold a minimum cash balance of £1.2m under the terms and conditions of the working capital loan.

Table: Short term cash flow movements.

Cash balance movement	**July £m**	**August £m**	**September £m**
Opening balance	1.2	1.2	1.2
In month surplus/(deficit)	(0.1)	(0.2)	(0.3)
Non cash flows in operating surplus	0.5	0.5	0.5
Increase / (decrease) in working capital	0.1	0.2	0.3
Capital expenditure	(0.5)	(0.5)	(0.5)
Closing balance	**1.2**	**1.2**	**1.2**

6. STATEMENT OF FINANCIAL POSITION (APPENDIX G)

Assets employed have decreased by £0.9m in the month as a result of the monthly deficit with the movements in the month detailed as follows:

- Non current assets have increased by £0.2m as capital spend has exceeded depreciation charges.
- Current assets have increased by £1.3m mainly due to an increase in trade and other receivables.
- Current liabilities have increased by £1.9m mainly due to an increase in trade and other payables.
- Non current liabilities have decreased by £0.1m mainly due to a decrease in borrowings.

7. AGED DEBT (APPENDIX H)

The number of outstanding invoices has decreased by 19 in the month to 759. The value of aged debt however has increased by £1.9m (with £1.5m increase relating to current debt) to £5.6m. Debt totalling £0.8m has been recovered in the early part of July thereby reducing overall aged debt to £4.8m.

8. AGED CREDITORS (APPENDIX I)

The number of unpaid invoices has increased by 1,834 in the month to 6,874. The value of aged creditors has increased by £2.4m in the month to £12.3m (with £7.7m overdue). Invoices totalling £1.9m have been paid in the early part of July thereby reducing the overall creditor value to £10.4m. The operating position reduces the amount of cash available to pay creditors in a timely manner and until the operating position improves the level of aged creditors will remain high. There is currently insufficient cash to pay all creditors. Priority is given to the payment of small local suppliers and then the selection criteria is based on the number, value and age of the invoices and the avoidance of potential interest charges levied by the creditors. The largest non NHS creditor by value is Glead Sciences Ltd with £0.2m outstanding as at 30 June. The volume and value of outstanding invoices is summarised in the following table (see Appendix I for further details).

Table – analysis of outstanding invoices by volume and value.

Narrative	Volume Number	Volume %	Value £000	Value %
Largest 15	2,053	30	5,994	49
Others	4,821	70	6,346	51
Total	**6,874**	**100**	**12,340**	**100**

9. WORKING CAPITAL LOAN

The Trust has requested a 2017/18 working capital loan of £3.7m to support the planned deficit. The first instalment of £1.6m was received in April at a 1.5% interest rate.

Due to the delay in receipt of STF monies for 2016/17 Q3 and Q4, additional loans totalling £4.0m were taken out in 2016/17. The loan relating to Q3 was repaid in April and Q4 will be repaid once the remaining monies have been received from Department of Health. NHSI has confirmed Q4 STF will be paid on 14 July 2017.

The cumulative value of working capital loans covering the period 2015/16 to 2017/18 equates to £25.8m.

10. CAPITAL LOAN

In 2015/16 the Trust secured a capital loan of £1.6m to support the balance of the capital programme that could not be funded from internally generated depreciation or cash reserves. The loan is repayable over 15 years at an interest rate of 1.78%. Principle and interest repayments commenced in 2016/17 and are paid twice yearly (August and February).

The 2017/18 capital programme is funded by internally generated depreciation and a carry forward of the 2016/17 underspend. There is no requirement for a capital loan in year.

11. LOAN INTEREST

The interest resulting from the capital and working capital loans is included within the 2017/18 financial position as a non operating expense. The interest associated with these loans is summarised in the following table.

Table: 2017/18 Interest Charges (forecast for the full year)

Narrative	Loan/ Facility Value £000	Interest Rate	Forecast Interest Charge £000
2015/16 Capital Loan	1,600	1.78%	26
2015/16 Working Capital Loan	14,200	1.50%	208
2016/17 Working Capital Loan (to cover deficit)	7,918	1.50%	119
2016/17 Working Capital Loan (to cover Q4 STF)	2,000	1.50%	30
2017/18 Working Capital Loan (to cover deficit)	3,657	1.50%	38
Total			**421**

12. RISK AND FORECAST

For the period ending 30 June the Trust has recorded a deficit of £3.1m which is in line with plan. In order to deliver plan reserves have been utilised which puts the annual plan at risk. A separate presentation setting out the risks and actions will be delivered at the July Finance and Sustainability Committee by the Director of Finance and Chief Operating Officer.

13. COSTING TRANSFORMATION PROGRAMME / SERVICE LINE REPORTING

There is a national drive to improve costing in the NHS, therefore NHS Improvement (NHSI) have launched the Costing Transformation Programme (CTP). Warrington and Halton Hospitals NHS Foundation Trust are early Implementers of the CTP.

The CTP project commenced in July 2017, it has a number of key objectives to support the improvement of costing and activity data. Quarterly updates will be provided to the Finance and Sustainability Committee, Andrea Chadwick is the Project Executive.

The new Patient Level Costing Information System (PLICS) has been successfully implemented. The 2016/17 Service Line Reporting (SLR) position is the first SLR position using the new system. This is the foundation which will be built upon in the forthcoming months in conjunction with the CTP project.

The launch of the CTP project will drive the need for more granular information which will inform the costing model and subsequently produce an improved SLR position. New reports will be developed to support the services understand their service line data. This will include a summary SLR statement by CBU, individual service line reports and portfolio matrix for each CBU. Visual style reports such as dashboards will be explored and tested with the services.

The next report to the Finance and Sustainability Committee will be in October 2017, it will include the draft reference costs position and an update on the CTP.

In line with the annual plan a paper will come to the August Committee on the Reference Cost process and to provide evidence of the costing approach to enable the Committee to satisfy itself as to the adequacy of the costing process prior to submitting the Reference Costs, as required by National guidance.

14. CONCLUSION

For the period ending 30 June 2017 the Trust has recorded a deficit of £3.1m which is in line with plan, a cash balance of £1.3m and a Use of Resources Rating of 3.

15. RECOMMENDATION

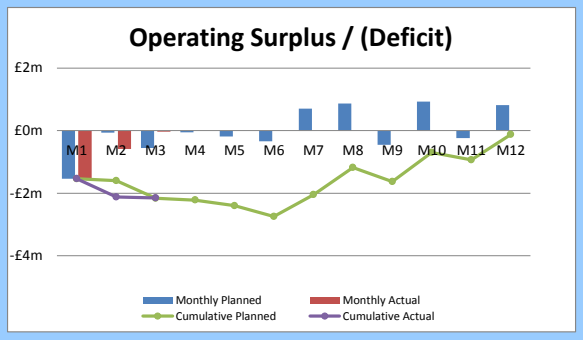
The Finance and Sustainability Committee is asked to note the content of the report.

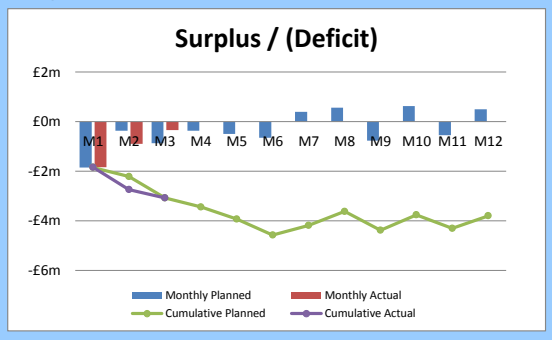
Andrea Chadwick
Director of Finance & Commercial Development

Warrington & Halton Hospitals NHS Foundation Trust

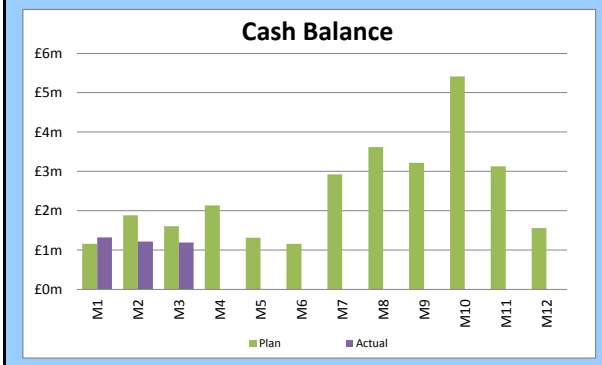
Finance Dashboard as at 30th June 2017 (Part A)

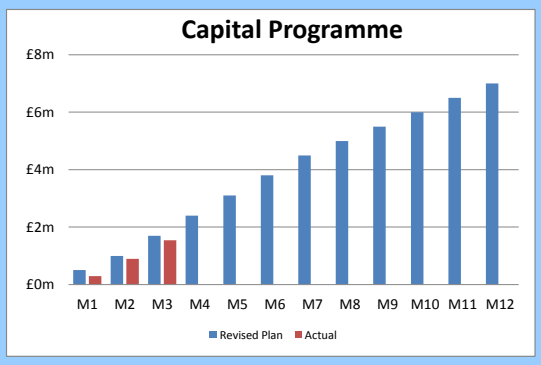
Profitability



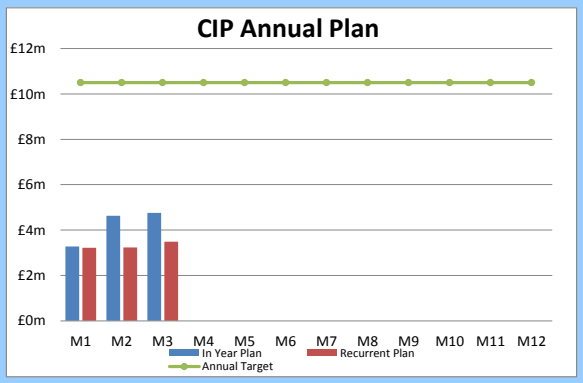


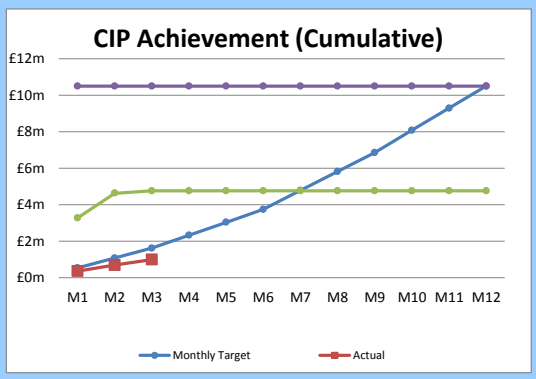
Cash and Investment





Cost Improvement Analysis





Divisional Position (net divisional income and expenditure)

Division	Annual Budget £000	Budget in month £000	Actual in month £000	Variance in month £000	Variance in month %	Budget to date £000	Actual to date £000	Variance to date £000	Variance date %
Clinical									
Surgery, Women's & Children's	76,897	7,075	7,170	-95	-1.3	21,049	21,334	-285	-1.4
Acute Care Services	75,219	6,612	7,230	-618	-9.3	19,947	21,493	-1,546	-7.8
Outpatients	3,533	301	329	-28	-9.4	898	927	-30	-3.3
Corporate									
Central Operations	145	12	12	0	1.0	36	24	13	34.7
Communications & Membership	226	19	19	0	1.0	58	50	8	13.6
Estates and Facilities	14,229	1,213	1,285	-72	-5.9	3,637	3,736	-99	-2.7
Finance and Commercial Devel	15,497	1,298	1,265	34	2.6	3,893	3,878	15	0.4
HR and OD	4,515	381	353	28	7.3	1,142	1,166	-24	-2.1
Information Technology	4,000	336	319	17	5.0	1,007	956	51	5.1
Nursing and Governance	1,953	168	174	-6	-3.7	478	525	-47	-9.8
Pharmacy	3,988	339	293	45	13.4	1,016	934	81	8.0
Transformation Team	412	35	34	1	3.2	104	100	4	3.6
Research and Development	61	5	5	0	0.0	15	15	0	0.0
Trust Executive	2,478	200	225	-25	-12.5	681	721	-40	-5.9
Total	**203,152**	**17,994**	**18,714**	**-720**	**-4.0**	**53,960**	**55,859**	**-1,898**	**-3.5**

Positive variance = underspend, negative variance = overspend.

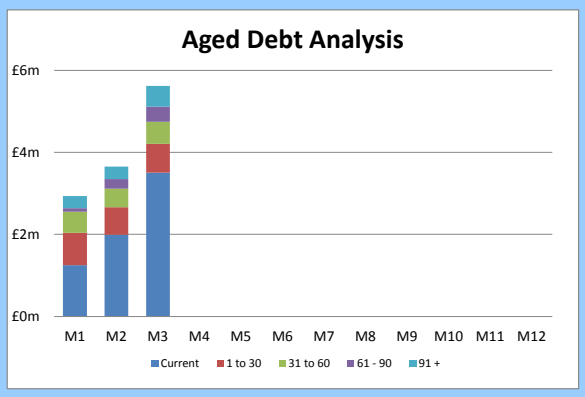
Use of Resources Rating

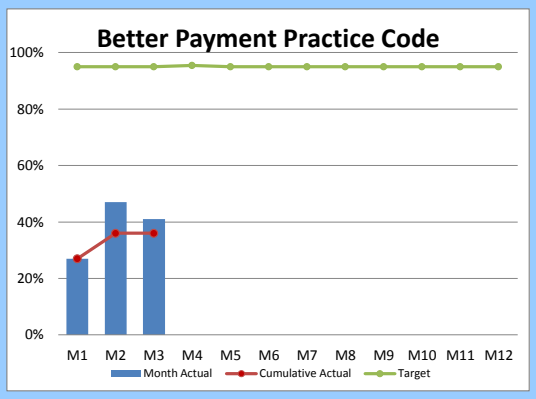
Use of Resources Rating	Actual Metric	Actual Rating
Capital Servicing Capacity (times)	-0.29	4
Liquidity Ratio (days)	-38.4	4
Income & Expenditure Margin (%)	-5.28%	4
Variance from control total	-7.24%	1
Agency Ceiling (%)	11.46%	2
Overall Risk Rating		3

Warrington & Halton Hospitals NHS Foundation Trust

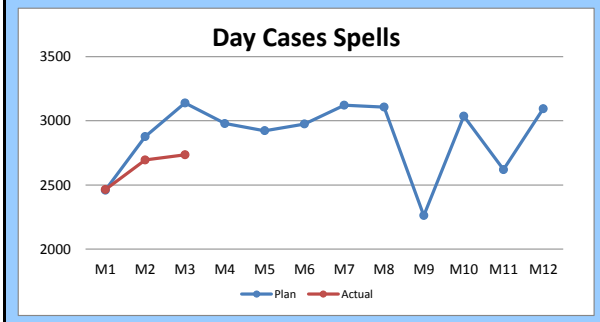
Finance Dashboard as at 30th June 2017 (Part B)

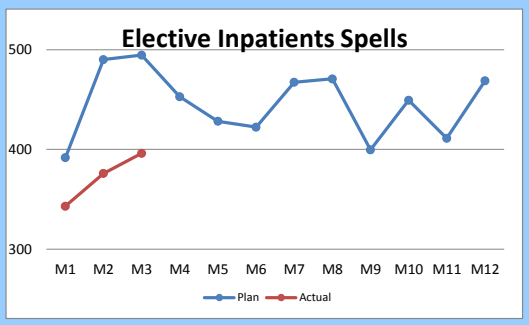
Balance Sheet and Liquidity

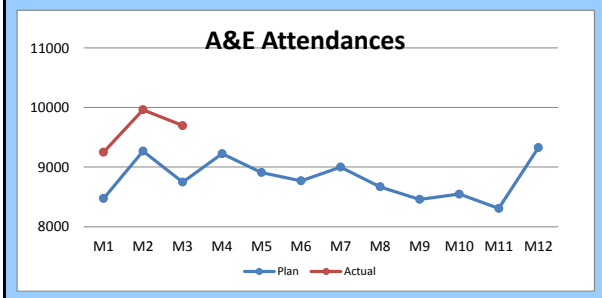


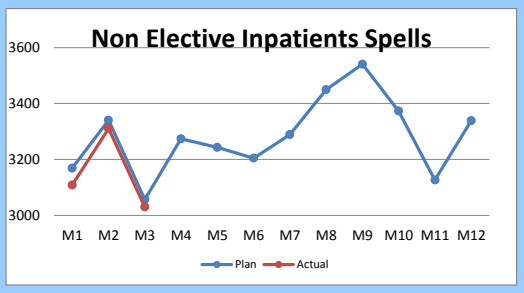


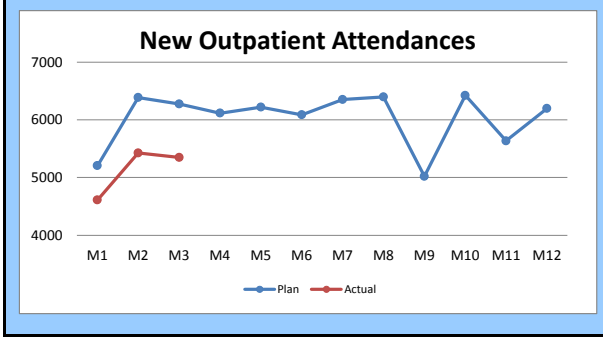
Activity Analysis

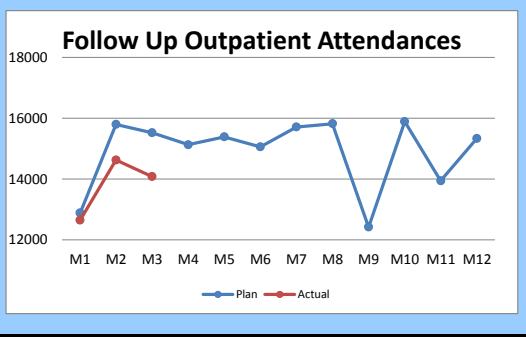












Warrington & Halton Hospitals NHS Foundation Trust **Appendix B**

Income Statement, Activity Summary and Use of Resources Ratings as at 30th June 2017

Income Statement	Month			Year to date			Forecast		
	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Operating Income									
NHS Clinical Income									
Elective Spells	3,315	3,143	-172	9,075	8,517	-557	36,228	36,228	0
Elective Excess Bed Days	14	-2	-16	40	61	21	155	155	0
Non Elective Spells	4,612	4,563	-49	14,432	14,865	433	59,452	59,452	0
Non Elective Excess Bed Days	171	152	-19	534	610	76	2,199	2,199	0
Outpatient Attendances	2,931	2,839	-92	8,346	8,003	-343	33,774	33,774	0
Accident & Emergency Attendances	1,081	1,131	50	3,275	3,357	82	13,066	13,066	0
Other Activity	5,182	5,775	593	15,716	16,135	419	62,999	62,999	0
Sub total	**17,306**	**17,601**	**295**	**51,417**	**51,548**	**131**	**207,873**	**207,873**	**0**
Non NHS Clinical Income									
Private Patients	9	16	7	27	23	-4	106	106	0
Other non protected	107	75	-32	321	295	-26	1,284	1,284	0
Sub total	**116**	**90**	**-26**	**348**	**318**	**-30**	**1,390**	**1,390**	**0**
Other Operating Income									
Training & Education	641	641	0	1,923	1,923	0	7,693	7,693	0
Donations and Grants	0	0	0	0	0	0	0	0	0
Sustainability & Transformation Fund	352	352	0	1,054	1,054	0	7,029	7,029	0
Miscellaneous Income	827	963	136	2,481	2,707	226	10,081	10,081	0
Sub total	**1,820**	**1,956**	**136**	**5,458**	**5,684**	**226**	**24,803**	**24,803**	**0**
Total Operating Income	**19,242**	**19,648**	**406**	**57,223**	**57,549**	**326**	**234,066**	**234,066**	**0**
Operating Expenses									
Employee Benefit Expenses	-13,891	-13,896	-6	-41,651	-42,252	-601	-164,359	-164,359	0
Drugs	-1,447	-1,435	12	-4,341	-4,178	163	-17,285	-17,285	0
Clinical Supplies and Services	-1,565	-1,547	18	-4,695	-4,758	-63	-18,264	-18,264	0
Non Clinical Supplies	-2,436	-2,419	17	-7,308	-7,206	103	-28,729	-28,729	0
Depreciation and Amortisation	-463	-381	82	-1,389	-1,307	82	-5,552	-5,552	0
Restructuring Costs	0	0	0	0	0	0	0	0	0
Total Operating Expenses	**-19,802**	**-19,678**	**124**	**-59,384**	**-59,700**	**-316**	**-234,189**	**-234,189**	**0**
Operating Surplus / (Deficit)	**-560**	**-30**	**529**	**-2,161**	**-2,151**	**10**	**-123**	**-123**	**0**
Non Operating Income and Expenses									
Profit / (Loss) on disposal of assets	0	0	0	0	0	0	0	0	0
Interest Income	2	1	-1	6	4	-2	26	26	0
Interest Expenses	-36	-36	0	-104	-110	-6	-426	-426	0
PDC Dividends	-273	-273	0	-818	-818	0	-3,275	-3,275	0
Impairments	0	0	0	0	0	0	0	0	0
Total Non Operating Income and Expenses	**-307**	**-308**	**-1**	**-916**	**-924**	**-8**	**-3,675**	**-3,675**	**0**
Surplus / (Deficit)	**-867**	**-338**	**528**	**-3,077**	**-3,075**	**2**	**-3,798**	**-3,798**	**0**
Depreciation on Donated and Granted Assets	12	13	1	36	37	1	141	141	0
Control Total	**-855**	**-325**	**529**	**-3,041**	**-3,038**	**3**	**-3,657**	**-3,657**	**0**
Activity Summary	**Planned**	**Actual**	**Variance**	**Planned**	**Actual**	**Variance**	**Planned**	**Actual**	**Variance**
Elective Spells	3,632	3,131	-501	9,848	9,009	-839	39,931	39,931	0
Elective Excess Bed Days	68	-8	-76	188	245	57	732	732	0
Non Elective Spells	3,056	3,030	-26	9,565	9,449	-116	39,402	39,402	0
Non Elective Excess Bed Days	815	623	-192	2,552	2,484	-68	10,512	10,512	0
Outpatient Attendances	28,519	27,669	-850	81,205	78,256	-2,949	328,622	328,622	0
Accident & Emergency Attendances	8,748	9,697	949	26,491	28,910	2,419	105,704	105,704	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)				-0.83	-0.29	0.54	1.43	1.43	0.00
Liquidity Ratio (Days)				-50.1	-38.4	11.6	-48.9	-48.9	0.0
I&E Margin (%)				-5.31%	-5.28%	0.04%	-1.56%	-1.56%	0.00%
Variance from control total (%)				0.00%	0.05%	0.05%	0.00%	0.00%	0.00%
Agency Ceiling (%)				0.00%	11.46%	11.46%	0.00%	0.00%	0.00%
Ratings									
Capital Servicing Capacity (Times)				4	4	0	3	3	0
Liquidity Ratio (Days)				4	4	0	4	4	0
I&E Margin (%)				4	4	0	4	4	0
Variance from control total (%)				1	1	0	1	1	0
Agency Ceiling (%)				1	2	1	1	1	0
Use of Resources Rating				**3**	**3**	**0**	**3**	**3**	**0**

Warrington & Halton Hospitals NHS Foundation Trust **Appendix C**

Income and Activity to 30th June 2017

Summary by Point of Delivery

Point of Delivery Description	Annual		Year to Date ACTIVITY			Year to Date INCOME		
	Planned Activity	Planned Income £	Planned Activity	Estimated Activity	Activity Variance	Planned Income £	Estimated Income £	Income Variance £
Elective								
Elective Inpatients	5,347	16,080,770	1,376	1,115	-261	4,139,330	3,534,389	-604,942
Elective Inpatients Excess Bed Days		155,050				39,911	60,541	20,629
Daycase	34,583	20,146,859	8,472	7,894	-578	4,935,388	4,982,839	47,451
SUBTOTAL	39,931	36,382,679	9,848	9,009	-839	9,114,630	8,577,768	-536,861
Emergency								
Non Elective Inpatients	39,402	59,451,889	9,565	9,449	-116	14,431,968	14,865,458	433,491
Non Elective Inpatients Excess Bed Days		2,199,466				533,921	609,596	75,674
SUBTOTAL	39,402	61,651,356	9,565	9,449	-116	14,965,889	15,475,054	509,165
Outpatients								
New Outpatients	72,307	12,220,653	17,868	15,384	-2,484	3,049,104	2,762,176	-286,928
Follow Up Outpatients	178,884	13,003,190	44,204	41,352	-2,852	3,168,935	2,933,555	-235,380
Outpatient Telephone Clinics	21,030	547,296	5,197	4,548	-649	135,242	111,047	-24,195
Outpatient Procedures	51,055	7,396,509	12,616	15,396	2,780	1,842,728	2,040,810	198,081
Ward Attenders	5,346	606,582	1,321	1,576	255	149,892	155,020	5,128
SUBTOTAL	328,622	33,774,229	81,205	78,256	-2,949	8,345,901	8,002,607	-343,294
Other								
A&E Attendances	105,704	13,066,000	26,491	28,910	2,419	3,275,000	3,357,333	82,333
Pathology Direct Access	2,957,045	5,248,624	739,261	723,542	-15,719	1,312,156	1,394,659	82,503
Radiology Direct Access (Excluding Unbundled)	34,359	1,149,326	8,590	8,973	383	287,332	290,318	2,987
Radiology Diagnostic Imaging (Unbundled)	30,923	2,178,456	7,731	7,673	-58	544,614	556,887	12,273
Outpatient Unbundled Radiology & Echos	47,605	4,482,230	11,764	12,608	844	1,107,597	1,175,446	67,848
Paediatric Diabetes		375,723				93,931	90,405	-3,526
CPAP Consumables & Maintenance		131,022				32,755	39,242	6,487
Critical Care (Neonatal)	4,369	2,036,443	1,092	1,047	-45	509,111	561,743	52,632
Critical Care Adult (Unbundled)	6,253	6,461,185	1,563	1,525	-38	1,615,296	1,663,119	47,823
Chemotherapy (Unbundled)	794	240,526	199	196	-3	60,132	54,201	-5,931
Palliative Care (Unbundled)	12,781	1,514,969	3,195	3,185	-10	378,742	377,364	-1,378
Maternity Pathway	7,768	13,082,892	1,921	1,724	-197	3,235,708	2,899,320	-336,387
Excluded Drugs		10,851,767				2,712,942	2,846,674	133,732
All Other Services (including CQUIN)		15,245,441				3,825,265	4,185,499	360,234
SUBTOTAL	3,207,601	76,064,604	801,807	789,383	-12,424	18,990,580	19,492,209	501,628
Total	**3,615,556**	**207,872,868**	**902,425**	**886,097**	**-16,328**	**51,417,000**	**51,547,638**	**130,638**
Elective Inpatients Excess Bed Days	732		188	245	57			
Non Elective Inpatients Excess Bed Days	10,512		2,552	2,484	-68			
Total	**3,626,800**		**905,165**	**888,826**	**-16,339**			

Warrington & Halton Hospitals NHS Foundation Trust **Appendix D**

Income and Activity to 30th June 2017

Summary by Division / CBU / Specialty

Division	Clinical Business Unit and Specialty	Annual		Year to Date ACTIVITY			Year to Date INCOME		
		Planned Activity	Planned Income £	Planned Activity	Estimated Activity	Activity Variance	Planned Income £	Estimated Income £	Income Variance £
Acute Care Services	**Airway, Breathing and Circulation**								
	Anaesthetics	447	32,809	111	40	-71	8,196	3,206	-4,991
	Cardiology	17,758	5,117,793	4,382	4,684	302	1,254,290	2,144,656	890,366
	CPAP	0	131,022	0	0	0	32,755	39,242	6,487
	Adult Critical Care	6,253	6,461,185	1,563	1,525	-38	1,615,296	1,663,119	47,823
	Critical Care	1,200	1,291,659	295	170	-125	314,992	317,974	2,982
	Respiratory Medicine	15,487	2,808,753	3,829	4,178	349	692,691	1,549,386	856,695
	CIP (ABC)	0	69,694	0	0	0	14,425	0	-14,425
	Clinical Business Unit Block Income (ABC)	0	555,211	0	0	0	138,803	138,803	0
	SubTotal	41,146	16,468,126	10,180	10,597	417	4,071,449	5,856,386	1,784,936
	Diagnostics								
	Haematology	51,657	2,891,601	12,761	12,162	-599	713,265	647,854	-65,411
	Direct Acess Pathology	2,957,045	5,248,624	739,261	723,542	-15,719	1,312,156	1,394,659	82,503
	Imaging - Direct Acess Radiology (Excl U/B)	34,359	1,149,326	8,590	8,973	383	287,332	290,318	2,987
	Imaging - Direct Acess Radiology Unbundled	30,923	2,178,456	7,731	7,673	-58	544,614	556,887	12,273
	Imaging - Echo's and OP U/B	47,605	4,482,230	11,764	12,608	844	1,107,597	1,175,446	67,848
	CIP (D)	0	71,636	0	0	0	14,827	0	-14,827
	Clinical Business Unit Block Income (D)	0	2,116,335	0	0	0	529,084	529,084	0
	SubTotal	3,121,589	18,138,208	780,106	764,958	-15,148	4,508,874	4,594,247	85,373
	Specialist Medicine								
	Diabetic Medicine	10,928	868,848	2,700	2,354	-346	214,700	204,740	-9,960
	Endocrinology	2,653	438,047	655	767	112	108,146	116,548	8,402
	Older Persons Services	1,891	679,303	468	978	510	166,387	508,792	342,405
	Palliative Care Medicine (U/B)	81	18,021	20	25	5	4,453	4,103	-351
	Sexual Health	3,191	471,496	789	732	-57	116,511	106,973	-9,537
	Stroke Medicine	1,054	161,965	261	408	147	39,991	56,738	16,747
	CIP (SM)	0	55,083	0	0	0	11,401	0	-11,401
	Clinical Business Unit Block Income (SM)	0	24,736	0	0	0	6,184	8,626	2,442
	SubTotal	19,799	2,717,499	4,893	5,264	371	667,773	1,006,519	338,746
	Urgent and Emergency Care								
	Emergency Medicine	120,142	19,357,900	30,007	32,173	2,166	4,803,550	4,679,013	-124,537
	General Internal Medicine	31,021	30,130,656	7,610	6,095	-1,515	7,324,943	5,490,917	-1,834,026
	CIP (UEC)	0	65,782	0	0	0	13,616	0	-13,616
	Clinical Business Unit Block Income (UEC)	0	2,517,857	0	0	0	629,464	629,464	0
	SubTotal	151,163	52,072,196	37,617	38,268	651	12,771,573	10,799,394	-1,972,179
Surgery, Women's & Children's	**Digestive Diseases**								
	Endoscopy	11,490	4,775,392	2,821	2,861	40	1,172,478	1,241,687	69,209
	Gastroenterology	8,881	2,297,285	2,194	2,711	517	565,453	1,050,132	484,679
	Vascular Surgery	3,094	557,349	765	765	0	138,475	136,599	-1,876
	General Surgery	23,662	13,861,876	5,835	5,968	133	3,415,547	3,481,082	65,535
	CIP (DD)	0	98,785	0	0	0	20,446	0	-20,446
	Clinical Business Unit Block Income (DD)	0	38,865	0	0	0	9,716	9,716	0
	SubTotal	47,127	21,629,552	11,615	12,305	690	5,322,116	5,919,217	597,101
	Musculoskeletal Care								
	Pain Management	3,892	1,174,743	959	614	-345	288,736	230,148	-58,588
	Rheumatology	14,185	1,710,707	3,505	2,958	-547	422,342	296,529	-125,812
	Trauma and Orthopaedics	57,185	24,186,242	14,135	13,612	-523	6,042,398	5,489,963	-552,435
	CIP (MC)	0	56,820	0	0	0	11,761	0	-11,761
	Clinical Business Unit Block Income (MC)	0	2,924,945	0	0	0	731,236	731,236	0
	SubTotal	75,261	30,053,457	18,599	17,184	-1,415	7,496,472	6,747,876	-748,596
	Specialist Surgery								
	ENT	17,629	3,356,464	4,356	4,011	-345	829,622	785,631	-43,991
	Maxillofacial Surgery	7,099	1,618,879	1,751	1,624	-127	398,085	367,480	-30,606
	Ophthalmology	46,031	7,319,073	11,364	10,961	-403	1,801,643	1,605,754	-195,890
	Ophthalmology - ARMD	6,010	2,463,353	1,479	1,395	-84	606,164	569,908	-36,256
	Opthalmology - Halton Cataracts Contract	509	47,388	126	72	-54	11,660	27,711	16,052
	Optometry & Orthoptics	11,683	739,895	2,887	2,968	81	182,834	181,956	-878
	Orthodontics	5,267	566,104	1,301	1,243	-58	139,889	137,032	-2,858
	Urology	12,544	4,201,465	3,105	2,713	-392	1,048,448	1,110,709	62,261
	CIP (SS)	0	28,486	0	0	0	5,896	0	-5,896
	Clinical Business Unit Block Income (SS)	0	1,102,816	0	0	0	275,704	329,301	53,597
	SubTotal	106,772	21,443,924	26,369	24,987	-1,382	5,299,947	5,115,482	-184,465
	Women's and Children's Health								
	Breast Surgery	7,630	1,826,613	1,887	1,845	-42	455,387	462,112	6,725
	Maternity (Pathway)	7,777	13,103,988	1,924	1,732	-192	3,240,829	2,903,485	-337,344
	Obstetrics	145	107,425	35	53	18	26,340	42,830	16,490
	Gynaecology	22,567	4,901,601	5,574	5,640	66	1,214,310	1,211,162	-3,149
	Paediatrics	21,316	7,388,181	5,241	4,946	-295	1,803,099	1,792,008	-11,091
	Neonatal Critical Care	4,369	2,036,443	1,092	1,047	-45	509,111	561,743	52,632
	CIP (WCH)	0	76,714	0	0	0	15,878	0	-15,878
	Clinical Business Unit Block Income (WCH)	0	687,473	0	0	0	171,868	176,584	4,716
	SubTotal	63,804	30,128,437	15,753	15,263	-490	7,436,823	7,149,924	-286,899
	Non divisional specific services	139	15,221,470	34	0	-34	3,841,972	4,358,593	516,621
	SubTotal	139	15,221,470	34	0	-34	3,841,972	4,358,593	516,621
	TOTAL	**3,626,800**	**207,872,868**	**905,165**	**888,826**	**-16,339**	**51,417,000**	**51,547,638**	**130,638**

Warrington & Halton Hospitals NHS Foundation Trust **Appendix E**

Income and Activity to 30th June 2017

Divisional Position (net divisional income and expenditure)

Division	Annual Budget £000	Budget in month £000	Actual in month £000	Variance in month £000	Variance in month %	Budget to date £000	Actual to date £000	Variance to date £000	Variance date %
Clinical									
Surgery, Women's & Children's Health									
Digestive Diseases	30,299	2,735	2,674	61	2.2	8,150	8,048	103	1.3
Musculoskeletal Care	18,050	1,800	1,775	25	1.4	5,223	5,102	121	2.3
Women's and Children's Health	17,708	1,520	1,716	-196	-12.9	4,556	4,958	-403	-8.8
Specialist Surgery	10,399	984	973	11	1.2	3,010	3,129	-119	-3.9
Divisional Administration	442	37	32	4	12.1	110	97	13	11.7
Total Surgery, Women's & Children's Health	**76,897**	**7,075**	**7,170**	**-95**	**-1.3**	**21,049**	**21,334**	**-285**	**-1.4**
Acute Care Services									
Urgent and Emergency Care	15,854	1,360	1,562	-202	-14.9	4,102	4,444	-342	-8.3
Diagnostics	23,056	2,103	2,273	-170	-8.1	6,318	6,731	-413	-6.5
Airway Breathing and Circulation	19,061	1,618	1,761	-143	-8.8	4,861	5,244	-383	-7.9
Specialist Medicine	15,419	1,379	1,478	-99	-7.2	4,211	4,579	-367	-8.7
Discharge / Patient Flow	934	78	77	1	0.8	232	233	0	-0.1
Divisional Administration	896	74	79	-5	-6.1	223	263	-41	-18.3
Total Acute Care Services	**75,219**	**6,612**	**7,230**	**-618**	**-9.3**	**19,947**	**21,493**	**-1,546**	**-7.8**
Outpatients	3,533	301	329	-28	-9.4	898	927	-30	-3.3
Total Operational	**155,650**	**13,988**	**14,729**	**-741**	**-5.3**	**41,894**	**43,754**	**-1,860**	**-4.4**
Corporate									
Central Operations	145	12	12	0	1.0	36	24	13	34.7
Communications & Membership	226	19	19	0	1.0	58	50	8	13.6
Estates and Facilities	14,229	1,213	1,285	-72	-5.9	3,637	3,736	-99	-2.7
Finance and Commercial Development	15,497	1,298	1,265	34	2.6	3,893	3,878	15	0.4
HR and OD	4,515	381	353	28	7.3	1,142	1,166	-24	-2.1
Information Technology	4,000	336	319	17	5.0	1,007	956	51	5.1
Nursing and Governance	1,953	168	174	-6	-3.7	478	525	-47	-9.8
Pharmacy	3,988	339	293	45	13.4	1,016	934	81	8.0
Transformation Team	412	35	34	1	3.2	104	100	4	3.6
Research and Development	61	5	5	0	0.0	15	15	0	0.0
Trust Executive	2,478	200	225	-25	-12.5	681	721	-40	-5.9
Total Corporate	**47,503**	**4,006**	**3,985**	**22**	**0.5**	**12,067**	**12,105**	**-38**	**-0.3**
Total	**203,152**	**17,994**	**18,714**	**-720**	**-4.0**	**53,960**	**55,859**	**-1,898**	**-3.5**

Page 67 of 320

Warrington and Halton Hospitals NHS Foundation Trust

Appendix G

Cash Flow Statement For 2017/18

	Actual	Actual	Actual	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Annual
	April £000's	May £000's	June £000's	July £000's	August £000's	September £000's	October £000's	November £000's	December £000's	January £000's	February £000's	March £000's	Position £000's
CASH FLOW FROM OPERATING ACTIVITES													
Surplus/(deficit) after tax	**(1,535)**	**(586)**	**(30)**	**(57)**	**(183)**	**(341)**	**699**	**868**	**(451)**	**929**	**(237)**	**801**	**(123)**
Non-cash income and expense	463	463	381	463	463	463	463	463	463	462	462	543	5,552
Operating cash flows before movement in working capital	**(1,072)**	**(123)**	**351**	**406**	**280**	**122**	**1,162**	**1,331**	**12**	**1,391**	**225**	**1,344**	**5,429**
(Increase)/decrease in working capital	1,911	657	306	1,035	(553)	356	1,097	(138)	85	1,305	(1,966)	(1,046)	**3,049**
Net cash generated from/(used in) operations	**839**	**534**	**657**	**1,441**	**(273)**	**478**	**2,259**	**1,193**	**97**	**2,696**	**(1,741)**	**298**	**8,478**
CASH FLOW FROM INVESTING ACTIVITIES													
Interest received	1	2	1	2	2	2	2	2	2	2	3	5	**26**
Purchase of property, plant and equipment and investment property	(291)	(604)	(645)	(463)	(463)	(463)	(463)	(463)	(463)	(463)	(463)	(1,756)	**(7,000)**
Net cash generated from/(used in) investing activities	**(290)**	**(602)**	**(644)**	**(461)**	**(461)**	**(461)**	**(461)**	**(461)**	**(461)**	**(461)**	**(460)**	**(1,751)**	**(6,974)**
CASH FLOW FROM FINANCING ACTIVITIES													
Public dividend capital received	-	-	-	-	-	-	-	-	-	-	-	1,000	**1,000**
Public dividend capital repaid	-	-	-	-	-	-	-	-	-	-	-	-	**-**
Loans from DH - received	1,603	-	-	-	-	1,503	-	-	-	-	-	551	**3,657**
Loans from DH - repaid	(2,000)	-	-	-	(53)	-	-	-	-	-	(53)	-	**(2,106)**
Interest paid	(30)	(33)	(36)	(31)	(32)	(33)	(31)	(32)	(33)	(31)	(33)	(29)	**(384)**
Interest elements of finance leases	(3)	(4)	(3)	(3)	(3)	(3)	(3)	(4)	(4)	(4)	(4)	(4)	**(42)**
PDC dividend (paid)/refunded	-	-	-	-	-	(1,637)	-	-	-	-	-	(1,638)	**(3,275)**
Net cash generated from/(used in) financing activities	**(430)**	**(37)**	**(39)**	**(34)**	**(88)**	**(170)**	**(34)**	**(36)**	**(37)**	**(35)**	**(90)**	**(120)**	**(1,150)**
Increase/(decrease) in cash and cash equivalents	**119**	**(105)**	**(26)**	**946**	**(822)**	**(153)**	**1,764**	**696**	**(401)**	**2,200**	**(2,291)**	**(1,573)**	**354**
Cash and cash equivalents at start of period	1,201	1,320	1,215	1,189	2,135	1,313	1,160	2,924	3,620	3,219	5,419	3,128	**1,201**
Closing Cash and Cash equivalents less bank overdraft	**1,320**	**1,215**	**1,189**	**2,135**	**1,313**	**1,160**	**2,924**	**3,620**	**3,219**	**5,419**	**3,128**	**1,555**	**1,555**

Warrington and Halton Hospitals NHS Foundation Trust **Appendix H**

Statement of Financial Position as at 30th June 2017

Narrative	Audited Position as at 31/03/17 £000	Actual Position as at 31/05/17 £000	Actual Position as at 30/06/17 £000	Monthly Movement £000	Forecast Position as at 31/03/18 £000
NON-CURRENT ASSETS					
Intangible Assets	2,308	2,274	2,232	(42)	1,047
Property, Plant and Equipment	117,890	117,917	118,192	275	124,091
Trade and Other Receivables, non-current	991	999	925	(74)	1,205
Total Non-Current Assets	**121,189**	**121,190**	**121,349**	**159**	**126,343**
CURRENT ASSETS					
Inventories	3,437	3,510	3,508	(2)	3,312
Trade and Other Receivables, current	13,163	13,784	15,141	1,357	8,398
Cash and Cash Equivalents	1,201	1,215	1,189	(26)	1,555
Total Current Assets	**17,801**	**18,509**	**19,838**	**1,329**	**13,265**
Total Assets	**138,990**	**139,699**	**141,187**	**1,488**	**139,608**
CURRENT LIABILITIES					
Trade and Other Payables	(16,405)	(20,091)	(21,939)	(1,848)	(22,824)
Other Liabilities	(4,070)	(4,434)	(4,435)	(1)	(3,880)
Borrowings, current	(454)	(14,655)	(14,655)	0	(14,491)
Provisions	(279)	(197)	(247)	(50)	(256)
Total Current Liabilities	**(21,208)**	**(39,377)**	**(41,276)**	**(1,899)**	**(41,451)**
TOTAL ASSETS LESS CURRENT LIABILITIES	**117,782**	**100,322**	**99,911**	**(411)**	**98,157**
NON-CURRENT LIABILITIES					
Borrowings, non-current	(28,152)	(13,493)	(13,374)	119	(13,562)
Provisions	(1,377)	(1,357)	(1,362)	(5)	(1,198)
Total Non Current Liabilities	**(29,529)**	**(14,850)**	**(14,736)**	**114**	**(14,760)**
TOTAL ASSETS EMPLOYED	**88,253**	**85,472**	**85,175**	**(297)**	**83,397**
TAXPAYERS' EQUITY					
Public dividend capital	87,742	87,742	87,742	0	88,742
Income and expenditure reserve	(21,967)	(24,748)	(25,045)	(297)	(27,823)
Revaluation Reserve	22,478	22,478	22,478	0	22,478
TOTAL TAXPAYERS' EQUITY	**88,253**	**85,472**	**85,175**	**(297)**	**83,397**

Warrington and Halton Hospitals NHS Foundation Trust

Appendix H

Aged Debt Analysis as at 30th June 2017

			Days Overdue							
Current month	**No. of Invoices**	**Current**	**1-30**	**31-60**	**61-90**	**91-120**	**121-180**	**181-360**	**361+**	**Total Debt**
NHS		**3,147,571**	**491,780**	**511,015**	**159,272**	**184,770**	**67,297**	**64,550**	**10,255**	**4,636,512**
Non NHS		**358,741**	**213,250**	**20,686**	**209,053**	**30,502**	**2,346**	**18,415**	**130,485**	**983,478**
	759	**3,506,312**	**705,031**	**531,701**	**368,325**	**215,272**	**69,643**	**82,965**	**140,740**	**5,619,990**
Percentage debt - by age (individual)		**62%**	**13%**	**9%**	**7%**	**4%**	**1%**	**1%**	**3%**	**100%**
Percentage debt - by age (cumulatively)		**62%**	**75%**	**84%**	**91%**	**95%**	**96%**	**97%**	**100%**	
Previous month	778	**1,994,650**	**671,327**	**453,806**	**233,664**	**52,124**	**45,716**	**60,941**	**139,554**	**3,651,783**
Change on previous month (-ve is a reduction on last month)	-19	**1,511,663**	**33,703**	**77,895**	**134,660**	**163,148**	**23,927**	**22,024**	**1,186**	**1,968,206**

			Days Overdue									
Customer	**No. of Invoices**	**Current**	**1-30**	**31-60**	**61-90**	**91-120**	**121-180**	**181-360**	**361+**	**Total Debt**	**Paid to 10.07.17**	**Revised Debt**
NHS WARRINGTON CCG	5	1,109,746	0	388,805	170	0	0	0	0	1,498,722	-2,002	1,496,719
NHS ENGLAND	19	814,348	59,194	26,737	18,000	-797	777	0	0	918,260	-2,407	915,853
BRIDGEWATER COMM HEALTHCARE FOUNDATION TRUST	69	57,124	111,149	70,346	108,966	185,567	66,520	44,377	10,194	654,241	-371,186	283,055
NHS HALTON CCG	5	452,778	-7,920	0	0	0	0	0	0	444,858	-5,054	439,804
HALTON BOROUGH COUNCIL	8	249,898	66,753	0	0	0	0	0	0	316,651	-217,569	99,082
ONE TO ONE (NW) LTD	46	5,449	2,586	13,948	185,939	0	0	0	29,656	237,577		237,577
ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST	15	38,715	146,744	4,100	4,529	0	0	0	0	194,088		194,088
NORTH WEST BOROUGHS HEALTHCARE NHS FOUNDATION TRUST	7	124,009	306	-8,802	2,820	0	0	20,000	-1,027	137,305	-47,715	89,590
CARDIFF & VALE UNIVERSITY HB	1	0	101,055	0	0	0	0	0	0	101,055	-101,055	0
NHS ST HELENS CCG	1	86,025	0	0	0	0	0	0	0	86,025		86,025
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	4	73,597	43	0	0	0	0	0	0	73,641	-24	73,617
THE CLATTERBRIDGE CANCER CENTRE NHS FT	6	28,650	35,570	0	0	0	0	0	0	64,219		64,219
HEALTH EDUCATION ENGLAND	4	60,328	0	0	0	0	0	0	0	60,328		60,328
WARRINGTON BOROUGH COUNCIL	5	1,005	1,005	1,005	432	0	0	0	46,036	49,483		49,483
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	6	28,616	6,784	2,050	0	0	0	0	0	37,450	-22,088	15,363
Other Debtors	558	376,025	181,762	33,512	47,469	30,502	2,346	18,588	55,882	746,087		746,087
	759	**3,506,312**	**705,031**	**531,701**	**368,325**	**215,272**	**69,643**	**82,965**	**140,740**	**5,619,990**	**-769,099**	**4,850,891**

Warrington and Halton Hospitals NHS Foundation Trust **Appendix I**

Analysis of Aged Creditors as at 30th June 2017

			Days Overdue				
Current month	**No. of Invoices**	**Current**	**1-30**	**31-60**	**61-90**	**91+**	**Total**
NHS	634	473,237	574,116	279,177	466,426	1,676,295	3,469,251
Non NHS Trade	6,209	3,997,569	3,127,675	947,206	87,532	461,109	8,621,090
Non NHS Other	32	117,936	2,196	37,107	1,048	92,239	250,526
	6,875	**4,588,742**	**3,703,986**	**1,263,490**	**555,006**	**2,229,643**	**12,340,867**
Percentage Credit - by age (individual)		37.2%	30.0%	10.2%	4.5%	18.1%	100%
Percentage Credit - by age (cumulatively)		37.2%	67.2%	77.4%	81.9%	100.0%	
Previous month	**5,041**	**3,503,351**	**3,440,800**	**765,732**	**450,651**	**1,797,227**	**9,957,761**
Change on previous month (-ve is a reduction on last month)	1,834	1,085,391	263,186	497,758	104,355	432,417	2,383,107

		Days Overdue						
Analysis of the largest 15 creditors (by value (£)) as at 30th June 2017	**Current**	**1-30**	**31-60**	**61-90**	**91+**	**Total**	**Paid to 06/07/17**	**Revised Credit**
NHS SUPPLY CHAIN	706,845	424,064	131,214	0	740	1,262,863	-115,086	1,147,777
NHS PROFESSIONALS LTD	631,921	212,468	0	0	0	844,388	-322,243	522,145
ST HELENS & KNOWSLEY HOSPITALS NHS TRUST	158,009	382,949	171,827	9,572	75,988	798,345	-186,788	611,557
BRIDGEWATER COMMUNITY HEALTHCARE NHS FOUNDATION TRUST	30,285	11,338	9,437	114,862	460,638	626,560		626,560
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	-4,774	0	2,341	603	319,636	317,806	-5,291	312,515
AINTREE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	8,078	8,516	13,105	13,932	263,199	306,831		306,831
COMMUNITY HEALTH PARTNERSHIPS LTD	0	0	0	0	281,661	281,661		281,661
GILEAD SCIENCES LTD	28,906	152,188	56,000	0	0	237,094		237,094
HEALTHCARE AT HOME LTD	54,270	168,752	0	0	-7,289	215,734	-215,733	0
CENTRAL MANCHESTER UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	41,748	38,585	30,544	44,499	54,998	210,374		210,374
CYNERGIN	205,746	0	0	0	0	205,746		205,746
JOHNSON & JOHNSON MEDICAL LTD	88,336	57,050	17,721	2,645	27,306	193,058	-6,571	186,487
ONE TO ONE (NORTH WEST) LTD	13,524	49,522	10,384	0	105,037	178,466		178,466
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	1,140	4,484	87	151,183	980	157,875	-10,457	147,417
NOVARTIS PHARMACEUTICALS UK LTD	72,412	63,500	21,316	0	0	157,229	-4,067	153,161
OTHER CREDITORS	2,552,296	2,130,570	799,514	217,709	646,749	6,346,838	-1,086,562	5,260,276
Total	**4,588,742**	**3,703,986**	**1,263,490**	**555,006**	**2,229,643**	**12,340,867**	**-1,952,799**	**10,388,069**

		Days Overdue						
Analysis of the largest 15 creditors (by volume) as at 30th June 2017	**Current**	**1-30**	**31-60**	**61-90**	**91+**	**Total**	**Paid to 06/07/17**	**Revised Volume**
MAWDSLEY BROOKS & CO LTD	82	177	28	-	0	287		287
JOHNSON & JOHNSON MEDICAL LTD	114	94	26	4	10	248	-9	239
HEALTHCARE AT HOME LTD	45	164	-	-	1	210	-179	31
PHOENIX HEALTHCARE DISTRIBUTION LTD	72	121	1	2	1	197		197
ONE TO ONE (NORTH WEST) LTD	10	4	9	-	129	152		152
JJR ORTHOPAEDIC SERVICES	49	73	25	-	0	147	-33	114
EAST CHESHIRE NHS TRUST	72	18	9	1	3	103	-22	81
VITESSE PLC	18	71	10	-	2	101	-22	79
ALLOGA UK LTD	49	51	1	-	0	101		101
DATA SPACE	47	39	2	-	9	97	-26	71
H JENKINSON & CO LTD	32	48	11	1	4	96	-8	88
MAX20 LTD	66	27	-	-	0	93	-2	91
MOLNLYCKE HEALTH CARE LTD	37	36	5	-	0	78	-29	49
PROMEDICS ORTHOPAEDIC LTD	29	35	9	-	0	73		73
COMMUNITY HEALTH PARTNERSHIPS LTD	-	-	-	-	70	70		70
OTHER CREDITORS	1,818	1,748	669	127	459	4,821	-869	3,952
Total	**2,543**	**2,706**	**805**	**135**	**688**	**6,874**	**-1,199**	**5,675**

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Warrington and Halton Hospitals NHS
NHS Foundation Trust

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/17/07/85 b**	
SUBJECT:	**Safe Staffing Assurance Report**	
DATE OF MEETING:	26th July 2017	
ACTION REQUIRED	**The Board of Directors are asked to note the contents of the report**	
AUTHOR(S):	John Goodenough, Deputy Chief Nurse	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon –Jamieson, Chief Nurse	
LINK TO STRATEGIC OBJECTIVES:	SO1: To ensure that all care is rated amongst the top quartile in the North West of England for patient safety, clinical outcomes and patient experience	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	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.	
RECOMMENDATION:	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.	
PREVIOUSLY CONSIDERED BY:	**Committee**	
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	
FREEDOM OF INFORMATION STATUS (FOIA):		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***		

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NHS Foundation Trust

Safe Staffing Assurance Report

Introduction

The purpose of this paper is to provide transparency with regard to the nursing and midwifery ward staffing levels during June 2017. It is forms part of the expectation set out in the National Quality Board (NQB) guidance published in November 2013 that Boards take full responsibility for the quality of care provided to patients, and, as a key determinant of quality, take full responsibility for nursing, midwifery and care staffing capacity and capability.

The Trust has a duty to ensure nursing and midwifery staffing levels are sufficient to maintain safety and provide quality care. This paper provides assurance that any shortfalls on each shift were reviewed and addressed as required with mitigating actions 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 of 90% and over is considered acceptable nationally.

The June Trust wide staffing data was analysed and cross referenced for validation by Divisional Matrons and Divisional Associate Director of Nurses

Appendix 1 identifies the fill rate for staff across the Trust with Care Hours Per Patient Day (CHPPD). The table also triangulates this information by illustrating the harms reported within each area.

Appendix 2 identifies the mitigating actions taken in areas where the actual numbers of registered nurses and health care support staff where below the planned numbers of staff. This report demonstrates the monthly CHPPD per ward across the Trust and provides assurance of the divisional actions taken to provide adequate staffing levels on a day to day / shift by shift basis.

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Appendix 1

Monthly Safe Staffing Report – June 2017																		
	Day	Day	Day	Day	Day	Day		Night	Night	Night	Night	Night	Night					
Division	Ward	Planned RN hours	Actual RN hours	Planned CS hours	Actual CS hours	% RN fill rate	% CS fill rate	Planned RN hours	Actual RN hours	Planned CS hours	Actual CS hours	% RN fill rate	% CS fill rate	Falls (Mod and Above)	Cdiff	MRSA	Pressure Ulcers
		= above 100%			= above 90%				= above 80%				= below 80%				
SWC	SAU	900	877.5	675	600	97.5	88.9	NA	NA	NA	NA	-	-				
SWC	Ward A5	1725	1479.5	1264	1134	85.8	89.7	1035	989	690	690	95.6	100				
SWC	Ward A6	1725	1420.5	1380	1663	82.3	120.5	1035	954.5	690	701.5	92.2	101.7				
SWC	Ward C22	1035	977.5	1035	879.5	94.4	85.0	690	690	690	655.5	100	95.0				
SWC	Ward B4	754.5	678.5	441.5	396.5	89.9	89.8	483	241.5	241.5	241.5	50.0	100				
SWC	CMTC	1541	1336	943	935	86.7%	99.2%	690	690	690	644	100.0%	93.3%				
SWC	Ward A9	1725	1379.5	1380	1944	80.0	140.9	1035	1005	1035	977.5	97.1	94.4				1
SWC	Ward B1	1541	1336	943	935	86.7	99.2	690	690	690	644	100	93.3	1			
SWC	Ward B11	1860.2	1823.3	949.5	864.9	98.0	91.1	1553.8	1543.4	0	0	99.3					
SWC	NCU	1725	1433.5	345	264.5	83.1	76.7	1782.5	1276.5	345	241.5	71.6	70.0				
SWC	Ward C20	941	917.5	642.5	620.5	97.5	96.6	705	713	0	0	101.1					
SWC	Ward C23	1380	1230.5	690	586.5	89.2	85.0	690	690	690	563.5	100.0	81.7				
SWC	Delivery Suite	2415	2262	352	308.3	93.7	87.6	2415	2328	345	310.5	96.4	90.0				

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ACS	Ward A1	2250	2043.5	1500	1500	90.8	100.0	1890	1543.5	630	619.5	81.7	98.3				
ACS	Ward A2	1380	1110.5	1556	1372	80.5	88.2	1035	977.5	690	828	94.4	120.0				1
ACS	Ward A3	1380	1198.5	1380	1730	86.8	125.4	1035	989	690	1070	95.6	155.1	1			2
ACS	Ward A4	1129.5	1079.5	1621.5	1484	95.6	91.5	724.5	724.5	1035	1000.5	100	96.7				
ACS	Ward A8	1725	1271	2070	1707.5	73.7	82.5	1035	1035	1725	1207.5	100	70.0				
ACS	Ward B12	1103.5	1063	2185	1928	96.3	88.2	690	690	1380	1322.5	100	95.8				
ACS	Ward B14	1380	1288	1380	1311	93.3	95.0	690	690	690	793.5	100	115.0	1			
ACS	Ward B18	1380	1070.8	1380	1311	77.6	95.0	1035	862.5	1035	977.5	83.3	94.4				
ACS	Ward A7	1725	1407	2012.5	1466.5	81.6	72.9	1380	1357	1633	1357	98.3	83.1				2
ACS	Ward C21	1035	1035	713	993.5	1000	139.3	690	690	690	942.9	100	136.7				
ACS	CCU	1725	1255	345	323.75	72.8	93.8	1035	1035	0	0	100					
ACS	ICU	4830	4749.5	1035	632.5	98.3	61.1	4830	4726.5	690	333.5	97.9	48.3				

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Appendix 2

	Day		Night		Mitigation Actions
	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	
SAU	97.5	88.9	-	-	SAU is closed overnight. Staff moved to help assist wards when quieter in SAU and short term sickness
A5	85.8	89.7%	95.6	100.0	On-going recruitment for the RN vacancies (1 RN newly qualified starting in Sept 17) All outstanding shifts escalated to NHSP
A6	82.3	120.5	92.2	101.7	A number of 1:1 enhanced care CSW shifts required during June. On-going recruitment for the RN vacancies (2 RN newly qualified starting in Sept 17) All outstanding shifts escalated to NHSP
C22	94.4	85.0	100.0	95.0	Short term sickness monitored by Matron and Ward Manager
B4	89.9	89.8	50.0	100.0	Ward Closes Sat a.m. and re-opens Monday a.m. Short term CW sickness.
CMTC	86.7	99.2	100.0	93.3	The activity varies at CMTC and the staff are rostered flexibly to manage the service.
A9	80.0	140.9	97.1	94.4	Increased dependency of patients has been supported by an increase in Care worker levels RN on-going recruitment. Redesign to T&O skill mix at night following team consultation with Senior Nurses.
B1	86.7	99.2	100.0	93.3	The acuity and dependency of the patients is assessed daily to ensure patient to staff ratio can support safe care, when required registered nursing numbers are flexed to reflect this. The increase in short term sickness and vacancies are now addressed.
NICU	83.1	76.7	71.6	70.0	Staffing is monitored daily against BAPM compliance and escalated as necessary to reflect the current acuity and dependency.

C23	89.2	85.0	100.0	81.7	Staffing and acuity reviewed daily by the Matrons. Daily assessment of areas made resulting in redeployment of staff and escalation to NHSP as per escalation policy
Delivery Suite	93.7	87.6	96.4	90.0	Staffing and acuity reviewed daily by the Matron. Daily assessment of areas made resulting in redeployment of staff and escalation to NHSP as per escalation policy
A1	90.8	100.0	81.7	98.3	Staffing reviewed daily by Matron and senior nurse team. Support given to ward by Matron and staff moved where possible
A2	80.5	88.2	94.4	120.0	Staffing reviewed daily by Matron and senior nurse team. Support given to ward by Matron and staff moved where possible
A3	86.8	125.4	95.6	155.1	Ward staffing is reviewed each day by the senior nurse team and adjustments made across the division from other wards support any gaps in the nursing rota. Increased Matron presence on the ward daily to support the delivery of safe care and a recent reduction in bed capacity is in place to mitigate against staffing gaps.
A8	73.7	82.5	100.0	70.0	Daily staffing for the ward is reviewed by the senior nursing team and staff are moved from across the division to support when required. On-going recruitment process in place increased matron presence.
B12	96.3	88.2	100.0	95.8	Newly qualified supernumerary in month. Ward requiring increase in CW due to increase in enhanced care demand
B18	77.6	95.0	83.3	94.4	Short term sickness in month. Ward reliant on temporary staff to backfill. Safety maintained with daily Matron support
A7	81.6	72.9	98.3	83.1	Increased staffing establishment continues both RN & CW, increased EC patients for June. Matron supported ward on days when staffing at 3 Q.
CCU	72.8	93.8	100.0		Awaiting RN to commence in post

ITU	98.3	61.1	97.9	48.3	The reduction in care workers had no negative impact on patient safety

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Warrington and Halton Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/17/07/85 (c)**	
SUBJECT:	**Engagement Dashboard June 2017**	
DATE OF MEETING:	Choose an item. 26 July 2017	
ACTION REQUIRED	**For Assurance**	
AUTHOR(S):	Pat McLaren Director of Community Engagement + Corp Affairs	
EXECUTIVE DIRECTOR SPONSOR:	Pat McLaren, Director of Community Engagement + Corp Affairs Choose an item.	
LINK TO STRATEGIC OBJECTIVES:	All	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	BAF2.4: Engaging & Involving Workforce	
	Choose an item.	
	Choose an item.	
STRATEGIC CONTEXT	The Trust is required to engage with its patients, public, staff and partners and many other stakeholders as set out in the Foundation Trust's membership and engagement strategy.	
EXECUTIVE SUMMARY (KEY ISSUES):	This report provides a high-level overview of how well the Trust is engaging and involving key stakeholder groups i.e. those who use, work, visit, volunteer, support, commission, partner or donate to our hospitals. It shows clear trends and progress against our key communication and engagement objectives.	
RECOMMENDATION:	The Board is asked to note the report	
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.	

Trust Engagement Dashboard Summary:

June 2017

Media dashboard:

Although media coverage was down in month more than 80% of the tone was positive or neutral. Key positive stories were the blood pressure checks at the Wolves stadium and fundraising-related reporting. Negative reporting related largely to the change to the stroke service which was reported heavily in Halton.

Social Media:

Twitter followers continue to climb steadily at around 100 per month. Twitter output almost doubled in month with an associated reach of 180K. Top tweet earned 275 engagements relating to our radiographers that presented at Trust Board in April, heavy tweeting around the Dragon Boat day significantly enhanced reach.

Facebook Reach was significantly up this month at almost 60K despite lower postings, again driven by shares of the Dragon Boat day. This continues to be our most engaging social media platform.

Website whh.nhs.uk

Website visits were up by 1k in month at 25.7K, with a 50% increase in referrals via social media, our second month of significantly extended referrals. In month our visitors through mobile devices (smart phones and tablets) reached 85%. Dwell time remains low however reflecting the fact that on arrival by mobile device our website is not mobile-enabled. A new website is out to procurement currently.

Staff Engagement

Engagement with Team Brief has got off to a slow start in 2017-18 but there are specific team objectives in place to address this. The merger of the Communications and the Staff Engagement Teams will be a really positive boost to addressing staff engagement; including the NHS staff survey and the Staff FFT which continues to be poorly supported (circa 200 responses) and with highly polarised results.

Patient Engagement

Healthwatch Warrington and Halton has begun seeking feedback through their local sites and early results are very promising for all hospitals. We will continue to encourage this level of public engagement with this vehicle as well as NHS Choices which remains poorly supported (significantly fewer posts than Healthwatch) It is heartening to see all hospitals rated at 4 or 5-stars at this early juncture.

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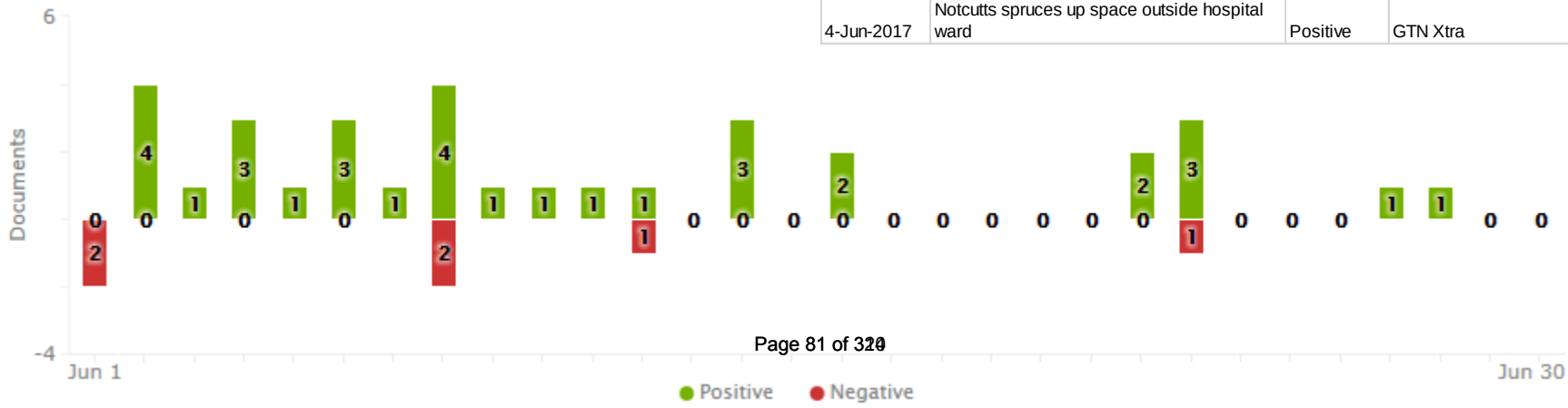
Total Media Coverage = 89 Reports
(↓ from 118 last month)

Media Sentiment 1 – 30th June 2017

Date	Headline	Sentiment	Publication	Reach
8-Jun-2017	The 24 A&E units facing closure across England	Negative	Metro.co.uk	10,106,534
23-Jun-2017	Stroke patients could be sent to Whiston Hospital for emergency treatment instead of Warrington Hospital	Negative	Warrington Guardian	46,827
23-Jun-2017	Stroke patients could be sent to Whiston Hospital for emergency treatment instead of Warrington Hospital	Negative	Warrington Guardian (eClips Web)	46,827
12-Jun-2017	'Musketeer' midwife admits conducting 'inadequate' reviews into tragic maternity scandal deaths	Negative	North West Evening Mail	37,489
19-Jun-2017	Whiston to get specialist stroke unit and will treat patients from wider geographical area	Negative	St Helens Star (eClips Web)	30,516
27-Jun-2017	Halton Hospital to merge day and short stay surgery units	Negative	Runcorn and Widnes World (eClips Web)	16,875
15-Jun-2017	Consultation over changes to stroke services	Negative	Runcorn and Widnes World (eClips Web)	16,875
23-Jun-2017	Consultation over changes to NHS services in St Helens	Negative	St Helens The Reporter	6,946
8-Jun-2017	The 24 A&E units facing closure across England	Negative	Angle News	1,592
13-Jun-2017	Three Peaks in three days for Clatterbridge	Positive	Liverpool Echo (eClips Web)	1,358,806
8-Jun-2017	Helsby and Kingsley friends complete coast to coast charity cycle ride	Positive	Chester Chronicle	79,918
26-Jun-2017	Warrington Wolves fans get blood pressure checked at Halliwell Jones Stadium ahead of Super League clash with Catalan Dragons	Positive	Warrington Guardian	46,827
23-Jun-2017	Nurses to check fans' blood pressure at Warrington Wolves' Super League clash with Catalan Dragons	Positive	Warrington Guardian	46,827
22-Jun-2017	Family thank Warrington Hospital midwives for saving baby Aubrey Diggle's life after newborn stops breathing for 16 minutes	Positive	Warrington Guardian	46,827
16-Jun-2017	Ryfields Retirement Village resident Elsie Birkinshaw raises hundreds for Warrington Hospital's Forget Me Not ward	Positive	Warrington Guardian	46,827
14-Jun-2017	Mum's shock at happy baby's heart operation	Positive	Warrington Guardian	46,827
14-Jun-2017	Curious youngsters learn how to take care of 'amazing heart' in workshop	Positive	Warrington Guardian	46,827
12-Jun-2017	Hospital's head of midwifery receives top honour from Royal College of Midwives	Positive	Warrington Guardian (eClips Web)	46,827
8-Jun-2017	Ward thanks	Positive	Warrington Guardian	46,827
7-Jun-2017	NHS praise	Positive	Warrington Guardian	46,827
4-Jun-2017	Support group for ex-patients of Warrington Hospital's intensive care unit set up	Positive	Warrington Guardian	46,827
2-Jun-2017	MAY: Born in Warrington 2017	Positive	Warrington Guardian (eClips Web)	46,827
2-Jun-2017	Mum-of-two Gail Bell set to mark milestone in recovery from having stroke aged 40 by taking part in Step Out for Stroke Walk	Positive	Warrington Guardian	46,827
1-Jun-2017	Hospital help	Positive	Warrington Guardian	46,827
11-Jun-2017	Friends donate new hospital equipment	Positive	Runcorn and Widnes World (eClips Web)	16,875
4-Jun-2017	Notcutts spruces up space outside hospital ward	Positive	GTN Xtra	318



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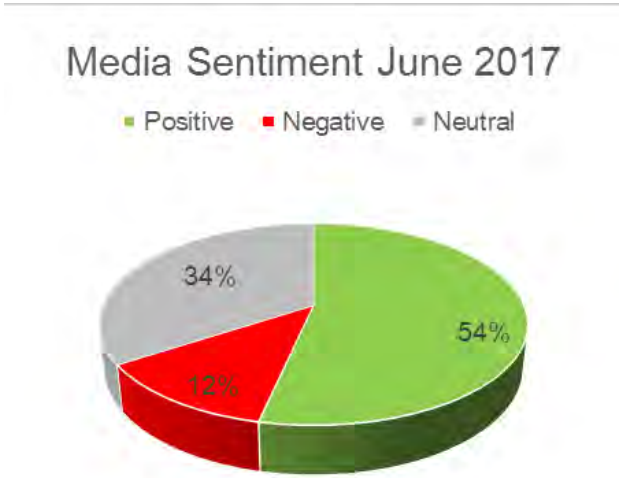
Media Sentiment 1 – 30th June 2017



Family thank Warrington Hospital midwives for saving baby Aubrey Diggle's life after newborn stops breathing for 16 minutes

Nurses will check fans' blood pressure during Saturday's clash between Warrington Wolves and Catalan Dragons at the Halliwell Jones Stadium.

Halton Hospital is merging its day and short stay surgery service from mid July

Halton Hospital to merge day and short stay surgery units

Ryfields Retirement Village resident Elsie Birkinshaw raises hundreds for Warrington Hospital's Forget Me Not ward

League of Friends donates two new observation machines to ward B1 at Halton Hospital

Stroke patients could be sent to Whiston Hospital for emergency treatment instead of Warrington Hospital

Page 82 of 320

Warrington&HaltonNHS @WHHNHS · Jun 18
Getting to becoming live shortly for the final of #dragonboatrace2017 @WHHCharity

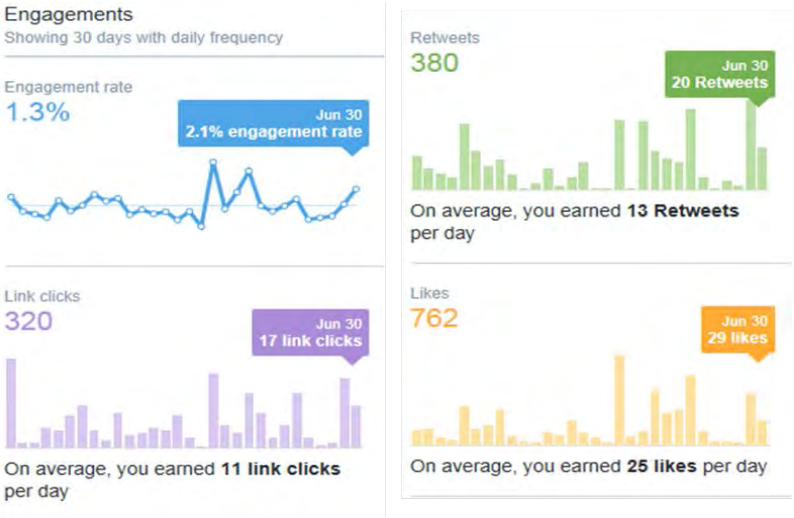
Warrington and Halton Hospitals NHS Foundation Trust
Published by Gina Coldrick [?] · 18 June at 11:15 ·
Dragon Boat for Warrington and Halton Hospitals Charity at Manley Mere with Mel Pickup, chief executive and Mayor of Warrington Cllr Les Morgan #dragonboatrace2017 Dragon Boat Races

Facebook

4,167 Total Likes (Last month: 4060)

38 WHH Posts (Last month: 131)

62.5K Reach (impressions) (Last month: 20.8K)



Published	Post	Type	Targeting	Reach
30/06/2017 12:45	Do you have a passion for supporting people in your local comm			2.9K
27/06/2017 11:49	Join us on Tuesday 4th July at our maternity experience worksho			937
27/06/2017 09:47	The trust operates a no smoking policy. Smoking is not allowed a			1.2K
26/06/2017 09:45	Do you know your rights? Find them out here: http://ow.ly/hL8W			630
24/06/2017 15:44	Successful event with over 100 blood pressure checks. Some hi			1.9K
24/06/2017 14:26	Never too young to get your #blood pressure checked Stroke Ass			1.2K
24/06/2017 13:44	The Stroke Association North West and B14 are ready at Warrin			1.6K

Twitter

8,434 Followers (Last month: 8,352)

156 WHH Tweets (Last month: 87)

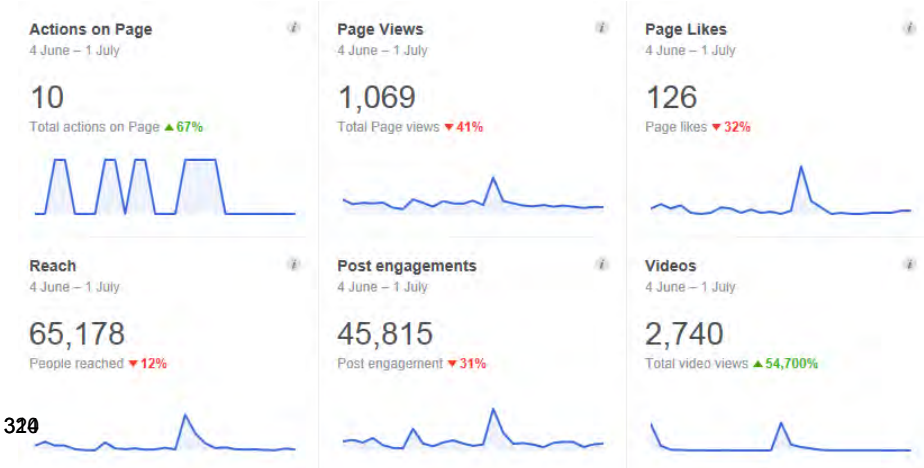
181K Reach (Last month: 186K)

Top mention earned 274 engagements

Louise Harding
@louiseaharding · Jun 22

We got a badge :-)"embracing change"for introducing #WMTY17 at @WHHNHS. Thnks @Mel_Pickup & team for support & embracingWMTY at r fab trust pic.twitter.com/iylgdbXV6K

1 3 16



Website Dashboard

Website

WHH

25,761 Visits

Last month: 24838

1443 Social Media Referrals

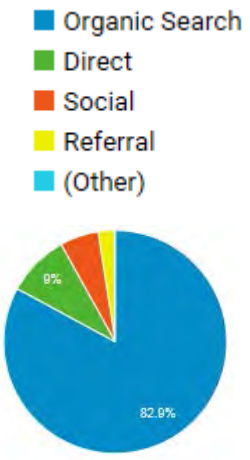
Last month: 903

1min 33s Length of average time

Last month: 1.31s

Device Category	Sessions	% New Sessions
	25,761 % of Total: 100.00% (25,761)	64.36% Avg for View: 64.35% (0.02%)
1. mobile	14,231 (55.24%)	59.39%
2. desktop	8,381 (32.53%)	73.44%
3. tablet	3,149 (12.22%)	62.69%

Mobile Device Info	Sessions	% New Sessions
	17,380 % of Total: 67.47% (25,761)	59.99% Avg for View: 64.35% (-6.78%)
1. Apple iPhone	7,493 (43.11%)	57.60%
2. Apple iPad	2,157 (12.41%)	62.36%
3. Samsung SM-G920F Galaxy S6	631 (3.63%)	58.95%
4. (not set)	558 (3.21%)	58.24%
5. Samsung SM-G935F Galaxy S7 Edge	524 (3.01%)	58.59%
6. Samsung SM-G930F Galaxy S7	518 (2.98%)	62.16%
7. Samsung SM-G900F Galaxy S5	231 (1.33%)	59.31%
8. Samsung SM-G925F Galaxy S6 Edge	220 (1.27%)	57.27%
9. Samsung SM-J500FN Galaxy J5	193 (1.11%)	49.74%
10. Apple iPhone 6s	162 (0.93%)	75.31%



Staff Engagement

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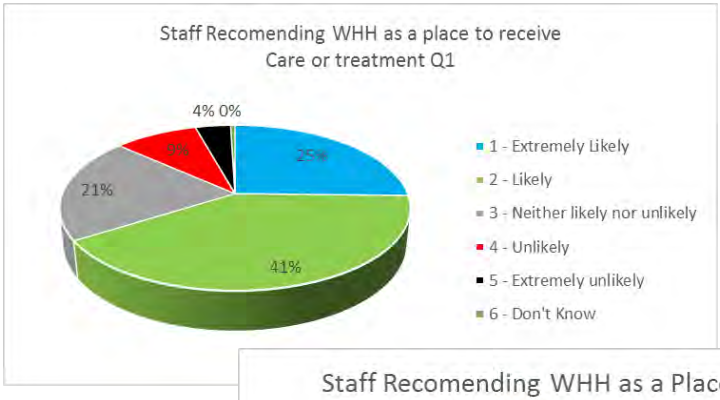
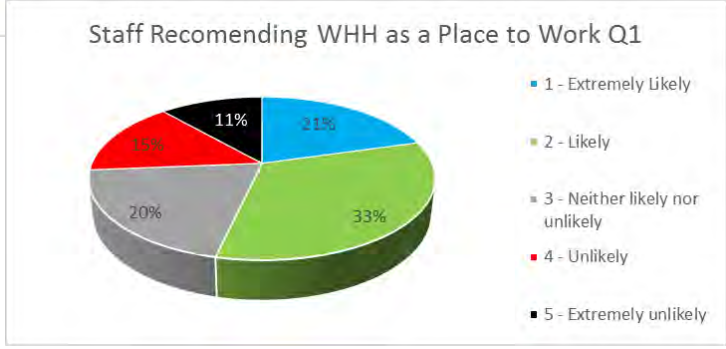
Team Brief Attendances

Staff engagement with Team, delivered at two sites on two separate days following Board each month, has got off to a challenging start in 2017-18. Additional programmes are being implemented to drive this engagement. Team Brief is a proven large, multi-site organisation engagement tool.



Staff FFT Q1



Patient Engagement/Experience 1 – 30th June 2017

Average Rating by NHS Choices

3.5
Average rating at Warrington
Last month: 3.5

5
Average rating at Halton
Last month: 5

5
Average rating at CMTC
Last month: 4.5

healthwatch

Warrington Hospital

Feedback Rating

★★★★☆

Based on 315 reviews

Halton Hospital

Feedback Rating

★★★★☆

Based on 37 reviews

CMTC

Feedback Rating

★★★★★

Based on 1 reviews

Warrington and Halton Hospitals NHS Foundation Trust		Postings/ratings	Total Engagements
Patient Opinion – Every voice matters	5 ★	7	14
	4 ★	3	
	3 ★	0	
	2 ★	2	
	1 ★	2	
iWantGreatCare – The trusted site for healthcare reviews	5 ★	7	7
	4 ★	1	
	3 ★	0	
	2 ★	0	
	1 ★	0	
NHS choices	5 ★	7	14
	4 ★	1	
	3 ★	1	
	2 ★	1	
	1 ★	4	

iWantGreatCare
The trusted site for healthcare reviews

15th June 2017
Written by a patient

Excellent service
All staff very considerate, friendly and helpful.
Procedure professionally carried out

1st June 2017
Written by a patient

I am really happy with the love n care I received. Got all The guidance needed as a new mum.
Extremely helpful staff. I recommend all new moms to this care unit
Thank u for all the support

HIGH QUALITY, SAFE HEALTHCARE
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Warrington and Halton Hospitals NHS
NHS Foundation Trust

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BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/17/07/85 d**	
SUBJECT:	**Key Issues Report from the Quality Committee 4 July 2017**	
DATE OF MEETING:	Choose an item. 26th July 2017	
ACTION REQUIRED	**For Assurance**	
AUTHOR(S):	Margaret Bamforth, Committee Chair	
DIRECTOR SPONSOR:		
LINK TO STRATEGIC OBJECTIVES:	All	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	BAF1.1: CQC Compliance for Quality	
	BAF1.2: Health & Safety	
	BAF2.2: Nurse Staffing	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	
EXECUTIVE SUMMARY (KEY ISSUES):	This report provides a high level summary of business at the July meeting.	
RECOMMENDATION:	**The Board note the report and the following issues for escalation. The Committee continues to lack assurance regarding the reduction of harm relating to falls, particularly those occurring at night. The area of safe staffing continues to be an area of concern and remains at a high level of risk.**	
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	

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KEY ISSUES REPORT
QUALITY COMMITTEE

Date of meeting:	**4th July 2017**
Standing Agenda Items	Quality Dashboard Corporate Risk Register and Board Assurance Framework
Formal Business	**Serious Incidents** • 7 SIs reported in June (as of 22.06.17) with 18 incidents reported year to date. Of particular concern are the 3 SIs relating to falls which have resulted in serious harm to patients. • Specialist medicine has the highest number of SIs followed by urgent and emergency care. • The report provided a table of wards with a significant number of SIs, with one ward having had 6 SIs in the period April 2016 – March 2017. • 36 breached actions remain and these are being managed at CBU level. • Duty of candour remains a concern but there are mechanisms in place to monitor application of duty of candour for the 7 incidents currently being investigated. The report also contains details of the recommendations, learning and improvement following the investigation of SIs and NEVER events. The Committee noted the report. The areas highlighted as concerns are escalated to the Board for noting. **Falls Action Plan** John Goodenough, Deputy Chief Nurse, presented the Falls Action Plan. Most actions are either complete or on track so it was disappointing to hear that patients are continuing to suffer serious harm through falling. There was a discussion about falls that occur at night and how these might be prevented. The action plan is to be reviewed and expanded by the newly recruited Falls Specialist Nurse. Due to the on-going lack of assurance, the Committee felt that there should be escalation to the Board for noting. The Committee will continue to monitor this issue and remains sighted regarding the on-going concerns through a number of sources. Progress on the action plan will also be monitored directly by the QC. **Safe Staffing** The Quality Committee has agreed to identify key risks currently on the Risk Register to examine more closely and in greater depth. This is in order to fulfil its role as the Committee with oversight of the Corporate Risk Register. The risk that relates to adequate and safe staffing currently stands at a score of 20 with likelihood score of 5 and an impact score of 4.

	At the previous meeting it was agreed to look at this risk in greater depth. As part of the deep dive into this risk, Kimberley Salmon-Jamieson, Chief Nurse, presented a paper on staffing incidents and related risks, as well as the 6 monthly safe staffing report. These reports identify some important trends and demonstrate that staffing levels correlate with Serious Incidents, allowing identification of the wards most at risk. Areas for escalation to Board include, agency and locum training, mandatory training being cancelled, lack of consistent medical cover, and the standard for staffing in paediatric services not being met. The use of the Safer Nursing Care Tool has identified lack of sufficient headroom or uplift, which takes account of planned and unplanned leave, compared to other equivalent Trusts. In addition, data extracted from the e-rostering tool showed significant variability in the allocation and usage of supervisory time for Ward Managers. The papers presented were complex and technical but offered significant data that triangulate with other quality metrics. The Quality Committee intends to return to complete the deep dive and further examine the issues. The concerns relating to safe staffing and staffing incidents are escalated to the Board for noting. **Complaints Improvement Report** The Quality Committee received the Complaints Improvement Report that highlighted a number of key issues. • A full data cleanse of complaints has now been completed – all in-boxes reviewed and all complaints will be recorded on Datix which is the sole system for recording complaints. • The Complaint Team function has been reviewed and additional resources put in place. • The PALS service has been reviewed and a business case developed. • Training will be delivered in June 2017 re complaints handling and a rolling programme put in place. • Both the number of open complaints and the complaints open over 6 months have shown a significant downward trend. 280 complaints have been closed since 1st February. • There is evidence that the quality of the complaints management process has improved with fewer reopened complaints proportionately. The Committee are partially assured given that there is clear evidence of progress. **Patient Stories** The Committee received a paper setting out a variety of methods for managing patient stories, both the gathering and sharing processes. The Committee acknowledges the importance of patient stories as a method of accessing directly the patient experience and as a source of good qualitative data. The Patient Experience Group will consider the proposals

	and take the work forward. **Inpatient Survey** The Committee received the Nation In-patients Survey Action Plan. The Committee was assured that the key issues were being addressed and the plan to improve 'Customer Care', aligned with the WHH values, was progressing. **Bed Reconfiguration Options Paper** Lucy Gardner, Head of Transformation, presented a paper that set out the options for bed reconfiguration. The Committee discussed the rationale for the various options for several areas of service delivery. It was agreed that this item would come back to the Committee when detailed Quality Impact Assessments were available. **High Level Briefing Papers:** The high level briefing papers are now written in a format that identifies clearly issues for escalation to the QC. I have identified one or two of the most significant of these for each of the sub-committees where appropriate. Patient Safety and Clinical Effectiveness • Spinal Surgery Review Medicines Governance • Enoxaparin – intermittent shortages – requires safe implementation of alternatives Event Planning • Lockdown – planning for an electronic lockdown system in A&E Acute Care Services Division High Level Briefing Paper Surgery Women and Children's Division High Level Briefing Paper In addition, the MBRRACE-UK Perinatal Mortality Report (2015 births) was received. There were no concerns identified and the Committee was assured.
Local Policies and Guidance Approved:	Annual Safeguarding Reports DIPC Infection Control Annual Report
Any Learning and Improvement identified from within the meeting:	The SI report specifically identifies learning.
Any other relevant items the Committee wishes to escalate?	On-going concerns re VTE and Duty of Candour

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Warrington and Halton Hospitals NHS
NHS Foundation Trust

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BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/17/07/85 e**	
SUBJECT:	**Key Issues Report from the Finance and Sustainability Committee held 19 July 2017**	
DATE OF MEETING:	26 July 2017	
ACTION REQUIRED	**For Assurance**	
AUTHOR(S):	Terry Atherton, Committee Chair	
DIRECTOR SPONSOR:		
LINK TO STRATEGIC OBJECTIVES:	All	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	BAF1.1: CQC Compliance for Quality	
	BAF1.2: Health & Safety	
	BAF2.2: Nurse Staffing	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	
EXECUTIVE SUMMARY (KEY ISSUES):	This report provides a high level summary of business at the June meeting.	
RECOMMENDATION:		
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	

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KEY ISSUES REPORT
FINANCE AND SUSTAINABILITY COMMITTEE

Date of meeting:	**19 July 2017**
Standing Agenda Items	The Minutes of the FSC held on 21 June 2017 were approved as a correct record without amendment. The Interim Director of HR & OD supported by the Medical Director and Chief Nurse presented the Pay Assurance dashboard alongside the NHSI Checklist. Pay costs for Month 3 at £13.9m are in line with Plan but ytd, they remain £600k ahead of plan. In relation to Agency expenditure as per NHSI Plan, our position has deteriorated June as compared to May. Total Agency Pay was £2.8m for June. Specialist Medicine and Urgent & Emergency Care are the CBUs/Departments with the highest Agency spend. The trajectory for Medical & Dental Staff shows an upward trend for both expenditure & shift breaches. A new Medical Recruitment Group has been formed and there are a significant number of initiatives in train against a difficult external background. In respect of Nursing and Midwifery Staff, expenditure is continuing to show a downward trend albeit there has been a slight increase in the number of breaches. Again there are a significant number of continuing initiatives in train to achieve further progress. Particular attention has been made in respect of the Emergency Department, with the appointment of permanent staff to reduce the reliance on Agency. In respect of AHP Staff, the trend continues to cause concern and a number of initiatives are under consideration. FSC considered schedules of the Top 10 earners Medical and Nursing Agency earners. The Minutes of the Pay Spend and Review Group Meeting of 4 July were considered. The main focus of the Meeting was to produce a Work Plan to catch all elements of pay expenditure and ensure all bases have been covered together with the production of project plans for each element to allow the Group to monitor progress at future meetings. An update was provided in respect of “Theatres at Night” The Chair stressed the limited focus FSC has in respect of this Project. In respect of financial performance for Month 3, the position remains extremely difficult. Whilst for the period to June we are reporting an on plan performance of a deficit of £3.1m, this has been at the expense of the utilisation of reserves, placing further risk to the achievement of the full year’s financial plan. Capex for the Month is below plan and cash is below forecast at £1.2m against plan of £1.6m. Our Creditor position has deteriorated in June albeit that

	elements of previously agreed STF that have been received post month end will be allocated for the benefit of Creditors. The position will be reported in more detail at this month's Private Board. In the light of the financial position presentations were received & debated at length in respect of individual CBUs alongside enhanced internal controls and selective mandatory support. There is now an extensive piece of work underway. For 2017/18, The Trust has a CIP Target of £10.5m. At the end of month 3, the Trust has delivered £1.001m CIP, £0.421m cost avoidance & income recovery, giving a total impact ytd of £1.422m, against a ytd CIP Target of £1.62m. As at 13 July, there are 778 individual savings ideas on the tracker of which 474 have a financial benefit attached to them. Best and worst CIP estimates for the full year reveal there remain significant challenges ahead. FSC received an update in respect of the Theatres Reconfiguration Programme alongside the options approved. The Director of IM&T provided a comprehensive update to the Committee alongside the latest minutes of the ePR Programme Board. A quarterly update was received in respect of Lorenzo benefits realisation. I was agreed that in future that these will be received half yearly. The Acting Chief Operating Officer presented the Corporate Performance Report for the Month of June & hence the first quarter. In terms of the 4 hour performance, we have achieved the first quarter of the agreed improvement trajectory of 90.5% at 91.55% albeit June was a challenge. For Q2, the target rises to 93.5%. An update was received in respect of Primary Care streaming; FSC supported a firm approach in respect of the financial risks that need to be mitigated. Ambulance handovers remain a challenge, NS a change in patient acuity in evening arrivals needs understanding. In the Month and the Quarter, RTT has been delivered, as has Diagnostics. Cancer performance has yet to be evaluated. There is a delayed transfer of care reduction trajectory set by NHSE to be reached by October. The letter dated 21 June from ECIP in respect of our April review was shared and were advised that the recommendations are in train. Outpatients DNAs remain high & F&SC again challenged the lack of progress in respect of the reminder service; advice was that we are now in the Procurement phase. As requested, the Committee received a Paper on the Manchester Attack Debrief, and the actions considered and taken in respect of Security Lockdown.

	An Estate Condition Briefing Paper – 6 Facet Survey was tabled following last month's discussion. This categorised various aspect of the Trusts Estate in this period of limited availability of Capital. Health & Safety Governance within the Trust was also described. A verbal update was received in respect of STP. Waiting List Initiatives were a recurring theme in this month's Meeting. The Director of Transformation presented a Paper outlining the current position regarding WLI payments and outlined the options for payments in the future to ensure productivity and profitability. The Paper went on to describe opportunities around My Choice and Self Funding and Privately Insured Patients
Formal Business	
Local Policies and Guidance Approved:	
Any Learning and Improvement identified from within the meeting:	
Any other relevant items the Committee wishes to escalate?	

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NHS Warrington and Halton Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/17/07/85 f**	
SUBJECT:	**Charitable Funds Committee Chairs Annual Report 2016-17**	
DATE OF MEETING:	26 July 2017	
ACTION REQUIRED	**Decision**	
AUTHOR(S):	Pat McLaren, Director of Community Engagement + Corporate Affairs	
EXECUTIVE DIRECTOR SPONSOR:	Pat McLaren, Director of Community Engagement Choose an item.	
LINK TO STRATEGIC OBJECTIVES:	All	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	Choose an item.	
	Choose an item.	
	Choose an item.	
STRATEGIC CONTEXT	In accordance with the Charitable Funds Committee's Cycle of Business an Annual Report will be produced. This report seeks to deliver assurance to the Board, that the Committee has met its Terms of Reference and has gained assurance throughout the reporting period of the Trust's performance.	
EXECUTIVE SUMMARY (KEY ISSUES):	This report is to provide assurance to the Board that the Committee has met its Terms of Reference and has gained assurance throughout the reporting period of the efficacy of the Trust's internal system of controls.	
RECOMMENDATION:	The Board reviews and approves the document.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Charitable Funds Committee
	Agenda Ref.	CFC17/07/24
	Date of meeting	5 July 2017
	Summary of Outcome	Approved
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.	

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Warrington and Halton Hospitals NHS Foundation Trust

Charitable Funds Committee

SUBJECT	Committee Chair Annual Report	AGENDA REF:	BM/17/07/88 g

The Charitable Funds Committee is required to report annually to the Board outlining the work it has undertaken during the year, and where necessary, highlighting any areas of concern. This paper presents the Charitable Funds Committee Chair's Annual Report which covers the reporting period February 2016 to 7th April 2017.

The Board is the Corporate Trustee of charitable funds, registered together under charity registration 1051858 and the Committee is appointed as the Trust's agent in accordance with s16 of the NHS Trusts (Membership and Procedures) Regulations 1990.

The Charitable Funds Committee (the Committee) is accountable to the Corporate Trustee, for providing oversight and assurance on all aspects of its fundraising practice – this includes strategy development, financial forecasting and monitoring, risk strategy and management and Charitable Funds governance relating to internal operations and compliance with regulatory standards/guidance and registrations.

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

During the reporting period, the Committee was composed of all independent Non-Executive Directors (excluding the Chairman), one of whom was appointed as Chair of the Committee. Ms Lynn Lobley, former Chair of the CFC left the organisation and was replaced by Ian Jones (SID) as interim Chair. Quorum is achieved with two (2) members ie two non-executive directors.

During the reporting period, there were 4 meetings. The Committee attendance record is attached in **Appendix 1**.

Terms of Reference

The Committee's Terms of Reference were reviewed during Quarter 4 of 2016/17, as was the business cycle, to ensure there was a focus on integrated systems of quality and assurance. The Committee has evolved in year and now includes (in attendance):

- Director of Finance & Commercial Development
- Director of Community Engagement and Corporate Affairs
- Fundraising Manager
- Head of Financial Services
- Publicly elected Governor (Alison Kinross)

Frequency of Meetings and Summary of Activity

The Committee met 4 times during the reporting period. A summary of the activity covered at these meetings follows:

- Charitable Funds strategy refreshed and approved April 2017
- Gift Aid claim
- Creation of Maternity services Capital campaign
- The Committee reviewed and approved the WHH Charity Annual Report and Accounts which were ratified at the Trust board in January 2017.
- Simplified the Bid Application and Approval process
- WHH Lottery created and launched
- Fundraising Manager case of need for substantive post and recruited to
- Redefined and improved working relationships with partner charities operating in and around the Trust, particularly CanSupport at the Delamere Centre.
- Draft Annual Report and Accounts review
- Fund raising report developed for assurance
- Risk Strategy and review process developed
- Charities Commission – new regulations implemented and monitored via a Trustee checklist
- Corporate relationships development programme commenced
- Revised Terms of Reference
- Approval of various threshold Bid applications

Summary

This has been an extremely busy year for the Charity and the Committee has closely monitored developments. Key has been the assurance on the ethical operations of fundraising, the focus on reducing cost/income ratios to ensuring that the maximum possible of donated funds was used for direct patient benefit as well as investing appropriately to ensure that the Charity can grow and deliver its ambitious strategy for the direct benefit of our patients and their families.

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

I JONES

30 June 2017

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Warrington and Halton Hospitals NHS Foundation Trust

Charitable Funds Committee

Attendance Record 2016-17

	June 2016	September 2016	December 2016	April 2017	% Attendance Exc deputy	% attendance incl deputy
CORE MEMBERSHIP						
Anita Wainwright, Non-Executive Director	A	✓	A	✓	50%	50%
Ian Jones, Non-Executive Director	✓	A	✓	✓	75%	75%
Terry Atherton, Non-Executive Director	A	✓	✓	✓	75%	75%
Margaret Bamforth wef May 2016			A	A	0	0
IN ATTENDANCE						
Helen Higginson Fundraising Manager	✓	A	✓	✓	75%	75%
Andrea Chadwick, Director of Finance and Commercial Development	✓	✓	✓	✓	100%	100%
Pat McLaren, Director of Community Engagement	✓	✓	✓	✓	100%	100%
David Ellis, Elected Governor to December 16	✓	✓	✓		100%	100%
Katie Armstrong Financial Accountant	✓	✓	✓	✓	100%	100%
Kimberley Salmon-Jamieson, Chief Nurse **wef Nov 16**		A	A	A	0	0
Karen Spencer, Head of Financial Services		A/D	A/D	A/D	0	0
Angela Wetton, Company Secretary **R = October 2016**	✓	✓			50%	50%
Karen Dawber, Director of Nursing + Organisational Development **R = October 2016**	A				0	0
Lynne Lobley, Non-Executive Director, Chair **R = Oct 16**	✓	✓			50%	50%

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

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NHS Warrington and Halton Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/17/07/86**	
SUBJECT:	**Board Assurance Framework and Strategic Risk Register**	
DATE OF MEETING:	26 July 2017	
ACTION REQUIRED	**Review, Discuss and approve**	
AUTHOR(S):	Ursula Martin, Deputy Director of Governance & Quality	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse Choose an item.	
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.	
EXECUTIVE SUMMARY (KEY ISSUES):	There are key updates to strategic risks. There is two new risks added to the risk register since the Board last reviewed the Strategic Risk Register and Board Assurance Framework	
RECOMMENDATION:	Discuss and approve the changes and updates to the Board Assurance Framework and Strategic Risk Register	
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Committee
	Date of meeting	July 2017
	Summary of Outcome	Approved for ratification by Board of Directors
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.	

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Warrington and Halton Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

SUBJECT	Board Assurance Framework	AGENDA REF:	BM/17/07/86

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 Committee. The Board Assurance Framework and full strategic risk register will be presented on a quarterly basis.

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. These updates have been mapped into the Board Assurance Framework (BAF) (Appendix 2).

2. KEY ELEMENTS

2.1 **New Risks** – there are two new risks that have been added to the Strategic Risk Register

Risk	**Failure to prevent harm to patients, caused by lack of timely and quality discharge summaries being sent to primary care, resulting in a lack of appropriate handover of care safety, operational, financial and reputational consequences.**
Controls and Assurances	▪ Discharge summary performance, both the 95% and 7 day standard, is now monitored through an electronic dashboard, and is overseen by the monthly Clinical Operational Board (and also Finance and Sustainability Committee). ▪ Performance is managed at ward level, with an escalation protocol through the Clinical Business Unit and division. ▪ Discharge Policy and processes in place to support staff ▪ Training provided to staff, including junior doctors on induction, on Lorenzo ▪ The current performance shows that we meet the 95% target for sending discharge summaries within seven days, whilst recognizing that improvement needs to continue to improve regarding sending discharge summaries within 24 hours. Current performance is 88% within 24 hours. ▪ Sample audit work undertaken with regard to the backlog to date (June 23rd 2017) has not revealed that a patient has been harmed ▪ A review of incidents and complaint information in the timeframe of the backlog has not identified that a patient has come to harm or that a patients has complained

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Gaps	▪ In Q1 of 17/18, there is a backlog of c160 discharge summaries, which suggests more work is needed ▪ Communication meeting with primary care (June 2017) suggest improvement still needed in handover of care and discharge summaries
Residual Risk Score	12
Actions	Ensure a daily report tracking discharge summary performance is established and sent out to Clinical Directors **Deputy Medical Director – end June 2017** Establish a Task and Finish Group, reporting to Digital Optimisation Group, to support taking the work of discharge summaries forward **Deputy Medical Director – end July2017** Ensure that a review if policy, procedures and training for discharge summaries is undertaken to ensure that they are fit for purpose **Deputy Medical Director /Task and Finish Group – end July 2017** Ensure an audit programme reviewing the quality of discharge summaries is established across the Trust **Deputy Medical Director/Deputy Director of Governance & Quality - end August 2017** Ensure an update report of improvement is presented to Trust Patient Safety & Effectiveness Sub Committee **Deputy Medical Director – end September 201**

Risk	**Risk of Industrial Action (IA) in theatres, caused by staff concerns regarding changes to terms and conditions, impacting on patient experience, service delivery, income and Trust reputation.**
Controls and Assurances	▪ Regular briefing submitted to Trust Board and Executive Team ▪ On-going negotiations to avoid IA with support of Trust Board ▪ Negotiations on going around emergency cover – to be in place for first strike action. ▪ Strike action card in place and operational team meeting regularly. ▪ Operational contingency plans are in progress ▪ Independent Review received which confirmed both proposals (i.e. Resident & Non-Resident on Call or Night Shift with Non Resident On Call) are safe. ▪ Recommendations were made from the Independent Review and are now included in future proposals. ▪ Currently discussing possibility of postponing first 2 weeks of strike action to allow further negotiations around a resolution ▪ Patients will be rearranged by risk factors – all patients with cancer, emergency and trauma will not be affected by the strikes
Gaps	Proposal to strike ▪ Overtime ban: 18/7/17 continuous ▪ Strike action 08:00 to 12:00: 24/7/17, 31/7/17, 7/8/17, 14/8/7, 21/8/17, 29/08/17 ▪ Strike action 13:00 to 17:00: 18/8/17, 25/8/17, 1/9/17

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	▪ 24 hour stoppage from 00:01: 4/9/17, 11/9/17, 18/9/17 This week (w/c 17/7/17- we had to cancel five patients as an impact of overtime)
Residual Risk Score	16
Actions	Continue to work with Unions – to further negotiate to avoid a strike – review proposal being currently discussed **Chief Operating Officer/Director of HR – by 7th August 2017** Develop an operational plan to have in place should strike action go ahead **Chief Operating Officer/Divisional Director of Surgery, Woman's and Children's- by 21st July 2017**

2.2 Existing Risks – updates

Strategic Risk	Update since last Risk review	Impact of update on risk rating
Failure to provide adequate staffing levels in some specialities and wards caused by inability to fill vacancies, sickness which may result in pressure on ward staff, potential impact on patient care and impact on Trust access and financial targets.	A staffing incident report was received at Patient Safety & Effectiveness Sub Committee – further risk assessment and visibility of medical staffing ratios on a dashboard requested by the Medical Director	No impact on risk rating
Failure to identify and manage patients' risk of sustaining a fall; caused by inadequate risk assessment and implementation of appropriate care plans. This may cause patient harm, has a negative effect on the patient's experience, may prolong their length of stay, and give rise to complaints and claims against the trust.	An internal audit of falls undertaken has shown limited assurance – actions from this audit have been integrated into the Trust falls plan.	No impact on risk rating
Lack of assurance regarding complaints handling within the Trust, caused by ineffective systems and processes, resulting in a poor experience for complainants, the Trust not meeting statutory and contractual complaints targets and not having effective systems in place to learn lessons from complaints	Trajectories for clearing the backlog being agreed at the weekly Executive Performance meeting regarding complaints. Trust has agreed all backlog cleared by end December 2017. The risk rating will be reviewed following all complaints over six months being closed	No impact on risk rating
Failure to maintain an old estate could result in staff and patient safety issues, increased costs and unsuitable accommodation.	A comprehensive review of estates and facilities risks on the risk register has been undertaken by the Chief Operating Officer, Deputy Director of Governance and Associate Director of Estates.	No impact on risk rating

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Warrington and Halton Hospitals NHS Foundation Trust

Strategic Risk	Update since last Risk review	Impact of update on risk rating
	A significant gap in control and assurance relates to breach of fire regulations regarding emergency lighting in some of the areas. There are mitigations in place, Cheshire Fire and Rescue Service are aware and the Trust has no enforcements in place. There is also a significant risk regarding the age and repair of generators in the Trust, for which there are mitigation and continuity plan in place for- which are under review. Chief Operating Officer reviewing the meetings/governance structure regarding estates to ensure oversight by Operational Board.	
Failure to comply with the Thromboprophylaxis procedure/policy caused by poor completion of thromboprophylaxis risk assessments and follow up investigation (Root Cause Analysis) of hospital associated VTE in some areas, resulting in the risk of patients not receiving the appropriate, preventative treatment for VTE in hospital.	Due to correct cohorting of patients and review retrospectively, the Trust can report compliance in the first quarter of VTE assessments being completed. Regarding RCA backlog, whilst there has been an improvement, the position is 15/16 - 5 patients 16/17 – 21 patients 17/18 – 32 patients The Medical Director has asked that the backlog is given priority and an assessment of harm undertaken. To date, there has been one Serious Incident reported.	No impact on risk rating
Clinical variation, caused by lack of systems/process or failure of systems/to follow process leading to lack of evidence based practice, potential patient harm and reputational impact.	Additional gaps in assurances added regarding: - concerns raised externally regarding spinal surgery services in the Trust – a meeting is to be held next week with the Trust and NHS England specialist commissioning - the results of the most recent National Inpatient Survey (2016) show considerable work to be undertaken regarding focused areas where the Trust position deteriorated	No impact on risk rating
Failure to provide adequate and	An action has been added regarding	No impact on

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Warrington and Halton Hospitals NHS Foundation Trust

Strategic Risk	Update since last Risk review	Impact of update on risk rating
timely IMT system implementations & systems optimisation caused by either increasing demands and enhanced system functionality which results in pressure on staff; potential in systems being poorly used resulting in poor data quality. Impact on patient access to services, quality of care provided, potential patient harm and financial & performance targets.	undertaking a Training Needs Analysis, and assessment of training on Critical systems in the Trust and to develop a plan as appropriate – this has been added following feedback from incident investigations and feedback from staff.	risk rating

3. RECOMMENDATIONS

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

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Warrington and Halton Hospitals NHS Foundation Trust

Appendix 1- Strategic Risk Register

Risk	Residual Risk Rating (Impact x Likelihood) March 2017	Residual Risk Rating (Impact x Likelihood) April 2017	Residual Risk Rating (Impact x Likelihood) May 2017	Residual Risk Rating (Impact x Likelihood) June 2017	Score at last review 18/7/17
Failure to provide adequate staffing levels in some specialities and wards caused by inability to fill vacancies, sickness which may result in pressure on ward staff , potential impact on patient care and impact on Trust access and financial targets.	20 (5x4)	20 (5x4)	20 (5x4)	20 (5x4)	
Failure to sustain financial viability, caused by internal and external factors, leading to potential impact to patient safety, staff morale and enforcement/regulatory action being taken.	20 (5x4)	20 (5x4)	20 (5x4)	20 (5x4)	
Failure to deliver national and local performance targets will impact on patient care, reputation and financial position.	20 (4x5)	20 (4x5)	20 (4x5)	20 (4x5)	
Risk of Industrial Action (IA) in theatres, caused by staff concerns regarding changes to terms and conditions, impacting on patient experience, service delivery, income and Trust reputation.					16 (4x4)
Failure to provide adequate and timely IMT system implementations & systems optimisation caused by either increasing demands and enhanced system functionality which results in pressure on staff; potential in systems being poorly used resulting in poor data quality. Impact on patient access to services, quality of care provided, potential patient harm and financial & performance targets.	20 (5x4)	16 (4x4)	16 (4x4)	16 (4x4)	
Lack of assurance regarding	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	

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Warrington and Halton Hospitals NHS Foundation Trust

Risk	Residual Risk Rating (Impact x Likelihood) March 2017	Residual Risk Rating (Impact x Likelihood) April 2017	Residual Risk Rating (Impact x Likelihood) May 2017	Residual Risk Rating (Impact x Likelihood) June 2017	Score at last review 18/7/17
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					
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.	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	
Failure to provide timely information caused by increasing internal and external demands for datasets, implementation of new systems and a lack of skilled staff with capacity to respond. This may cause financial impact, external reputation damage and poor management decision making due to lack of quality data.	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	
Lack of assurance regarding the 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.	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

Risk	Residual Risk Rating (Impact x Likelihood) March 2017	Residual Risk Rating (Impact x Likelihood) April 2017	Residual Risk Rating (Impact x Likelihood) May 2017	Residual Risk Rating (Impact x Likelihood) June 2017	Score at last review 18/7/17
Failure to influence sufficiently within the STP and LDS may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position.	15 (5x3)	15 (5x3)	15 (5x3)	15 (5x3)	15 (5x3)
Failure to maintain an old estate could result in staff and patient safety issues, increased costs and unsuitable accommodation.	15 (5x3)	15 (5x3)	15 (5x3)	15 (5x3)	15 (5x3)
Failure to prevent harm to patients, caused by lack of timely and quality discharge summaries being sent to primary care, resulting in a lack of appropriate handover of care safety, operational, financial and reputational consequences.					12 (4x3)
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	N/A	N/A	N/A	12 (4x3)	12 (4x3)
Failure to meet the standards relating to administration of blood, caused by non completion of this role specific training, resulting in potential harm to patients, and non compliance with regulatory standards, thereby increasing the risk of reputational harm and litigation for the organisation.	N/A	N/A	N/A	12 (4x3)	12 (4x3)
Failure to comply with the Thromboprophylaxis procedure/policy caused by poor completion of thromboprophylaxis risk assessments and follow up investigation (Root Cause Analysis) of hospital associated VTE in some	N/A	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

Risk	Residual Risk Rating (Impact x Likelihood) March 2017	Residual Risk Rating (Impact x Likelihood) April 2017	Residual Risk Rating (Impact x Likelihood) May 2017	Residual Risk Rating (Impact x Likelihood) June 2017	Score at last review 18/7/17
areas, resulting in the risk of patients not receiving the appropriate, preventative treatment for VTE in hospital.					
Clinical variation, caused by lack of systems/process or failure of systems/to follow process leading to lack of evidence based practice, potential patient harm and reputational impact.	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)
Failure to successfully engage the Workforce, causing the potential for a negative working environment and the consequential loss of discretionary effort and productivity, or loss of talented colleagues to other organisations, which would impact patient care, staff morale and delivery of the Trust's strategic objectives	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)
Review required of paediatric urgent and emergency care due to escalated staffing issues, which may impact on patient care	12 (3x4)	12 (3x4)	12 (3x4)	12 (4x3)	12 (4x3)
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 (4x3)	12 (4x3)	12 (4x3)	12 (3x4)	12 (3x4)

Appendix 2 - Strategic Risk Register and Board Assurance Framework – June 2017

Risk	Residual Risk Rating (Impact xLIkelihood)
Failure to provide adequate staffing levels in some specialities and wards caused by inability to fill vacancies, sickness which may result in pressure on ward staff , potential impact on patient care and impact on Trust access and financial targets.	20 (5x4)
Failure to sustain financial viability, caused by internal and external factors, leading to potential impact to patient safety, staff morale and enforcement/regulatory action being taken.	20 (5x4)
Failure to deliver national and local performance targets will impact on patient care, reputation and financial position.	20 (4x5)
Risk of Industrial Action (IA) in theatres, caused by staff concerns regarding changes to terms and conditions, impacting on patient experience, service delivery, income and Trust reputation.	16 (4x4)
Failure to provide adequate and timely IMT system implementations & systems optimisation caused by either increasing demands and enhanced system functionality which results in pressure on staff; potential in systems being poorly used resulting in poor data quality. Impact on patient access to services, quality of care provided, potential patient harm and financial & performance targets.	16 (4x4)
Lack of assurance regarding complaints handling within the Trust, caused by ineffective systems and processes, resulting in a poor experience for complainants, the Trust not meeting statutory and contractual complaints targets and not having effective systems in place to learn lessons from complaints	16 (4x4)
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.	16 (4x4)
Failure to provide timely information caused by increasing internal and external demands for datasets, implementation of new systems and a lack of skilled staff with capacity to respond. This may cause financial impact, external reputation damage and poor management decision making due to lack of quality data.	16 (4x4)
Lack of assurance regarding the 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.	16 (4x4)
Failure to influence sufficiently within the STP and LDS may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position.	15 (5x3)
Failure to maintain an old estate could result in staff and patient safety issues, increased costs and unsuitable accommodation.	15 (5x3)
Failure to prevent harm to patients, caused by lack of timely and quality discharge summaries being sent to primary care, resulting in a lack of appropriate handover of care safety, operational, financial and reputational consequences.	12 (4x3)
Failure to deliver essential services, caused by a Cyber Attack, resulting in loss of data and vital IT systems, resulting in potential patient harm, loss in productivity and Trust reputation	12 (4x3)
Failure to meet the standards relating to administration of blood, caused by non completion of this role specific training, resulting in potential harm to patients, and non compliance with regulatory standards, thereby increasing the risk of reputational harm and litigation for the organisation.	12 (4x3)
Clinical variation, caused by lack of systems/process or failure of systems/to follow process leading to lack of evidence based	12 (4x3)

practice, potential patient harm and reputational impact.	
Failure to comply with the Thromboprophylaxis procedure/policy caused by poor completion of thromboprophylaxis risk assessments and follow up investigation (Root Cause Analysis) of hospital associated VTE in some areas, resulting in the risk of patients not receiving the appropriate, preventative treatment for VTE in hospital.	12 (4x3)
Failure to successfully engage the Workforce, causing the potential for a negative working environment and the consequential loss of discretionary effort and productivity, or loss of talented colleagues to other organisations, which would impact patient care, staff morale and delivery of the Trust's strategic objectives	12 (4x3)
Review required of paediatric urgent and emergency care due to escalated staffing issues, which may impact on patient care	12 (3x4)
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 (4x3)

Strategic Objective 1	Risk: Failure to provide adequate staffing levels in some specialities and wards caused by inability to fill vacancies, sickness which may result in pressure on ward staff , potential impact on patient care and impact on Trust access and financial targets.
Risk Source: Escalated from risk assessments	**Exec Lead:** **Chief Nurse/ Medical Director**
	Operational Lead **Divisional Nurse Directors/Chiefs of Staff**
	Assurance Committee: **Strategic People Committee**
	Date to be reviewed **Monthly:**
Initial Risk Rating (1-25)	**20**
Impact (1-5)	**5**
Likelihood (1-5)	**4**
Controls: *(What are we doing about the risk?)* • Recruitment and Retention strategy has been developed for nursing and is being operationalised • Nursing Recruitment and Retention meetings held 3 weekly • Nursing Recruitment Leads x 2 Matrons in place • Business case developed to support Nursing recruitment and retention • Senior staffing meeting put in place and processes at an operational level to ensure safe nurse staffing along with staffing checks at every capacity meeting • Reporting on safe staffing monthly to Board and staffing will be reported on all wards in line with national requirements. • Risk Management Systems allow for reporting of incidents re staffing and escalation of risk, when required • Individual staffing action plans for high risk areas • Review of skill mix and creating roles in teams e.g. pharmacy technicians to support medication administration • With regards to Consultant Recruitment – an external company has been appointed to recruit at Consultant Level with a review of JD's/Marketing of our posts; supported by EXIT Interviews for Leavers.	**Gaps in Control/Assurance** *(What additional controls and assurances should we seek?)* • 6 monthly nursing acuity & dependency review undertaken, Results being collated • Recruitment and Retention Strategy developed December 2016 and in being operationalised and implemented • The Trust has had concerns raised by Health Education North West/Deanery regarding supervision and education of junior doctors in some medical specialities (acute medicine and geriatric care) • There is a gap in control regarding implementation of IR35 across the Trust

Assurances *(How do we know if the things we are doing are having an impact and can we validate or evidence e.g. Inspections; Committees; Working Groups; Reports; Monitoring Returns etc)*	**Mitigating Actions** *(What more should we do?)*
• Staffing rates monitored on a shift by shift basis (actual versus planned numbers) and reported to the Board • 6 monthly acuity & Dependency review undertaken across all areas – Adults, Paediatric, Maternity & NICU. Results to be reported to Board. • Incident data regarding staffing reviewed by Chief Nurse • Escalation protocols in place – evidence of these being activated by nursing team • We have recently been successful in appointing 4 Cardiology Consultants and are attending ES Training in due course and will be allocated Trainees as required. • The Trust is ensuring safe medical staffing via use of long term locums in some specialities and also by breaking the cap, when required. • There is an action plan in place following concerns raised by HENW/Deanery	Undertake the Allocate Safer Nursing Care Acuity review to understand establishments with regard to acuity Acuity / Dependency review undertaken in May 2017. Results being collated. **Deputy Chief Nurse/Divisional Associate Director of Nursing – end June 2017** **This has been undertaken and will be being presented to June Quality Committee and July 17 Board of Directors.** Develop a risk assessment process for opening/closing beds/ward **Deputy Chief Nurse – end March 2017** **COMPLETED** Monthly reporting of Recruitment and Retention Strategy to Strategic People Committee and Nursing and Midwifery Board. **Chief Nurse – monthly** **ON-GOING** Ensure a report is given to the Board of Directors regarding medical staffing in medical specialities, including a progress update of the action plan **Medical Director – end March 2017** **COMPLETED** Ensure a report is given to the Board on nurse staffing assurance processes **Chief Nurse – end March 2017** **COMPLETED** All areas to have risk assessed implications of IR35 **CBU Managers – end April 2017** **COMPLETED** Ensure a deep dive is undertaken of the risk regarding staffing and reported to Quality Committee **Chief Nurse/Deputy Chief Nurse/Deputy Director of Governance & Quality – end June 2017** Ensure a monthly incident report on staffing incidents is presented to Patient Safety & Effectiveness Sub Committee **Deputy Director of Governance & Quality – end June 2017** **COMPLETED**
Residual Risk Rating (1-25)	**20**
Impact (1-5)	**5**
Likelihood (1-5)	**4**
Target Risk Rating (1-25)	**12**
Impact (1-5)	**4**
Likelihood (1-5)	**3**

Strategic Objective 1	Risk: Failure to deliver national and local performance targets will impact on patient care, reputation and financial position.
Risk Source: Performance Reporting	**Exec Lead:** **Chief Operating Officer**
	Operational Lead Associate Directors of Operations
	Assurance Committee: **Finance and Sustainability**
	Date to be reviewed **Monthly :**
Initial Risk Rating (1-25)	**20**
Impact (1-5)	**4**
Likelihood (1-5)	**5**
Controls: *(What are we doing about the risk?)* • Weekly monitoring of all performance indicators • KPI meeting attended by all CBU managers • IT support to develop accurate data reports • Business case approved to have a centralised RTT function with a lead manager • Business case approved to increase outpatient call centre and reception staff to locally manage issues • Four hour performance meeting in place weekly to monitor performance and required actions • Reporting on all key performance metrics to FSC on a monthly basis • Risk Management Systems allow for reporting of incidents • Individual action plans for high risk areas including outpatients • ECIP support to establish key areas for improvement	**Gaps in Control/Assurance** *(What additional controls and assurances should we seek?)* • Electronic solution to data reporting including e outcomes • Further validation of migrated patients from meditec to Lorenzo • Further capacity and demand work required

Assurances *(How do we know if the things we are doing are having an impact and can we validate or evidence e.g. Inspections; Committees; Working Groups; Reports; Monitoring Returns etc)*	**Mitigating Actions** *(What more should we do?)*
• Outpatients is on the Trust Internal Audit Plan for 2017 • An outpatients steering group takes place monthly and feeds into the outpatient board chaired by the CEO there are 8 identified work streams all with individual KPIs and dashboards • All performance metrics are reported monthly externally • ECIP dashboard benchmarks against other trusts • Daily performance metrics circulated • FSC and board papers • CCG contract review meeting	Development of an OPD dashboard **Outpatient and Medical records Service Manager – end June 2017** Live accurate data – business intelligence review to be undertaken **Head of Information – end September 2017** Capacity and demand work to be undertaken across the trust **Director of Operations – end September 2017** Review of WLI payments to be undertaken **Director of Operations – end July 2017** Ensure a review of cancer processes is undertaken **Director of Operations – end June 2017** **COMPLETED – reported to June Quality Committee**

Residual Risk Rating (1-25)	**20**
Impact (1-5)	**4**
Likelihood (1-5)	**5**
Target Risk Rating (1-25)	**12**
Impact (1-5)	**4**
Likelihood (1-5)	**3**

Strategic Objective 1	Risk: Risk of Industrial Action (IA) in theatres, caused by staff concerns regarding changes to terms and conditions, impacting on patient experience, service delivery, income and Trust reputation.

Risk Source - Escalated from risk assessments	Exec Lead: Chief Operating Officer
	Operational Lead Divisional Director Surgery Division
	Assurance Committee: Executive Directors
	Date to be reviewed: Daily review currently

Initial Risk Rating (1-25)	**4**
Impact (1-5)	**4**
Likelihood (1-5)	**16**

Controls: *(What are we doing about the risk?)*

- Regular briefing submitted to Trust Board and Executive Team
- On-going negotiations to avoid IA with support of Trust Board
- Negotiations on going around emergency cover – to be in place for first strike action.
- Strike action card in place and operational team meeting regularly.
- Operational contingency plans are in progress
- Independent Review received which confirmed both proposals (i.e. Resident & Non-Resident on Call or Night Shift with Non Resident On Call) are safe.
- Recommendations were made from the Independent Review and are now included in future proposals.

Gaps in Assurance *(What additional assurances should we seek?)*

Proposal to strike

Overtime ban:

- 18/7/17 continuous

Strike action 08:00 to 12:00:

- 24/7/17, 31/7/17, 7/8/17, 14/8/7, 21/8/17, 29/08/17

Strike action 13:00 to 17:00:

- 18/8/17, 25/8/17, 1/9/17

24 our stoppage from 00:01:

- 4/9/17, 11/9/17, 18/9/17

This week (w/c 17/7/17- we had to cancel five patients as an impact of overtime)

Assurances *(How do we know if the things we are doing are having an impact and can we validate or evidence e.g. Inspections; Committees; Working Groups; Reports; Monitoring Returns etc)*	**Mitigating Actions** *(What more should we do?)*
• Currently discussing possibility of postponing first 2 weeks of strike action to allow further negotiations around a resolution • Patients will be rearranged by risk factors – all patients with cancer, emergency and trauma will not be affected by the strikes	Continue to work with Unions – to further negotiate to avoid a strike – review proposal being currently discussed **Chief Operating Officer/Director of HR – by 7th August 2017** Develop an operational plan to have in place should strike action go ahead **Chief Operating Officer/Divisional Director of Surgery, Woman's and Children's- by 21st July 2017**

Residual Risk Rating (1-25)	**4**
Impact (1-5)	**4**
Likelihood (1-5)	**16**
Target Risk Rating (1-25)	**4**
Impact (1-5)	**2**
Likelihood (1-5)	**8**

Strategic Objective 1	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.
Risk Source: Incident Reporting	**Exec Lead:** **Chief Nurse**
	Operational Lead **Deputy Chief Nurse**
	Assurance Committee: **Quality Committee**
	Date to be reviewed **Monthly :**
Initial Risk Rating (1-25)	**20**
Impact (1-5)	**5**
Likelihood (1-5)	**4**
Controls: *(What are we doing about the risk?)* • Falls Policy in place. • The Trust participates in NHS Safety Thermometer, which gives benchmarking data. • Risk Management systems and incident policy require staff to report incidents regarding falls so that any incidents can be appropriately investigated and learning can be cascaded.	**Gaps in Control/Assurance** *(What additional controls and assurances should we seek?)* • There have been a number of falls within the Trust causing Serious Harm • There is a requirement to review falls prevention equipment • There is a requirement to have a bed replacement programme in place • Falls training is not mandated for staff • Lack of senior specialist input for falls prevention • MIAA audit into falls showed limited assurance

Assurances *(How do we know if the things we are doing are having an impact and can we validate or evidence e.g. Inspections; Committees; Working Groups; Reports; Monitoring Returns etc)*	**Mitigating Actions** *(What more should we do?)*
• Audits undertaken of falls policy on at least an annual basis • All patients have falls Positive risk factor and bed-rails assessments completed on admission, and are reassessed in accordance with policy. • Trust is meeting the required performance in NHS Safety Thermometer- • Projects are being piloted in the Trust for falls prevention e.g. slippers socks and yellow blankets for patients etc. • Falls RCAs in place with Senior Nurses reviewing this post fall. Quarterly reporting of falls analysed within the Trust Governance Report. • Falls nurse has commenced in roll	Recruit Falls Nurse Specialist **Chief Nurse – end February 2017** **COMPLETED** Develop a business case for bed replacement programme **Chief Nurse – end February 2017 rescheduled to end April 2017** **Tender process underway. Trial of various beds has been undertaken by operational staff.** Ensure Falls Prevention training is mandated for staff **Chief Nurse – end March 2017** **COMPLETED** Ensure a review of falls equipment is undertaken across the Trust to assess requirements **Deputy Chief Nurse- end March 2017** **COMPLETED** Ensure internal audit actions are incorporated into overarching action plan re falls prevention **Deputy Chief Nurse- end July 2017**

Residual Risk Rating (1-25)	**16**
Impact (1-5)	**4**
Likelihood (1-5)	**4**
Target Risk Rating (1-25)	**12**
Impact (1-5)	**4**
Likelihood (1-5)	**3**

Strategic Objective 1	Lack of assurance regarding complaints handling within the Trust, caused by ineffective systems and processes, resulting in a poor experience for complainants, the Trust not meeting statutory and contractual complaints targets and not having effective systems in place to learn lessons from complaints
Risk Source: Performance Reporting	**Exec Lead:** **Chief Nurse**
	Operational Lead **Deputy Director of Governance & Quality**
	Assurance Committee: **Quality Committee**
	Date to be reviewed **Monthly**
Initial Risk Rating (1-25)	**20**
Impact (1-5)	**5**
Likelihood (1-5)	**4**
Controls: *(What are we doing about the risk?)* • An external review has been undertaken of the complaints function in the Trust • Complaints Policy been updated • Central and divisional complaints teams in place	**Gaps in Control/Assurance** *(What additional controls and assurances should we seek?)* • The Trust is not meeting performance targets with regard to complaints – a significant number of complaints are greater than 6 months old • Data quality issues with regard t complaints – multiple databases and systems to record complaints • There are a lack of standardised processes for complaints handling centrally and divisionally/CBU level • There is a lack of training in the Trust with regard to complaints management and handling • Lack of being able to evidence lessons learned and action plan monitoring as a result of complaints • A review of PALS and complaints function needs to be undertaken • Lack of patient experience strategy in the Trust to promote local resolution

Assurances *(How do we know if the things we are doing are having an impact and can we validate or evidence e.g. Inspections; Committees; Working Groups; Reports; Monitoring Returns etc)*	**Mitigating Actions** *(What more should we do?)*
• Additional capacity has been put into the complaints team – including integration of the divisional and corporate complaints teams • Process mapping of complaints has been undertaken, to ensure the process is streamlined and everyone understands their roles and responsibility- Standard Operating procedures have started to be developed • Mapping of complaints spreadsheets into Datix has started and will complete by end March 2017 • The Chair of the Trust will chair a Complaints Quality Assurance Group – terms of reverence being agreed by Quality Committee March 2017	Develop a complaints improvement plan following the external review **Deputy Director of Governance & Quality – end February 2017** **COMPLETED** Put in place additional capacity in the complaints team to improve performance **Deputy Director of Governance & Quality – w/c 1st February 2017** **COMPLETED** Ensure the complaints process in the Trust is process mapped **Deputy Director of Governance & Quality – end March 2017** **COMPLETED** Ensure a review is undertaken of complaints data, all complaints spreadsheets are mapped over to Datix, and new KPIs are developed for Board/Quality Committee and Divisions/CBUs **Interim Complaints Improvement Lead – end March 2017** **COMPLETED** Convene a Complaints Quality Assurance Group **Deputy Director of Governance & Quality – end March 2017 – first meeting scheduled June 2017** **Ensure a new complaints training programme is developed** **Interim Complaints Improvement Lead – end April 2017** **COMPLETED** Ensure KPIs are developed to monitor effectiveness of complaints improvement plan and report to Quality Committee **Deputy Director of Governance & Quality – end March 2017** **COMPLETED** Development of a Lessons Learned Framework for the Trust **Deputy Director of Governance & Quality – end July 2017** Ensure the pilot of the new complaints process commences **Deputy Director of Governance & Quality with selected specialities – end July 2017** **Ensure trajectories are set for improvement** **Deputy Director of Governance & Quality– end July 2017**

Residual Risk Rating (1-25)	**16**
Impact (1-5)	**4**
Likelihood (1-5)	**4**
Target Risk Rating (1-25)	**6**
Impact (1-5)	**3**
Likelihood (1-5)	**2**

Strategic Objective 1	Lack of assurance regarding the 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.
Risk Source: External review	**Exec Lead:** **Chief Nurse**
	Operational Lead **Deputy Chief Nurse**
	Assurance Committee: **Quality Committee**
	Date to be reviewed **Monthly:**
Initial Risk Rating (1-25)	**16**
Impact (1-5)	**4**
Likelihood (1-5)	**4**
Controls: *(What are we doing about the risk?)* • External review conducted • Safeguarding teams in place • Training in place	**Gaps in Control/Assurance** *(What additional controls and assurances should we seek?)* • Review of safeguarding governance structure required • Review of the safeguarding team and functions • Requirement to review practices of chemical restraint • A review of safeguarding training required • A policy review • Representation at Local Safeguarding Boards to be reviewed • A review of policies to be undertaken • Development of an electronic system for use by the safeguarding team • Lack of LD specialist support • CQC raised issues regarding mental capacity assessments and DOLS

Assurances *(How do we know if the things we are doing are having an impact and can we validate or evidence e.g. Inspections; Committees; Working Groups; Reports; Monitoring Returns etc)*	**Mitigating Actions** *(What more should we do?)*
• External support put in place re safeguarding with newly appointed Deputy Chief Nurse • Supervision put in place for named nurses • Commissioning of level 3 safeguarding training	Development of an action plan following on from external review Deputy Chief Nurse – end February 2017 **COMPLETED** Progress update on action plan bi-monthly to Quality Committee **Deputy Chief Nurse – March 2017 onwards** **COMPLETED** Ensure an audit of Mental Capacity is undertaken **Safeguarding Adults lead – end March 2017** **COMPLETED** Following a stocktake of the action plan in place – determine if the risk is reducing **Deputy Chief Nurse – end July 2017**
Residual Risk Rating (1-25)	**16**
Impact (1-5)	**4**
Likelihood (1-5)	**4**
Target Risk Rating (1-25)	**6**
Impact (1-5)	**3**
Likelihood (1-5)	**2**

Strategic Objective 1	Risk: 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.

Risk Source: Performance reporting	Exec Lead: Medical Director
	Operational Lead Deputy Medical Director
	Assurance Committee: Quality Committee Digital Optimisation Group
	Date to be reviewed: Monthly

Initial Risk Rating (1-25)	**4**
Impact (1-5)	**4**
Likelihood (1-5)	**16**

Controls: *(What are we doing about the risk?)*	**Gaps in Assurance** *(What additional assurances should we seek?)*
▪ Discharge summary performance, both the 95% and 7 day standard, is now monitored through an electronic dashboard, and is overseen by the monthly Clinical Operational Board (and also Finance and Sustainability Committee). ▪ Performance is managed at ward level, with an escalation protocol through the Clinical Business Unit and division. ▪ Discharge Policy and processes in place to support staff ▪ Training provided to staff, including junior doctors on induction, on Lorenzo	▪ In Q1 of 17/18, there is a backlog of c160 discharge summaries, which suggests more work is needed ▪ Communication meeting with primary care (June 2017) suggest improvement still needed in handover of care and discharge summaries

Assurances *(How do we know if the things we are doing are having an impact and can we validate or evidence e.g. Inspections; Committees; Working Groups; Reports; Monitoring Returns etc)*	**Mitigating Actions** *(What more should we do?)*
▪ The current performance shows that we meet the 95% target for sending discharge summaries within seven days, whilst recognizing that improvement needs to continue to improve regarding sending discharge summaries within 24 hours. Current performance is 88% within 24 hours. ▪ Sample audit work undertaken with regard to the backlog to date (June 23rd 2017) has not revealed that a patient has been harmed ▪ A review of incidents and complaint information in the timeframe of the backlog has not identified that a patient has come to harm or that a patients has complained	Ensure a daily report tracking discharge summary performance is established and sent out to Clinical Directors **Deputy Medical Director – end June 2017** Establish a Task and Finish Group, reporting to Digital Optimisation Group, to support taking the work of discharge summaries forward **Deputy Medical Director – end July2017** Ensure that a review if policy, procedures and training for discharge summaries is undertaken to ensure that they are fit for purpose **Deputy Medical Director /Task and Finish Group – end July 2017** Ensure an audit programme reviewing the quality of discharge summaries is established across the Trust **Deputy Medical Director/Deputy Director of Governance & Quality - end August 2017 n** Ensure an update report of improvement is presented to Trust Patient Safety & Effectiveness Sub Committee **Deputy Medical Director – end September 2017**

Residual Risk Rating (1-25)	**4**
Impact (1-5)	**3**
Likelihood (1-5)	**12**
Target Risk Rating (1-25)	**4**
Impact (1-5)	**2**
Likelihood (1-5)	**8**

Strategic Objective 1	Risk: Failure to meet the standards relating to administration of blood, caused by non completion of this role specific training, resulting in potential harm to patients, and non compliance with regulatory standards, thereby increasing the risk of reputational harm and litigation for the organisation
Risk Source: Escalated from risk assessments	**Exec Lead:** **Chief Nurse/ Medical Director**
	Operational Lead **Divisional Nurse Directors/Chiefs of Service**
	Assurance Committee: **Quality Committee**
	Date to be reviewed **Monthly :**
Initial Risk Rating (1-25)	**15**
Impact (1-5)	**5**
Likelihood (1-5)	**3**
Controls: *(What are we doing about the risk?)* • Hospital Transfusion Committee in place • Audit processes in place • Transfusion Practitioners • Education Programme	**Gaps in Control/Assurance** *(What additional controls and assurances should we seek?)* • In the most recent audit the Trust met 3 out of 6 standards relating to administration of blood. Concerns related to: a. Documentation b. 36% of patients did not have their transfusion observations performed correctly c. 51% of staff had not received the administration of blood competency assessment d. 10% of transfusions had been administered by agency staff e. 22% had not received a mandatory training session

Assurances *(How do we know if the things we are doing are having an impact and can we validate or evidence e.g. Inspections; Committees; Working Groups; Reports; Monitoring Returns etc)*	**Mitigating Actions** *(What more should we do?)*
• Reports regularly from Hospital Transfusion Committee into Patient Safety & Effectiveness Sub Committee	Ensure there is an assessment of which areas need to have training **Divisional Nurse Directors – end July 2017** Assess what staff in the areas identified have received training and develop a plan for all relevant staff to have received training **Divisional Nurse Directors/Transfusion Practitioner – end July 2017** Report transfusion/administration of blood training monthly into the Patient Safety & Effectiveness Sub Committee **Transfusion Practitioner – from June 2017 onwards** Ensure the results of the transfusion audit are presented to all relevant clinical areas **Transfusion Practitioner/Governance Leads – end July 2017**

Residual Risk Rating (1-25)	**12**
Impact (1-5)	**4**
Likelihood (1-5)	**3**
Target Risk Rating (1-25)	**8**
Impact (1-5)	**4**
Likelihood (1-5)	**2**

Strategic Objective 1	Failure to maintain an old estate could result in staff and patient safety issues, increased costs and unsuitable accommodation.
Risk Source: Escalated from risk assessments	**Exec Lead:** **Chief Operating Officer**
	Operational Lead **Associate Director of Estates**
	Assurance Committee: **Quality Committee**
	Date to be reviewed **Monthly :**
Initial Risk Rating (1-25)	**20**
Impact (1-5)	**5**
Likelihood (1-5)	**4**
Controls: *(What are we doing about the risk?)* • Estates strategy • PLACE assessment action plan • Risk Management systems and incident reporting • General capital investment • Compass reporting re: water flushing • Matron and estates walkabouts • Reporting structure for maintenance • On call service for OOH issues • Maintenance log	**Gaps in Control/Assurance** *(What additional controls and assurances should we seek?)* • Maintenance improvement program • Medical equipment maintenance is managed by a risk assessed approach whereby equipment is identified as: High Medium Medium/Low Low All high and medium is fully maintained. Medium/low and low is operator assessed and reported to medical equipment engineering as required. A significant gap in control and assurance relates to breach of fire regulations regarding emergency lighting in some of the areas. There are mitigations in place, Cheshire Fire and Rescue Service are aware and the Trust has no enforcements in place. There is also a significant risk regarding the age and repair of generators in the Trust, for which there are mitigation and continuity plan in place for- which are under review.

Assurances *(How do we know if the things we are doing are having an impact and can we validate or evidence e.g. Inspections; Committees; Working Groups; Reports; Monitoring Returns etc)*	**Mitigating Actions** *(What more should we do?)*
• Water quality group • Fire safety group • Medical gasses group • Estates safety • Medical Equipment group • Capital Planning group • Six Facet survey – condition appraisal of estate (annually) 5 Year program 20% each year • Asbestos survey annually • Premises Assurance model (PAM) Self-assessment tool estate compliance • Good Corporate Citizen self-assessment (review of sustainability)	Alignment the Estates Strategy to the Trust Clinical Strategy and Financial Strategy **Associate Director of Estates – end September 2017** Participate in Halton Healthy Hospitals strategy **Director of Transformation/Associate Director of Estates – ongoing** Review of the Health & Safety risks aligned to estates and facilities to be undertaken **Associate Director of Estates/Deputy Director of Governance & Quality/Head of Health & Safety – end July 2017** **COMPLETED** **Review the governance/meetings structure regarding Estates** **Chief Operating Officer/ Associate Director of Estates/Deputy Director of Governance & Quality – end September 2017**

Residual Risk Rating (1-25)	**15**
Impact (1-5)	**5**
Likelihood (1-5)	**3**
Target Risk Rating (1-25)	**12**
Impact (1-5)	**4**
Likelihood (1-5)	**3**

Strategic Objective 1	Risk: Failure to comply with the Thromboprophylaxis procedure/policy caused by poor completion of thromboprophylaxis risk assessments and follow up investigation (Root Cause Analysis) of hospital associated VTE in some areas, resulting in the risk of patients not receiving the appropriate, preventative treatment for VTE in hospital.
Risk Source: Performance Reporting	**Exec Lead:** **Medical Director**
	Operational Lead **Divisional Chiefs of Staff**
	Assurance Committee: **Quality Committee**
	Date to be reviewed **Monthly :**
Initial Risk Rating (1-25)	**20**
Impact (1-5)	**4**
Likelihood (1-5)	**5**
Controls: *(What are we doing about the risk?)* • Policy and guidelines in place regarding VTE • Process in place regarding VTE investigations	**Gaps in Control/Assurance** *(What additional controls and assurances should we seek?)* • Performance report shows numbers of VTE RCAs outstanding and poor compliance in some areas with risk assessments • Lack of assurance that that numbers of hospital associated VTEs are being monitored within clinical governance processes within Divisions/CBUs and being fed back to individuals • Thrombysis Committee terms of reference need to be reviewed

Assurances *(How do we know if the things we are doing are having an impact and can we validate or evidence e.g. Inspections; Committees; Working Groups; Reports; Monitoring Returns etc)*	**Mitigating Actions** *(What more should we do?)*
• Monitor of progress by Patient Safety and Clinical Effectiveness committee, Quality Committee; monthly assessment of progress with number of RCAs • Harm free care figures • Mortality/coroners data does not suggest that the Trust is an outlier in terms of harm being caused to patients	Develop a revised process for VTE RCAs **Lead Clinicians VTE/Deputy Director of Governance/Deputy Medical Director** **End April 2017** **COMPLETED** Develop a plan for VTE RCA backlog to be delivered **Lead Clinicians VTE** **End June 2017 – reviewed** Ensure information regarding VTE assessments and RCAs are circulated to individuals/CBUs and Divisions **Lead Clinicians VTE** **COMPLETED** Review Terms of Reference for Thrombosis Group **Lead Clinicians VTE** **COMPLETED – to be ratified by Patient Safety & Effectiveness Sub Committee** Ensure there is a trajectory for undertaking backlog of VTE assessments and ensuring that the process going forward is monitored at Patient Safety & Effectiveness Sub Committee **Medical Director – end July 2017**

Residual Risk Rating (1-25)	**16**
Impact (1-5)	**4**
Likelihood (1-5)	**4**
Target Risk Rating (1-25)	**8**
Impact (1-5)	**4**
Likelihood (1-5)	**2**

Strategic Objective 1	Clinical variation, caused by lack of systems/process or failure of systems/to follow process leading to lack of evidence based practice, potential patient harm and reputational impact.
Risk Source: Escalated from risk assessments	**Exec Lead:** **Medical Director**
	Operational Lead **Associate Medical Director Quality**
	Assurance Committee: **Quality Committee**
	Date to be reviewed **Monthly :**
Initial Risk Rating (1-25)	**16**
Impact (1-5)	**4**
Likelihood (1-5)	**4**
Controls: *(What are we doing about the risk?)* • Policies and procedures in place across the Trust governing systems and processes to minimise potential for service failure. • Incident reporting regime enables issues to be raised and lessons learnt. • Governance structure– Quality Committee and Patient Safety & Effectiveness Committee and high level reporting from Divisional Bi-lateral Committees • Integrated Performance Report in place. • Dashboards to assess against standards • Mortality review processes • Mortality action group strengthened focusing on reducing mortality with detailed action plan developed. • Independent mortality review process • Associate Medical Director overseeing Mortality Review process	**Gaps in Control/Assurance** *(What additional controls and assurances should we seek?)* • Clinical Governance systems within the Trust need to be reviewed e.g. Lack of integrated effectiveness agenda corporately • Clinical/CBU leadership model still embedding • Further work to develop integrated performance report, dashboards and cross referencing / escalation of issues • The Trust is reporting higher than expected mortality rates in HSMR, although SHMI showing a significant downward trend. • UTI outlier in term of mortality • Lack of co-ordinated learning framework within the Trust • Lack of assurance regarding NICE guidance compliance within the Trust • Inpatient survey showed significant decrease in performance in some areas • Concerns regarding spinal surgery services raised internally and externally by NHSE

Assurances *(How do we know if the things we are doing are having an impact and can we validate or evidence e.g. Inspections; Committees; Working Groups; Reports; Monitoring Returns etc)*	**Mitigating Actions** *(What more should we do?)*
• Risk based internal audit programme linked to potential identified gaps in controls with Trust policies. • External audit process • Incident analysis completed monthly and weekly updates on SI/red incidents given to Senior Management Team. • Review of Quality Committee terms of reference and workplan been undertaken • Integrated Performance Report reported at monthly Board, prior to this scrutiny given at Trust and Divisional Quality & Governance meetings • Good Clinical audit participation in the national programme • A recent JAG visit described our endoscopy services as an 'excellent service', demonstrating cohesive leadership, exceptional governance standards and robust processes both clinically and administratively. • The Trust has been named as the best performing Trust in the region for providing hip and knee replacement surgery by AQUA. • Excellent feedback received in the Cheshire and Merseyside Critical Care Network report.	Ensure a governance review is undertaken, including a review of integrated effectiveness agenda **Director of Integrated Governance & Quality Improvement/Associate Medical Director Quality – end June 2017** Ensure a review of quality indicators reporting on dashboard undertaken **Director of Integrated Governance & Quality Improvement/Associate Medical Director Quality/Deputy Chief Nurse – end June 2017** Ensure there is a review of Patient Safety and Effectiveness Sub Committee terms of reference and reporting groups **Director of Integrated Governance & Quality Improvement- end May 2017 COMPLETED** Ensure that there is a UTI deep dive on mortality **Associate Medical Director Mortality/Clinical Effectiveness Manager – end July 2017** Development of a Lessons Learned Framework **Director of Integrated Governance & Quality Improvement/Associate Medical Director Quality/Deputy Chief Nurse – end July 2017** Ensure the Trust's NICE policy is reviewed **Head of Clinical Effectiveness – end June 2017**

Residual Risk Rating (1-25)	**12**
Impact (1-5)	**4**
Likelihood (1-5)	**3**
Target Risk Rating (1-25)	**8**
Impact (1-5)	**4**
Likelihood (1-5)	**2**

Strategic Objective 1	Review required of paediatric urgent and emergency care due to escalated staffing issues, which may impact on patient care
Risk Source: Incident Reporting	**Exec Lead:** **Chief Nurse**
	Operational Lead **Deputy Chief Nurse**
	Assurance Committee: **Quality Committee**
	Date to be reviewed **Monthly :**
Initial Risk Rating (1-25)	**12**
Impact (1-5)	**3**
Likelihood (1-5)	**4**
Controls: *(What are we doing about the risk?)* • Increased staff at night and robust escalation process in place • Review of paediatric service in A&E underway via an external consultant from Alderhey. • Review of paediatric A&E staffing (nursing and medical) to be considered and pathways of care.	**Gaps in Control/Assurance** *(What additional controls and assurances should we seek?)* • Staffing and skill mix • Pathway of care to be reviewed
Assurances *(How do we know if the things we are doing are having an impact and can we validate or evidence e.g. Inspections; Committees; Working Groups; Reports; Monitoring Returns etc)* • Increased staff at night to ensure service is safe • A review of incidents and complaints undertaken to seek assurance that service is safe	**Mitigating Actions** *(What more should we do?)* Commission a review of Paediatric care in A&E **Director of Transformation – end March 2017** **COMPLETED** Development of an action plan following on from external review **Service leads – by end April 2017** **COMPLETED** **Ensure the action plan us presented to Quality Committee for approval** **Head of Midwifery – end June 2017**
Residual Risk Rating (1-25)	**12**
Impact (1-5)	**3**

Likelihood (1-5)	**4**
Target Risk Rating (1-25)	**6**
Impact (1-5)	**3**
Likelihood (1-5)	**2**

Strategic Objective 2	Risk: . Failure to successfully engage the Workforce, causing the potential for a negative working environment and the consequential loss of discretionary effort and productivity, or loss of talented colleagues to other organisations, which would impact patient care, staff morale and delivery of the Trust's strategic objectives
Risk Source: Performance Reporting	**Exec Lead:** **Director of Workforce & Organisational Development/Director of Communications**
	Operational Lead **Head of HR/Head of Communications**
	Assurance Committee: Strategic People Committee
	Date to be reviewed: Monthly
Initial Risk Rating (1-25)	**20**
Impact (1-5)	**4**
Likelihood (1-5)	**5**
Controls: *(What are we doing about the risk?)* • Communications: We have developed a Communications and Engagement Work plan 2016-17 which is being delivered across the WHH workforce • There is a revised leadership model in place within the Trust • Priorities for the Trust are promoting learning and development, driving clinical leadership, having efficient job plans, celebrating success through staff awards and supporting innovation and working with partner organisations • There is an established Strategic People Committee of the Board • Investment in training and Support for staff • Open Mic sessions/Team Talk in place to engage staff and offer them a voice	**Gaps in Control/Assurance** *(What additional controls and assurances should we seek?)* • CBU leadership structure still embedding • Gaps in information/data due to lack of service line reporting in place enable it difficult to analyse significance of staffing impact on productivity e.g. staff sickness levels due to work related stress etc. • Periodic staff survey (added to Staff FFT Qs) to include communications awareness/engagement • Establishment of evaluation parameters linked to 'communication tools' ie google analytics • Theatre at Night Consultation – staff have raised significant concerns
Assurances *(How do we know if the things we are doing are having an impact and can we validate or evidence e.g. Inspections; Committees; Working Groups; Reports; Monitoring Returns etc)* • Engagement Dashboard reported to Trust Board (includes monitoring of Team Brief attendance) • Staff FFT and Annual NHS Staff Survey (published March each year) both reported to SPC	**Mitigating Actions** *(What more should we do?)* Further diversification of communication tools – greater use of social media and developing site-specific communications **Director of Communications – end July 2017** Further opportunities for staff to engage with senior managers/executive Team – Open Mic

	Director of Communications – ongoing Following development of Trust Strategy, ensure staff engagement events/communications are developed **Director of Communications – end September 2017** Creation of 'People Champions' network **Director of Communications – end July 2017** Ensure there is an external review of the Impact Assessment of Theatre at Night Transformation work **Director of HR and Organisational Development – end August 2017**
Residual Risk Rating (1-25)	**12**
Impact (1-5)	**4**
Likelihood (1-5)	**3**
Target Risk Rating (1-25)	**6**
Impact (1-5)	**3**
Likelihood (1-5)	**2**

Strategic Objective 3	Risk: 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.
Risk Source: Performance Reporting	**Exec Lead:** **Director of Finance**
	Operational Lead **Deputy Director of Finance**
	Assurance Committee: **Finance and Sustainability Committee**
	Date to be reviewed: **Monthly**
Initial Risk Rating (1-25)	**20**
Impact (1-5)	**5**
Likelihood (1-5)	**4**
Controls: *(What are we doing about the risk?)* • Core financial policies controls in place across the Trust • Revised governance structure within the Trust to enable strengthened accountability • Finance and Sustainability Committee (FSC) established overseeing financial planning • CIP programme in place aligned to the Transformation agenda • Monthly financial monitoring with NHSI • Regular review at Executive team meeting and development sessions • Attendance at the STP boards and Committee • Annual plan development process • Health economy commissioning meetings to identify any financial performance issues/demand management etc. – aim to accelerate LDS/STP • Support agreed to help achieve CQUIN monies with weekly Executive review • Performance monitoring of financial governance within the Trust. • Negotiations with Commissioners on Contract income on going • Monitor SLAs and contracts to enable extension of contracts or tenders to be managed • Charitable funds strategy in place • Review of non pay expenditure daily • Fortnightly income meeting – Executive Lead • Mitigating actions to avoid cost remain in place	**Gaps in Control/Assurance** *(What additional controls and assurances should we seek?)* • Failure to achieve Financial control total may result in loss of STF and worsening cash position. • The Trust was found in breach of its licence in August 2015 and was subject to enforcement. Significant improvements have been made. The Trust continues to be financially challenged and has a control total for 2017/18 of £3.7 million deficit • Failure to manage fines and penalties and CQUIN which may result in loss of STF and worsening cash position • Risk to financial stability due to loss of income relating to STP changes • Inability to develop a strategic plan to deliver a breakeven position over the next 5 to 10 years • Loss of contracts due to competitive market which may result in Trust no longer being sustainable. There is a gap in Market analysis and Knowledge of our competitors • Loss of income through the failure of WHH Charity • Risk of under delivery of CIP

Assurances *(How do we know if the things we are doing are having an impact and can we validate or evidence e.g. Inspections; Committees; Working Groups; Reports; Monitoring Returns etc)*	**Mitigating Actions** *(What more should we do?)*
• New Director of Finance appointed 2016, with a Deputy Director of Finance also appointed and a reconfiguration of the finance function • Robust financial controls introduced • Director of Transformation appointed as a new post in the Trust in 2016 • Increased focus on delivering CIPs, via the Trust Transformation agenda • Corporate Trustee Charities Commission Checklist, reporting bi-annually through Board • Monitoring of charitable funds income, assessment of return on investment and controls on overhead ratios via quarterly financial reports • Annual external audit and reporting to Charities Commission • Trust achieved better than planned for deficit 2016/17 and achieved STF bonus • Successful bid for £1 million capital funds from Primary Care Streaming	Continue to seek support from Commissioners **Director of Finance – ongoing** Continue to seek support from NHSI approach to management and repayment of loans **Director of Finance – ongoing** Development of a Market analysis of Trust competitors to understand imminent and future risk to income **Director of Finance – end May 2017- revised date end July 2017** *An analysis of the market is underway down to specialty level, led by the Commercial Development Team. This will for example enable the Trust to understand which GP / Patients from the Warrington and Halton postcodes (and surrounding areas) attend other providers. The marketing reporting has been developed and is on the Trust extranet for use by the services for business planning. The financial strategy is being updated to incorporate the marketing information to be consulted upon June/July 2017.* Development of a Financial Strategy (aligned to the Trust Strategy) with a sensitivity analysis of delivery **Director of Finance – end June 2017 – this data has been amended to end July 2017** Greater involvement of the Corporate Trustee in Charitable Funds strategy development (planned for Board Workshop in 2017) **Director of Communications – end December 2017**

Residual Risk Rating (1-25)	**20**
Impact (1-5)	**5**
Likelihood (1-5)	**4**
Target Risk Rating (1-25)	**10**
Target Impact (1-5)	**5**
Target Likelihood (1-25)	**2**

Strategic Objective 3	Risk: Failure to provide adequate and timely IMT system implementations & systems optimisation caused by either increasing demands and enhanced system functionality which results in pressure on staff; potential in systems being poorly used resulting in poor data quality. Impact on patient access to services, quality of care provided, potential patient harm and financial & performance targets.
Risk Source: Escalated from risk assessments	**Exec Lead: Director of IT**
	Operational Lead **IT Leads/CIO**
	Assurance Committee: **Finance and Sustainability Committee** **Digital Optimisation Group** **e PR Programme Board**
	Date to be reviewed: 15/03/2017
Initial Risk Rating (1-25)	**20**
Impact (1-5)	**5**
Likelihood (1-5)	**4**

Controls: *(What are we doing about the risk?)*	**Gaps in Control/Assurance** *(What additional controls and assurances should we seek?)*
• IT Strategy in place • Routine RAG reporting of IM&T projects to ePR Programme Board and upwards to Finance and Sustainability Committee • Reviewing EPR system upgrade plans with suppliers and agreeing revised dates based around resource contention • Working with CBUs to involve more admin and clinical staff for testing upgrades • Reviewing contingency plans • Cross training staff to increase leveraging of resources and minimise single points of failures • Cross skilling help desk to strengthen first line support • IG sub-group reviews contingency plans with Information Asset Owners from the CBUs • Anti-virus has been added to IM&T Capital Shortlist for 17/18 and will be agreed at the next Capital Planning Group • IT Seniors routinely act upon CareCERT information security bulletins released by NHS Digital's Data Security Centre. Actions performed in response to bulletins are documented. • Information Security Management System reports to Information Governance and Corporate Records Sub-Committee to provide assurance on the effectiveness of controls • Inspection by Trust's auditors on IT infrastructure security • Capital paper submitted to secure funding for hardware to improve infrastructure in time for requisite Windows 10 migration	• Failure to provide IMT system support caused by lack of staff or single points of expertise in the structure; resulting in systems being unavailable for longer periods of time in the event of a failure. Impact on trust access, quality of care and financial targets with potential for reputational damage. • Failure to secure trust's IMT systems from cyber-attacks due to poor end user training and awareness, limited and out of date security systems and increasing complexity of attacks. Impact is loss of patient data resulting in fines, organisational reputational damage or extended downtime of systems, resulting in loss of financial information and loss of ability to treat patients. • Failure of IMT infrastructure to be available 24*7 due to increasing demands requiring additional hardware which cannot be purchased due to funding restraints. • Assurance that DQ reports available within the BIS are being accessed and acted upon by operational staff • Sufficient time for engagement from CBUs around system management • Certification to the Cyber Essentials standard in quarter 1 Financial year 2017/18 is required. This was recommended in the National Data Guardian/CQC report of 2016

Assurances *(How do we know if the things we are doing are having an impact and can we validate or evidence e.g. Inspections; Committees; Working Groups; Reports; Monitoring Returns etc)*	**Mitigating Actions** *(What more should we do?)*
• Monitoring of Data Quality in systems implemented and reporting of DQ metrics via Data Quality and Management Steering Group • Monitoring of external data quality reports such as the NHS Digital Data Quality Maturity index and benchmarking with other organisations • Clear communications of upgrades changes • Good user engagement for testing • Monitoring of helpdesk tickets to understand trends after upgrades • Assess hot stops from IMT Helpdesk calls • Critical systems continuity plans identify key staff who will work to ensure systems return to normal as quickly as possible • Capital programme spend reviewed by Capital group and F&S, hardware inventory maintained to ensure end user equipment remains fit for purpose. • ePR programme Board reviews each project progress against Programme Plan expectations • Internal IMT department progress recorded at Seniors meetings • New diagnostic post being recruited linking to identifying single points of failure • The Director of IT has undertaken a review regarding IT infrastructure risks, which may impact upon 24/7 availability of key services and systems and the capital programme has been updated to reflect these risks. • Actions have been completed regarding commencement of a information and IT restructure. An additional diagnostic team member has been recruited. • Regular analysis of data to show compliance with processes in place – Data Quality dashboard work and links back to Clinical Directors.	Work with other Trusts to share testing resources **Director of IT – ongoing** Invest in additional IMT staffing as workload increases, restructures based on work being reviewed with IMT management **Director of IT – COMPLETED – new application support staff in place** Comprehensively identify all single points of failure and assess risks surrounding each **Director of IT – end June 2017** **COMPLETED – quarterly test of backups are now scheduled and results will be documented and reported on** Test contingency plans regularly- development of a plan **Director of IT – end May 2017** **COMPLETED** Routinely report all Cyber-attacks via Datix incident reporting system to ensure SIRO and Caldicott Guardian are sighted on the issues **Director of IT – end June 2017** **COMPLETED** Include Cyber Security element in annual SIRO report **Director of IT – end April 2017** **COMPLETED** IT Manager to produce a report detailing IT infrastructure risks which may impact upon 24/7 availability of key services and systems **Director of IT- end April 2017** **COMPLETED** Continuous audit of IMT infrastructure- development of a plan **Director of IT – end May 2017** **COMPLETED** Disaster recovery plan and its relevance to key IT systems to be reviewed **Director of IT – end August 2017** Improve the disaster recovery for the ICE system (currently hosted on a physical server with limited resilience) **Director of IT – end August 2017** Undertake a Training Needs Analysis and assessment of training on Critical systems in the Trust and develop a plan as appropriate **Director of IT – end Sept 2017**
Residual Risk Rating (1-25)	**20**
Impact (1-5)	**5**

Likelihood (1-5)	**4**
Target Risk Rating (1-25)	**10**
Impact (1-5)	**5**
Likelihood (1-5)	**2**

Strategic Objective 3	**Risk: Failure to provide timely information caused by increasing internal and external demands for datasets, implementation of new systems and a lack of skilled staff with capacity to respond. This may cause financial impact, external reputation damage and poor management decision making due to lack of quality data.**
Risk Source: Escalated from risk assessments	**Exec Lead: Director of IT** **Operational Lead** **CCIO** **Head of Information** **Assurance Committee: ePR Programme Board** **Date to be reviewed: 15/03/2017**
Initial Risk Rating (1-25)	**16**
Impact (1-5)	**4**
Likelihood (1-5)	**4**
Controls: *(What are we doing about the risk?)* • Prioritising work around BAU i.e. statutory and contractual dataset returns such as daily/weekly Sitreps, monthly Board reporting, FOI's, Ad-hoc information requests and CQC inspection. • Providing regular updates to the project board and current plans, progress and risks/issues • Recruited one temporary staff to cover Maternity datasets as replacement for one of the Band 6 staff that has left. • Re-planned and allocated work to the team for other Band 6 staff that has now left. • Recruiting for a Band 5 replacement that leaves end of March. • Taking on the NVQ data quality staff from Lorenzo team. He will initially work 2/3 days per week from 27th Feb and permanently then once a DQ backfill has been recruited. • Appointed new Head of Information that starts at the beginning of April • Interim Head of Information re-developing plans and prioritising work	**Gaps in Control/Assurance** *(What additional controls and assurances should we seek?)* • The new Head of Information will be joining end of March who will review the overall strategy for delivering information services, she has already started to look at this following a meeting on 15/02/17 – on going • New interactive tools to allow users to manually 'data mine' the reports is in pilot.

Assurances *(How do we know if the things we are doing are having an impact and can we validate or evidence e.g. Inspections; Committees; Working Groups; Reports; Monitoring Returns etc)*	**Mitigating Actions** *(What more should we do?)*
• The key objective is to ensure all BAU work is being maintained i.e. statutory returns, adhocs and FOI's and support CQC inspection. Escalate to Exec level if any delays are likely • Continue to Access reports via the BIS application, new reports are being made available all the time • Continue to report progress, risks and issues through finance and project board meetings	Continue to work with the Business and clinical teams to help manage expectations and ensure work is prioritised around key objectives (BAU, CQC, etc) and then by the high priority datasets **Head of Information – ongoing** Establish new information reporting structure lead by the new Head of Information starts **Head of Information – End September 2017** Develop interactive Business Intelligence system for end users for self-service to reduce demand for routine information enquiries **Head of Information – End September 2017**
Residual Risk Rating (1-25)	**16**
Impact (1-5)	**4**
Likelihood (1-5)	**4**
Target Risk Rating (1-25)	**8**
Impact (1-5)	**4**
Likelihood (1-5)	**2**

Strategic Objective 3	Risk: 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
Risk Source: Escalated from risk assessments	**Exec Lead:** **Director of Communications**
	Operational Lead **Board Secretary**
	Assurance Committee: **Audit Committee**
	Date to be reviewed: Ongoing
Initial Risk Rating (1-25)	**16**
Impact (1-5)	**4**
Likelihood (1-5)	**4**
Controls: *(What are we doing about the risk?)* • Compliance with license conditions – reportable quarterly via Audit Committee • Appointment of Advisor to Board • Re-establishment of Foundation Trust Office • Recruitment of Secretary to Board and support	**Gaps in Control/Assurance** *(What additional controls and assurances should we seek?)* • Need to relaunch the Board Assurance Framework and align to the Strategic Risk Register • Lack of ongoing regular review of Well Led standards • Lack of assurance regarding a centralised system to monitor Duty of Candour compliance

Assurances *(How do we know if the things we are doing are having an impact and can we validate or evidence e.g. Inspections; Committees; Working Groups; Reports; Monitoring Returns etc)*	**Mitigating Actions** *(What more should we do?)*
• Well Led Review and CQC inspection 2017 • NHS Improvement Assessment • Board Evaluation Surveys • Well-led Self-Assessment • Assurance has been received following the Well Led review commissioned by the Trust from Deloitte. Actions from this review will be monitored by the Board.	Complete the Well-led Self-assessment and develop an action plan **Chief Executive/Director of Communications – end May 2017** **COMPLETED – action plan underway** Ensure there is an annual review of Well –led assessment mapped into the Audit Committee and Board business cycles **Chief Executive/Director of Communications – end May 2017** **COMPLETED** Review the Trust Risk Management Strategy **Chief Nurse/Deputy Director of Integrated Governance & Quality – end May 2017** **COMPLETED** Ensure a Duty of Candour protocol and centralised system is developed, which is reported monthly to the Board of Directors **Deputy Director of Integrated Governance & Quality – end March 2017** **COMPLETED** Ensure Head of Corporate Governance role recruited to **Director of Communications – end August 2017**

Residual Risk Rating (1-25)	**12**
Impact (1-5)	**4**
Likelihood (1-5)	**3**
Target Risk Rating (1-25)	**10**
Impact (1-5)	**5**
Likelihood (1-5)	**2**

Strategic Objective 3	Risk: 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
Risk Source: Escalated from risk assessments	**Exec Lead: Director of IT** **Operational Lead** **CCIO** **Head of Information** **Assurance Committee: ePR Programme Board** **Date to be reviewed: 15/03/2017**
Initial Risk Rating (1-25)	**12**
Impact (1-5)	**4**
Likelihood (1-5)	**3**
Controls: *(What are we doing about the risk?)* • Anti-virus/anti-spam measures deployed on servers and desktops. The McAfee product used is due for review/renewal in September 2017. Capital funds allocated for this purpose. • Firewall deployed to protect the network by filtering the traffic that is permitted in and out of the WHH network. The Stonegate Firewall product is due for renewal in March 2018. Capital funds being sought as part of improvements to the overall security suite. • Blocking file extensions recommended by NHS Digital on WHH Fileshare areas. CareCert bulletins containing information security measures which need to be implemented are produced by NHS Digital and measures taken to implement their requirements are documented at IT Seniors meeting on a weekly basis. • Information Security Management System (ISMS) in use to protect WHH IT assets. The ISMS is based on the principles contained within the ISO27001 standard in use to control physical and network access and the controls required to protect said assets. • Daily backups and 4 hour replication to the Halton site which replicates data on the Halton site storage area network (SAN). Data loss in the event of a Cyber-attack would be minimised due to the replication of data. • Achievement of Cyber essentials certification and completion of the requisite network penetration testing. Certification to the Cyber Essentials standard has been recommended for all Trusts and compliance with its requirements can enhance protection against circa 80% of Cyber-attacks. • Removal of obsolete operating systems (eg Windows XP) and automatic patching of	**Gaps in Assurance** *(What additional assurances should we seek?)* • Implement security 'bubble' around the medical VLAN. The 'bubble' will protect medical devices (eg MRI and CT scanners which run the Windows XP operating system) with a firewall. Replacement of Windows XP will necessitate replacement of some medical equipment. • Act on recommendations made in the Cyber essentials report to ensure improved cyber security. • Ensure upgrade of security systems such as web filtering, anti-virus and firewalls. • Routine, quarterly reporting of attacks to the Information Governance and Corporate Records Sub-Committee

critical updates offered by Microsoft. Removal of XP operating system across WHH continues and three tier patching regime is proposed	
Assurances *(How do we know if the things we are doing are having an impact and can we validate or evidence e.g. Inspections; Committees; Working Groups; Reports; Monitoring Returns etc)* • Cyber Essentials network penetration testing to be completed as soon as possible. This will provide evidence that robust protection is in place. • Evidence that the WHH network wasn't infected during the recent Cryptolocker cyber-attack can be provided MIAA have been provided with evidence that patching of operating systems is carried out. Significant assurance awarded. • MIAA Information Governance assurance audit 2017-significant assurance awarded.	**Mitigating Actions** *(What more should we do?)* • Ensure capital monies are available in 2018/19 for upgrade of vital security software and hardware Director of IT/Director of Finance – end March 2018 • Implement security 'bubble' around the medical VLAN. The 'bubble' will protect medical devices (eg MRI and CT scanners which run the Windows XP operating system) with a firewall. Replacement of Windows XP will necessitate replacement of some medical equipment – development of a plan Director of IT – end July 2017 • Act on recommendations made in the Cyber essentials report to ensure improved cyber security. Director of IT – end July 2017 • Ensure upgrade of security systems such as web filtering, anti-virus and firewalls – development of a plan Director of IT – end July 2017 • Ensure that Information Governance messages around safe use of IT assets are reiterated via corporate induction and training Director of IT – ongoing • Report serious cyber-attacks and a trend demonstrating increases in attacks on the Datix system – send out an alert to all staff on a regular basis and report quarterly to Information Governance and Corporate Records Sub-Committee Director of IT – ongoing
Residual Risk Rating (1-25)	**12**
Impact (1-5)	**4**
Likelihood (1-5)	**3**
Target Risk Rating (1-25)	**8**
Impact (1-5)	**4**
Likelihood (1-5)	**2**

Strategic Objective 4	Risk: 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.
Risk Source: Escalated from risk assessments	**Exec Lead:** **Chief Executive** **Operational Lead: Divisional triumvirates** **Assurance Committee: Finance and Sustainability Committee, Strategic People Committee, Quality Committee** **Date to be reviewed: Quarterly**
Initial Risk Rating (1-25)	**20**
Impact (1-5)	**5**
Likelihood (1-5)	**4**
Controls: *(What are we doing about the risk?)* • Members of the board have secured lead roles on a range of programmes within the LDS and STP, most notably High Quality Hospital Care, which is led by our Chief Executive and Medical Director for the STP. • The board is further developing the Trust's strategy and governance for delivery of the strategy to ensure that all risks are escalated promptly and proactively managed. • We are developing plans, with partners, to establish Accountable Care Organisations in both Halton and Warrington. • We have developed an engagement strategy in partnership with our Governing Council • We have developed a Communications and Engagement Work plan 2016-17 • We are delivering a programme of 'Your Health' Events across all of our services to which public, partners, members and governors are invited/involved • We have established a community-wide newsletter Your Hospitals • We have a programme of visiting GP practices on a 'customer care' platform	**Gaps in Control/Assurance** *(What additional controls and assurances should we seek?)* • Our CQC rating will likely impact our ability to influence and at this stage is not known. • Organisational sovereignty and the need for individual Trusts, CCGs and others to meet performance targets at an organisational level have the potential to slow or block progress. • Failure to successfully engage with all of our stakeholders across our catchment population • Measurement of GP engagement

Assurances *(How do we know if the things we are doing are having an impact and can we validate or evidence e.g. Inspections; Committees; Working Groups; Reports; Monitoring Returns etc)*	**Mitigating Actions** *(What more should we do?)*
• Evidenced by lead roles in STP and LDS. • No service changes with a detrimental impact on the Trust or our patient population have been agreed to date or included within the STP. • The Trust has developed effective clinical networking and integrated partnership arrangements: • The Trust is successfully leading and co-ordinating the delivery of new integrated care pathways for the frail elderly with partners from primary and social care, the voluntary sector, 5 Boroughs NHSFT and Bridgewater Community NHSFT. • The Trauma and Orthopaedic service has developed excellent links with the Walton Centre for all complex spinal patients. • The Musculoskeletal team are undertaking collaborative work with Warrington CCG and Walton Neuro Vanguard developing a CPMS service meeting patients' needs. • Monitoring engagement by stakeholders (attendance at events, membership survey) • Well Led Review and CQC inspection 2017 • Reports and Feedback from Healthwatch • Board Talk reinstated for partners and stakeholders – The first issue will be June Board – Purdah completed. Staff comms is continuing as per existing work plan/strategy • 'What Matters to Me' conversation cafes being established across both sites (17/18) in partnership with patient experience committee and governors. Will also include WHH volunteers, WHH careers and WHH charity	Continue to hold lead roles. **Chief Executive – ongoing** Ensure evidence is provided to support decision making. Development of Trust Strategy document aligned to Trust planning priorities and external agenda **Director of Transformation – end June 2017** Ensure robust communications, engagement and consultation. Review the internal/external communications strategy for staff and partners **Director of Communications – end June 2017** **COMPLETED** Re-establish 'Board Talk' stakeholder newsletter **Director of Communications – end May 2017** **COMPLETED** Create more opportunities for stakeholder engagement at our hospitals **Director of Communications – end June 2017** **COMPLETED** Revisit the Your Hospitals newsletter/membership communications to ensure optimised **Director of Communications – end May 2017** **COMPLETED** Establish clinician-led GP engagement opportunities **Director of Communications – end June 2017 – date rescheduled to end December 2017, due to capacity and conflicting priorities**

Residual Risk Rating (1-25)	**15**
Impact (1-5)	**5**
Likelihood (1-5)	**3**
Target Risk Rating (1-25)	**8**
Impact (1-5)	**4**
Likelihood (1-5)	**2**

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/17/07/87**
SUBJECT:	**Annual Reports for Safeguarding Adults at Risk and Safeguarding Children and Young People**
DATE OF MEETING:	26/7/17
ACTION REQUIRED	For the annual reports to be reviewed and accepted.
AUTHOR(S):	Wendy Turner and Katie Clarke
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse Choose an item.
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):	BAF1.1: CQC Compliance for Quality
	Choose an item.
	Choose an item.
STRATEGIC CONTEXT	The Annual Report for Safeguarding Adults at Risk and Safeguarding Children and Young People provide assurance and evidence that the Trust is meeting the Care Quality Commission (CQC) safeguarding standards and that our practice is aligned to national and local policy and guidance. The areas in which gaps are identified are highlighted with accompanying mitigation within the reports.
EXECUTIVE SUMMARY (KEY ISSUES):	The Annual Reports for both Safeguarding Children and Safeguarding Adults at Risk have now been completed. Overall the safeguarding objectives for 2016/2017 were met. Going forward the focus for the year will be on the following; Mental Capacity Act (MCA) / Deprivation Of liberty Safeguards (DoLS) Workshop to Raise Awareness of Prevent Modern Slavery Safeguarding Adults at Risk and Safeguarding Children's levels, one, two and three Training programs and scrutiny of compliance Safer recruitment Child Sexual Exploitation

	Child Protection Information Sharing system Supervision Domestic Abuse Partnership working Develop a joint Did Not Attend policy with Bridgewater NHS Health Care	
RECOMMENDATION:	The Annual Report is to be received by the Board of Directors Once the reports have been accepted, the Annual Reports will be shared with the relevant Local Safeguarding Boards The Annual Reports are to be shared with the safeguarding links across the Trust, who on receipt will cascade within their departments. The Annual Reports are to support and the guide the development of the Safeguarding Strategy 2017 to 2020	
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Committee
	Agenda Ref.	**QC/17/07/151**
	Date of meeting	4 July 2017
	Summary of Outcome	Key points from the Annual Reports for Safeguarding Adults and Children were highlighted and an update of the Trust safeguarding action plan was given and asked to be noted. The Quality Committee noted both items and accepted the information and updates noting the progress described.
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

Safeguarding Children Annual Report 2016/2017

Katie Clarke - Named Nurse Safeguarding Children.

Contents

Introduction....3
Review of 2016/2017 Objectives....3
External and Internal Assurance....4
CQC inspection....4
Section 11 Audit....5
Key Performance Indicators (KPIs)....6
Safeguarding Activity....6
Referrals....6
Safeguarding Children Care Pathway....7
Maternity Pathway....9
Early Help....10
Joint Liaison Meeting....11
Child Death....11
Domestic Abuse....11
Female Genital Mutilation (FGM)....13
Child Sexual Exploitation (CSE)....13
Serious Case Review / Multi Agency Case Review....14
Training Activity....15
Audit Activity....15
Safeguarding Children Supervision....16
Safeguarding Incidents....17
Objectives for 2017/2018....17

Introduction

This is the 13th annual report on Safeguarding Children 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.

National picture:- There are currently over 57,000 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).

Review of 2016/2017 Objectives

Objective	Outcome	
Training compliance at level 1 and 2 to be 85%	Achieved	Updated in training activity section of this report
Maintain and improve on level 3 training figures	Achieved	Updated in training activity section of this report
Work load and Capacity to be reviewed for the team	Achieved	Safeguarding review completed in December 2016. Action plan in place
Number of CAFS to be increased.	Achieved	36% increase.
Safeguarding Children Supervision to be more robust and embedded across the trust.	Partially achieved	Safeguarding children supervision process has been in development throughout 2016/2017 and has moved forward significantly. On reflection the 2016/2017 objective was unrealistic based on time scales and will be carried forward to 2017/2018.

External and Internal Assurance

CQC inspection

In April 2016 WHHFT were visited by the CQC as part of the CQC inspection 'Review of health services for Children Looked After and Safeguarding in Warrington Borough Council'. The inspectors spent 2 days with the Named Nurse for Safeguarding Children and visited the Trusts Emergency Department, Paediatric ward and maternity services. Overall, feedback from the review was positive. An action plan was developed and reviewed regularly at the WSCB Health Sub-group. The table below details the recommendations made and any areas for improvement identified within the report.

CQC Identified Risk / Immediate Areas for Improvement
IMMEDIATE The location of the paediatric waiting area means that at times children are not directly observable by staff. This carries a risk of the deteriorating child not being promptly identified.
IMMEDIATE on the day of the inspector's visit a floor standing electric fan in the paediatric area was considered to be a potential risk
It is positive that, although older teens could opt to wait in the adult ED reception, they were still seen and treated in the paediatric area. Paediatric documentation, including a safeguarding risk assessment, was routinely used; and helped reinforce staff recognition of their statutory responsibilities for older children. However, the child protection risk assessment checklist sat outside of the paediatric clinical assessment and record template and had to be manually pasted into the template. Adult documentation asks only for the next of kin and does not probe about parental responsibilities or whether there are children living within the household. This is a missed opportunity to identify the potential for hidden harm. ED and safeguarding senior staff recognised the opportunity to strengthen practice in these areas as part of the current review of the IT system.
Not all relevant Trust Managers are aware of the pathways for children who access services as a result of drug or alcohol misuse.
Formal contracting arrangements in relation to the paediatric liaison service with Bridgewater Community Trust ended in April 2016. Warrington and Halton Hospital trust are in process of developing their own paediatric liaison role. Action needs to be urgently progressed to secure a timely and seamless handover.
Midwives do not routinely seek information from GP's to inform the social needs section of maternity assessments.
Midwives routinely ask about Domestic abuse at the first appointment. Guidance from The Royal College of Midwives highlights the need for routine enquiry into domestic abuse throughout the pregnancy and post-natal period
Ongoing work required to improve liaison between health visitors and midwives
Warrington children and child protection plans or are in care are not flagged on WHHFT's electronic case management system. The Trust needs to take immediate action to ensure a robust system is in place.
The Did Not Wait protocol in ED is not sufficiently robust to ensure a consistent and appropriate response when children are removed by those who brought them prior to triage or treatment or when vulnerable adults are waiting to be seen.
Referrals made to the MASH by ED staff are made using the multi-agency referral form and followed up with a telephone call. However, the referrer is not routinely informed of the outcome.
The need to develop CSE champions in front line health care teams.
Safeguarding capacity within WHHFT is overstretched with the current post holder responsible for the named nurse and named midwife role.
Safeguarding children training across the wider workforce is an area for further improvement.
An area for immediate action is to ensure that the use of neglect tools is embedded into the work of front line professionals (graded care profile).
CAMHS professionals need to share a copy of their care plan with paediatric ward staff. Paediatric ward to strengthen and tailor their approach to risk assessment, to promote early recognition of risk for young people with high or complex mental health needs.
Referrals made to the MASH by ED staff are made using the multi-agency referral form and followed up with a telephone call. However, the referrer is not routinely informed of the outcome.

In March 2016 the lead inspector from the CQC formally closed down the inspection with an agreement that no outstanding recommendations are allowed to drift. The action plans will still continue to be monitored, with all exception reporting and/or drift reported via the WSCB Health Sub Group. A detailed action plan with outcomes is review by the safeguarding committee with exception reporting. All actions for WHHFT are on track or completed.

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 monthly basis updating evidence and the action plan where necessary.

Overall the trust is 100% complete and is graded at Level 3 – 95%. The action plan is generated through the electronic system and is monitored through the safeguarding steering group.

Section 11 completion

Section	Grade
11.1	Grade 3 - 96 %
11.2	Grade 3 - 96 %
11.3	Grade 3 - 92 %
11.4	Grade 4 - 100 %
11.5	Grade 4 - 100 %
11.6	Grade 3 - 75 %
11.7	Grade 4 - 100 %
11.8	Grade 3 - 96 %
11.9	Grade 3 - 96 %
11.10	Grade 4 - 100 %
11.11	Grade 3 - 94 %
11.12	Grade 3 - 96 %

WHHFT have only 1 section graded at 2 – 50%. Section 12.8 recommends that there is a system for flagging children for whom there are safeguarding concerns. WHHFT currently flag children who reside in Halton Local Authority however arrangements have not been agreed with Warrington Local Authority regarding Warrington Children. This was identified in the 2016 CQC inspection 'Review of health services for Children Looked After and Safeguarding in Warrington Borough Council'. Developments are underway with regards to implementing CP-IS in WHHFT. Child Protection - Information Sharing (CP-IS) is a nationwide

system that enables child protection information to be shared securely between local authorities and NHS trusts across England. Once this is implemented and established the score will increase to level 4 – 100%

Key Performance Indicators (KPIs)

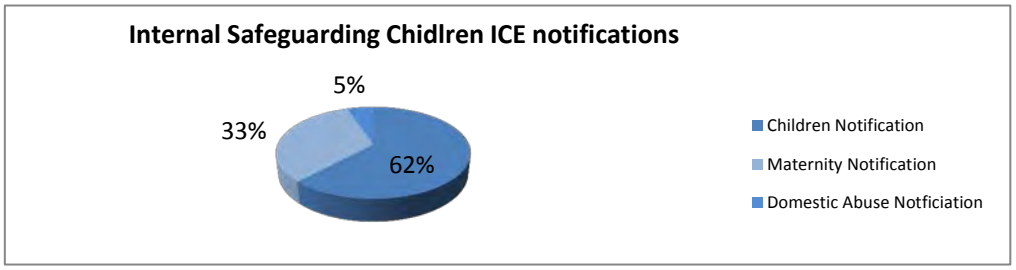
Quarterly key performance indicators are completed and submitted to the designated nurses. The Named Nurse meets with Warrington CCG Designated nurse every 8 weeks for planned supervision. Additional to the supervision the KPIs are reviewed and assurance is provided. An exception report is provided alongside the KPI's. Please see appendix A for detailed list of data requested as part of the KPIs.

Safeguarding Activity

Referrals

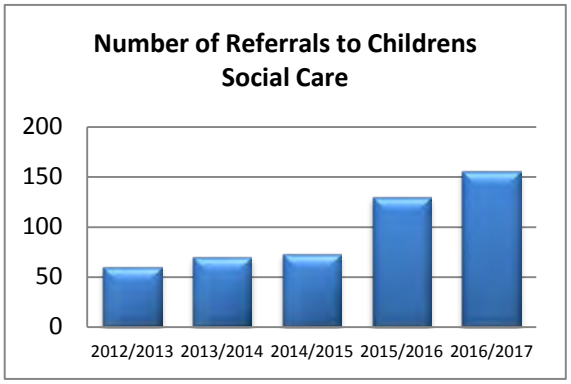
Internal referrals / Notifications

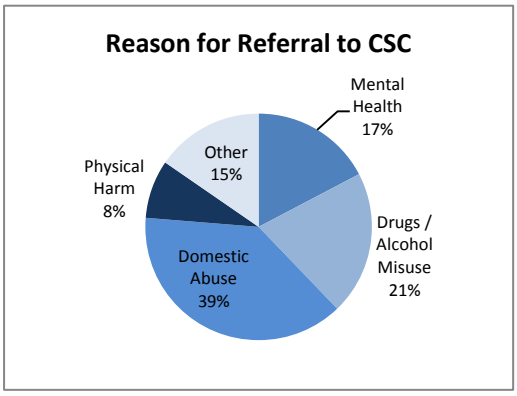
2016/2017 there was a total on 2423 electronic ICE referrals completed asking for further advice from or sharing information with the Safeguarding Children Team. This is an increase of 8% from 2015/2016. The number of internal notifications has continued to increase year on year. Since the introduction of this process in 2011 there has been a 24% 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.



Children's Social Care (CSC) Referrals

The number of referrals to CSC have increased year on year. 2016/2017 saw an increase of 20% on the previous year. This is a significant improvement and can be linked to the increased training compliance which is explored later in the report. Staff from across WHHFT are recognising children and young people who are vulnerable and at risk resulting in appropriate referrals to external agencies.





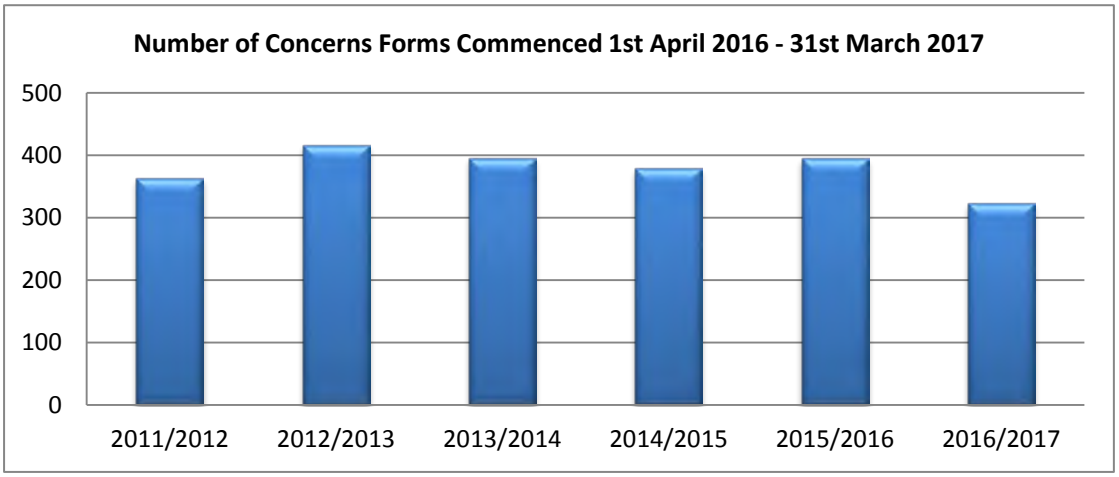
This is the first year where categories of reasons for referrals to CSC were collated.
On reviewing the data it appears that the majority of the referrals under the category drugs / alcohol misuse have been completed on adult patients who have children or dependants. A flow diagram was developed following a CQC inspection which directed staff to consider the children when dealing with adult patients. It is evident from this data that the flow diagram has had a positive impact.

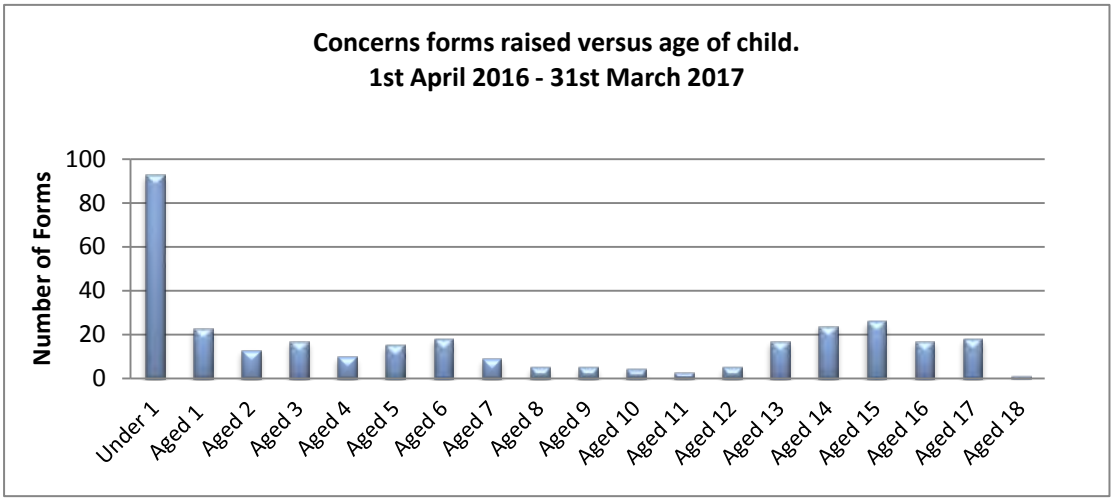
Safeguarding Children Care Pathway

Concerns Forms

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. 323 forms were completed in 2016/2017 which is a slight decrease.

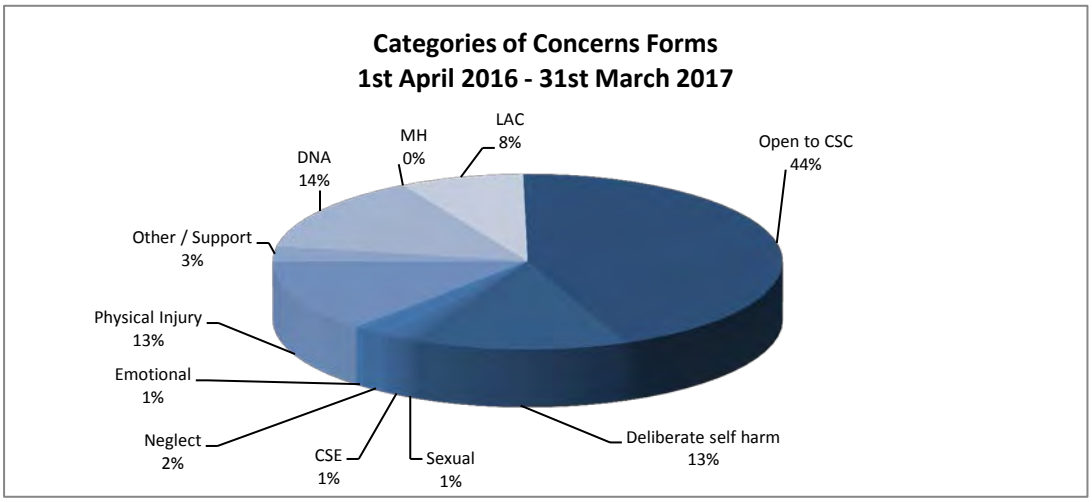




Similar to previous years there are peaks in the under 1's and over 13 year olds. Analysis of the data identified that 13-18 years old were predominately commenced on concerns forms due to deliberate self-harm. The most common reason for commencing the concerns forms on babies under 1 year old was due 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 1 – 18% of concerns forms commenced due to physical abuse.

1-2 years old – 47 % of concerns forms commenced due to physical abuse.



Prior to 2016/2017 the number of concerns forms commenced due to children not being brought to appointments (DNA) was not captured seperately and would be categorised within neglect. The safeguarding children team recognised that children not being brought to appointment was increasily becoming an issue therefore data was collected seperately. 14% of all concerns form is a significant number of forms when compared to the 6% of forms completed in last years data for neglect. Work has been ongoing with our community colleagues to tackle this issue with plans to develop a joint policy in 2017/2018.

Child Protection Medical

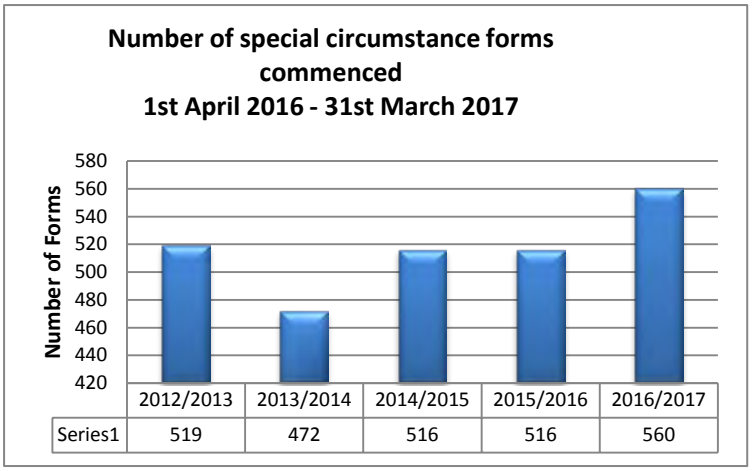
A child protection medical (CPM) assessment should always be considered when there is a suspicion of, or a disclosure of, child abuse and/or neglect involving injury, suspected sexual abuse or serious neglect. The need to consider a medical assessment in these cases arises from section 47 of the Children 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. 49 CPM were completed within 2016/2017. This is only a slight increase of 5 from the previous 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.
Additional to the new template, in 2017/2018 the Police, Children's social care and community health will be invited to attend the Hospital Safeguarding Child Protection Medical Peer Review Meeting, this will strengthen multi-agency working and relationships providing better outcomes for children.

Peer Review

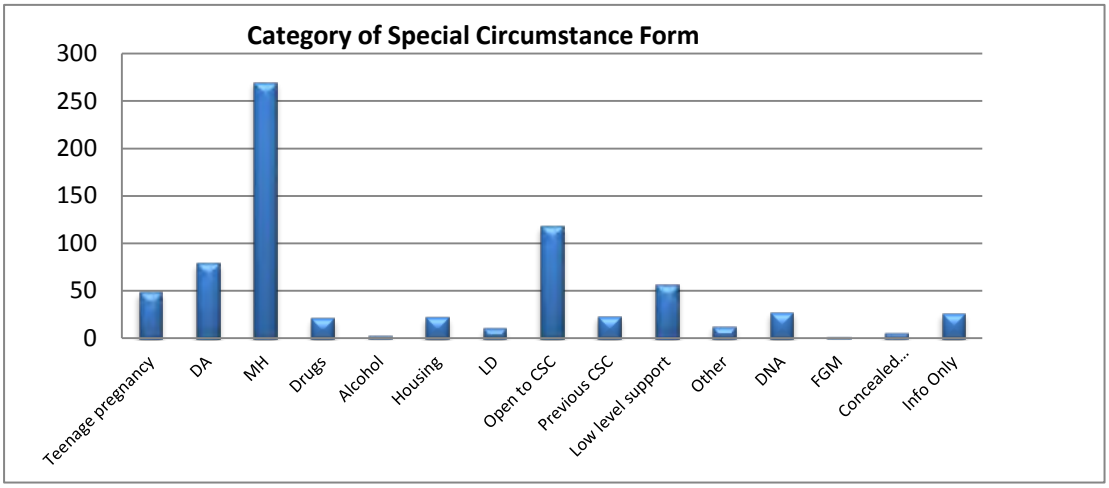
Peer review is the evaluation of work or performance by colleagues in the same field in order to maintain or enhance the quality of the work or performance in that field. The word peer is often defined as a person of equal standing. However, in the context of peer review, it is generally used in a broader 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. 55 cases were discussed as part of the peer review process with attendance from medical staff has been consistent.

Maternity Pathway



Special circumstance forms (SCF) are commenced when concerns are identified during midwifery care. 2016/2017 saw a 9% increase in number of forms commenced. There is no clear explanation for this. The distribution of categories remains the same which is shown in the graph below.



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.

Early Help

Common Assessment Framework

Early 2016 saw the introduction of the Graded Care Profile tool and as predicted the number of CAFS / pre-CAFS completed in 2016/2017 increased significantly by 36%. This increase coincides with the GCP training and raising awareness of early help providing by the safeguarding children team.

The LSCB recognised that the GCP was 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 rather that 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. Warrington early help services have made significant developments within the past 12 months and will be launching a new early help assessment. The proposed early help assessment will be more user friendly for professionals and for the families involved. Training will be rolled out in 2017/2018; appropriate WHHFT staff will be asked to attend.

A representative from the early help services continues to attend the Hospital Joint Liaison Meeting where they offer support and advice. WHHFT completed 3 GCP / Home conditions tool last year

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.

Last year saw a reduction in the number of cases discussed however this is not viewed negatively. Cases referred have been reviewed and challenged where appropriate to ensure that only cases that met the criteria were focussed on.

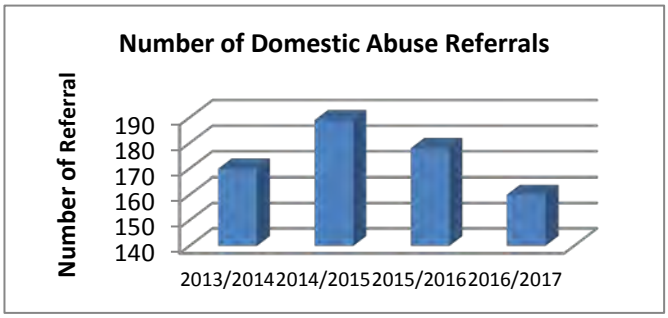
Child Death

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. In 2016/2017 1 child died at WHHFT however the safeguarding children team supported the SUDIC process for 5 child deaths in total (Warrington residents but did not die at WHHFT). This is a change in process from the previous years as the safeguarding children team were only dealing with deaths that occurred in WHHFT. The 1 child death that occurred at WHHFT was due to prematurity. No lessons to be learnt identified, this was a tragic case that could not be foreseen.

Domestic Abuse

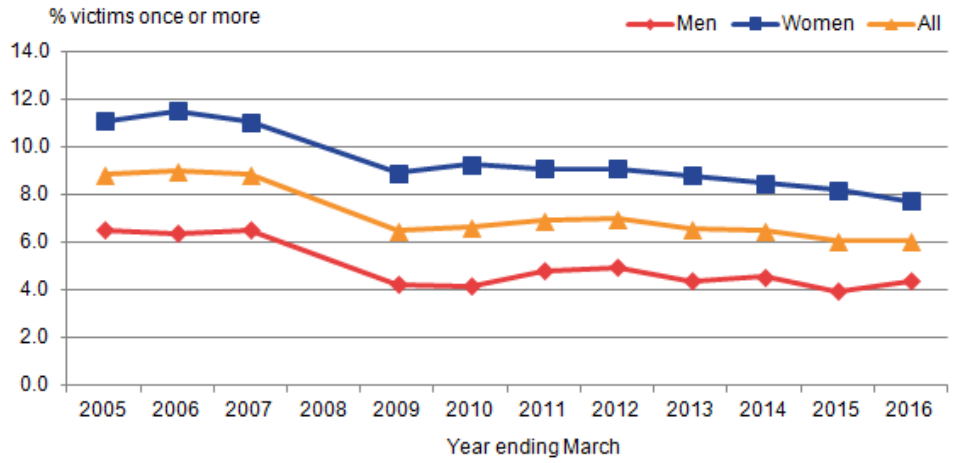
Referrals

The number of domestic abuse referrals completed has declined for the second 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.

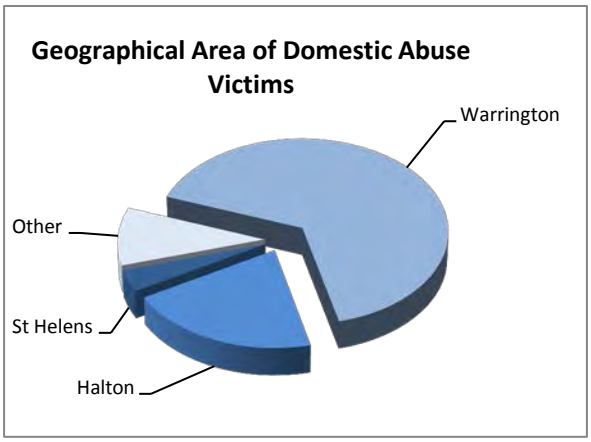


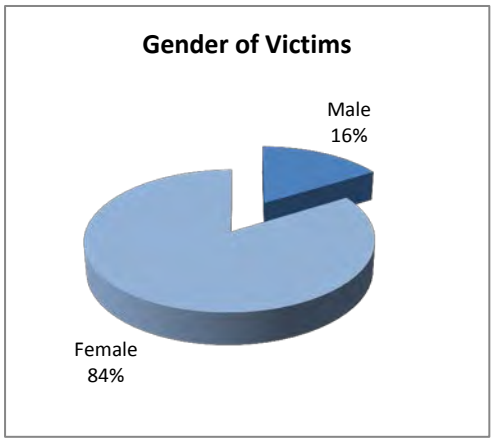
For the year ending March 2016 The Crime Survey for England and Wales (CSEW), estimated 1.8 million adults aged 16 to 59 experienced domestic abuse in the last year, equating to a prevalence rate of 6 in 100 adults (Figure 1). Women were more likely to say they have experienced domestic abuse than men, with an estimated 1.2 million female victims compared to 651,000 male victims, according to the survey (7.7% compared with 4.4%). However the difference between the number of male and female victims (506,000) is at its lowest compared with previous years.

Prevalence of domestic abuse in the last year for adults aged 16 to 59, by sex, year ending March 2005 to year ending March 2016 CSEW



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. Despite the national decrease, further awareness raising will be a priority in 2017/2018 for the safeguarding teams. The majority of the referrals continue to be received from the Emergency Department. 11% of the referrals completed were on pregnant victims. This is a significant increase from the previous year. The number of cases where children were in the family remains static at 45%.





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. The below table details the number of MARACs contributed to and the number of cases discussed. (Each case will discuss a minimum of 2 people)

MARAC	Team	MARAC Reports produced.	Cases discussed (Each case will discuss a minimum of 2 people)
Warrington	Safeguarding Children & Safeguarding Adults	25 (reports / attendance)	327
Halton	Safeguarding Children	25	235
St Helens	Safeguarding Children	22	319

Raising Awareness

In November 2016 The Safeguarding Teams took part in 2 campaigns.

- 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.
- Against Honor Based Violence campaign. Information stalls were presented.

Both campaigns 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. WHHFT have not identified / reported any cases of FGM in 2016/2017. This is a significant decrease from 2015/2016 where 6 cases were identified. A single point lesson was shared in March 2017 to raise further awareness.

Child Sexual Exploitation (CSE)

CSE continues to be high on the agenda nationally. The pan-Cheshire CSE strategy 2015-2017 was launched 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 have increased, with WHHFT being required to review attendance.

In 2016/2017 the Safeguarding Children Team positively raised awareness of CSE across the trust. July 2016 saw all of the Safeguarding Children Champions trained by Catch 22 to become CSE champions.

In March 2016 the team took part in the National Awareness Day for CSE. Information packs were shared across the trust and the Safeguarding Children Team created an information stand. The number of visitors to the stall was incredible proving the campaign to be a success.

Despite the ongoing awareness raising the number of hospital CSE screening tools remains static at 27. This is disappointing however further work to educate staff and promote CSE will continue.

Serious Case Review / Multi Agency Case Review

WHHFT were not part of any SCR this year however WHHFT did contribute to a multi-agency case audit. The report for Family M was finalised and agreed in May 2016. A specific recommendation for health partners was to:

Recommendation	Action	Outcome
Ensure that guidance with regard to missed (cancelled or DNA'd) health appointments as a potential concern is clear and that all professionals understand the decision making process (sharing of information/referral) in relation to missed health appointments.	Ensure that all staff are briefed on the importance of sharing of information in relation to missed health appointments.	This was discussed at the appropriate governance and safeguarding meetings. Information regarding the DNA process was shared with Safeguarding champions to cascade to their teams / departments.

The safeguarding children team supported the LSCBs as auditors for a number of multi-agency case file audits. These audits would have specific topics that would be reviewed. These topics included

- Domestic Abuse
- Neglect
- Interfamilial Sexual Abuse.

There has been no specific learning from WHHFT from these audits however personal learning from these audits have been shared through the safeguarding children forum meeting.

Training Activity

Increasing training compliance was the main objective within the Annual Report of 2015/2016.

Safeguarding Children Training

The safeguarding children action plan was updated and further developed. Support was requested by the Named Nurse to the senior management teams across the trust detailing their responsibilities to ensure their staff are trained. Individual emails were also sent to staff out of date. Training has been provided through e-learning and face to face sessions. Monthly domestic abuse training sessions were introduced midway through the year.
With the support of the safeguarding team and managers across the trust training compliance steadily increased throughout the year.

Safeguarding Children	Quarter 4	Quarter 1	Quarter 2	Quarter 3	Quarter 4
	2015/2016	2016/2017			
Level 1	84%	90%	91%	94%	94%
Level 2	61%	73%	76%	81%	85%
Level 3	76%	80%	83%	90%	88%

Audit Activity

The data for child protection medical audit for 2016/2017 is currently being collated and the outcome from this will be shared later in the year.

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.

An audit of CSE cases identified by WHHFT was completed. The documentation in all 4 cases was of a good standard. There was evidence of clear decision making and rational for completed the necessary referrals. The main concern identified from the audit relates to the small number of referrals completed. The WHHFT Safeguarding Children Team have continued to raise awareness of CSE however little impact in noted. Moving forwards, the safeguarding Children team are currently undertaking an audit of ED attendances to establish whether there are missed opportunities to identify children and young people who may be vulnerable to CSE. This audit is expected to be completed in September 2017. The audit will review a sample of children / young people who have attended and have been recorded as:

- They know are sexually active
- Disclose they are sexually active on history taking for another related health issue
- Are seeking advice about contraception / termination of a pregnancy or a pregnancy
- Who present as pregnant
- who misuse drugs / alcohol
- Deliberate self-harm
- Of no fixed abode / missing from home

Safeguarding Children Supervision

The requirement for Trust employees to have access to safeguarding children supervision is laid down in Working Together to Safeguard Children, (HM Government, 2015)
These state that:

4.48 "Working to ensure children are protected from harm requires sound professional judgements to be made. It is demanding work that can be distressing and stressful. All of those involved should have access to advice and support from, for example, peers, managers, or named and designated professionals. Those providing supervision should be trained in supervision skills and have an up to date knowledge of the legislation, policy and research relevant to safeguarding and promoting the welfare of children.
4.50 For many practitioners involved in day-to-day work with children and families, effective supervision is important to promote good standards of practice and to supporting individual staff members. Supervision should help to ensure that practice is soundly based and consistent with LSCB and organisational procedures. It should ensure that practitioners fully understand their roles, responsibilities and the scope of their professional discretion and/or authority. It should also help to identify the training and development needs of practitioners, so that each has the skills to provide an effective service.
4.52 Supervision should include reflecting on, scrutinising and evaluating the work carried out, assessing the strengths and weaknesses of the practitioner and providing coaching, development and pastoral support. Supervisors should be available to practitioners as an important source of advice and expertise and may be required to endorse judgements at certain key points in time."

The Trust recognises that Safeguarding Children supervision is integral to providing an effective child centred service. The Trust has a responsibility to provide clinical supervision for staff. Safeguarding children supervision is provided in addition to clinical supervision which it complements but does not replace.

2016/2017 saw significant developments in relation to safeguarding Children supervision. 6 members of staff completed the NSPCC Safeguarding Children Supervision 5 day course. Following this a policy was produced with expectations of the trained supervisors detailed. The policy will be uploaded to the intranet and available in May 2017.

Group supervision sessions were provided to child health however the attendance was low and the group sessions dissolved. To ensure that this does not happen again the new policy will be launched raising more awareness of safeguarding supervision and the expectations on the practitioners themselves to access supervision. Group supervision will be held 4 times per month and will be accessible for all hospital staff.

Safeguarding Incidents

Over the past 12 months there has been 53 incidents reported under the categories Safeguarding Children or Domestic Abuse. These incidents have been reviewed by the Named Nurse and deemed: Appropriate action taken; Additional information required or incident needs further investigation.
This figure does not include incidents that have been reported under a different category however have progressed to require safeguarding children review. This figure is not collated.

Category	Number of incidents
Safeguarding Children	41
Domestic Abuse	12
Total	53

Objectives for 2017/2018

- Safeguarding Children Supervision to be embedded across the trust
- Increase awareness of CSE, resulting in increased pre-screening tools completed.
- Training compliance to remain above 85% across all levels
- Develop a joint DNA policy with Bridgewater NHS Health Care
- Strengthen WHHFT relationship with multi-agency partners
- Continue to raise awareness around domestic abuse, increasing the number of referrals.

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

Safeguarding Adults at Risk

Annual Report 2016/2017

Produced By Wendy Turner Lead Nurse Adult Safeguarding

Contents

Introduction and National Context	Page 3
Strategic Context	Page 4
Safeguarding Activity	Page 5
Referrals	Page 6
Training	Page 11
Appendix 1 – Improvement / Action Plan	Page 12
Clinical Audit Report	Page 15

Introduction

This is the seventh Adult Safeguarding Annual Report and the second report following the review and reconfiguration of the trusts management structure in which Clinical Business Units (CBU's) were introduced. The Adult Safeguarding Team consists of a Lead Nurse for Adult Safeguarding, a Matron and administration support.

The year following this reconfiguration has been an exciting and eventful one for the organisations Safeguarding Teams. A whole service review of the structure and provision of safeguarding services was commissioned by the Chief Nurse in December 2016 resulting in the formation of an action plan. The teams have been working towards its completion making improvements to the service and making the provision of safeguarding against abuse a safer more robust process, creating improved systems that better protect our patients.

This report provides assurance to the Board that the necessary safeguarding framework is in place. The quantitative and qualitative data demonstrates the effectiveness of the training, systems, processes and accountability arrangements whilst ensuring that the Trust continues to fulfil its statutory obligations in relation to discharging it's duties of safeguarding at Warrington and Halton Hospitals NHS Foundation Trust (WHHNHSFT).

National Context

The Care Act 2014

This Act introduced the first statutory framework for protecting adults from abuse and neglect it is a land mark piece of legislation that places care and support law into a single, modern statute for adults for the first time.

Abuse is defined widely, however following the Care Act 2014 there is a crucial difference from the previous definition and this is that the duties to safeguard apply regardless of whether the adult lacks mental capacity. The Care Act 2014 states; Safeguarding means protecting an adult's right to live in safety, free from abuse, neglect and exploitation; these are some of our most basic needs everyone has a right to be safe.

'Safeguarding' is a range of activities aimed at upholding the fundamental right to be safe, at the same time as respecting people's right to make choices. The process involves six key principals; Partnership, prevention, protection, accountability, proportionality and empowerment. The principals are about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult's wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in making decisions on their behalf.

We no longer use the term *Vulnerable Adult* because it implies that some of the fault for the abuse lies with the adult being abused, it has been replaced by the term A*dult at Risk.* An adult at risk is defined as any person aged 18 years and over who is or may be in need of community care services by reason of mental health issues, learning or physical disability, sensory impairment, age or illness and who is or may be unable to take care of him/herself or unable to protect him/herself against significant harm or serious exploitation. *(The Care Act2014).*The Care Act instructs partner agencies to engage closely with the victims to establish their needs and what they want to happen? There was now an expectation that provider agencies should produce for their staff a set of *internal guidelines* which relate clearly to the Safeguarding Boards multiagency policy, which set out the responsibilities of all staff to operate within it. Our organisation is obliged to adopt and support the practice described above, we achieve

this by ensuring our own policies and procedures reflect those of our partner agencies and by adhering to our regulatory responsibilities. Assurance is reported via the Joint
Safeguarding Committee to the Trust Patient Safety and Clinical Effectiveness Committee
and Quality Committee

Key Performance Indicators (KPI'S)

The Trust works in partnership with the statutory and voluntary agencies across The Warrington and Halton area's in order to discharge its responsibilities in relation to the safeguarding of Adults, learning disabilities and Mental Capacity Act. We are required to report quarterly on our Key Performance Indicators, they are submitted to the Warrington Clinical Commissioning Group via the Designated Nurse for Adult Safeguarding. The Trust Adult Safeguarding Lead Nurse meets with the Designated Nurse every eight for safeguarding supervision and for assurance review of the KPI's progress. Please see the most recent (Quarter four 2017) reported information at appendix one.

Strategic Context

Responsibilities under the Home Office 'Prevent' strategy have now been placed on a statutory footing from July 2015 with the introduction of the Counter Terrorism and Security Act 2015. Contest is the government anti-terrorist/anti-radicalisation program, the Prevent /WRAP program is part of this. The trust now delivers WRAP at induction for all newly appointed clinically facing staff. Level three Adult Safeguarding master classes are in place to capture the remaining group of clinically facing staff who require this training. All staff groups receive prevent training as part of their induction and level one and two eLearning programs.

Review of Adult Safeguarding objectives for the year 2015/16:

objective	Action	Outcome
To ensure compliance of the MCA	Audit compliance and identify gaps in training requirements	Provide training for all clinically facing staff
To improve Safeguarding Adults levels one and two training compliance ensuring the target of 85% is met.	Promote and provide training for staff to access level one and two training	Level one training has moved from 75% to 92%. Level two training has moved from 69% to 89%
To introduce a WRAP training program	Provide level three WRAP training for all clinically facing staff with timely prevent updates. Provide prevent training for all other staff groups.	All non-clinical staff receive prevent training with level one Safeguarding Adults training, every three years. All new clinically facing staff receive level three Workshop to Raise Awareness of Prevent (WRAP) training at induction with a three yearly prevent update with level two Safeguarding Adults training. WRAP training sessions are now available for all clinical staff.
To improve the monitoring of DoLS throughout the trust	Audit knowledge and compliance. Put systems and processes in place to assist staff with DoLS and MCA practice.	Training at level three for Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Data base that holds a register of all patients who are subject to DoLS, monitored weekly by the Adult Safeguarding Team. Compliant with CQC notifications of DoLS. Improved mortality review. Electronic daily check of all in-patients capacity status monitored by the Adult Safeguarding Team DoLS SOP now in place for staff to reference
Create easy access to Safeguarding information	Provide information in a user friendly format	Adult Safeguarding web page containing learning resources, video's SOP, referral instructions, links to all safeguarding related policies, links to safeguarding meetings and links to the local authority web pages.

In order to achieve the above objectives the Adult Safeguarding Team have put systems, processes and training in place that enable us to be compliant with Care Quality Commission (CQC) standards and to improve patient safety. WRAP training is now a regular occurrence and compliance figures for both level one and two Adult Safeguarding have improved. We now have a data base that records details of all patients subject to DoLS at the trust.

Following a recent CQC inspection in which we were criticised for our capacity assessment compliance, we now have an electronic daily capacity check. The completion of the form ensures that all in patients have their capacity considered on admission and if there is a change in their mental health.

The Trust now has access to a Safeguarding Adults web page containing information on all aspects of Adult Safeguarding. There are videos, links to local authority web sites, policies and information specific to categories of abuse. There is a 'ask us a question' icon that when completed sends the team an email which can be answered by return email. See screen shot below. Click on the Icon and you will be taken via the link to the Web Page (if you are reading an electronic copy)


The Team


Reporting Abuse


Learning Resources


Adult Safeguarding Group

Prevent

Domestic Violence


Ask us a question

Sexual Abuse

Financial Abuse

Deprivation of Liberty Safeguards

Safeguarding Activity

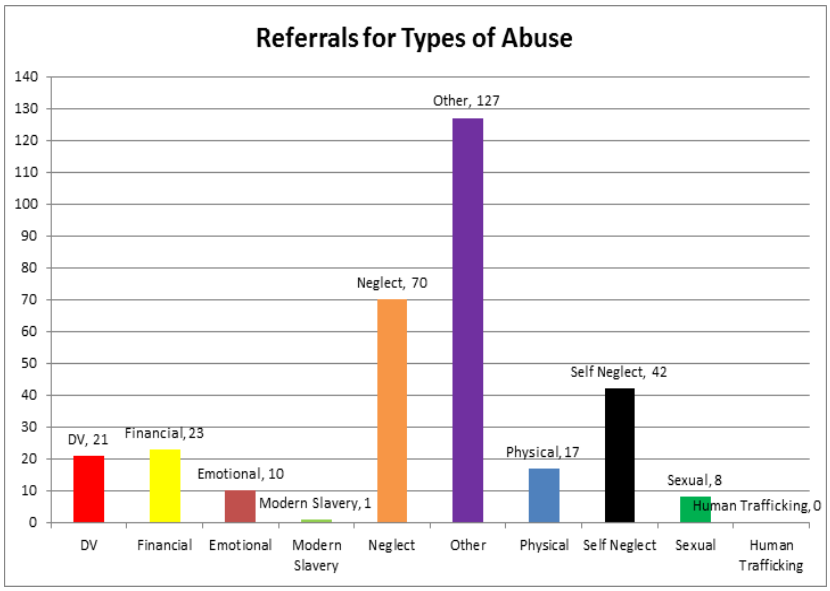
The following information describes some of the work and activity undertaken by the Trust Adult Safeguarding Team. It is usual practice to compare activity from previous years however on this occasion due to a rapid change and departure of a number of staff during the previous reporting year of 2015/16 data was incomplete and therefore unable to be used in comparison to this reporting year. However the data below demonstrates that there were **4207** separate direct patient related activities.

This equates to **81** contacts per week (with the addition of the associated work streams that accompany the contacts) between the two trained team members.

Referrals

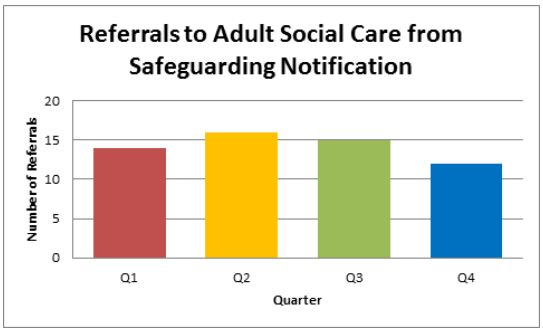
Internal Ice Notifications

Between 31/3/16 and 1/4/17 there were **321** notifications to the Adult Safeguarding team.



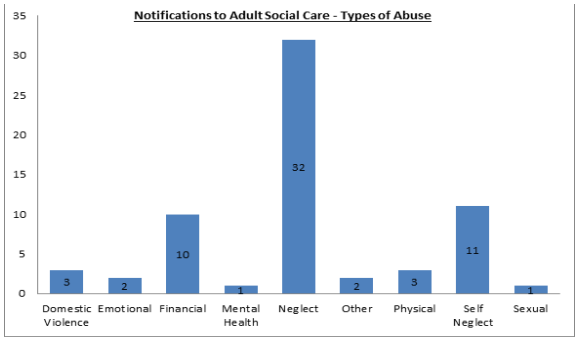
Domestic Violence – 21
Financial – 23
Emotional – 10
Human Trafficking - 0
Modern Slavery – 1
Neglect – 70
Other – 127
Physical – 17
Self-Neglect – 42
Sexual - 8

Adult Social Care



There have been **75** referrals from the Trust to adult social care. These are concerns that our staff have raised about patients who have been admitted to the Trust from care settings or their own homes. The concerns were serious enough to warrant Adult social (Care ASC) investigation. Each investigation requires a written report form the Adult Safeguarding Team

The referrals above were categorized as described below.



Telephone Referrals

The team receives many calls from our partner agencies and from people wanting to make a referral or discuss a concern. In the reporting year there have been **200** calls received by the Adult Safeguarding Team for the reporting year.

Domestic Abuse

The team shares the responsibility for managing domestic abuse across the trust with the Children's Safeguarding Team. Most referrals come from the Emergency Department, those concerning children are reviewed by the Children's team and those concerning adults only are reviewed by the Adult team. A hospital Independent Domestic Abuse Advocate (IDVA) is based at the hospital for two days each week to support the domestic abuse agenda at the Trust. In the reporting year the Adult team have received **30** adult specific Domestic abuse referrals two of which resulted in the patients being transferred to a refuge.

Multi-Agency Risk Assessment Conference (MARAC)

This is a bi-monthly meeting in which victim focused information is discussed between professionals from statutory agencies and the voluntary sector. The highest risk cases are heard here and some are directly referred from the Trust.

Attendance to MARAC at Warrington is shared between the Adult and Children's teams, there is a significant commitment required in preparing for the meeting as a five year chronology is required for each victim and perpetrator, a member of the safeguarding team attends the meeting to present the cases in which a minimum of two people are discussed per case, there are often 20 cases per meeting. During the reporting year there have been **25** separate reports and attendances at MARAC. The work generated around MARAC continues to increase, causing increased pressure on the teams with no attached resource.

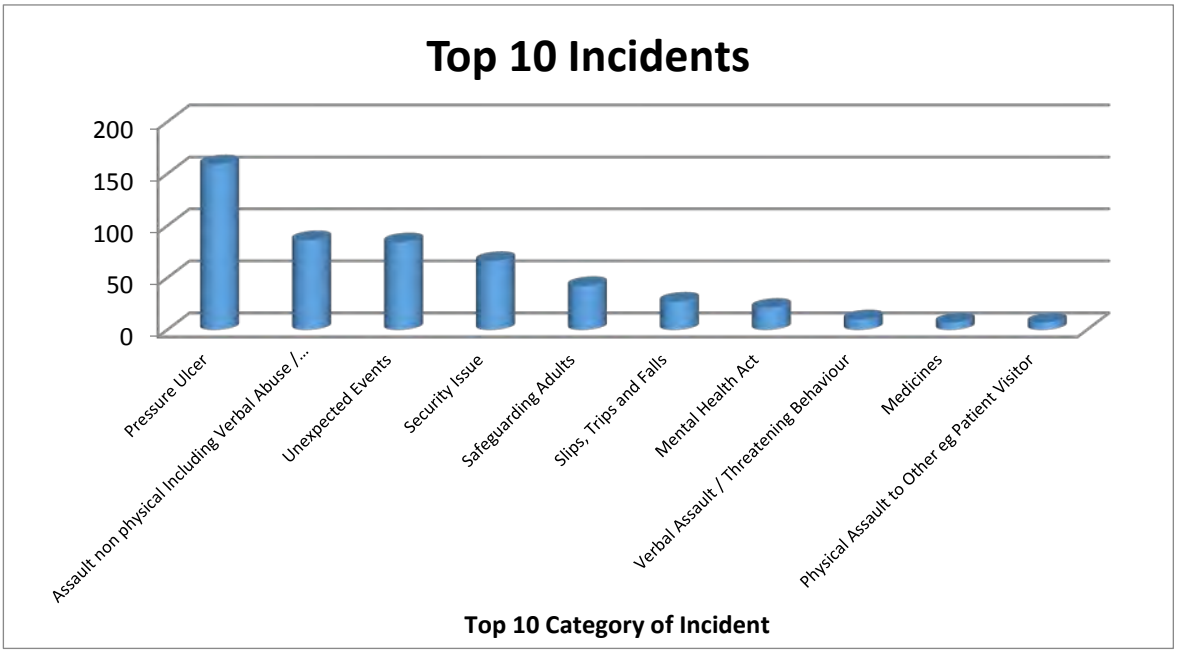
Serious case reviews

The Adult Safeguarding Team are asked to contribute reports and attend panels for Serious Adult case Reviews, the team have supported **13** such reviews across both local authorities in this reporting year.

DATIX / incident management.

The Adult Safeguarding Team receives notifications for all incidents that have a safeguarding element to them. They require review in order to evaluate any possible safeguarding concerns. Once reviewed the incident is either closed or escalated for further investigation. The ongoing incidents are reviewed weekly and the matrons and lead nurses are sent a report on the progress of the incident and informed of what is outstanding.

The team have reviewed **3166** incidents in the reporting year. We provide advice and support for all reviewed incidents. The main themes from these are;



Hour and Serious Incident reviews

The Adult Safeguarding Team will request a 72 hour review during the activity of DATIX reviews if it is thought to be necessary and they will attend the review to participate in the process. The CBU's will also invite the team to 72 hour reviews where harm has occurred as a result of the incident. The Adult Safeguarding Team have attended **103** reviews in this reporting year. Our attendance is required at level one panels and Serious Review panels, the team have attended **4** this reporting year

MCA DoLS

As a result of the Trust wide Safeguarding Review it was recommended that MCA/DoLS should formerly become part of the safeguarding portfolio. Although it was recognised that DoLS had already been part of the Adult Safeguarding work plan some months prior to the review. It was also recommended that Learning Disability was also attached to the safeguarding portfolio. CA responsibility was added to the safeguarding portfolio in February 2017. Although the DoLS element was already a part of the work plan for the team as described above. However the additional associated work has no attached resource. During this reporting year the Adult Safeguarding Team have supported the Trust with **225** DoLS applications. The activity associated with DoLS is described at the beginning of this report.

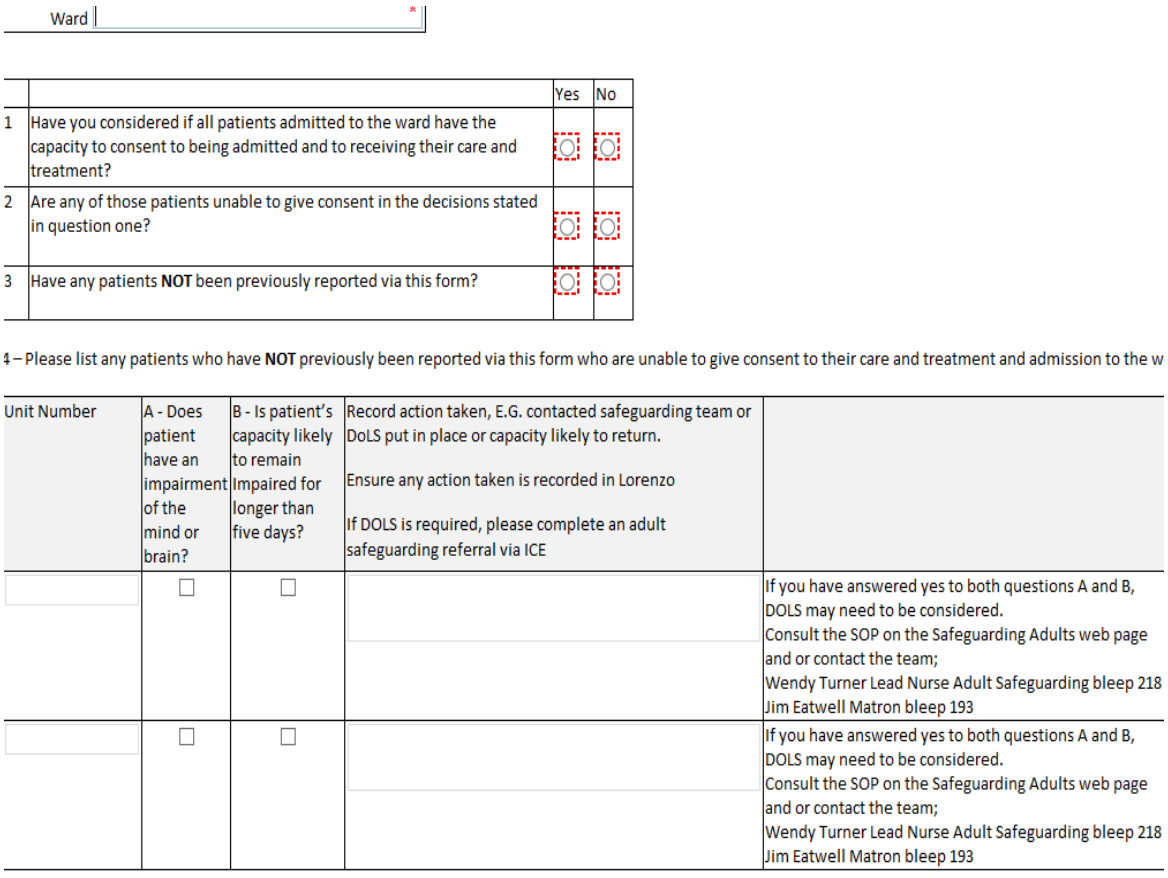
Following our recent CQC inspection in March of this year, it was highlighted that our compliance around capacity assessment and the MCA was poor. As this is a matter of law and had potentially serious consequences we were tasked with rapidly improving the situation. An audit was the first course of action in order for us to assess our base line this can be found at appendix two The audit is due to be repeated in June of this year.

Training was high on the agenda to support the improvement in our compliance. The Trust Solicitors have now supported this agenda with four training sessions and more are planned later in the year. MCA / DoLS training has now been added to the junior Drs training program at the Trust and will be delivered by the Adult Safeguarding Team. Face to face sessions have been arranged for nursing staff to access on a regular basis and will again be delivered by the Adult Safeguarding team. Consultants and senior nurses will receive training through audit meetings. The DoLS standard operating procedure which can be accessed via our web page has been found to be a very good resource for our teams.

All staff are required to conduct capacity assessments in cases where a patients' capacity is in doubt in line with the Trust policy. Each of the forms completed has copies attached, one of which comes to the Adult Safeguarding Team where is audited for compliance.

All DoLS documents arrive into the trust via the Adult Safeguarding Team where they are reviewed and then discussed with the receiving ward to ensure that the restrictions become a part of the patients' care plan. The data base which was described earlier allows the team to liaise on weekly basis with the wards enabling discussion and tracking of the expiry dates of the DoLS .

The Adult Safeguarding Team have introduced an electronic form which is to be completed on a daily basis by all in patient areas. This is a daily check demonstrating that all in patients have had their capacity to consent to their care and treatment and to staying in hospital, considered. The form is sent to the Adult Safeguarding Team for review, the form is scrutinised to ensure compliance with the MCA, the team contact the wards the same day that the form is received in order to discuss any issues they may find. An example of this form can be seen below.



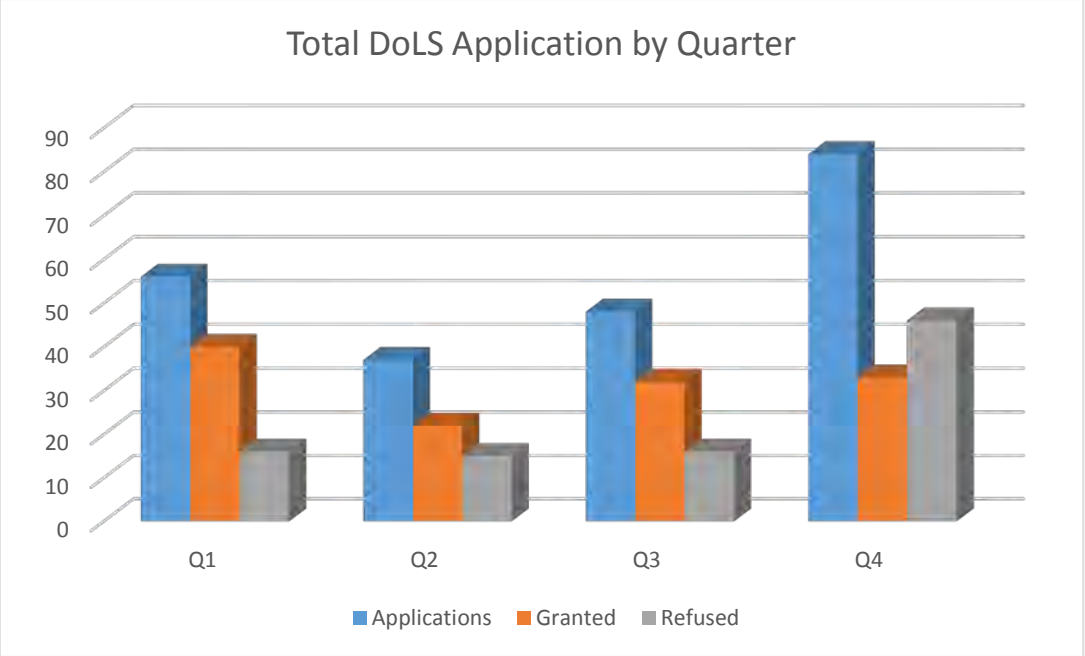
Ward *

		Yes	No
1	Have you considered if all patients admitted to the ward have the capacity to consent to being admitted and to receiving their care and treatment?	○	○
2	Are any of those patients unable to give consent in the decisions stated in question one?	○	○
3	Have any patients **NOT** been previously reported via this form?	○	○

4 – Please list any patients who have **NOT** previously been reported via this form who are unable to give consent to their care and treatment and admission to the w

Unit Number	A - Does patient have an impairment of the mind or brain?	B - Is patient's capacity likely to remain Impaired for longer than five days?	Record action taken, E.G. contacted safeguarding team or DoLS put in place or capacity likely to return. Ensure any action taken is recorded in Lorenzo If DOLS is required, please complete an adult safeguarding referral via ICE	
	☐	☐		If you have answered yes to both questions A and B, DOLS may need to be considered. Consult the SOP on the Safeguarding Adults web page and or contact the team; Wendy Turner Lead Nurse Adult Safeguarding bleep 218 Jim Eatwell Matron bleep 193
	☐	☐		If you have answered yes to both questions A and B, DOLS may need to be considered. Consult the SOP on the Safeguarding Adults web page and or contact the team; Wendy Turner Lead Nurse Adult Safeguarding bleep 218 Jim Eatwell Matron bleep 193

The table below demonstrates the DoLS activity during the reporting year. You will note the increase in applications for quarter four. It is worth noting that the above form was commenced during this quarter. The table describes applications for both of our local authorities and some that are out of our usual area.



Due to this increased activity, Warrington local authority have reported that they are struggling to keep up with the applications and there is a back log. This has affected the data above as the DoLS granted or refused activity is no longer in real time. To assist with this the Adult Safeguarding Team have worked closely with the local authority to introduce a triage system in which applications can be prioritised hence ensuring those in most need are reviewed in a timely manner.

Learning Disabilities

The data around the Learning Disability (LD) activity is recorded from 1st January 2017 to 31st March due to the specialty becoming part of the safeguarding portfolio in December 2016. In this reporting period there were **27** ICE notifications with a further **18** contacts via telephone. The Warrington LD Specialist Nurse joins the Adult Safeguarding team once every month for a Learning Disability ward round in which we visit the all wards to remind staff of how to contact the community teams and to discuss any LD issues.

There is currently a huge amount of activity around LD following the introduction of the LeDAR process. We are currently working with our community partners in developing a flagging system in which an alert will be created as an LD patient is admitted to the trust enabling well fare checks around reasonable adjustments and ensuring that specific care needs are met. This has been a somewhat drawn out process with governance concerns sited as the reason from our partners. This has recently been resolved and we hope to see progression at pace moving forward. The Adult Safeguarding Team are currently working with the Trust training team in order to put an eLearning program in place to provide specialist training to the Trust teams with regard to LD. The possibility of an LD/mental health specialist Nurse for the trust is to be scoped.

Mortality Review

The Lead Nurse Adult Safeguarding attends the Trust monthly Mortality Review meeting providing a safeguarding view of the deaths reviewed. All patients on DoLS or who have an LD automatically have a secondary review via this group. Any learning from the reviews is shared with the trust teams via the Safeguarding Committee. There have been four patients who have died that had an LD in this reporting year.

Raising awareness of Adult Safeguarding matters.

There have been a number of events held at the Trust over the reporting year that have sought to improve staff awareness of Safeguarding at the Trust.

- World Elder Abuse Day
- A regional WRAP event in which the Safeguarding team invited the NHS England Northwest Lead to deliver this important training to Trust staff. The event was advertised regionally and was a successful event that was well attended. The Adult Safeguarding Team also took the opportunity to receive training to enable them to become WRAP facilitators. This training is now delivered on the induction program and in level three training sessions.
- Domestic abuse training form the IDVA's based at the Trust.
- Attendance from the Trust Solicitors to deliver MCA training
- Attendance from Cheshire Police to present information about the new national Herbert Protocol, which aims to support patients in the community who wander away from home. Our role will be to promote this initiative with families of patients who may wander.
- MAYBO training; to support staff in their practice of clinical holding and conflict resolution.

The following policies have been reviewed and in some cases re-written;

- Adult Safeguarding
- Clinical Holding
- Learning Disability
- Care of patients who may wander
- Care of Prisoners Policy

Training

The Adult Safeguarding Team have delivered two face to face level two training sessions per month over the reporting period. Training took place both at Halton and at Warrington. At the point the current team took post training was less than the required contractual target of 85% with level one training compliance at 75% and level two training compliance at 69%. Please see the information below for the Trust Total training figures up to 31/31/7 (the end of quarter four).

Safeguarding Procedures (Adults) - Level 1 1st April 2014 - 31st March 2017				**Safeguarding Procedures (Adults) - Level 2** 1st April 2014 - 31st March 2017		
Heads		**Number Completed**	**% Completed**	**Heads**	**Number Completed**	**% Completed**
3909	**3573**	**91.40%**	**2365**	**2045**	**86.47%**	

Objectives for 2017/2017

"Safeguarding means protecting people's health, well-being and human rights, and enabling them to live free from harm, abuse and neglect. It's fundamental to high-quality health and social care." Care Quality Commission 2016

Therefore with this in mind this coming year's objectives will build on last years. A great deal of progress has been made in bringing the service into a safer more robust position. Processes and systems have now been put in place that have improved how we protect our patients. The following will be in place to support this work;

- Continued staff education for MCA/DoLS
- Level three safeguarding training program to include WRAP and LD
- LD flagging system
- Robust policies and procedures
- Completion of the safeguarding review action plan
- Improved level of support from safeguarding link staff who will be supported with specific training
- Scoping of LD/mental health Specialist Nurse
- Co-location of Adult and Children's Safeguarding Teams
- Continue to work collaboratively with our local partners and commissioners.

Appendix one

Improvement / Action Plan

Name of Organisation: Warrington and Halton Hospitals

RAG Rating Key:

Amber		Improvement plans in place to ensure full compliance and progress is being made within agreed timescales
Red		Non-compliance against standards and actions have not been completed within agreed timescales

Safeguarding Improvement/Action Plan Following NHS Warrington Clinical Commissioning Group Annual Safeguarding Self-Assessment

Standard Number	Standard	Action	Lead Person	Target Date	Progress	Date of Review	Date of Completion	RAG
1.2	Through training needs analysis staff who require MCA training are identified and training is delivered via a structured program.	Organise a new program of training for all clinically facing staff	Wendy Turner	September 2017	Following MCA/DoLS being moved to Adult Safeguarding in February 2017 training has been reviewed. The current eLearning package is to be updated to better suit the trust's needs. There have been sessions recently conducted by the trust solicitors for medical and nursing teams around MCA and DoLS. The adult safeguarding team will also be delivering training over the coming months and the trust solicitors will return to deliver further training. The local authority is also to support this training process. There is now an SOP for guidance and a daily electronic capacity check for wards to complete on all patients guiding them to make decisions about DoLS. Although the structured program has now been planned it is in its infancy and re audit is required to assess the efficiency of the training.	June 2017	September 2017	
3.1	A policy and procedure and easily accessible flow charts to support staff in preventing abuse, reporting abuse, managing abuse and assisting with Local authority led investigations in line with Warrington Council Safeguarding Adults Board (SAB).	An Adult Safeguarding policy exists but is in process of being updated with reference to care act and new categories of abuse.	Wendy Turner	September 2016	Policy complete and awaiting ratification Policy has been updated to include the new categories of abuse in the Health & Social Care Act 2014 (2015)	August 2016	Ratified Jan 17	
4.1	There are agreed template and paper work for staff to use to document their findings when allegations of abuse and or neglect is suspected.	Evidence of safeguarding documentation, use of body maps, chronologies and templates for reports Evidence of information sharing polices, adherence to the data protection act.	Wendy Turner	September 2016	There are a number of documentation to support staff in referring pt for adult safeguarding. Policy is updated to include the new categories of abuse and is awaiting ratification	December 2016	Dec 16	
4.2	Adult patients are routinely assessed to ensure that their vulnerability to abuse exploitation, inclusive of any predatory behaviour is risk assessed and managed.	1.Contact details for referral and information sharing to be included in Adult Policy 2. Risk assessment documents need to be updated.	Wendy Turner Jim Eatwell	July 2016 March 2017	PPU ASC details included Current documentation has been updated and the policy is ratified.	July 2016 October 2016		

7.2	Plan for training for staff which is accredited, underpinned by the MCA and relevant to the post holder.	Training figures to be provided as part of the dash board	Wendy Turner Jim Eatwell	September 2017	Following MCA/DoLS being moved to Adult Safeguarding in February 2017 training has been reviewed. The current eLearning package is to be updated to better suit the trust's needs. There have been sessions recently conducted by the trust solicitors for medical and nursing teams around MCA and DoLS. The adult safeguarding team will also be delivering training over the coming months and the trust solicitors will return to deliver further training. The local authority is also to support this training process. An audit of compliance around the MCA has resulted in a new action being added to the overall trust safeguarding review action plan to support the training requirements. There is now an SOP for guidance and a daily electronic capacity check for wards to complete on all patients guiding them to make decisions about DoLS. A data base checked by the adult safeguarding team helps maintain this activity. Further audits are planned to track progress.	June 2017	September 2017	
7.3	Clinical holding policy	Ratification	Wendy Turner	September 2016	Awaiting ratification	Septem ber 2016	Ratified Jan 17	
9.1	There is a policy/procedure in place for the safe recruitment of staff who may be working with vulnerable people.	There should be evidence of compliance with the Saville enquiry covering chaperoning, and the safety of patients who may come into contact with celebrities, religious leaders, volunteers, other patients, visitors.	Wendy Turner Jim Eatwell Katie Clarke	December 2017	The trust has a HR policy for recruitment which includes safe recruitment of staff who may be working with Vulnerable adults. There is a newly ratified policy for visiting celebrities and volunteers, the trust action plan around the Laming report has recently been updated and submitted to the Designated Safeguarding Children's Nurse and NHSI Work is underway to update trust information, policy and guidelines around people in positions of trust. This will require ratification when complete. Therefore this point will remain amber until the policy is ratified. The chaperone policy is currently under review	June 2017	December 2017	
12.1	The organisation can demonstrate that reasonable adjustments are built into polices procedures and pathways.	The disability equality duty is enshrined in the organisation's patient care pathway to ensure that timely, safe, and efficient care, investigations and treatment are delivered under The Disability Equality Duty Act.	Wendy Turner Jim Eatwell	September 2017	Following a review of Adult Safeguarding services Learning Disability is now part of the Adult Safeguarding umbrella. The trust now has a recently updated and ratified Learning Disability policy available to staff. Work is currently underway to put a flagging system in place for Learning disability patients. Wards are aware that they should contact the adult safeguarding team to discuss patients with a Learning Disability and they have the contact numbers of the community specialist Learning Disability Nurse Specialists. The Nurse Specialist have the contact numbers of the Adult Safeguarding team and contact the team when issues arise, they are aware of all ward Sister and Matron contact details. I have changed this item to amber as review is now required and underway around pathways and flagging.	June 2017	September 2017	
13.1	Evidence of planned audits to be implemented in the year to assist in improving safeguarding practice.	Yearly restraint audit; this has recently been completed. Lessons	Wendy Turner/ Jim	March 2017	Clinical holding will be re audited in October 2017, however the work underway to support and train staff in caring for patients with this need and is expected to be complete by May 2017	March 2017	Completed March 2017	

		learnt were discussed and high risk areas identified. Work is currently under way to review levels of training across the trust. This will be assessed and training needs will be addressed with the identified high risk areas in the first instance. Work is also under way to look at a risk assessment that identifies patients who may need holding so that staff consider this issue earlier and are able to assess trigger points and make adjustments which may prevent patients challenging behaviors, in those patients where this is expected. We are promoting the updated clinical holding policy for those patients where the need to hold arises out of an emergency situation. A core care plan is also under development	Eatwell/ Phil Sloane		Following a recent safeguarding review by an external expert it was noted that further work and training would be required a task and finish group has been set up to support the above work			
		Yearly audit of adult referrals This was reported on in 2015/16 annual report, however the data was incomplete due to the gap in data collection resulting from change of post holders. Themes and trends are currently being reviewed	Wendy Turner/ Jim Eatwell	December 2016	Themes and trends are currently being reviewed Complete; WRAP delivery has now begun with clinically facing staff new starters at induction		Completed Jan 2017	
		Yearly audit of training contents a recent audit of training content revealed that updates were required around WRAP. The slides used are care act compliant and up to date with all categories of abuse with information to help staff to recognise and refer/deal with situations where abuse is suspected.	Wendy Turner/ Jim Eatwell	Complete	Training has been reviewed as part of an overall safeguarding review and all training will now be delivered as eLearning with face to face master classes to take place to support level 3 training MCA compliance practice and knowledge To be audited	October 2016	Completed March17	
		MCA auditing now sits with Adult Safeguarding next audit due quarter 4	Wendy Turner/ Jim Eatwell	March 2017		October 2016 March 2017	Completed Jan 2017	

CLINICAL AUDIT REPORT
(Corporate)

Topic: Mental Capacity Act Audit / DoLs

REPORTED BY:- Wendy Turner / Jim Eatwell

Date: 15th March 2017

This document provides a brief detail summary of this audit and the expected actions to be undertaken following the results

Audit lead: John Goodenough

Introduction / Background

The Mental Capacity Act (MCA) covering England and Wales provides a statutory framework for people who lack capacity to make decisions for themselves, or who have capacity and want to make preparations for a time when they may lack capacity in the future.

It sets out who can take decisions, in which situations, and how they should go about this. The Code has statutory force, which means that certain categories of people have a legal duty to have regard to it when working with or caring for adults who may lack capacity to make decisions for themselves. People working with or caring for adults who lack capacity to make decisions for themselves have a legal duty to consider the MCA Code of Practice.

Following our recent CQC review it was highlighted that trust staff were not following the MCA there was a poor understanding demonstrated across the trust of the MCA and DoLS process and the law around this. It was found that where capacity assessments were required they had not been carried out. Patients had been placed under DoLS without their capacity having formally been assessed meaning there was a risk that patients who were under an urgent DoLS and awaiting assessment by the best interest assessors from the local authority were having restrictions imposed on them unlawfully.

Following the inspection we were asked to conduct an audit and to provide assurance that our patients were safe with regard to the MCA and that all those patients who required capacity assessment and subsequently a DoLS had undergone the assessment and where appropriate had DoLS applied.

Aim / Objective

The aim of the audit is to scrutinise the effectiveness of the use of the MCA across the trust in order to gain the assurance that our patients are safe and where required staff have adhered to the MCA and applied its process.

The objective is to recognise the learning from the scrutiny and for this learning to inform the action plan.

The provision of targeted specialist training across the trust using the evidence from this audit to improve the clinical teams understanding of the MCA is a given.

Methodology

Date audited: 13th March 2017

Age ranged from: 19 – 101 years (average age 73 years)

Total number of patients audited: 480

Standards used

Mental Capacity Act

Local DoLs Policy

National or Local Audit

Local

Results

480 in-patients audited across the Warrington, Halton and CMTC sites.

Criteria	Yes	No
Is there any doubt over the person's capacity to decide to remain in hospital for care and treatment?	115 (24%)	365 (76%)

Criteria	Yes	No	Not recorded
Has the person's capacity to decide to remain in hospital for care and treatment already been assessed	63 (55%)	50 (43%)	2 (2%)
Is there impairment or disturbance in the functioning of the persons mind or brain	99 (86%)	6 (5%)	10 (9%)

If yes to the above or no to below the reason or condition was recorded. DoLS put in place in line with responses below = 5/4 (11%)

Criteria	Yes	No	Not recorded
Is this impairment likely to resolve in the next 5 days	13 (11%)	91 (79%)	11 (10%)
Is the person subject to continuous supervision and control (Acid Test)	43 (37%)	62 (54%)	10 (9%)
Does the person have capacity to decide to remain in hospital for care and treatment (Acid Test)	13 (11%)	85 (74%)	17 (15%)
DoLs required	46 (40%)	60 (52%)	9 (8%)

Standards Met (NICE / National)

Standards	National %	W&H NHSFT %
Mental Capacity Act	Partially compliant	
Mental Capacity Code of practice	Partially compliant	
Trust Mental Capacity Policy		Partially compliant

Compliant

(If audited against NICE / National standards, please tick appropriate box)

Please note: you must complete all 3 sections

Compliance Level		Assurance Rating		Risk Rating	
Compliant		Fully		Low	
Partial compliant	x	Not		Moderate	
Not compliant		Partial	x	High	x
Unknown				Extreme	

To Be Added to risk register (please circle) Yes No Not Applicable

Conclusions / Summary

One of the most important terms in the MCA and the Code of Practice is **'a person who lacks capacity'.**
Whenever the term 'a person who lacks capacity' is used, it means a person who lacks capacity to make a particular decision or take a particular action for themselves at the time the decision or action needs to be taken.
This reflects the fact that people may lack capacity to make some decisions for themselves, but will have capacity to make other decisions. For example, they may have capacity to make small decisions about everyday issues such as what to wear or what to eat, but lack capacity to make more complex decisions about financial matters. It also reflects the fact that a person who lacks capacity to make a decision for them at a certain time may be able to make that decision at a later date. This may be because they have an illness or condition that means their capacity changes. Alternatively, it may be because at the time the decision needs to be made, they are unconscious or barely conscious whether due to an accident or being under anesthetic or their ability to make a decision may be affected by the influence of alcohol or drugs. The audit found across the trust, that staff said that they had doubts about some of their patient's capacity. Some of the patients who staff had highlighted as needing a capacity assessment had not been assessed.
Those patients who were without capacity and who had a disturbance of the mind or brain and who were deemed not to be able to consent to their care and treatment, make a decision about staying in hospital and were under constant supervision, required DoLS. However although staff had responded to the audit questions positively about this they had not applied a DoLS. This demonstrated further that staff had a poor understanding of capacity assessments, the acid test terms of reference and the DoLS process

Recommendations

An urgent review of training content and provision is required.
A review of how the nursing and medical teams receive training and updates should be undertaken.

Learning and Improvement Identified

There is a trust wide variation in the knowledge of MCA and DoLS, of capacity itself what is meant by this and how to assess capacity.
Some individuals do not recognise their responsibility and accountability to assess and safeguard patients MCA care and provision.
There is also a lack of understanding of the statutory obligations of the MCA and the sections within it, for example the five 'statutory principles' which are the values that underpin the legal requirements in the Act.

Quality Improvement Action Plan

Audit Title: Mental Capacity Act Audit / DoLs

Presenter: Wendy Turner / Jim Eatwell

Key
1 – Agreed but not yet actioned
2 – Action in progress
3 – Made partial implementation
4 – Full implementation completed

	Quality Improvement Actions	Responsible Person	Change stage (see Key)	Date Action(s) to be Completed
1	MCA and DoLS Training provision should be reviewed immediately. A meeting is to be arranged with the Associate Director of Education and the Organisational Development Team to discuss training to look at the content of level three MCA and DoLS training and how this can be delivered to the nursing and medical teams.	Wendy Turner Wendy Johnson	2 3	Meeting to take place by 7/4/17 Training dates to be in place and circulated to the trust by 21/4/17 Dates circulated
2	Support is required across the CBU's to embed and support the wards and departments with the MCA and DoLS statutory obligations and trust policy and procedures. The group of staff responsible for this support must undergo training as soon as dates are confirmed along with other priority staff, including ward managers and ward sisters.	ADoN Lead Nurses Matrons	2 3	First training sessions awaiting confirmation Dates now confirmed
3	Repeat this audit in three months' time to assess the effectiveness of the training program and follow up with regular audits thereafter	Lead Nurses Matrons Wendy Turner Jim Eatwell	2	June 2017

We are WHH

Warrington and Halton Hospitals NHS
NHS Foundation Trust

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/17/07/88**
SUBJECT:	Safe Staffing Report – 6 monthly review
DATE OF MEETING:	26 July 2017
ACTION REQUIRED	To discuss, note the contents and actions outlined within the report.
AUTHOR(S):	John Goodenough – Deputy Chief Nurse
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse Choose an item.
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 forms the six monthly review of nurse staffing in line with the commitment requested by the National Quality Board in 2013 and the refreshed, broadened and re issued guidance in July 2016. The original paper was presented to the July 2017 Quality Committee although some amendments have been made to this paper. The report represents the outcome of the Safer Nursing Care Tool acuity and dependency reviews that took place in April 2017 which overall shows a deficit of 80.83 WTE; however it should be noted that the Safer Nursing Care Tool will be re-run in October, which affords time to adequately train staff in the subtleties of the tool and understand the positon further. In the meantime senior staff have been requested to review staffing on a daily basis and escalate any areas of concern where actual staffing numbers do not meet those planned. Furthermore the ongoing Nursing Recruitment and Retention Strategy continues to be delivered at pace; work is underway to better understand the supervisory time afforded to Ward Managers, along with further work to ensure the maximum benefit of the E Rostering system and identification and escalation of Red Flag events. Daily shift checks by the Senior Nursing team along with real time escalation is in place to ensure safe, high quality care

	continues to be delivered to WHH patients.	
RECOMMENDATION:	It is recommended that the Board of Directors review and discuss this report.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

Contents

1.0	Introduction / Context	4
2.0	National Context and expectations of the National Quality Board	4
3.0	Workforce Information	5
3.1	Local Context / Warrington and Halton Hospitals (WHH) Current Position	5
4.0	An Overview of available methodologies for safe nurse staffing	9
5.0	Safer Nursing Care Tool	10
6.0	Safer Nursing Care Tool Results – Adult In Patient Wards	11
7.0	Women & Children	12
7.1	Paediatrics	12
7.2	Neonatal Unit	12
7.3	Midwifery Workforce Position	13
8.0	Additional Safe Staffing Considerations	13
8.1	Establishment uplift	13
8.2	Ward Manager Supervisory time	16
8.3	Allocate Safe Care Module	16
8.4	Reported Staffing Incidents	17
8.5	Red Flags – NICE Requirements	17
8.6	E-Rostering	18
8.7	Use of Temporary Staff	18
8.8	Workforce Repository and Planning Tool (WRaPT)	19
9.0	Overall Conclusions	20
10.0	Recommendations	20
Appendix 1		21
Appendix 2		22
Appendix 3		33
Appendix 4		34

1.0 Introduction /Context

This paper forms the six monthly review of nurse staffing in line with the commitment requested by the National Quality Board (NQB) (2013) document, 'How to ensure the right people, with the right skills are in the right place at the right time', in response to the Francis enquiry (2013). This guidance has been refreshed, broadened and re issued in July 2016 to cover all staff and to include the need to focus on safe, sustainable and productive staffing (National Quality Board 'Supporting NHS Providers to deliver the right staff, with the right skills, in the right place at the right time – safe and sustainable staffing July 2016'.
The following report is presented as an expectation of the NQB guidance and represents the outcome of the acuity and dependency reviews that took place in March 2017 at WHH.

All Ward Sisters / Charge Nurses, Matrons, Lead Nurses and Divisional Associate Director of Nursing participated in the acuity and dependency review process. A further meeting has been organised on the 28th July with all Ward Managers to go through their individual staffing establishments for further detailed discussion and next step acknowledgement directly with the Chief Nurse.

2.0 National context and expectations of the National Quality Board

Boards of organisations 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.

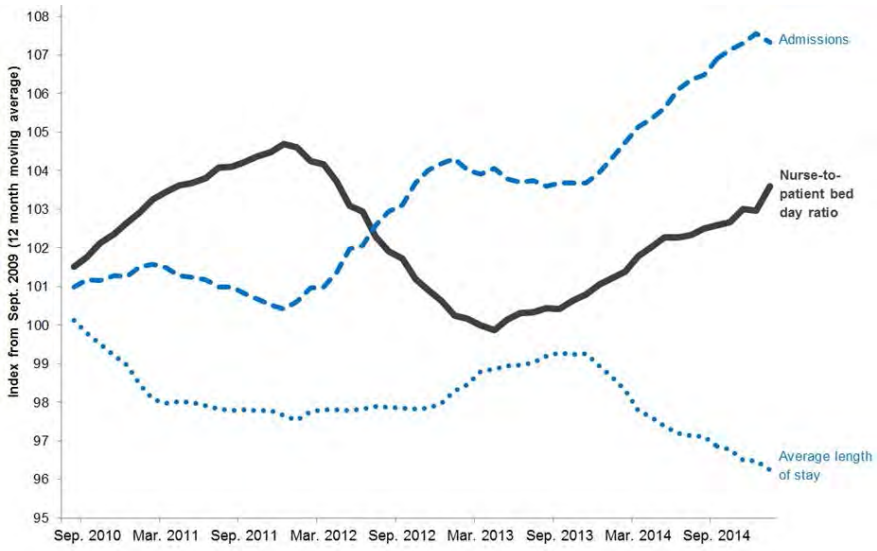
The NQB (2016) described three main expectations of NHS Provider Boards to ensure their organisation has the right culture, leadership and skills in place for safe, sustainable and productive staffing. They are also responsible for ensuring proactive, robust and consistent approaches to measurement and 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

3.0 Workforce information

Current information informs us that the number of nursing staff has increased nationally by 1.8 per cent from 281,064 FTEs in 2010 to 286,020 FTEs in 2017. This increase in nursing resource reflects the NHS response to various reports on the quality of patient care. Nationally, demand for nurses caring for adult acute patients in 2014 was 189,000, around 7,000 more than hospitals had been forecasting just a year earlier and 24,000 more than was forecast the two years before .
A rapid increase in the number of nurses employed over the last two-and-a-half years has resulted in an increase in the ratio of nurses to patients in hospitals. However, the recent increase has only returned this ratio to where it stood at the end of 2011 (see table 1 below).

Table 1
Trends in nurse-to-patient ratio, admissions and length of stay 2010 to 2015



The supply of nurses has failed to keep up with this rapid growth in demand

Although there is increasing demand on NHS services, there remains a significant shortage in the supply of nurses available to NHS. In March 2015 Health Education England (HEE) predicted an estimated shortfall in nursing staff of approximately 8.9 % and has now projected that this could rise to 11.4 per cent by 2020.

Significant shortfalls have driven up the use and associated costs of agency nurses by around 30% from 2012 to 2015 nationally. It is reported that the number of newly qualified nurses available to be employed will increase by up to 2,200 more per year in 2019, as a result of expansion in nurse training places commissioned by HEE between 2013 and 2016.

3.1 Local Context / Warrington and Halton Hospitals (WHH) Current Position

At March 2017 there were 18,997 registered nurses in Cheshire and Merseyside. A third of these nurses are aged 50+. High-level data shows that nationally there has been a 2% increase in the supply of the

registered nursing workforce in the NHS, however this masks a picture of significant reductions in Mental Health (12%), Community (13%) and Learning Disability (33%) and, for the first time in over a decade, more nurses are leaving the NMC register than joining it.

Table 2 shows the total number of budgeted band 5 Full Time Equivalents (FTE), the number of band 5 staff nurses in post against current and predicted vacancies and also turnover rates; Nursing and Midwifery "leaving reasons" are also presented for context.
Turnover in 2016 was 14.64%, which has slightly reduced to 14.00% in 2017 to date.

Band 5 nursing vacancies reduced from 148.7 FTE in 2016 to 131.7FTE in 2017 to date, however it must be recognised that whilst we are celebrating some success in managing to recruit large number of qualified nurses in a competitive market, we need to be cognisant that the lead in time for the staff to commence in post and the attrition rates prior to commencement must be considered in the round.
Band 5 Staff Nurses only. Nursing staff reasons for leaving the Trust are detailed in Table 3.

Table 2

Overall N&M Vacancy Rate	2016				
Staff Group	Budget FTE	In Post	Current Vacancy (FTE)	Vacancy %	Turnover
Nursing and Midwifery	1088.8	940.1	148.7	13.66%	14.64%
Midwifery	99.5	100.4	-0.9	0.00%	10.26%

Overall N&M Vacancy Rate	2017				
Staff Group	Budget FTE	In Post	Current Vacancy (FTE)	Vacancy %	Turnover
Nursing and Midwifery	1099.0	967.3	131.7	11.98%	14.00%
Midwifery	101.7	97.4	4.3	4.23%	8.32%

Table 3

Description	N&M Leaving Reasons
A review of the reasons Nursing and Midwifery staff leave the organisation over the last 12 months	

Table 4 below demonstrates the age demographics of the nursing and midwifery workforce and highlights that 29.73% are aged 51 years or over and as such may choose to retire within the next five years. Table 5 identifies employee numbers by Division and CBU are also presented for reference.

Table 4

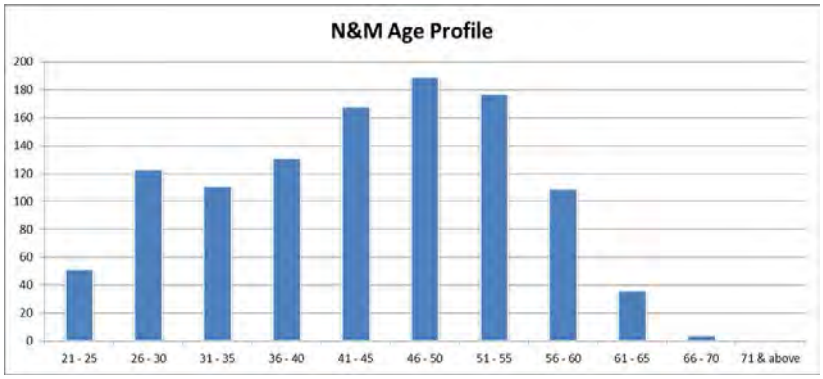


Table 5

Count of Employee		Employee Age		
Division	CBU	50 and Above	Below than 50	Grand Total
370 Acute Care Services RWW251	370 Airway Breathing & Circulation RWW358	18	88	106
	370 Diagnostics RWW356	5	10	15
	370 Specialist Medicine RWW358	29	61	90
	370 Urgent & Emergency Care RWW355	5	59	64
370 Acute Care Services RWW251 Total		**57**	**218**	**275**
370 Corporate - RWW252	370 HR & OD RWW368	1		1
	370 Nursing & Governance RWW369	1		1
	370 Outpatients RWW3	9	4	13
	370 Research & Development RWW364		1	1
370 Corporate - RWW252 Total		**11**	**5**	**16**
370 Surgery, Women's & Children's RWW250	370 Digestive Diseases RWW350	32	107	139
	370 Musculoskeletal Care RWW351	21	25	46
	370 Specialist Surgery RWW353	4	12	16
	370 Womens & Childrens Health RWW352	63	142	205
370 Surgery, Women's & Children's RWW250 Total		**120**	**286**	**406**
Grand Total		**188**	**509**	**697**

The Recruitment and Retention Strategy has been developed under the leadership of the Chief Nurse working closely with the Human Resources and Divisional Nursing Teams to identify all of the actions necessary to both recruit and retain staff at WHH, bringing together national, regional and local best practice and idea's whilst closely monitoring the effects of our actions through a specific key performance indicator report (KPI's) presented at the monthly group meeting. The Strategy has also enabled us to be creative and develop new ways of working at a ward level; for example we have ward based Pharmacy Technicians on wards A6 and A7 with pilots taking place on wards A3 and A4. The Pharmacy Technicians assist with all aspects of medicines management for our patients and is proving to be a huge success.

We have also recruited a Nurse Consultant / Lead Advanced Nurse Practitioner to further develop both our Advanced Nursing Strategy alongside current Advanced Nurse Practitioner roles ensuring we have highly skilled and trained staff to deliver high quality safe care to our patients

The Nursing Associate role is an exciting development at WHH and we are proud to be part of the national pilot with 10 Nursing Associates undergoing training currently, with an intention that they will support ward skill mix going forward once qualified. On completion of the pilot, it is necessary to review and understand how the new role will fit into existing ward teams. 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 that this ought to work well for some of our wards at WHH.

Table 6 demonstrates **overall** Nursing and Midwifery in post v's vacancy numbers with predictions for 2018

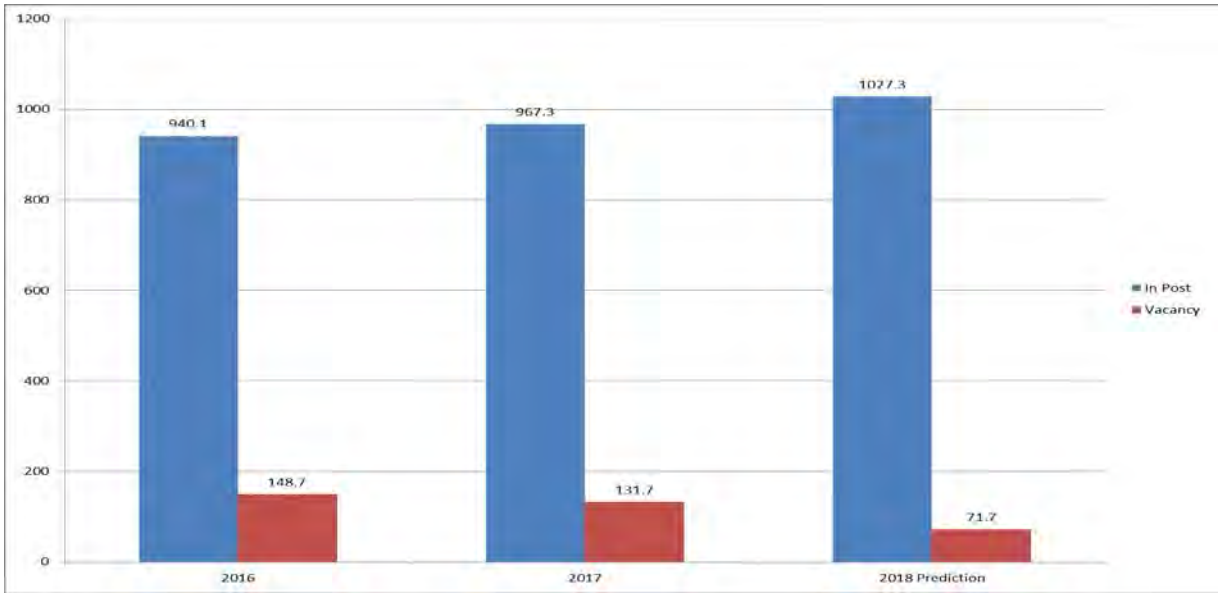
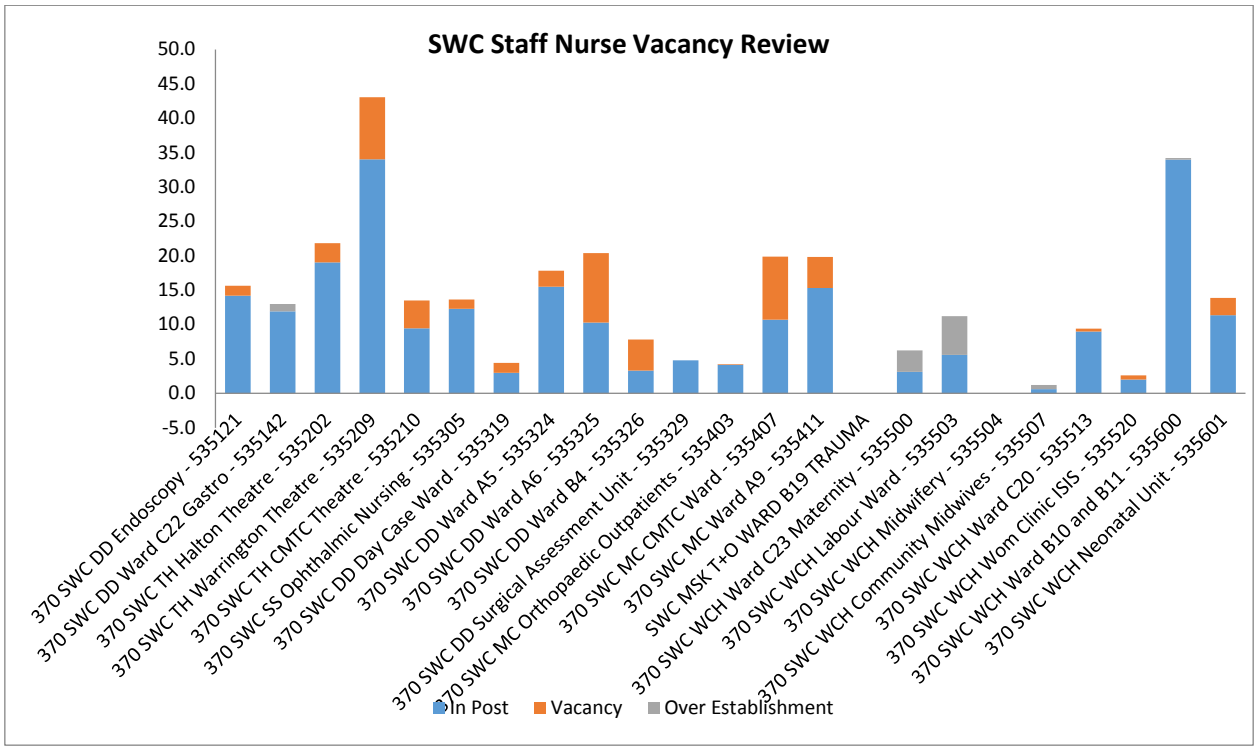


Table 7 illustrates Band 5 vacancy 'v' establishment per clinical area as of 6th June 2017



4.0 An overview of available methodologies for safe nurse staffing

NICE recommend the use of a validated tool and there are a range of tools and methods available to use in the determination of nurse staffing levels, these are briefly described in the table below.
Whilst there is no single tool that is recommended above the others, all of these, when used in combination, provide evidence to ensure that staffing levels and patient outcomes are correlated. Professional judgement and scrutiny of the information gained from the use of these evidence based tools should be used to interpret the results they produce.

Nursing professional judgement and knowledge should inform our decisions in utilising the skill mix of our staff at all levels. Our decisions should be made in real time to reflect the needs of the service in terms of case mix, acuity / dependency and activity. The skill mix between registered and non-registered care staff reflects likely workload and skills and competencies required to care for patients locally.
Determining safe and sustainable staffing must follow a clear and logical process that is consistent across the trust. Staff must be trained in the use of any of the preferred tools available; there should be agreed routes for decision making. There should be independent interrogation and systematic validation along with transparency of the results gained in order to provide assurance that the application of the tool is reliable.

Table 8 illustrates the different Acuity and Dependency monitoring tools available

Method	Description
Safer Nursing Care Tool (SNCT)	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: • Level 0: patient receiving standard ward care • Level 1a: acute care (unstable patient) • Level 1b: basic nursing care (significantly dependant) • Level 2: HDU level unstable patients • Level 3: ITU level ventilated patients Appropriate for use in any acute hospital within the UK (although further work is underway to refine the tool for use in particular clinical environments). Used in conjunction with Nurse Sensitive Indicators (NSI) such as patient falls and pressure ulcer incidence; this can be linked to staffing. Able to support benchmarking activity in organisations when used across Trusts. Facilitates consistent nurse-to-patient ratios in line with agreed standards across similar care settings in England.
The Professional Judgment model (Telford method)	Simple to use and takes into account clinical staff views but is seen to be subjective, has no evidence-base and is not sensitive to workload intensity.
Staff to Bed ratio	Simple to use, allows benchmarking but assumes that base staffing levels are accurate and reflect patient need and is insensitive to changes in workload.

Activity Monitoring (GRASP)	Uses care plans / pathways and related nursing time but are task oriented, can be time consuming (to gather data / undertake workload studies) and may require support from commercial systems.
Care hours per patient day (CHPPD)	Calculates the number of Registered nurses and healthcare support workers and dividing the total by every 24hours of inpatient admissions.
Regression Methods (Teamwork)	Commercial systems are available and have been useful where workload predictions are possible, but is not easily understood by nurses and there is an underlying assumption that all wards are efficient and effective.

5.0 Safer Nursing Care Tool

The Trust uses the Safer Nurse Care Tool (SNCT) to collect acuity and dependency data. This information has previously been manually collated however as training is rolled out across the trust the data will be collected utilising the Allocate E rostering Safe Care system from June 2017.

We publish Nursing and Midwifery staffing data on a daily basis at entrances to our wards and staffing data is also submitted on a monthly basis through a Unify submission to the NHS Choices site, published on the Trusts website and reported to the Trust Board. .

6.0 Safer Nursing Care Tool Results- Adult In-Patient Wards

The Nursing teams across the Trust conducted twice daily analysis of patient acuity and dependency utilising the Safer Nursing Care Tool, for two weeks during April 2017. Every patient within the auditable clinical areas was included within this analysis. Table 6 illustrates the results from this audit.

Table 9

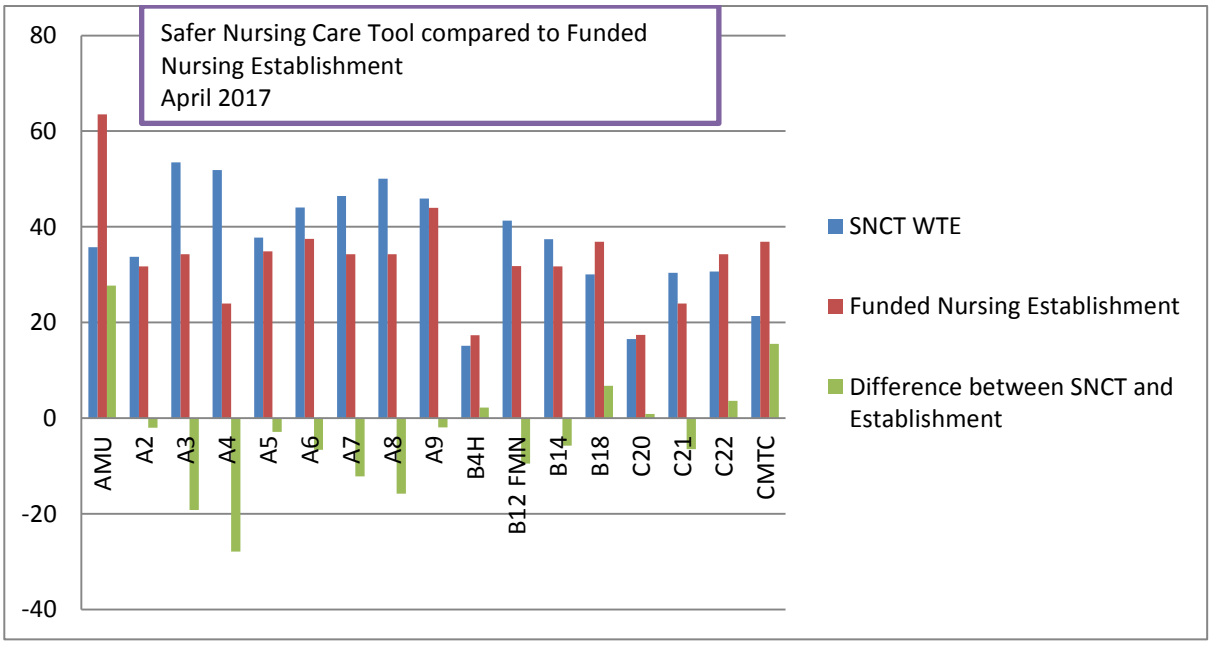


Table 10 illustrates the results from the Safer Nursing Care monitoring in comparison to the funded nursing establishment.

Table 10 – Gap analysis of SNCT v's Actual

Ward	Funded Establishment Compared with SNCT Recommended Staffing									Patient Harm			
	Est'ment Qualified	SNCT Qualified	Qualified +/-	Est'ment CSW	SNCT CSW	CSW +/-	Est'ment Total	SNCT Total	Overall +/-	Falls	Pressure Ulcers	HCAI	VTE
A2	18.83	20.23	-1.40	12.88	13.49	-0.61	31.71	33.72	-2.01	0	1	0	0
A3	18.83	32.09	-13.26	15.45	21.40	-5.95	34.28	53.49	-19.21	0	0	0	2
A4	13.68	31.11	-17.43	10.3	20.74	-10.44	23.98	51.85	-27.87	0	0	0	0
A5	20.83	22.66	-1.83	14.08	15.11	-1.03	34.91	37.77	-2.86	0	0	0	1
A6	23.41	26.44	-3.03	14.08	17.63	-3.55	37.49	44.07	-6.58	0	0	0	0
A7	18.83	27.86	-9.03	15.46	18.57	-3.11	34.29	46.43	-12.14	0	0	0	0
A8	18.84	30.02	-11.18	15.45	20.01	-4.56	34.29	50.03	-15.74	0	0	0	2
A9	26.7	27.55	-0.85	17.3	18.36	-1.06	44	45.91	-1.91	1	0	0	1
B4H	10.36	9.09	1.27	7	6.06	0.94	17.36	15.15	2.21	0	0	0	0
B12 FMN	13.68	24.77	-11.09	18.09	16.51	1.58	31.77	41.28	-9.51	1	0	0	0
B14	16.26	22.47	-6.21	15.46	14.98	0.48	31.72	37.45	-5.73	1	0	0	0
B18	18.84	18.05	0.79	18.02	12.03	5.99	36.86	30.08	6.78	1	0	0	0
C20	12.43	9.94	2.49	5	6.62	-1.62	17.43	16.56	0.87	0	0	0	0
C21	13.68	18.25	-4.57	10.3	12.17	-1.87	23.98	30.42	-6.44	0	0	0	0
C22	18.83	18.38	0.45	15.46	12.25	3.21	34.29	30.63	3.66	0	0	0	0
CMT C	23.71	12.80	10.91	13.18	8.54	4.64	36.89	21.34	15.55	0	0	0	0
Total	287.74	351.71	-63.97	217.51	234.47	-16.96	505.25	586.18	-80.93	4	0	0	6

Overall the Safer Nursing Care Tool (SNCT) has identified that there is a shortfall of 80.93 FTE staff members for the ward areas that utilised the assessment tool, based upon the acuity and dependency of the patient group over the two week sampling period.

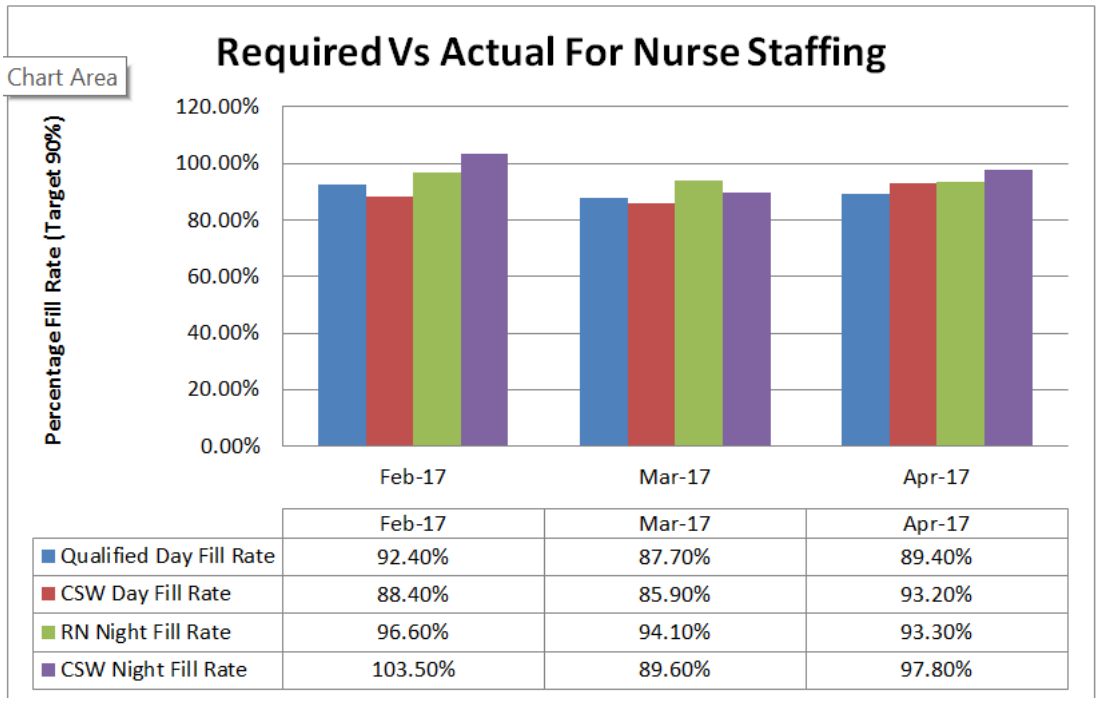
It is important to note that some wards needed to repeat the SNCT exercise as additional training was needed to ensure variance was reduced with regard to data collection. SNCT data collection is particularly subjective as patients do not always "fit" into the categories within the tool. As nurse staffing numbers are calculated based on the acuity of individual patients, it is important that the outputs of the SNCT are triangulated with other safety, experience and quality metrics and measured regularly to show any change over time.

Utilising the Royal College of Nursing recommended 60:40 Registered Nurse to Health Care Assistant (HCA) ratios identifies that there are 16.96 FTE HCA and 63.97 FTE Registered Nurse shortfalls. The Chief Nurse review of ward establishments in the main aligned with the 60:40 skill mix, however, a business case has been prepared with regard to the high acuity respiratory patients within ward A7 which outlines the requirement for further nursing support to ensure safe care delivery.

Table 8 below identifies planned versus actual staff on duty per day over a monthly period. The set standard of 90% has been consistently achieved for RN fill rates for nights which have previously been highlighted as an area of concern regarding the quality of patient care. Although the 90% standard has not been constantly achieved during the day time there have been mitigating actions with Senior Nurse

escalation and an increase in CSW fill rates, which supports the information identified within this paper with regard to vacancy, uplift, supervisory time and indeed patient acuity and dependency.

Table 11 illustrates planned versus Actual Staff on Duty- as per monthly unify report Table 10



	Feb-17	Mar-17	Apr-17
Qualified Day Fill Rate	92.40%	87.70%	89.40%
CSW Day Fill Rate	88.40%	85.90%	93.20%
RN Night Fill Rate	96.60%	94.10%	93.30%
CSW Night Fill Rate	103.50%	89.60%	97.80%

7.0 Women and Children

7.1 Paediatrics

Nurse Staffing Levels for Paediatrics are based on 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.

Acuity against staffing was monitored at 2 different time points through a 24 hr period on B10, B11 and PAU for 14 days (18/4/17- 1/5/17) and ??

To ensure safe quality care delivery in the paediatric department staff were moved flexibly from one area to another within the speciality, and temporary staff utilised where there was a shortfall. A business plan for paediatric staffing is currently underway along with a review of paediatric urgent care.

7.2 Neonatal Unit (NNU)

The Department of Health in England, in its Toolkit for workforce planning 2011, has endorsed the use of the British Association of Perinatal Medicine (BAPM) staffing recommendations as a definitive workforce planning tool for Neonatal workforces.

BAPM staffing recommendations are assessed at 2 points of a 24 hour period on the Badgernet system for the NNU at Warrington. This system is used across the whole of the region for all NNU's. Acuity against BAPM standards using the Badgernet system was assessed over a 14 day period (17th- 30th April 2017).

On the occasion when staffing was less than the recommended number for the activity, a number of mitigations were put in place to ensure safe , high quality care continued to be delivered. These ranged from the NNU Manager working clinically on the Unit, the use of temporary agency staff or staff stayed over their normal working hours to cover until the activity levels reduced. A business case for paediatric staffing, including NNU staffing is underway.

7.3 Midwifery Workforce Position

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 Trust wide audit of nursing/midwifery staffing and acuity was completed 17/04/17 - 01/05/17 to benchmark staffing levels across the trust.

The Birthrate Plus Acuity Tool provides staff with a framework to assess the demands within the Labour Ward and the number of staff needed. Using 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 that staffing available.

The two week snapshot has provided limited data and a longer reporting period would be more useful to show trends in activity and acuity. 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.

It should be noted that our 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).
Our current staffing to birth ratio remains at 1:29; this is based on 95.28wte midwives and 2800 births. Our current staffing ratio provides reassurance of safety in line with the nationally recommended tool of Birthrate Plus.

8.0 Additional Safe Staffing Considerations

8.1 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). This uplift should include time for annual leave in line with Agenda for Change, study leave, sickness and any other absences that are within Trust Human Resource policies. Local factors must be considered when calculating the percentage allowances in an agreed uplift. Factors to be 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. 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 important that the level of uplift is realistic and reviewed at least annually.

Table 12 identifies the WHH position against the (2013) NQB considerations identifying the gap of 1.8 % between positions

	Example	***WHH position***	***Rationale***
Element	%	%	
Annual leave	14.7	15.8	This is the average annual leave across the nursing workforce, in line with Agenda for Change, and taking account of local patterns of length of service
Sickness/absence	3	3.1	This is the target/aspiration level for the organisation and should be aligned to plans to implement improvement
Study leave	3	1.2	This includes mandatory and core/job-specific training and learning activities such as link nurse roles
Parenting leave	1		In some organisations this is managed centrally. It includes maternity, paternity and adoption leave. This is driven by local workforce demography
Other leave	0.5		This includes carers leave, compassionate leave, etc
Total	22.2	20.0	**2.2% gap**

Table 13 Details WHH current uplift arrangements

	%	No of days
Number of working days (5 days*52.143 weeks)		261
Less bank holidays	3.1	8
Less annual leave entitlement estimated at 33 days	12.7	33
Less mandatory training	1.2	3
	16.9	44
Days available after holiday and training		217
Less sickness @ 3.75% of days available after holidays and training	3.1	8
Working days available		209
Total days for holiday, training and sickness		52
Percentage cover required	**20.0**	**20.0%**

There has been work undertaken by the Transformation Team with regard to establishment uplift, with table 11 identifying the national Royal College of Nursing recommendations against the current WHH position and the suggested uplift position going forward in order to address the shortfalls.

Table 14 Transformation Team analysis of uplift requirements

	Rationale	*RCN recommended*	*WHH position*	*Comments*	*Suggested WHH*	*Comments*
Annual leave	This is the average annual leave across the nursing workforce, in line with Agenda for Change, and taking account of local patterns of length of service	17.0%	15.5%	15.5% is sufficient to cover the AfC minimum annual leave of 27 days + 8 days bank hol per person	17.0%	17% is sufficient to cover an average of 30 days + 8 days bank hol per person. A significant proportion of our staff will be on the maximum 33 days annual leave as the age profile of our staff is weighted towards the higher age groups.
Sickness/absence	This is the target/aspiration level for the organisation and should be aligned to plans to implement improvement	4.5%	3.5%	This is the target/aspiration level for the organisation and should be aligned to plans to implement improvement	3.5%	This is the target/aspiration level for the organisation and should be aligned to plans to implement improvement. Actual sickness levels on wards areas are likely to run at closer to 6% - this needs validating.
Study leave	This includes mandatory and core/job-specific training and learning activities such as link nurse roles	2.0%	1.0%	WHH currently has 1% provision within establishments for covering study leave	2.0%	The actual requirement for study leave cover is likely to be closer to 2% based upon the current mandatory & essential training demands of the organisation. Anaylsis of the training requirements for ICU are 2.92%
Parenting leave	In some organisations this is managed centrally. It includes maternity, paternity and adoption leave. This is driven by local workforce demography	1.0%	0.0%	WHH currently has no provision within establishments for parenting leave	0.0%	
Other leave	This includes carers leave, compassionate leave, etc	0.5%	0.0%	WHH currently has no provision within establishments for other leave	0.0%	
Total		**25.0%**	**20.0%**		**22.5%**	

The uplift required in total for WHH is suggested to be 22.5 %.
This appears to be in line with 2 other Trusts across the Region; however 5 Trusts are already currently above our aspiration of 22.5%; with 3 Trusts at 25% and only 1 Trust below the current WHH position of 20.4% as per Table 9 below.

Table 15 Regional uplift positions

Trust	**Current uplift position**	**Under review to**
The Royal Liverpool & Broadgreen University Hospitals NHS Trust	22%	24%
Aintree University Hospital NHS Foundation Trust	22%	
Mid Cheshire Hospital's NHS Foundation Trust	22.5%	25%
Alder Hey Children's NHS Foundation Trust	23%23.06%	
The Walton Centre NHS Foundation Trust	21% qual & 20% unqual	
Bridgewater Community Healthcare NHS Foundation Trust	20%	
Wirral University Teaching Hospital NHS Foundation Trust	25%	
Cheshire & Wirral Partnership NHS Foundation Trust	25%	
St Helens & Knowsley Teaching Hospitals NHS Trust	20.1%	
Southport & Ormskirk Hospital NHS Trust	22.5%	

Table 16 below shows the high level financial estimate of the impact of increasing the headroom within establishments from 20% to 22.5% is around £700k as per below:

	Band 7	Band 6	Band 5	Band 4	Band 3	Band 2	Band 1	Total
WTE	0.76	2.94	10.48	0.53	0.04	6.94	0.47	**22.15**
Estimated £	£32,682	£111,601	£335,339	£14,740	£1,076	£159,578	£9,390	**£664,407**

8.2 Ward Manager Supervisory time.

There appears to be significant variability in the allocation and usage of supervisory (also known as Management) time for Ward Managers on our wards. Data extracted from the E Rostering system showed that one ward had zero hours allocated for supervisory time over a 4 week roster. At the other end of the spectrum one ward had 135.5 hours allocated for the same period which appeared to include the ward manager and her 2 deputies.

It is clear however that a significant amount of supervisory time which has been allocated in the E Rostering system is actually being spent by the Ward Managers on the ward, caring for patients in order to adequately manage the risks of day to day staffing. It is also apparent that the E-Rostering system does not appear to be subsequently updated, as a culture has emerged whereby Ward Managers routinely drop back into the ward staffing numbers to ensure safe care on their respective wards. The refreshed E Rostering update and roll out programme continues to support a well utilised live system consistently.
It should be noted that historically the amount of time that was budgeted for supervisory time was 0.3 WTE per Ward Manager.

In addition we need to recognise additional impacts on Ward Manager's time, for example, we are currently creating a Ward Manager Development Programme which will provide essential skills and leadership to better support our senior leaders going forward; however considerations must be taken with regard to further release of these staff members from ward duties in order that we realise all of the benefits and opportunities.

8.3 Allocate Safe Care Module

The Trust has implemented a tool within the E-Rostering system that provides daily information that is equivalent to the previous twice yearly census of the Safer Nursing Care Tool. This provides daily assurance that staffing on our wards is safe for the patients that are with us now rather than a retrospective view of acuity up to 6 months ago.
WHH ADoN for Surgery and Matron visited East & North Hertfordshire Trust; an exemplar site in order to ensure that we make best use of the system. Going forward, as a result of the visit we aim to centralise our E Rostering team with the Patient Flow Team to ensure we can utilise all of our staffing resource more flexibly and more efficiently to meet the needs of our patient acuity utilising the live Safe Care system.

Please see Appendix 1 for more information on the Safe Care System

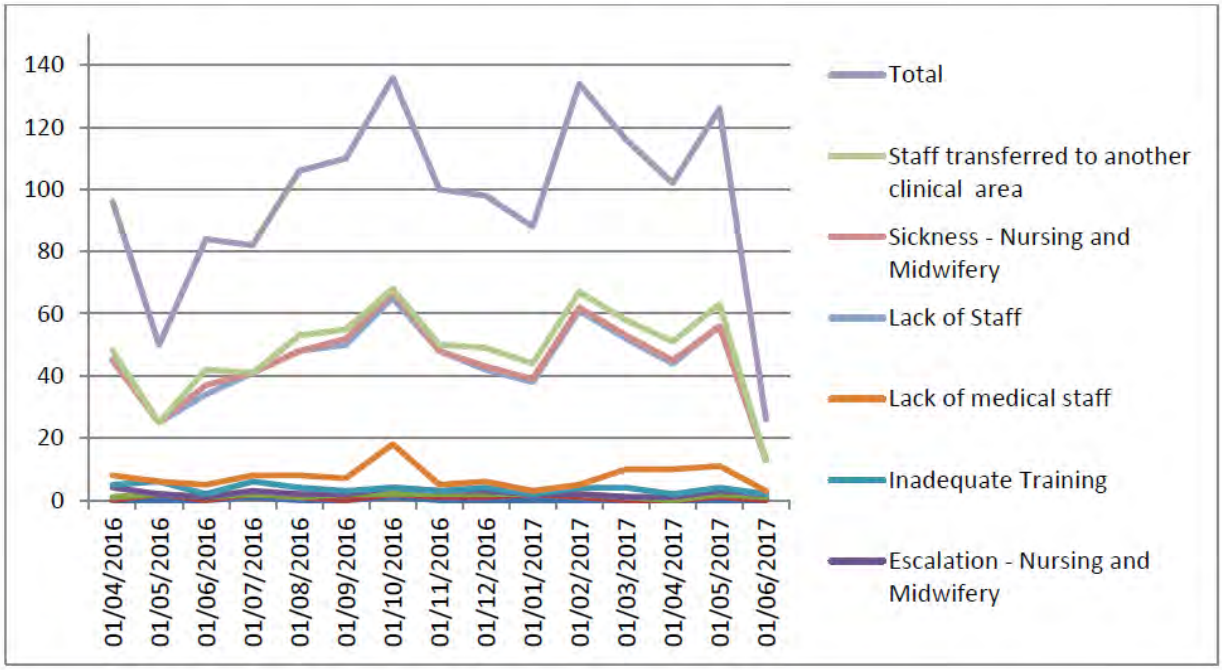
8.4 Reported Staffing Incidents

In order to ensure effective triangulation of data the following information was gathered from the Trusts Datix system to understand staff reporting rationales under the heading of staffing incidents.
Lack of staff, sickness 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 however from initial analysis the predominant reason is due to lack of either Registered Nurse (RN) or Care Support Worker (CSW)

Table 17 Number of staffing incidents from April 16 to June 17.

Table 17 is taken as an extract from the Staffing Incident and Risk Report presented to the Quality Committee and is attached at Appendix 2

Graph Showing Incident Numbers and Types of Incidents Reported



8.5 Red Flags -NICE Requirements

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.

Appendix 3 shows the red flags that we are to report.
Red flag events 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 can be created and documented in the E Rostering Safe Care system in real time, however currently there is some variance across a small number of wards; hence the refreshed rollout support for ward teams by the E Rostering team.

It should be noted however that red flag type events are raised as part of the staffing element of the regular patient flow capacity meetings by Ward Managers, Matrons and Lead Nurses where actions to mitigate are implemented
Please see appendix 3 for further information

8.6 E- Rostering

The Carter Report (Operational productivity and performance in English NHS acute hospital: Unwarranted variations, Feb 2016) is clear that workforce and financial plans must be consistent to optimise clinical quality and the uses of resources. The report highlighted variation in how acute trusts currently manage staff, from annual leave, shift patterns and flexible working through to the use of technology and e rostering. In addition to the implementation of E Rostering, Lord Carter recommends a new metric, care hours per patient day (CHPPD) as a metric for measuring a single consistent way of recording and reporting staff deployments.

The Allocate system (Health Roster) began rollout across the Trust in January 2014. Forty- six clinical areas are now live on the system, however the initial roll out programme needed to be repeated to ensure staff were both sufficiently trained and had the underpinning knowledge to best utilise the system for maximum benefit.

The Table presented at Appendix 3 demonstrates the areas that are trained to use the e- rostering system, safe care and a system that links directly to NHSP in order to immediately escalate staff shortages in real time.

8.7 Use of temporary staffing

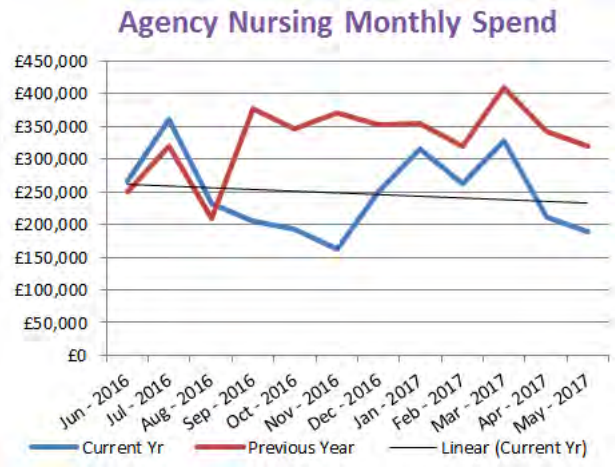
NHS Professionals (NHSP) are the preferred supplier of temporary staffing to the Trust. At times of high demand NHSP have been unable to meet the demand which has resulted in the use of agency staff as per table 17. Table 18 shows reduction in usage since last year with a reducing trend, however it is recognised we need to do more to reduce our reliance on the temporary workforce.

Table 18 Identifies Bank and Agency demand and fill rates over the last 6 months.

	Agency Filled	Bank Filled	Unfilled	Demand	Overall Fill
Acute Care Services	101	506	391	998	**60.8%**
AIRWAY BREATHING & CIRCUL	618	1660	1118	3396	**67.1%**
DIAGNOSTICS	60	383	218	661	**67.0%**
DIGESTIVE DISEASES	1051	1742	817	3610	**77.4%**
DISCHARGE/PATIENT FLOW	1	28	8	37	**78.4%**
MUSCULOSKELETAL CARE	145	514	547	1206	**54.6%**
OUTPATIENTS		192	72	264	**72.7%**
SPECIALIST MEDICINE	629	4669	3899	9197	**57.6%**
SPECIALIST SURGERY		36	0	36	**100.0%**
UCC HALTON		1	7	8	**12.5%**
URGENT & EMERGENCY CARE	1443	2245	1932	5620	**65.6%**
WOMEN'S & CHILDREN'S HEAL	218	933	274	1425	**80.8%**

Mitigation against low fill rates takes place four times a day at the capacity, demand and flow meetings supported by the operational teams.

Table 19 Agency Nursing Monthly Spend



8.8 Workforce Repository and Planning Tool (WRaPT)

The Trust has recently been investigating the potentials of WRaPT, a new and transformational workforce planning tool and is currently scoping a trial for a general medical and general surgical ward. WRaPT is a strategic workforce planning tool for health and social care. It is a web based application that enables the collection, analysis and modelling of workforce information from providers across the whole health and social care economy. It is a flexible tool which, at its core, establishes the relationship between workforce capacity and service activity.

In addition to the work being undertaken with regard to the WRaPT tool, a number of Ward Managers have already agreed they would be willing to trial the replacement of some funded band 5 posts with Assistant Practitioner posts, Nursing Associates and additional Carers in order to provide greater support to the band 5 nurses that we do have. The Ward Managers and senior nursing team have also considered other non-nursing duties with a range of ideas that could be explored to release nursing care hours. Table 19 below identifies ideas to release nursing care hours.

Table 20 Ideas to release time to care

	Issue identified by ward staff	Actions to date
1	Install ward dishwashing machines to stop nursing staff from washing patient dishes/ carrying out domestic duties	Actioned. Installation underway
2	Catering staff to hand out meals as well as deliver food	Currently under review
3	Increased Pharmacy support - ward-based pharmacy technicians	In place on Wards A6 & A7 Pilot to take place on Wards A3 & A4
4	Increase number of bed managers/bed management process	Currently under review

5	Invest in equipment - drip stands, IV pumps	Nursing Team reviewed – not actioned
6	Review Open Visiting Policy	Completed
7	Move to pre-made IVs	Currently under review
8	Review HCSW pool arrangements	Currently under review
9	Stagger Physio & OT lunchtime/breaks so that there is a continual service across the day	Under review To be actioned
10	Explore use of volunteers/students on wards (Ward Companions)	Being explored with Volunteers Managers
11	Upskill HCAs to be able to pick up lower level nursing duties	Under review as part of Education Strategy
12	Portering cover (especially out of hours)	Scoping exercise to be undertaken to understand next steps
13	Review supervisory ward manger status and plan audit	Under review
14	Specialist Nurses review	Non Ward Based Nursing review to be scoped

9.0 Overall conclusions

The report represents the outcome of the Safer Nursing Care Tool acuity and dependency reviews that took place in April 2017 which overall shows a deficit of 80.83 WTE; however it should be noted that the Safer Nursing Care Tool will be re-run in October, which affords time to adequately train staff in the subtleties of the tool and understand the positon further. In the meantime senior staff have been requested to review staffing on a daily basis and escalate any areas of concern where actual staffing numbers do not meet those planned.

Furthermore the ongoing Nursing Recruitment and Retention Strategy continues to be delivered at pace; work is underway to better understand the supervisory time afforded to Ward Managers, along with further work to ensure the maximum benefit of the E Rostering system and identification and escalation of Red Flag events.

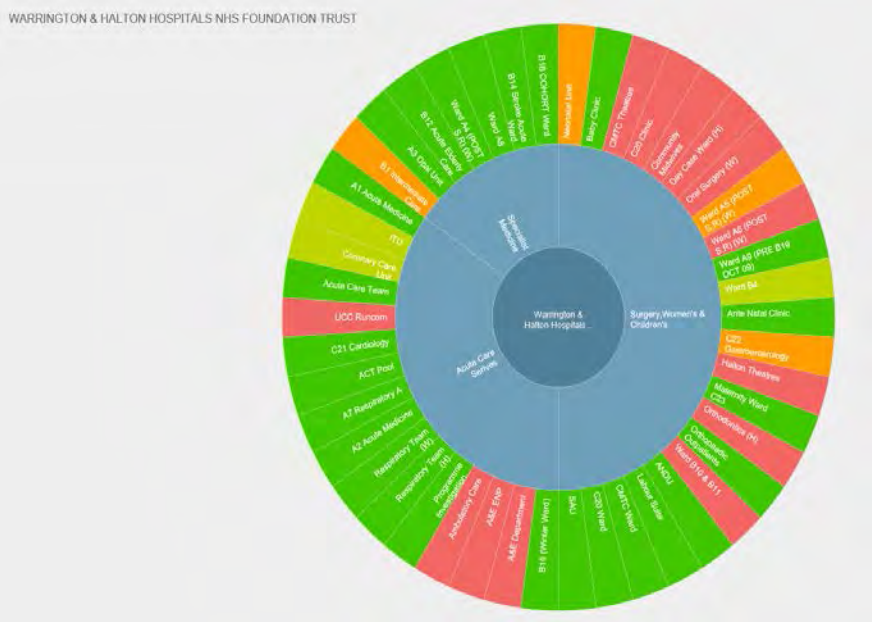
Daily shift checks by the Senior Nursing team along with real time escalation is in place to ensure safe, high quality care continues to be delivered to WHH patients.

10.0 Recommendations

It is recommended that the Board of Directors review and discuss this report.

Appendix 1

Allocate Safe Care Module



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 problem (insufficient staff to provide adequate care) or haven't submitted the required patient information.

Following the visit to the exemplar site there are now plans in place to create a ward staffing meeting every day that will utilise the information within the wheel. A strategy discussion between the Lead Nurses and Matrons from each division will review the information, make a judgement on patient safety and move staff between wards as appropriate.

Appendix 2

QUALITY COMMITTEE

AGENDA REFERENCE:	**QC/**
SUBJECT:	**Staffing Incident and Risk Report**
DATE OF MEETING:	**4th July 2017**
ACTION REQUIRED	**The Committee are asked to discuss the paper and agree the recommendations within**
AUTHOR(S):	**Ursula Martin, Deputy Director of Integrated Governance and Quality**
EXECUTIVE DIRECTOR	**Kimberley Salmon-Jamieson, Chief Nurse**

EXECUTIVE SUMMARY	Key points for discussion in the paper are as follows
	
	- There are many different types of staffing incidents reported
	- The peaks in staffing incidents are unsurprisingly seasonal with winter periods peaking in both financial years. There is a decreasing trend from 1st April with regarding to staffing incident being reported
	- Of the staffing incidents reported, 90% have been reviewed and closed.
	- There are some concerning trends within the incidents reporting figures and detail
	  ▪ Escalation of bed numbers within insufficient staff – A3/A4
	  ▪ Agency and locum staff training
	  ▪ Mandatory training being cancelled for staff last minute in some high risk areas – manual handling/resus
	  ▪ Lack of adequate and consistent medical cover A1,A4, A8 ,B12 , B18
	  ▪ Staff transferring to other areas – which is a process of managing site risk, can sometimes be perceived by staff to be stressful and unsafe

	- Out of 727 staffing incidents from April 2016, 3 were reported as moderate harm, the rest were no to low harm. - When reviewing the Serious Incident profile in the Trust, this does have a correlation with those areas reporting staffing incidents, particularly those areas reporting reduced medical cover - Complaint numbers in general do not correlate with staffing incidents - A8 has more Serious Incidents and in the top 10 of complaints 16/17, with more serious 'red' rated complaints from patients and/or their families - The Trust has recognised a significant risk regarding staffing – which reports to the Board of Directors and Quality Committee - This significant strategic risk does not correlate with the risk profile within the services, with the majority of staffing risks operationally being low (apart from pharmacy) - The incident profile does not affect the risk assessments undertaken, with only 3 out of the top 10 wards/depts. Reporting highest numbers of staffing incidents having risk assessments
RECOMMENDATIONS	Discuss and approve the recommendations within the paper.
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.

SUBJECT	**Staffing Incident and Risk Report**

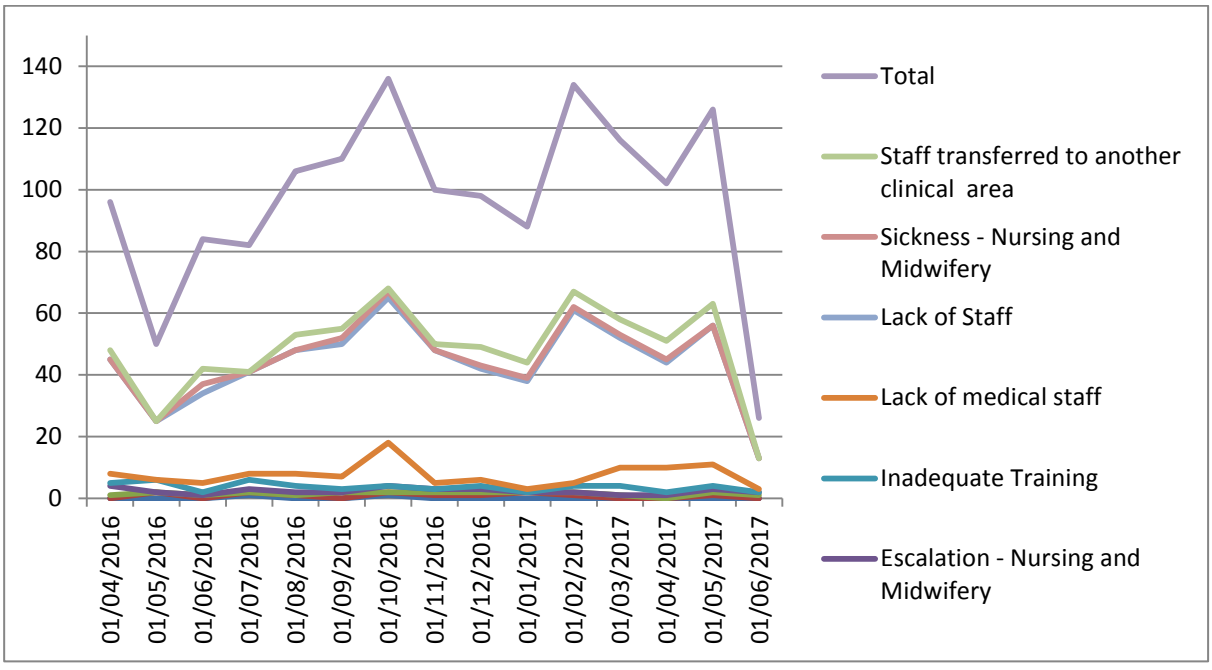
1. BACKGROUND/CONTEXT

This paper has been produced as part of a deep dive into the risk regarding staffing within the Trust. This has been requested by the Chief Nurse and Deputy Director of Governance & Quality to report to the Trust Quality Committee, in order to have full visibility and scrutiny of the risk. The paper will be presented at the same time as the Trust's six monthly nurse staffing and acuity paper.

2. KEY ELEMENTS

2.1 Numbers of Incidents relating to staffing and types of staffing incidents

Graph Showing Incident Numbers and Types of Incidents Reported



Type	Number	Themes
Bleep not Answered	2	

Type	Number	Themes
Breach or working hours	11	3 incidents in SAU
Breakdown in lines of communication	10	
Escalation – Nursing & Midwifery	12	A3/A4 – 3 incidents -escalation of bed numbers – 34 patients with 2 RNs and enhanced care
Inadequate training	20	Agency/locum staff needing training Mandatory training (manual handling and resus) cancelled at short notice
Lack of Medical Staff	58	A1 – 3 incidents – acute medical take and having 1 Junior Doctor A4 – 3 incidents no medical cover A8 – lack of medical cover B12 – 12 incidents – No medical cover (x4) and sometimes only 1 Junior Doctor B18 – 5 incidents – one Junior Doctor covering ward
Lack of staff	549	Top 10 wards are 1. A4 2. A8 3. Neonatal Unit 4. B12 5. A3 (OPAL) 6. A7 7. A9 8. A2 9. A&E Majors 10. B19 The key themes in these incidents are lack of capacity to undertake clinical tasks (observations, IVs etc.) and lack of capacity for enhanced observations
Sickness - Nursing and Midwifery	12	B12 – 4 incidents
Staff transferred to another clinical area	53	Top areas A8 – 13 incidents B18 – 6 incidents A3 (OPAL) – 3 incidents B12 – 3 incidents A7 – 3 incidents

Type	Number	Themes
		A2 – 3 incidents Halton Theatre 4 – 3 incidents

Top 10 Wards/Depts Reporting Incidents

Row Labels	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	
A8	5	0	3	0	0	1	5	2	9	4	9	14	18	8	0	78
A4	5	2	2	1	6	5	6	3	2	7	7	9	9	3	2	69
B12	0	2	4	1	6	2	6	7	3	6	2	10	3	5	1	58
Neonatal Unit	5	1	7	15	1	4	5	3	3	5	0	0	2	1	1	53
A3 (OPAL)	3	0	3	2	4	6	6	6	4	1	2	1	2	3	1	44
A7	1	3	0	1	2	2	5	1	3	6	7	1	1	6	0	39
A9	7	1	1	0	1	3	1	1	2	2	6	3	0	9	1	38
B18	1	0	3	2	1	1	1	6	0	0	1	2	4	2	1	25
A2	0	1	0	0	3	5	2	1	3	0	4	2	2	0	0	23
A&E Majors	0	0	1	3	0	2	4	0	4	3	1	0	0	0	0	18

2.2 Severity and Harm

Grade	Number
1 – No harm	468
2 – Low harm	257
3 Moderate harm	3

Moderate harm incidents are as follows

23/05/2017 – Outpatients Dept.

Patient attended breast clinic and was delivered bad news by the consultant. There was no specialist nurse available to attend this devastated patient who was put in the counselling room on her own where she was left to contact her husband/relatives to attend for support

01/06/2017 – Intervention Radiology

Not enough nursing staff. 3 patients to admit/ follow through to procedure and recover along with completing necessary paperwork. Also receiving phone calls from ward staff/ secretaries about appointments needing to be booked when there was no time to do so. Additionally has 2 further

ward patients to follow through to procedures whilst leaving 1 nurse on ward (no rda or apprentice assistance). Both nurses had no break 8.00am-6pm. One nurse came in half an hour early to do necessary ward checks to accommodate busy shift.

2.3 Staffing incidents aligned to Serious Incidents and Complaints

Ward/Dept	Numbers of SIs (April 2016 – March 2017)	Staffing Incidents Top 10 Ranking	Ward/Dept	Numbers of SIs (April 2017 – present)	Staffing Incidents Top 10 Ranking
A8	6	1	B18	2	3
A3 (OPAL)	5	5	A9	2	7
A1	4	N/A			
A4	3	2			
A2	3	9			
B18	3	8			
B12	2	3			
Coronary Care Unit	2	N/A			

Ward/Dept	Numbers of Complaints (April 2016 – March 2017)	Themes	Severity	Staffing Incidents Top 10 Ranking
Out-Patients department	53	Appointment delays and attitude of staff	• 5 High • 25 Mod • 23 Low	N/A
A&E – Majors	25	All Aspects of Clinical treatment	• 2 High • 16 Mod • 7 Low	N/A
Outpatient Department (Orthopaedics Clinics)	25	All Aspects of Clinical treatment, and appointment delays	• 3 High • 9 Mod • 13 Low	N/A
Outpatients	15	All Aspects of Clinical treatment, and appointment delays	• 0 High • 5 Mod • 10 Low	N/A

A6	13	All Aspects of Clinical treatment, and admissions, discharge and transfer	• 1 High • 8 Mod • 4 Low	N/A
A8	13	All Aspects of Clinical treatment	• 0 High • 12 Mod • 1 Low	1
A1	12	All Aspects of Clinical treatment	• 1 High • 8 Mod • 3 Low	N/A
A&E – Minors	12	All Aspects of Clinical treatment and attitude of staff	• 1 High • 8 Mod • 3 Low	N/A
Ophthalmology	10	Appointment cancellations	• 0 High • 3 Mod • 7 Low	N/A
A5	10	All Aspects of Clinical treatment	• 0 High • 9 Mod • 1 Low	N/A

Ward/Dept	**Numbers of Complaints (April 2017 – YTD)**	**Themes**	**Severity**	**Staffing Incidents Top 10 Ranking**
Out-Patients Department	13	All Aspects of Clinical treatment, and appointment delays	• 2 High • 10 Mod • 1 Low	N/A
A1	6	All Aspects of Clinical treatment	• 0 High • 6 Mod • 0 Low	N/A
A&E Majors	5	All Aspects of Clinical treatment	• 1 High • 2 Mod • 2 Low	N/A
Outpatients	5	appointment delays	• 0 High • 4 Mod • 1 Low	N/A
B14	4	Privacy and dignity, and all Aspects of Clinical treatment	• 2 High • 2 Mod • 0 Low	N/A

Ward/Dept	Numbers of Complaints (April 2017 – YTD)	Themes	Severity	Staffing Incidents Top 10 Ranking
A&E Peads	4	Attitude of staff	• 0 High • 4 Mod • 0 Low	N/A
A7	4	All Aspects of Clinical treatment	• 1 High • 2 Mod • 1 Low	6
A9	4	All Aspects of Clinical treatment	• 3 High • 1 Mod • 0 Low	7
A2	3	All Aspects of Clinical treatment	• 1 High • 2 Mod • 0 Low	9
A5	3	All Aspects of Clinical treatment	• 0 High • 3 Mod • 0 Low	N/A

2.4 Staffing Risk Assessments

The Trust has a corporate strategic risk on staffing as follows:

Failure to provide adequate staffing levels in some specialities and wards caused by inability to fill vacancies, sickness which may result in pressure on ward staff , potential impact on patient care and impact on Trust access and financial targets.	20 (5x4)

The following areas have logged a staffing risk assessment on CIRIS

Risk	Score	Area
Risk of breaching diagnostic targets due to backlog of appointments through increased workload of admin staff and decreased staffing	9	ACS – all acute care services
Risk due to insufficient resources due to increased demand on infection control and reduced staffing levels	6	Infection Prevention & Control
Risk of Increased Falls due to inadequate staffing levels Two risks on risk register re falls and staffing and	8 and 10	B12 (Specialist Medicine)

environment		
Risk of deterioration of existing pressure ulcers due to inadequate staffing levels	9	B18 (Specialist medicine)
Risk of increased pressure sores through missed/delayed care interventions due to inadequate staffing levels	6	B12 (Specialist Medicine)
Risk of missed care/interventions due to inadequate staffing levels	6	B12 (Specialist Medicine)
Risk of Missed/delayed core nursing duties, medication errors, patient obs, due to staffing levels	6	B12 (Specialist Medicine)
Risk of lack of supervision due to reduced staffing numbers	2	B12 (Specialist Medicine)
Lack of facilities and welfare breaks due to reduced staffing levels and unsocial hours	2	B12 (Specialist Medicine)
Lack of water flushing due to inadequate staffing levels	2	B12 (Specialist Medicine)
Risk of non acceptable levels of stress to staff members due to staffing levels, skill mix and unpredictable workload	6	A&E
Risk of failure to meet the requirements of the public in providing a PALS service due to staffing and workload issues	9	Corporate Nursing & Governance
Insufficient Band 5 nursing staffing across OPD leading to poor quality nursing actions/interaction and pressure on staff. Impacting on retention	9	Outpatients
Risk of expenditure on temporary staffing significantly exceeding budget/affecting future viability of the Trust with reports to NHS Improvement	16	Human Resources
Risk of reduced workforce to meet CQC standard on staffing which could impact on the standard of care and/or continuity of care to patients	8	Human Resources
Risk of meeting key objectives and risk to patient safety due to staffing capacity issues	16	Pharmacy
Risk of fatigue, ill health, understaffing and poor performance due to frequent night shifts	4	C22
Risk of not meeting national and local targets for SLT input for Stroke and financial penalties to Trust due to insufficient staffing levels of SLT	10	Therapies
Risk of harm to patients because demand exceeds current medical staffing capacity due to inadequate number of Consultants	9	Rheumatology
Annual Leave, absenteeism, understaffing, staff turnover	6	CMTC ward
Risk of delayed patient assessment due to insufficient staffing	6	Dietetics
Risk of delayed patient feeding due to insufficient staffing	6	Dietetics

Risk of shifts, due to fatigue, ill health, annual leave/absenteeism, understaffing, staff turnover, emergencies, injuries, poor performance	4	CMTC Ward
Risk of NNU having to close due to staffing shortages. Increased risk of infection. Increased risk of infants being transferred out within the network	12	Paediatrics and Neonatology
Risk of suboptimal care on paediatric wards due to increased throughput, acuity and requirement to provide additional staffing to Paediatric AED	9	Paediatrics and Neonatology
Increas in turnover resulting in reduced staffing levels	12	Human Resources
Risk of understaffing due to emergency annual leave or sickness	6	C22

3. DISCUSSION

The following are key issues and points of discussion within the report.

- There are many different types of staffing incidents reported.
- The peaks in staffing incidents are unsurprisingly seasonal with winter periods peaking in both financial years. There is a decreasing trend from 1st April with regarding to staffing incidents being reported.
- Of the staffing incidents reported, 90%v have been reviewed and closed.
- There are some concerning trends within the incidents reporting figures and detail.
    - Escalation of bed numbers within insufficient staff – A3/A4
    - Agency and locum staff training
    - Mandatory training being cancelled for staff last minute in some high risk areas – manual handling/resus
    - Lack of adequate and consistent medical cover A1,A4, A8 ,B12 , B18
    - Staff transferring to other areas – which is a process of managing site risk, can sometimes be perceived by staff to be stressful and unsafe
- Out of 727 staffing incidents from April 2016, 3 were reported as moderate harm, the rest were no to low harm.
- When reviewing the Serious Incident profile in the Trust, this does have a correlation with those areas reporting staffing incidents, particularly those areas reporting reduced medical cover.
- Complaint numbers in general do not correlate with staffing incidents.
- A8 has more Serious Incidents and in the top 10 of complaints 16/17, with more serious ‘red’ rated complaints from patients and/or their families.
- The Trust has recognised a significant risk regarding staffing – which reports to the Board of Directors and Quality Committee.

- This significant strategic risk does not correlate with the risk profile within the services, with the majority of staffing risks operationally being low (apart from pharmacy).
- The incident profile does not affect the risk assessments undertaken, with only 3 out of the top 10 wards/depts. reporting highest numbers of staffing incidents having risk assessments in place.

4. RECOMMENDATION

Quality Committee are asked to discuss and consider this paper, in conjunction with the six monthly staffing and acuity paper.

CBUs are asked to review their staffing risks based on both papers and determine what further actions are required e.g. provisions of senior support is being agreed for Ward A8.

A monthly review of staffing incidents will be undertaken and reported to patient Safety & Effectiveness Sub Committee.

Appendix 3

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.

The team leading on the implementation of the E Rostering have recently taken advantage of some networking opportunities to benchmark with other Trusts with regard to the introduction of Red Flags that are pertinent at WHH. Developments are underway in order to ensure the consistent recording of these events across the Trust and to ensure that they are mitigated in real time via interventions by senior nurses in line with the Nursing Staffing Escalation process.

Appendix 4

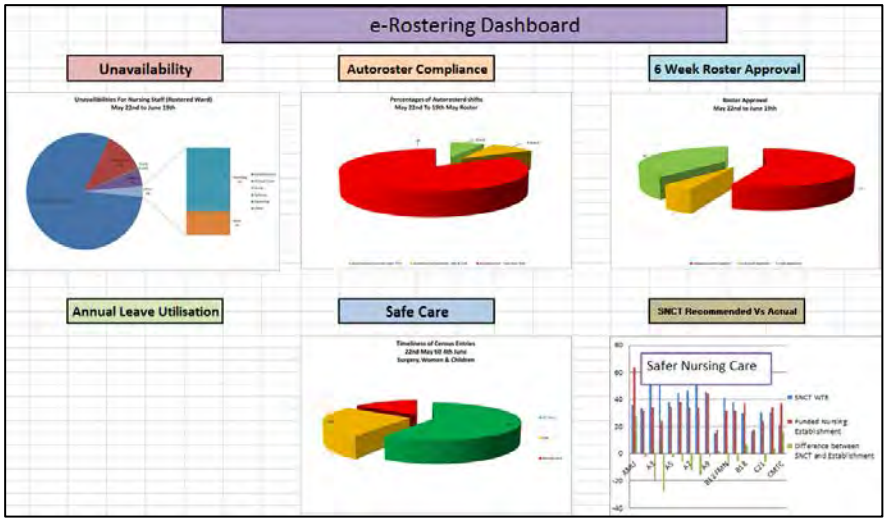
Health Roster, Safe Care and NHS(P) Interface Rollout

Ward	e Rostering	Safe Care	NHS(P)
A&E Department	Green	N/A	Green
A1 Acute Medicine	Green	Green	Green
A2 Acute Medicine	Green	Green	Green
A3 Opal Unit	Green	Green	Green
A7 Respiratory A	Green	Green	Green
ACT Pool	Green	N/A	N/A
Ambulatory Care	Green	N/A	Amber
ANDU	Green	N/A	N/A
B1 Intermediate Care	Green	Green	Green
B12 Acute Elderly Care	Green	Green	Green
B14 Stroke Acute Ward	Green	Green	Green
B18 COHORT Ward	Green	Green	Green
C20 Ward	Green	Green	Green
C21 Cardiology	Green	Green	Green
C22 Gastroenterology	Green	Green	Green
CMTC Ward	Green	Green	Green
Coronary Care Unit	Green	Green	Green
ITU	Green	Green	Green
Labour Suite	Green	N/A	Green
Maternity Ward C23	Green	N/A	Green
Neonatal Unit	Green	N/A	Green
Programme Investigation Unit	Green	N/A	N/A
Respiratory Team	Green	N/A	N/A
SAU	Green	N/A	Green
UCC Runcorn	Green	N/A	Green
Ward A4	Green	Green	Green
Ward A5	Green	Green	Green
Ward A6	Green	Green	Green
Ward A8	Green	Green	Green
Ward A9	Green	Green	Green
Ward B10 & B11	Green	N/A	Amber
Ward B4-Halton	Green	Green	Green
Theatres	Amber	N/A	N/A

Under Implementation

Rollout complete

The table below shows the current E-Rostering performance dashboard which is currently in the early developmental stage


e-Rostering Dashboard
Unavailability
Autoroster Compliance
6 Week Roster Approval
Annual Leave Utilisation
Safe Care
SNCT Recommended Vs Actual
Safer Nursing Care

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/17/07/89**
SUBJECT:	**Director of Infection Prevention and Control Annual Report**
DATE OF MEETING:	26 July 2017
ACTION REQUIRED	**For information and assurance**
AUTHOR(S):	Lesley McKay Associate Director of Infection Prevention and Control
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Medical Director & Deputy CEO Choose an item.
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
	Choose an item.
STRATEGIC CONTEXT	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. NHS Improvement use Clostridium difficile infection rates as one of a number of metrics to assess Trust performance.
EXECUTIVE SUMMARY (KEY ISSUES):	This report outlines the arrangements, activities and achievements of the Trust relating to infection prevention and control for the April 2016 to March 2017 financial year. A nil return was submitted for MRSA bacteraemia cases and a reduction in Clostridium difficile cases. This report builds on previous annual reports submitted to the Board to give a whole year account of infection prevention and control activity.

RECOMMENDATION:	Action plans for reduction of healthcare associated infections to continue: • Health and Social Care Act (2008) Code of practice on preventing infections and related guidance (2015) • Meticillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia reduction • Meticillin-sensitive *Staphylococcus aureus* (MSSA) bacteraemia reduction • Clostridium difficile infection reduction • Introduce an action plan for reduction of gram negative bloodstream infections Increase infection control audits to demonstrate compliance with policies and guidelines.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Committee
	Agenda Ref.	
	Date of meeting	4th July 2017
	Summary of Outcome	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

BOARD OF DIRECTORS

SUBJECT	Infection Prevention and Control	AGENDA REF:	

EXECUTIVE SUMMARY 4
Organisation 4
Activities 4
Infection prevention and control work plan for the year 4

DESCRIPTION OF INFECTION CONTROL ARRANGEMENTS 6
Infection Prevention and Control Team 6
Infection Control Sub-Committee 6
Reporting line to the Trust Board 7
Links to Drugs and Therapeutics Committee 7
Links to Quality Committee and Health and Safety Sub-Committee 7

DIPC REPORTS TO THE TRUST BOARD (SUMMARY) 8
Board reports 8
Annual work plan 8
Incidents/outbreak reports 10
Carbapenemase-producing enterobacteriaceae screening 12
VRE 13

BUDGET ALLOCATION TO INFECTION CONTROL ACTIVITIES 13

HEALTHCARE ASSOCIATED INFECTION STATISTICS 13
Results of mandatory reporting 13

HAND HYGIENE AND ASEPTIC PROTOCOLS 19
National inpatient survey 2016 20

DECONTAMINATION 20

CLEANING SERVICES 21

INFECTION CONTROL AUDIT 26
Sharps audit 29
Side room facilities survey 30
Saving Lives/High Impact Interventions 30
Antibiotic Prescribing 31
Matching Michigan 35

TARGETS AND OUTCOMES 36
Activities 36
Updated policies and guidelines 36

Contribution to other initiatives 37
External groups 38
External reviews 38

TRAINING ACTIVITIES 38
Training attended/ provided by Infection Prevention and Control Team Members 39

CONCLUSION 41

Appendix 1 - Infection Prevention and Control Work Plan 2017 - 2018 44

Appendix 2 - Infection Prevention and Control Strategy 50

Appendix 3 Orthopaedic Surgical Site Infection Surveillance (SSIS) April 2016 - March 2017 57

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 laid out in a five year strategy document 'creating tomorrow's healthcare today' and aims to 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 the April 2016 to March 2017 financial year.

Infection prevention and control work plan for the year

The Infection Prevention and Control Team worked towards delivery of the annual work plan. Extreme pressures and a significant period of reduced staffing had an impact on full achievement of the work plan in that the ward/department audit programme was not fully completed.

A robust work plan (appendix 1) has been devised for the 2017/18 financial year (FY). The work plan will ensure that the Trust complies with all mandatory surveillance requirements, policy reviews are completed within appropriate timescales, reports are received from the Clinical Business Units (CBUs) and unannounced audits are carried out.

In addition a strategy has been produced detailing priorities for action over the next 3 years (appendix 2).

Progress against action plans

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

- Health and Social Care Act (2008) Code of practice on preventing infections (2015)
    - All policies and guidelines are within review date

- Meticillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia reduction

- A nil return was submitted for MRSA bacteraemia.

- Meticillin-sensitive *Staphylococcus aureus* (MSSA) bacteraemia reduction
  - An increase in cases was noted

Cases of hospital apportioned MSSA bacteraemia increased from 4 to 14 cases. Some of these patients had deep seated infections and were likely to have been incubation the infection prior to admission.

- Clostridium difficile infection reduction
  - An overall reduction by 9 cases was noted

Total hospital apportioned cases of Clostridium difficile infection fell from 33 to 24 cases and 54% (13) of the cases were considered unavoidable.

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

Simon Constable
Executive Medical Director/Director of Infection Prevention and Control (DIPC)
June 2017

Acknowledgements

Marcia Anthony	Facilities Manager
George Creswell	Associate Director of Estates and Facilities
Natalie Crosby	Matron Intensive care
Cheryl Finney	Lead Nurse 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
Karen Smith	Infection Prevention and Control Nurse
Jacqui Ward	Antibiotic Pharmacist

2. KEY ELEMENTS

DESCRIPTION OF INFECTION CONTROL ARRANGEMENTS

Infection Prevention and Control Team

The Infection Prevention and Control Team meet weekly. Membership includes:-

- Director of Infection Prevention and Control:-
  - Professor Simon Constable
  - Dr Anne Robinson – Consultant AED and Medical Quality Lead

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

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

- Infection Prevention and Control Nurses:-
  - Karen Smith
  - Glynn Marriott (until October 2016)
  - Andrew Sargent (0.4WTE) until May 2016

- Antibiotics Pharmacist:-
  - Rachael Cameron (0.4 WTE) until August 2016
  - Jacqui Ward from (WTE) from August 2016

- Infection Control Administrator (part time):-
  - Karen Brobyn (0.6WTE) until December 2016

Infection Control Sub-Committee

The Trust's Infection Control Sub-Committee met monthly. Membership includes:-

- Consultant Medical Microbiologist – Chairman
- 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)
- Divisional Infection Control Lead Consultant – Women's, Children's and Surgical Services Division
- Divisional Infection Control Lead Consultant – Acute Care Services

- Associate Directors of Nursing/Head of Midwifery (infection prevention and control leads)
- Matrons Women's, Children's and Surgical Services Division
- Matrons Acute Care Services
- Workplace Health and Wellbeing Nurse Manager
- Consultant for Communicable Disease Control/PHE representative (to attend quarterly or co-opted more frequently if required)
- Facilities Manager
- Estates Manager
- Primary Care Infection Prevention and Control Nurse (Bridgewater)
- 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:-

- Director of Infection Prevention and Control
- Quality Committee

Links to Drugs and Therapeutics Committee

The links are via:-

- Consultant Medical Microbiologists
- Antibiotics Pharmacist
- Antimicrobial Management Steering Group meetings

Links to Quality Committee and Health and Safety Sub-Committee

The links are via:-

- Director of Infection Prevention and Control
- Associate Director of Infection Prevention and Control
- Chief Nurse
- 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 apportioned Clostridium difficile toxin positive cases
- Post infection review of hospital apportioned MRSA/MSSA bacteraemia cases
- Divisional/ departmental Infection Control Groups
- Infection Prevention and Control and Sepsis Link Practitioner Group
- Environment Group
- Clostridium difficile Action Group

DIPC REPORTS TO THE TRUST BOARD (SUMMARY)

Board reports

Reports, which included key performance indicators, outbreak/incident details and investigation findings, were submitted to the Trust Board in:-

- April 2016
- July 2016
- July 2016 (Annual Report on previous years activity)
- January 2017

Annual work plan

The Infection Control Sub-Committee annual work plan was devised 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 discussed 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 Matrons 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 Committee and the Trust Board that compliance with the Code of practice is maintained and that there is a programme of continued improvement.

There were 4 action plans which were reviewed on a quarterly basis. These included:-

Health and Social Care Act (2008) Action plan

This action plan sets out the 10 criteria against which the Care Quality Commission (CQC) judge a registered provider on how it complies with the cleanliness and infection control requirement set out in the regulations. The requirements are 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).

Compliance at the end of March 2017 and areas requiring further input 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*	*A review of how surveillance is conducted is underway*
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. Occasional concerns have been raised about standards of cleanliness. An action plan is in place to meet the nationally revised specification for Cleaning and monitoring services*
3. Ensure appropriate antibiotic use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance	*Partially compliant*	*A plan is in place to strengthen Antimicrobial stewardship in terms of training and prescribing competencies*

Criterion	Assessment	Action required
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*	*Continuous improvements in communication about patients conditions when transferring patients (inter/intra hospital transfers and to social care facilities) are sought via the IT upgrade work stream*
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*	*Review of side room capacity in progress. Guidance on isolating and screening inter-hospital transfers is impacting on these resources. Continuous liaison with the Patient Flow Team occurs to maximise 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*	
10. *Providers have a system in place to manage the occupational health needs of staff in relation to infection*	*Compliant*	

MRSA bacteraemia reduction action plan

This action plan sets out the work required to reduce the risks of MRSA bacteraemia. The Trust submitted a nil return for MRSA bacteraemia cases. This is an improvement to the previous financial year where 4 cases (2 community and 2 hospital) apportioned cases were reported. There was a rolling 18 month period without an MRSA bacteraemia case.

MSSA bacteraemia reduction action plan

This action plan sets out the work required to reduce the risks of MSSA bacteraemia. During 2016/17 the Trust reported 43 MSSA bacteraemia cases (14 hospital apportioned and 29 community apportioned). This is an increase of 10 hospital apportioned 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 2016/17 financial year was 27 cases. The Trust reported a total of 65 cases of Clostridium difficile, 24 of which were initially apportioned to the Trust. Compared to the previous financial year this equates to a decrease of 9 hospital apportioned cases. All 24 cases were referred to the CCG for review. This resulted in 13 cases being assessed as unavoidable, leaving 11 cases attributed to the Trust. Details are included on page 16.

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

- Surveillance of cases/monitoring for increased incidences in defined locations
- Antimicrobial steering group – governance strengthened
- Hand hygiene awareness raising events
- Safety alerts on management of potentially infectious diarrhoea
- Increase in 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

Next year's Clostridium difficile objective remains unchanged with the threshold remaining at 27 cases.

Incidents/outbreak reports

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

Chickenpox exposure incidents

Incident 1 – (May 2016) Paediatric AED

A paediatric patient attended AED. Rash illness was noted in a sibling 2 hours after presentation. Nil patients were in the identified high risk groups. All staff contacts were reported to have immunity. A patient notification exercise was completed.

Incident 2 – (February 2017) B11

A paediatric patient admitted into a bay. Suspected chickenpox rash developed the following day. All staff contacts were reported to have immunity. A patient notification exercise was completed. The serology test excluded chickenpox as a diagnosis. Sampling did not include a swab of vesicular fluid for VZV PCR which may have better clinical utility than serology in early chickenpox.

Posters showing chickenpox rash are now displayed as an aide memoire to diagnosis and to prompt timely isolation of patients with this highly transmissible infection.

Vancomycin-resistant enterococcus

Incident 1 (September 2016) Ward A9

Two patients were identified to have Vancomycin-resistant enterococcus (VRE) from clinical specimens. Contact screening specimens were obtained and carriage of VRE was identified in 4 other patients. The isolates were different:-

- 3 E. faecalis
- 3 E. faecium

Additional action was taken to decontaminate the ward and all patient care equipment using chlorine based cleaning products. The ward was targeted for antibiotic ward rounds with nil concerns identified.

Information leaflets were provided for patients and the E. faecalis isolates were referred for typing. The results confirmed 2 patients had the same strain and the 3rd patient had a similar strain.

Following an infection control audit concerns were raised about standards of environmental cleanliness despite the enhanced cleaning and further cleaning environmental cleaning was carried out.

Incident 2 (February - March 2017) Ward A9

Two patients were identified to have VRE from wound swabs. Both isolates were *E. faecalis*. No concerns of surgical site infection were reported for one of the patients. Typing results confirmed the isolates were different. Contact screening was not requested due to turnover of patients. A third VRE case *E. faecium* was identified from a urine specimen in March. Contact screening was requested (5 other patients in the same bay) with 2 positive results. Following discussion a plan was implemented to decontaminate the environment with hydrogen peroxide vapour.

Clostridium difficile periods of increased incidence

The Infection Prevention and Control Team has 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, 2 periods of increased incidence were investigated. Table 2 provides details of the PII findings.

Table 2 Findings of Clostridium difficile PII investigations

Ward	Cases	Month	Year	Ribotyping	Comment/ areas of concern
C21	2 toxin positive cases	12	2016	045	Ribotyping was identical indicating transmission occurred between the 2 cases
A8	6 toxin positive cases	01 - 03	2017	045 (4 patients) 015 (1 patient) 002; 039 (1 patient)	Ribotyping was identical for 4 patients indicating transmission occurred between these cases. The 2 other patients had ribotypes distinct from each other and the 4 linked cases

One of the cases from ward C21 was transferred to ward A8 and is included in the 4 linked cases for that ward.

Viral gastroenteritis (Norovirus)

Viral gastroenteritis infections can occur at any time of year. The viruses that cause gastroenteritis (including norovirus) are now generally accepted as the most important causes of non-bacterial gastroenteritis that can affect people of all age groups. 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.

In December 2016 the Trust introduced in-house testing for viral gastroenteritis pathogens. This has assisted 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).

It is recognized that 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 the year with the causative organisms identified as norovirus or rotavirus. Table 3 provides details of the number of reported incidents by month and findings.

Table 3 Viral gastroenteritis incidents

Month	Year	No of wards affected	Closure	Causative organism(s)
Apr	2016	1	Bay	Not identified
May	2016	5	Bay	Not identified
Jun	2016	4	Bay	Not identified
Jul	2016	2	Bay	Not identified
Aug	2016	4	Bay	Not identified
Sep	2016	3	Bay	Not identified
Oct	2016	1	Bay	Not identified
Nov	2016	4	Bay	Norovirus 1 ward
Dec	2016	5	Bay	Not identified
Jan	2017	9	Bay	Rotavirus 1 ward
Feb	2017	7	Bay – ward	Norovirus 6 wards
Mar	2017	2	Bay – ward	Norovirus and Clostridium difficile 1 ward

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 only 3 wards were fully closed.

The increase in wards reporting diarrhea and vomiting from January to March 2017 was noted to be reflective of the situation within the wider community. A similar increase in care home reports and closures was noted during the same time period.

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 and simultaneously maintaining safe infection prevention/control practice.

Carbapenemase-producing enterobacteriaceae screening

Antimicrobial resistance is viewed as one of the current major threats 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 the following screening was carried out and results are as detailed below:-

- 341 patients were screened for CPE carriage
    - 4 patients were identified with CPE
        - 1 KPC (known positive pre-admission)
        - 2 Acinetobacter baumanii (OXA 23 like and OXA 51 like). Both patients were repatriated from healthcare facilities abroad with positive results on admission and no cross over to other patients identified

VRE

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

- 74 patients had VRE detected on rectal screening
- 67 patients had VRE detected from clinical specimens (some patients may have more than 1 clinical site specimen)
    - 48 urine specimens
    - 20 wound/pus/fluid or tissue swabs
    - 4 blood culture specimens
    - 1 IV device tip
    - 1 bronchial washing

All patients were reviewed by the Infection Prevention and Control Team and advice on Infection Control precautions provided.

The number of VRE isolates has increased this financial year and work is in progress to address screening and isolation of cases.

BUDGET ALLOCATION TO INFECTION CONTROL ACTIVITIES

The budget allocation to infection control includes:-

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

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

HEALTHCARE ASSOCIATED INFECTION STATISTICS

Results of mandatory reporting

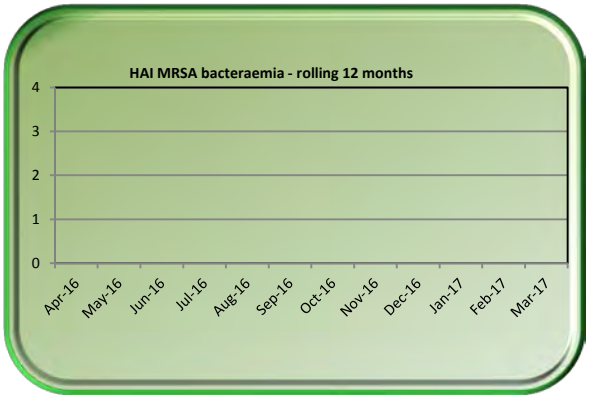
The Trust participates in the mandatory reporting of the following healthcare associated infections.

MRSA bacteraemia

The Trust submitted a nil return for MRSA bacteraemia for the FY and has had an eighteen month period without a case.

The number of hospital apportioned cases of MRSA bacteraemia reduced by 2 cases compared to the previous FY.

Figure 1 - MRSA bacteraemia cases

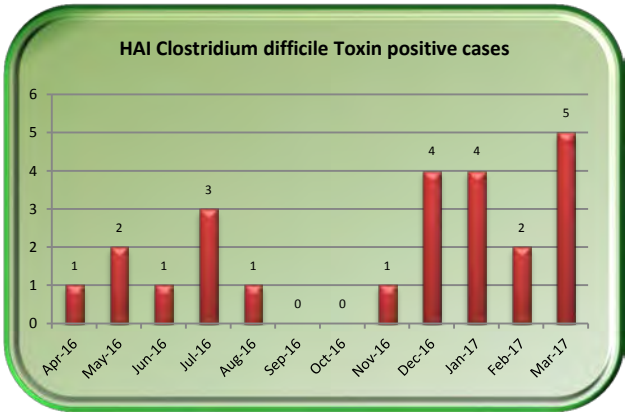


Clostridium difficile (toxin positive)

The Trust reported 65 Clostridium difficile toxin positive cases (41 community apportioned; 24 hospital apportioned). The number of hospital apportioned cases decreased by 9 cases compared to the previous financial year. The number of patients affected is equal to 22 as 2 patients had repeat positive tests (after 28 days of the initial sample) and were reported in line with mandatory requirements.

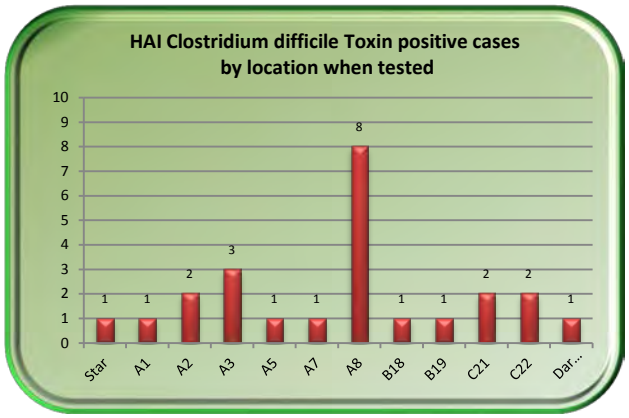
The number of cases reported by month is displayed in figure 2.

Figure 2 – Hospital apportioned Clostridium difficile cases by month



The distribution of the hospital apportioned cases by location when the sample was taken is displayed in figure 3.

Figure 3 – Clostridium difficile <u>toxin positive</u> 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 the 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 13 cases (54%) from those counted for contractual purposes. This is an improvement from the previous FY where only 48% of cases were removed. Figure 4 depicts the Clostridium difficile toxin positive case review outcomes by month.

Figure 4 – Outcome of CCG review panel decisions by month

2015/16	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Total HAI C difficile	1	2	1	3	1	0	0	1	4	4	2	5	**24**
Not due to lapse in care		2	1	2	1			1	1	2	1	2	12
Due to lapses in care	1			1					3	2	1	3	**11**

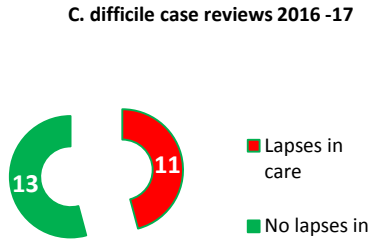
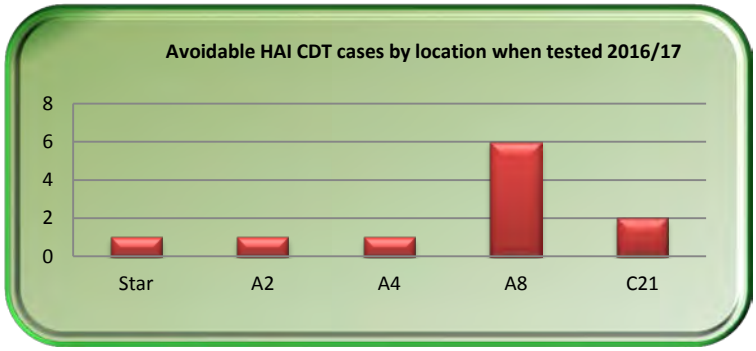


Figure 5 provides adjusted data on the 11 Trust apportioned cases (by revised location) following decisions taken by the CCG review panel.

Figure 5 Avoidable Hospital apportioned Clostridium difficile <u>toxin positive</u> cases by location



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 are not always documented
- isolation not always carried out timely
- Duty of Candour compliance requires improvement

There are actions in place to address these findings. Feedback of investigation conclusions 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)

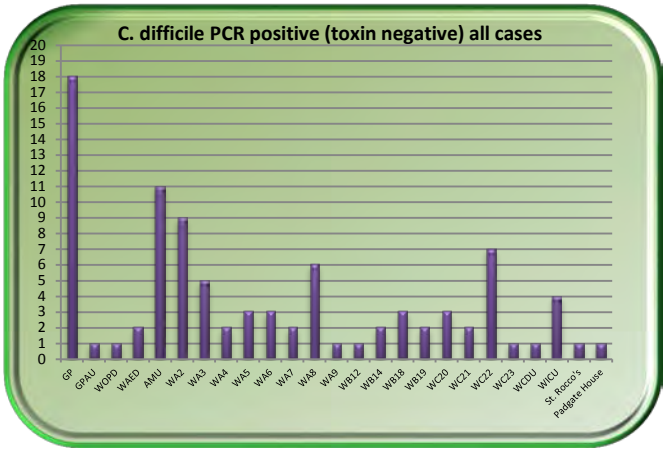
Diagnostic testing methods for Clostridium difficile infection distinguished between patients who are colonised with Clostridium difficile (PCR positive), and those with Clostridium difficile toxins present which indicates infection is more likely.

The Infection Prevention and Control Team are conducting local surveillance on the patients who are Clostridium difficle PCR positive without the presence of toxins. These patients are at a higher risk of developing Clostridum 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 6 demonstrates the results for all patients (no apportionment) who were Clostridium difficile toxin negative/PCR positive and at the time of testing. Some of these patients have subsequently tested positive for Clostridium diffcile toxins or have had a previous history with toxins present.

Figure 6 - Clostridium difficile PCR positive/toxin negative cases by location detected



Collaborative work, brought about by the work of the Clostridium diffiicle Action Group has resulted in a more united approached to address the Clostridium difficile agenda across the health economy.

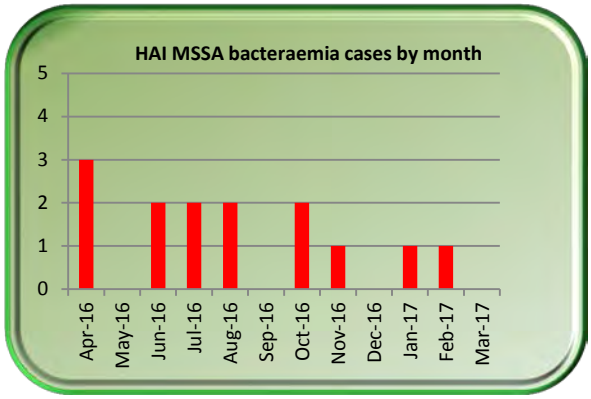
Glycopeptide resistant enterococci bacteraemia

The Trust has reported 4 cases of Glycopeptide resistant enterococci (GRE) bacteraemia during the report time period. These were unrelated in terms of organism, time period and locations.

MSSA bacteraemia

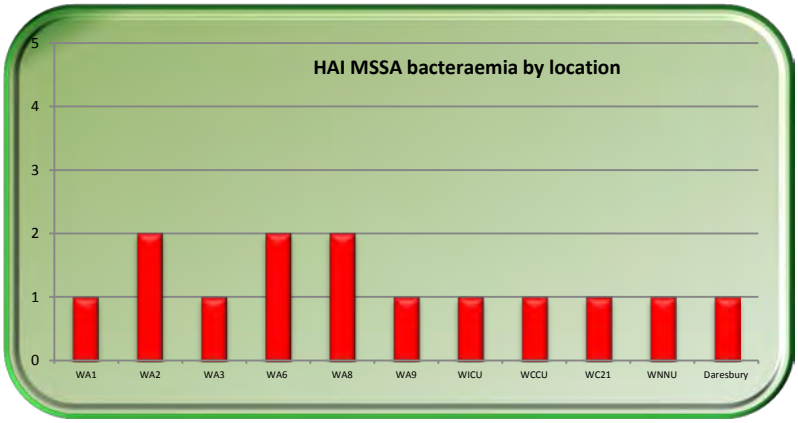
The Department of Health has not set targets for the reduction of MSSA bacteraemia. During the financial year 14 hospital apportioned cases were reported. Figure 7 shows the cases of MSSA bacteraemia identified within the Trust by month.

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



This was an increase by 10 hospital apportioned 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 findings from the post infection reviews are detailed in table 4.

Table 4 MSSA bacteraemia investigation findings

Month	No	Location	Root cause	Avoidability status	Areas for care improvement
Apr	3	A6	Endocarditis	Unavoidable, Sampling delay	Timely sampling
		A8	Unknown	Unknown	Documentation of specimen collection
		ICU	IV device associated	Avoidable	Sample labelling – location of requestor
May	0				
Jun	2	A6/AMU	IV device associated	Avoidable	Sample labelling – specimen site; documentation of cannula insertion
		CCU	Endocarditis	Unavoidable, Sampling delay	Timely sampling blood cultures were taken within 40 hours of admission
Jul	2	A2	IV device associated	Not determined Neutropaenia	Documentation of cannula removal
		CDU/C21	IV device associated	Avoidable	Improvement plan for insertion and monitoring of cannulas
Aug	2	A3	Unknown	Unknown	
		A9	Septic arthritis	Unavoidable, Sampling delay	Timely sampling
Sep	0				
Oct	2	A1	IV device associated	Not determined	Improvement plan for insertion and monitoring of cannulas
		NNU	Foetal scalp electrode associated	Avoidable	Admission screening to be agreed
Nov	1	A8	Unknown source	Unknown	Improvement plan for insertion and monitoring of cannulas in AED
Dec	0				
Jan	1	Daresbury	Invasive device associated	Avoidable	Urinary catheter management, peripheral cannula management, wound management
Feb	1	A2	Unknown source	Unavoidable	Midline insertion; Documentation of cannula removal
Mar	0				
Total	14				

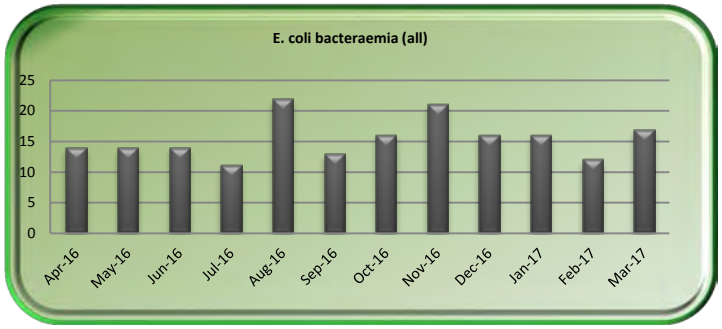
The PIRs identified late sampling resulted in 3 of these 14 cases being apportioned to the Trust. Additional training of staff in AED on blood culture sampling has taken place to promote timely specimen collection on admission.

Currently the Trust does not have a clinical IV insertion service. A limited service is provided by the Clinical Education Team. An option appraisal is in progress to look at the feasibility of introducing this type of service.

Escherichia coli (E. coli) bacteraemia

E. coli bacteraemia data was being collated for surveillance purposes only and the data capture system did not make a distinction between hospital/community apportioned cases. Figure 9 displays the total number of cases (186) reported by month between April 2016 and March 2017.

Figure 9 - E. coli bacteraemia cases April 2016 – March 2017



All E. coli bacteraemia cases are reviewed by the Consultant medical Microbiologists. Of the 186 cases reported:-

- 155 were assessed as not likely to be associated with healthcare
- 5 were likely to be associated with healthcare
- 5 were source unknown
- 21 were possibly associated with healthcare

From the likely, possible or unknown healthcare associated cases (32), the primary source of the bacteraemia was assessed as most likely primary focus being associated with:-

- 7 hepatobiliary
- 5 respiratory tract source
- 14 urinary tract
- 6 other or no clear source

Public Health England is introducing a target to reduce gram negative bloodstream infections (50% reduction by 2021). This is a health economy target linked to the quality premium. Apportionment of previously reported E. coli bacteraemia cases is being retrospectively applied. The E. coli data is being analysed to identify target areas for improvement action. The initial focus will be on urinary catheters. In addition reporting of Pseudomonas aeruginosa and Klebsiella spp. bacteraemia cases has been made mandatory from April 2017.

MRSA screening

The Trust continues to provide MRSA screening for patients in line with the Department of Health guidance. Due to changes with the patient administration system it has not been possible to gain exact compliance rates for MRSA screening. The data warehouse team are working on generating a solution. 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. The surveillance data demonstrates there were 9 reported cases of surgical site infection which is a slight increase compared to the previous financial year.

Due to the nature of implant surgery infections can manifest themselves beyond this surveillance period. Surveillance data is provided in more detail in appendix 3.

HAND HYGIENE AND ASEPTIC PROTOCOLS

Audits of compliance with the Hand Hygiene Policy are undertaken weekly at ward and department level. On average 89% of clinical areas were audited with an average compliance rate for the year of 99% (table 5). Peer audits have been reintroduced for the next financial year.

Table 5 Trust wide hand hygiene audit results

	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Total
% areas audited	95%	87%	89%	88%	94%	88%	86%	82%	88%	95%	95%	85%	89%
Compliance	98%	98%	98%	98%	99%	99%	99%	98%	99%	99%	99%	99%	99%

National inpatient survey 2016

Trust scores from the National Inpatient Management Survey 2016 included questions on cleanliness. The results compared to the 2015 survey and nationally are detailed below.

Figure 10 National inpatient survey results

- Cleanliness of hospital rooms/wards

17. In your opinion, how clean was the hospital room or ward that you were in?	2015 RWW		2016 RWW		2016 All	
	#	%	#	%	#	%
Very clean	396	76%	338	71%	13,822	74%
Fairly clean	113	22%	113	24%	4,448	24%
Not very clean	14	3%	20	4%	347	2%
Not at all clean	1	0%	3	1%	71	0%
Missing	5		8		418	

- Cleanliness of toilets and bathrooms

18. How clean were the toilets and bathrooms that you used in hospital?	2015 RWW		2016 RWW		2016 All	
	#	%	#	%	#	%
* *Very clean*	*348*	*70%*	*303*	*65%*	*11,803*	*66%*
* *Fairly clean*	*126*	*25%*	*133*	*29%*	*5,251*	*29%*
* *Not very clean*	*17*	*3%*	*27*	*6%*	*736*	*4%*
* *Not at all clean*	*7*	*1%*	*3*	*1%*	*162*	*1%*
I did not use a toilet or bathroom	28	5%	7	1%	741	4%
Missing	3		9		413	

The Trust has been rated just below the national average for patients' perceptions of cleanliness. The Environmental hygiene group was re-established to address concerns in relation to standards of cleanliness.

DECONTAMINATION

The Decontamination Group was previously 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.

Meetings have been established quarterly.

CLEANING SERVICES

Management arrangements

The Domestic staff working at the Trust are employed in-house and are part of the Facilities team, 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 continues to provide 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 has also recently purchased 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 2016/17 was £3.36m with 145.18 whole time equivalent (WTE) staff employed by the Department.

Monitoring arrangements

There is a dedicated Monitoring Team within Facilities, who monitor for standards of cleanliness within clinical and non-clinical areas at both sites. This team is managed separately from the Domestic team to ensure there is no conflict of interest.

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.

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 and 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 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 2016/17 staff responded to 3490 terminal clean requests, which was an increase of 20% on the previous year and curtain changes also increased by 20**%** in the same period.

Table 6 Terminal cleans

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Terminal Cleans 2014/15	166	225	174	142	213	237	237	270	229	270	344	227	**2568**
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**

Table 7 Curtain changes

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Curtain changes 2014/15	111	169	108	79	134	155	173	169	153	190	217	153	**1700**
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**

Cleanliness scores

The 2016/17 cleanliness monitoring scores for clinical areas were as follows:

- Warrington: 93%
- Halton: 96%

Table 8 Cleanliness scores Warrington

WARRINGTON	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cleanliness stats 2016/17	96%	94%	92%	91%	94%	94%	94%	93%	94%	93%	92%	92%

Table 9 Cleanliness scores Halton

HALTON	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cleanliness Stats 2016/17	95%	95%	97%	95%	94%	94%	97%	97%	96%	96%	96%	97%

PLACE (Patient Led Assessments of the Care Environment)

In 2016 the PLACE assessments were carried out throughout the Trust by a team of patient assessors, including representatives from Warrington and Halton Health Watch, supported by representatives from the Trust. Results from the assessments are detailed below, along with National averages.

Table 10 PLACE results Halton Hospital:

Domain	2016 PLACE %	National Average %
Cleanliness	99.34%	98.06%
Food	88.72%	88.24%
Privacy, dignity and wellbeing	78.13%	84.16%
Condition, Appearance and maintenance	92.83%	93.37%
Dementia	63.68%	75.27%
Disability	62.33%	78.84%

The following graph, produced by the Health and Social Care Information Centre, indicates comparison with WHH PLACE scores from 2013-2016 for the Halton site:

Figure 11 PLACE assessment results Halton

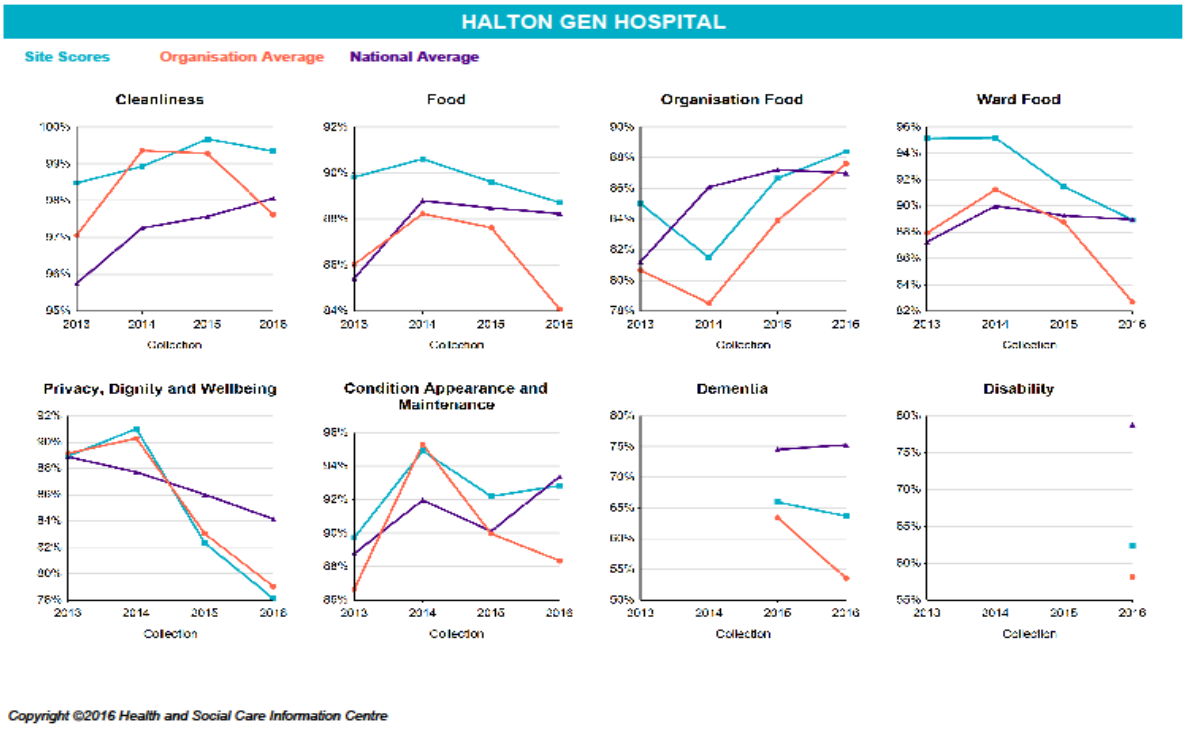
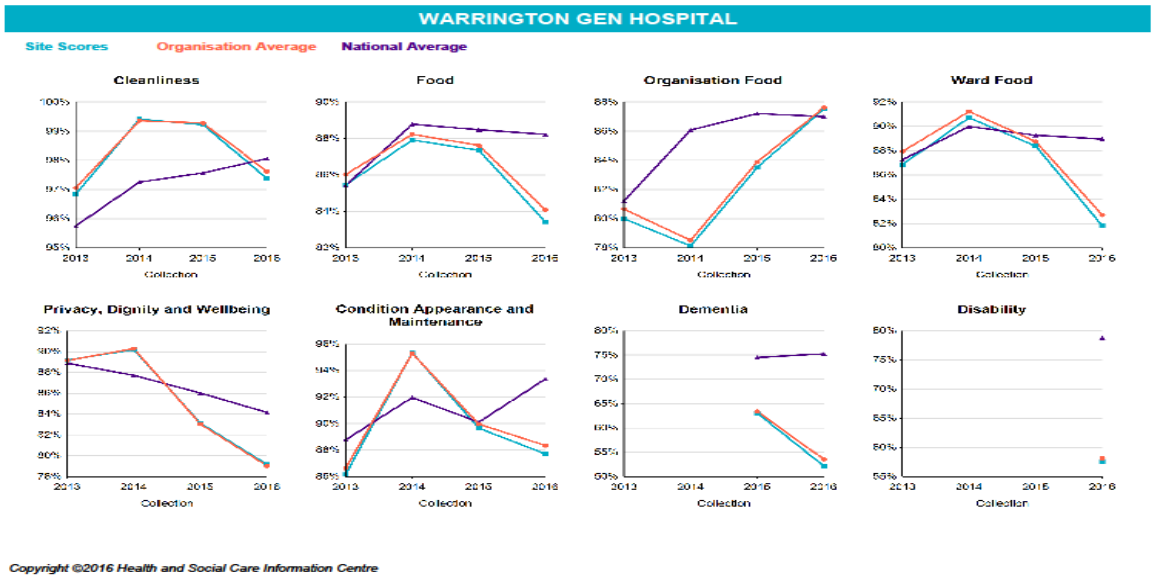


Table 11 PLACE assessment results for Warrington Hospital

Domain	2016 PLACE %	National Average %
Cleanliness	97.38%	98.06%
Food	83.43%	88.24%
Privacy, Dignity and Wellbeing	79.17%	84.16%
Condition, Appearance and Maintenance	87.71%	93.37%
Dementia	52.18%	75.18%
Disability	57.54%	78.84%

The following graph, produced by the Health and Social Care Information Centre, indicates comparison with WHH PLACE scores from 2013-2016 for the Warrington site:

Figure 12 PLACE assessment results Warrington



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
- 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 monthly 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. In 2016 a staff competency audit was introduced 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 the ward regarding day to day priorities. There is also close liaison with the Matrons, who have a specific responsibility for cleanliness standards for their Division.

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 5 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, e.g. two or more cases of hospital apportioned cases of C. difficile within a ward. Wards A3 and A8 had repeat audits due to concerns identified from alert organism surveillance.

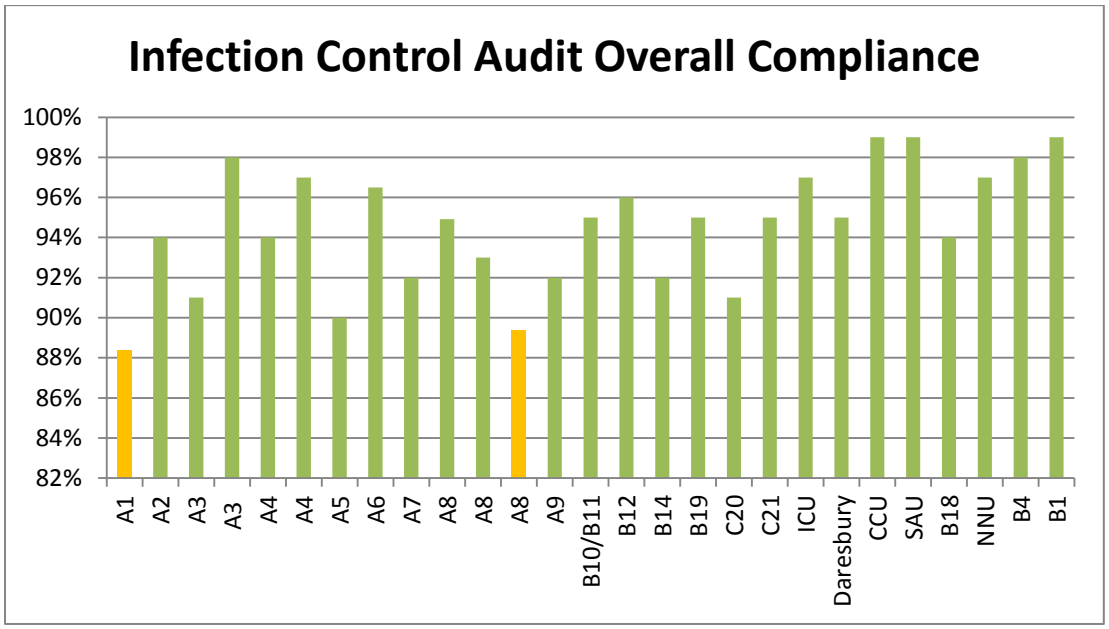
Reports on findings are fed back to the nurse in charge of the clinical area at the time of the audit. This is followed up by a written report within one week of the audit. The manager of the clinical area is responsible for producing an action plan to address areas of non-compliance. The action plan 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 added to an excel spreadsheet to provide an overall compliance score for the Trust. Overall Trust compliance was 95%.

Results

A total of 23 inpatient areas were audited during the financial year 2016/17. The majority of areas attained above 90% compliance. The exceptions to this were A1 (89%) and A8 (89%). Improvement actions were requested from these areas.

Figure 13 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

Ward	Total
Environment	90%
Ward Kitchens	89%
Handling/Disposal of Linen	94%
Departmental Waste	93%
Safe Handling Disposal of Sharps	94%
Patient Equipment (General)	98%
Hand Hygiene	97%
Patient Equipment (Specialist)	100%
Personal Protective Equipment	96%
Short Term Catheter Management	97%
Enteral Feeding	98%
Non-Tunnelled Central Venous Catheters	100%
Care of Peripheral Intravenous Lines	88%
Isolation Precautions	100%
Overall Compliance	95%

The lowest scoring components were ward kitchens and care of peripheral vascular cannula. In terms of ward kitchens, 11 areas scored less than 90% compliance. The audits of ward kitchens, completed by the Facilities Manager have also shown low compliance. An improvement strategy has been requested.

Ten areas scored less than 90% compliance with care of peripheral cannula. This gives cause for concern in relation to bacteraemia risk. The increase in MSSA bacteraemia cases was discussed at Infection Control Sub-Committee and the emphasis on care of these invasive devices re-iterated.

Other areas of concern include:-

- General ward environment - 10 areas less than 90% compliant
- Handling and disposal of linen – 8 areas less than 90% compliant
- Waste handling - 8 areas less than 90% compliant
- Safe handling and disposal of sharps – 5 areas less than 90% compliant
- Personal protective equipment – 5 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. Action for improvement is being monitored via the environment group. This also includes linen handling and waste management.

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.

There is a plan in place to have focus months on each of the audit elements. In addition a number of other actions have been initiated which include:-

- Matrons are reviewing domestic cleaning staffing establishment for their areas
- Hand hygiene – peer audits are in place
- PPE has been noted as a problem intermittently and requires further focus
- Urinary catheter management will be a focus area as part of the gram negative bloodstream reduction action plan
- Peripheral cannula management is a priority area for action. There was an increase in bacteraemia cases during the last financial year, some of which were associated with IV devices

Limitations

The Infection Prevention and Control Team staffing was reduced due to a whole time equivalent vacancy for 5 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 (December 2016) 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 (111) wards/departments were visited during the audit and five hundred and fifty (550) 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
- 0 that were not properly assembled
- 2 that were more than three quarters full
- 2 sharps container had the wrong lid on the wrong base
- 3 sharps containers were sited on the floor or at an unsuitable height
- 52 sharps containers were unlabelled whilst in use
- 43 sharps containers had significant inappropriate non sharp contents
- 38 sharps containers did not have the temporary closure in place

The audit recommendations included:-

- Train staff not to overfill sharps containers
- Train staff to match lids and labels correctly
- Keep sharps containers off the floor
- 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 December 2017.

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 15 side rooms were being used for non-clinical functions (11 beds on the Warrington site and 4 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 en-suite facilities.

A number of the side rooms are in areas that are ring fenced for specific patient groups (e.g. planned orthopaedic surgery, 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 is in a compromised position in relation to the requirement for provision of adequate isolation facilities. This is 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.

The reduction in side room facilities has resulted in an increased impact on infection prevention and control resources to undertake risk assessments and provide advice on prioritisation for side room use at a time when resources are under increased demand. There will be continuous liaison with the Patient Flow and clinical team 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

Two joint Consultant Microbiologist and Pharmacist ward rounds are carried out each week at Warrington hospital. One ward round targets patients on specific "target antibiotics" - piperacillin/tazobactam (Tazocin®), meropenem, ciprofloxacin, teicoplanin, cefuroxime co-amoxiclav and levofloxacin. These antibiotics have historically been targeted and monitored as they are broad-spectrum or thought to be more commonly associated with the development of *Clostridium difficile* infection. Previously the other ward round primarily focused on wards where there were concerns about compliance with the Trust antibiotic formulary. However the introduction of the Anti-microbial Resistance (AMR) CQUIN in 2016 has meant that extra emphasis has had to be placed on reviewing two key antibiotics used within the Trust - piperacillin/tazobactam (Tazocin®) and meropenem and so in addition to targeting wards with low compliance this ward round is also used to target these antibiotics. Referrals are also taken from ward pharmacists who may be concerned that a patient is deteriorating despite antibiotics or a patient is well enough for rationalisation of IV antibiotics, oral step down or stopping antibiotics but the team with clinical responsibility for the patient are not undertaking this.

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

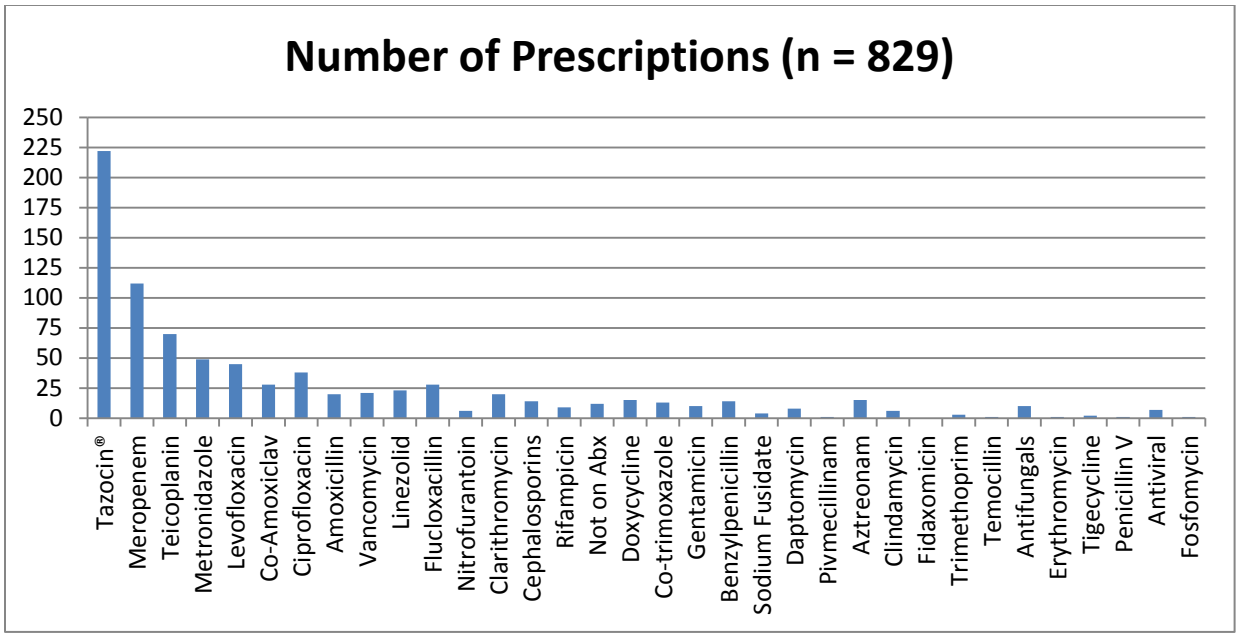
A total of 713 patients and 829 antimicrobials were reviewed between April 2016 and March 2017. This is a significant increase on the 395 patients reviewed in the previous financial year and the appointment of a full-time antimicrobial pharmacist post will account for some of this. 420 antibiotics were reviewed on the Tuesday "target" ward round and 409 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 Consultant Microbiologist time.

Summary of Antibiotics Reviewed

The graph below (figure 14) indicates which antibiotics were reviewed on the ward rounds. 64% of the antimicrobials which were reviewed were "target antibiotics," which is higher than the 48% last year which were from this group. This 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 % reduction in use of these antibiotics required by the AMR CQUIN. These 2 antibiotics alone made up 40% of all the antibiotics reviewed on the ward rounds.

12 patients were reviewed who were not on 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 14 Summary of antibiotics reviewed

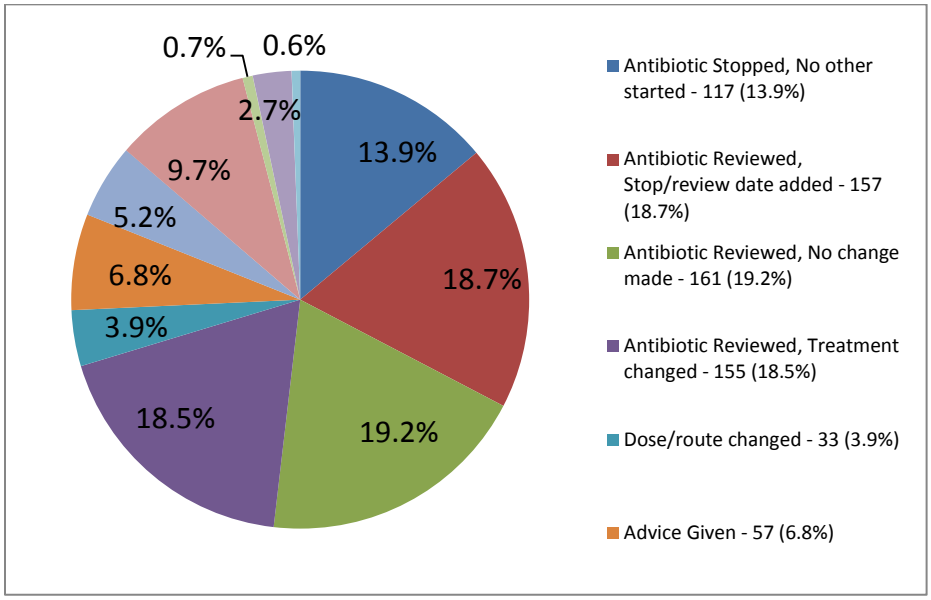


Summary of Ward Round Interventions

Of the 829 antibiotics reviewed, 117 antibiotics (14%) were stopped and 155 antibiotics (18.5%) were changed to a more appropriate antibiotic. Changes were only made if the team looking after the patient could be contacted. A further 157 antibiotics (19%) had a stop date added or a date for further review added.

The pie chart (figure 15) below summarises the outcome of the antibiotic reviews in more detail.

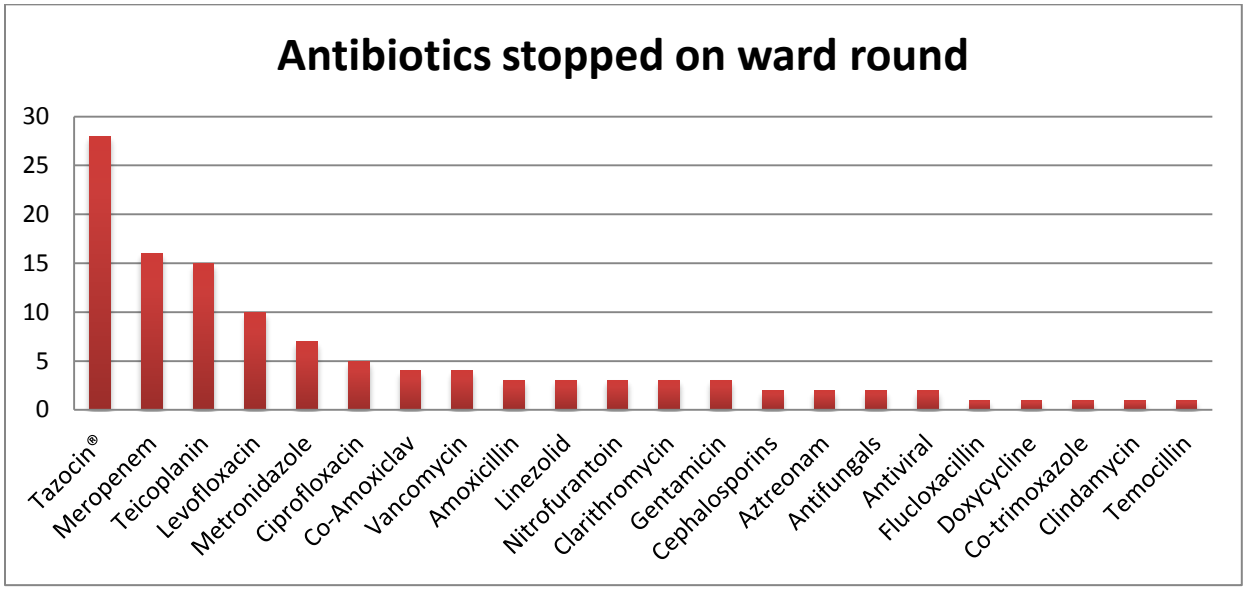
Figure 15 Outcome of antibiotic reviews



Summary of Antibiotics Stopped

117 (14%) of the antibiotics which were reviewed on the ward round were stopped because no further antibiotic treatment was considered appropriate at that point, there was no positive microbiology to indicate that that antibiotic was required or there was duplication in antibiotic cover. The antibiotics which were stopped are detailed in Figure 16 below. Antibiotics were stopped only if the team with clinical responsibility for the patient could be contacted and 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 at the time of the ward rounds however a note was left on the patients EPR documenting that a discussion with a Consultant Microbiologist was required as there was a more appropriate antibiotic regimen for the patient. As these conversations occur after the ward round then it is not possible to include the outcome of all these discussions in the data collection.

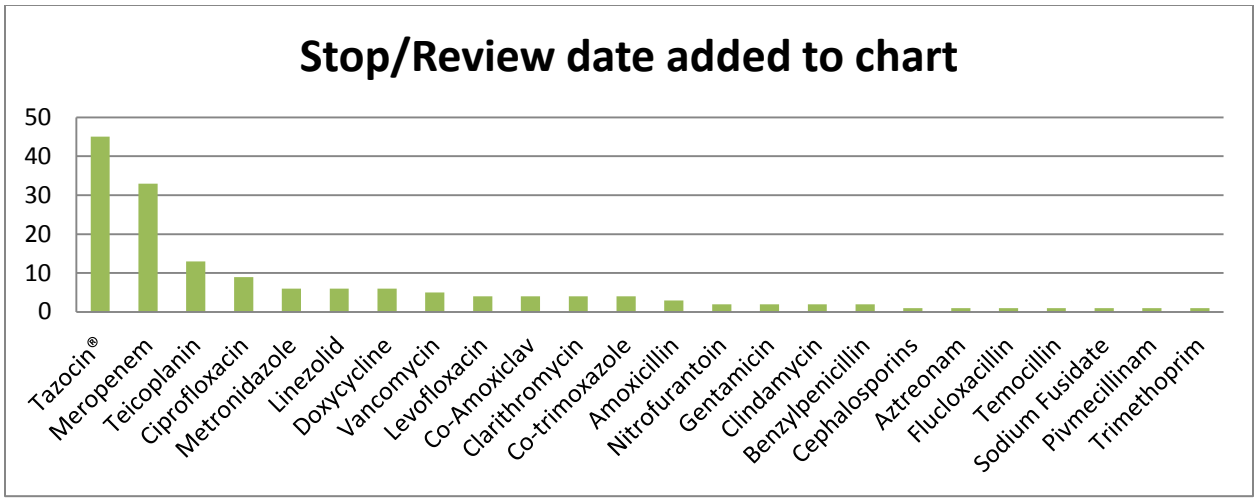
Figure 16 Summary of the antibiotics which were stopped following the ward round



Summary of antibiotics with stop or review date added

157 (19%) of the antibiotics reviewed were considered to be appropriate but did not have a documented stop or review date on the prescription chart and so these were added on the ward round. The antibiotics which had a stop date or review date added to the prescription chart are detailed below in Figure 17. This is an area for improvement, as all antibiotics should have a stop or review date documented when they are first prescribed. This would provide the nurse or ward pharmacist with clear guidance on when to challenge the antibiotic prescription.

Figure 17 Stop/review dates added



Benefits of the ward round

The ward rounds are beneficial because patients are exposed to fewer days of antibiotic treatment or changed to more appropriate antibiotic treatment in a more timely manner. Microbiology and blood results are reviewed by the Consultant Microbiologist and Pharmacist before the patient is seen on the ward, which allows treatment to be tailored as appropriate. 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. In addition 7 antibiotics which require therapeutic drug monitoring were stopped which results in reduced nursing time and ward pharmacist time.

The ward rounds also provide a good educational opportunity for the Consultant Microbiologists and pharmacist to educate the ward doctors on antimicrobial resistance and promote prescribing as per the Trusts antibiotic formulary.

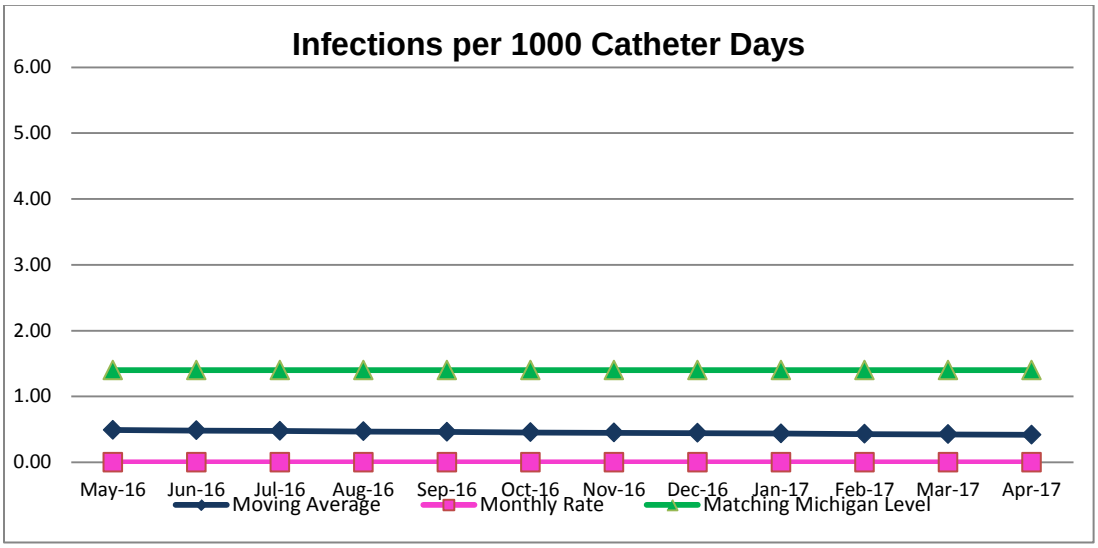
Future developments

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 2016/17 financial year is displayed in figure 18.

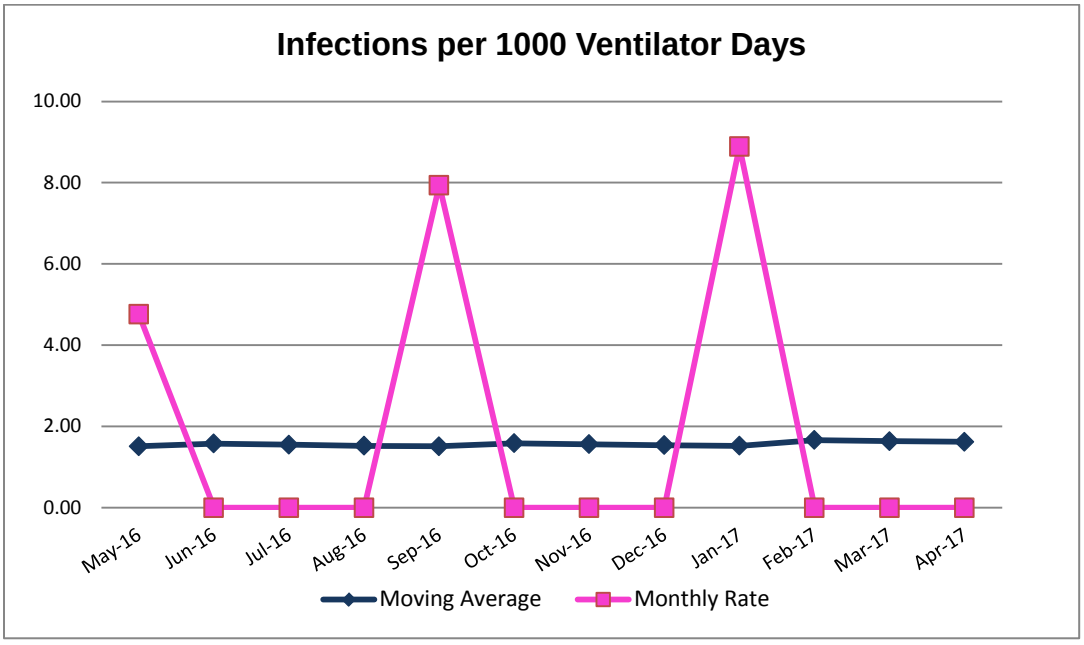
Figure 18- Matching Michigan data



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 2016/17 year is displayed in figure 19.

Figure 19 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
- Clostridium difficile Action Group
- Hand hygiene awareness raising events
- 24 hour 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:-

- Multi-drug resistant organisms infection control guidelines
- Occupational Health Clearance Policy
- Trust Food Safety Policy
- Audit Timetable for Infection Control Policies and Guidelines
- SOP for decontamination of video laryngoscope
- Decontamination Policy
- Decontamination Policy on a page
- Assessing Infection Risks When Admitting, Transferring or Discharging Patients
- Meningitis Guidelines
- SOP for Investigation of HCAI incidents
- Amendments to PHE contact details were made in several policies following their relocation
- Scabies Guidelines
- Scabies Policy on a page
- Laundry Policy
- Planned Preventative Maintenance Policy
- TB guidelines
- Specimen collection guidelines
- Influenza (seasonal and pandemic) guidelines
- SOP for isolation and MDRO admission screening
- Uniform and Workwear policy
- RSV Policy
- Nursing Management of TSE (CJD/vCJD) policies
- Handling instrument and devices in procedures being carried out on patients who are suspected, known or “at increased” risk of CJD/vCJD guidelines
- Water Policy
- Water Safety Plan

- Blood culture policy

Information leaflets

- Clostridium difficile – Patient information leaflet
- CPE patient contact information leaflet
- Hand hygiene and insulin pump 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 - 2018

Updated proforma

- Lorenzo - Static Care plan – infection risk assessment

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

- Theatre 1 UCV upgrade
- Sluice upgrades A2 and A7
- Removal of pantry on ward C23
- Replacement flooring in Croft Wing, paediatric OPD and Ward A5/A6 landing
- Relocation of pre-operative clinic at Halton
- Upgrade to toilets in Warrington AED

Contribution to FMEA assessments

- Opening Ambulatory Care Centre
- Acute Care of the Elderly Assessment Clinics
- Replacement of flooring ward B14
- Relocation of the Anticoagulation clinic
- Opening escalation areas/ full capacity (Daresbury and B19
- Bed replacement scheme
- Decanting ward A8 to Daresbury Unit for HPV fogging

Group documents

- Terms of reference Decontamination Group
- Terms of reference for Infection Prevention and Control and Sepsis Link Practitioner Group
- Role profile for Infection Prevention and Control and Sepsis Link Practitioner
- Revision to Matron's report template for Infection Prevention and Control sub Committee
- Terms of reference Environment Group
- SBAR reports to DIGGs – re C difficile CCG review panels

Service tenders

- Wirral Borough Council Infection Control Service (following initial review bid was not entered)

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 greater than 85% 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

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

Trust Open day

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 2016 – Mar 2017	Attended various Grand round lectures where relevant
Apr 2016 – Mar 2017	Attended Appraiser Forums (3 / year)
7 Apr 2016	Year 4 Medical Student Teachings on various microbiology and infection topics
26 May 2016	Trust Mandatory Training

Jun 2016	Supervising a regional audit on Community Acquired Pneumonia – Microbiological Investigation and Management
9 Sep 2016	Lecture at 5 BP Hospital's Clinical Staff on Antimicrobials and Infection Management
12 Sep 2016	MSD Infection Meeting in Manchester – a variety of interactive presentations on antibiotic resistance, newer antibiotics and role of point of care tests
13 Sep 2016	Quality Governance Workshop – Warrington Hospital
16 Sep 2016	Diabetic Integrated Care Conference
20 Sep 2016	E-learning Dementia training
21 Sep 2016	FY1 teaching – on prudent antimicrobial prescribing and collecting blood cultures with aseptic technique
24 Oct 2016	Educational / Clinical Supervisors training CPD – presentation by Dr Alistair Thomson, Associate Postgraduate Dean from Health Education North West
31 Oct 2016	BSAC Educational Workshop on Multi- resistant Gram Negative Infection – Reducing Transmission and Identifying effective Treatment and Management
26 Jan 2017	1st Infection Dilemma – Meeting in Manchester – a variety of interactive presentations on infectious diseases including hepatitis, malaria, Cryptococcus CMV etc.
13 Mar 2017	Appraisers Refresher Training

Dr Thamara Nawimana – Consultant Microbiologist/Infection Control Doctor

9-12 Apr 2016	26th European Congress of Clinical Microbiology and Infectious Diseases
20 Apr 2016	Trust Mandatory training
12 May 2016	Medical leadership master class: Resilient leadership
20 Jul 2016	Teaching GP speciality training doctors Action plan for C difficile reduction and Antibiotic stewardship
6 Sep 2016	Infection prevention control meeting – sharing knowledge improving care

22 Feb 2017	Infection prevention control conference in London
27 Mar 2017	Mandatory training
Apr 16 – Mar 17	Grand Rounds Warrington Hospital Grand round lectures: world AIDS and National HIV awareness day, Community IV antibiotic therapy

Lesley McKay – Associate Director for Infection Prevention and Control

12 May 2016	Resilient Leadership lecture
15 May 2016	Leading and Managing Change lecture
16 May 2016	Vascular access lecture Whiston
6 Sep 2016	Infection Control Conference Manchester
20 Sep 2016	Quality Improvement lecture
17 Oct 2016	Norwic Meeting
18 Oct 2016	NHSE HCAI Network event
16 Nov 2016	NHSE HCAI Network event
23 Mar 2017	NHSE HCAI Network event

Karen Smith – Infection Prevention and Control Nurse

29 Jun 2016	Day with the community Infection Control Team
19 Sep 2016	Practical Teaching Skills Workshop in House Training 3 Hours
Sep 2016	Quality Improvement Champion Course (4 days)

Glynn Marriott – Infection Prevention and Control Nurse

21 Apr 2016	Antimicrobial Stewardship Conference
8 Jun 2016	Community Infection Control Team visit

Rachel Cameron – Antibiotics Pharmacist

Quarterly	North West Antimicrobial Pharmacist Group educational session

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 several incidents and the noted increase in diarrhoea and vomiting outbreaks. It is to their great credit that these issues have been managed alongside a proactive agenda to address both MRSA and Clostridium

difficile. Reductions on both of these healthcare associated infections have been observed. Concurrently they have maintained attention to a demanding audit, education and training and surveillance work plan. The policy revere action plan was successfully achieved to ensure all policies and guidelines were in date.

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 in light of the reduction in staffing.

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

Simon Constable
Executive Medical Director/Director of Infection Prevention and Control (DIPC)
June 2017

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

To note this report and 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 27 cases

Zero tolerance to avoidable MRSA bacteraemia cases

National Sepsis and AMR CQUIN

7. MONITORING/REPORTING ROUTES

Infection Control Sub-Committee

Quality Committee

Trust Board

8. TIMELINES

Financial year 2016/17

9. ASSURANCE COMMITTEE

Infection Control Sub-Committee

10. RECOMMENDATIONS

Action plans for reduction of healthcare associated infections to continue:

- Health and Social Care Act (2008) Code of practice on preventing infections and related guidance (2015)
- Meticillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia reduction
- Meticillin-sensitive *Staphylococcus aureus* (MSSA) bacteraemia reduction
- Clostridium difficile infection reduction
- Introduce an action plan for reduction of gram negative bloodstream infections

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

Appendix 1 - Infection Prevention and Control Work Plan 2017 - 2018

The Infection Control Work Plan has been devised to give assurance to the Infection Control Sub-Committee that each element of the Health and Social Care Act (2008) is discussed and the appropriate evidence of compliance is available. This will allow the Infection Control Sub-Committee to give assurance to the Trust Board that compliance with the Act is maintained and there is a programme of continued improvement.

It is essential that each subject, when discussed at the Infection Control Sub-Committee, is reviewed against the evidence required by the Care Quality Commission as defined in the Code of Practice 2015. An action plan is in place to ensure continued compliance. Any changes in compliance need to be notified to the Infection Control Sub-Committee and addressed irrespective of the Work Programme reporting.

Additional items of work will be added to the Work Programme as required. Written reports will be submitted from the Matrons, Workplace Health and the Estates and Facilities Departments at each meeting as a regular agenda item.

This work programme is underpinned by objectives which have been set for individual members of the Infection prevention and Control Team.

The action plans in place (Health and Social Care Act, MRSA, and Clostridium difficile reduction) are under quarterly review and will identify priorities for action.

The robust programme of audit will provide evidence of policy/guideline implementation. Action plans will be produced to rectify any compliance issues identified.

Reports on progress in relation to the annual work programme will be included in the DIPC annual report.

Warrington and Halton Hospitals NHS Foundation Trust

Warrington and Halton Hospitals NHS Foundation Trust Infection Control Sub-Committee Work Plan 2017 - 2018

DIVISION/DEPARTMENT	LEAD	Receipt of draft / approved minutes required	MAY	JUL	SEP	NOV	JAN	MAR
Infection Prevention and Control Team submissions (DIAGNOSTICS CBU)								
Action plans								
Health and Social Care Act	ADIPC							
Clostridium difficile Reduction	ADIPC							
Staphylococcus aureus bacteraemia prevention plan	ADIPC							
Infection Control Team Reports								
Antibiotic Prescribing Compliance Point Prevalence Audit Report	AP							
Antibiotic Ward Round annual report	AP							
HCAI surveillance data	IPCNs							
C difficile CCG review panel feedback	IPCNs							
Isolation Facilities Audit	IPCNs							
Laboratory Mandatory Enhanced Surveillance Data	CMM							
Training statistics	IPCNs/ Matrons							
Audit report	IPCNs							

Page 270 of 320

Warrington and Halton Hospitals NHS Foundation Trust

Warrington and Halton Hospitals NHS Foundation Trust Infection Control Sub-Committee Work Plan 2017 - 2018

DIVISION/DEPARTMENT	LEAD	Receipt of draft / approved minutes required	MAY	JUL	SEP	NOV	JAN	MAR
DIPC Annual Report	ADIPC							
DIPC Board report	ADIPC							
Infection Control Risk Register	IPCT							
Trust wide sharps audit (External company)	IPCNs							
IV Team report	CNS IV Therapy							
Annual Work plan and Strategy Compliance with previous year	ADIPC							
ICSC Terms of reference	IPCNs							
Annual Work plan for next financial year	ADIPC							
ICT Assurance framework	ADIPC							
Other Committee/meeting minutes/action notes								
Decontamination Group	OEM	✓						
Water Safety Group (within Estates report)	OEM	✓						
Antimicrobial Management Steering Group	CMM	✓						
External Reports								

Warrington and Halton Hospitals NHS Foundation Trust

Warrington and Halton Hospitals NHS Foundation Trust Infection Control Sub-Committee Work Plan 2017 - 2018

DIVISION/DEPARTMENT	LEAD	Receipt of draft / approved minutes required	MAY	JUL	SEP	NOV	JAN	MAR
Primary Care Infection Control Report - Bridgewater	IPCN							
3 Boroughs Public Health Commissioning Team	IPCN							
PHE								
Divisional Reports to be received and reviewed								
Acute Care								
Urgent and Emergency Care AED and CDU and UCC; Ambulatory care	Lead Nurse Matron							
Urgent and Emergency Care AMU and A2	Lead Nurse Matron							
Airway Breathing and Circulation A7, CCU, C21, Catheter Laboratory	Lead Nurse Matron							
Airway Breathing and Circulation ICU	Lead Nurse Matron							
Specialist medicine Wards A4, A8, B12, B14,	Lead Nurse Matron							
Specialist medicine Wards A3, B18, B1 (Halton), PIU (Halton)	Lead Nurse Matron							

Page 272 of 320

Warrington and Halton Hospitals NHS Foundation Trust

Warrington and Halton Hospitals NHS Foundation Trust Infection Control Sub-Committee Work Plan 2017 - 2018

DIVISION/DEPARTMENT	LEAD	Receipt of draft / approved minutes required	MAY	JUL	SEP	NOV	JAN	MAR
Diagnostics CBU Radiology, Cardiorespiratory, Pathology	Lead AHP							
Surgery and Women's and Children's Health								
Digestive Diseases Wards A5, A6, C22, SAU, Endoscopy,	Lead Nurse Matron							
Digestive Diseases Warrington Theatres	Lead Nurse Matron							
Specialist Surgery Ophthalmology, Orthodontics, Audiology, Warrington OPD	Lead Nurse							
Musculoskeletal Care Wards A9, CMTC	Lead Nurse Matron							
Musculoskeletal Care Halton Site wards B4, OPD	Matron							
Musculoskeletal Care Halton Site Theatres	Lead Nurse Matron							
Women's Health Birthing Suite, C23, Maternity	Matron							
Women's Health C20,	Matron							
Women's Health ANDU, ANC, Community Midwives	Matron							
Children's Health Paediatrics and NNU	Matron							

Page 273 of 320

Warrington and Halton Hospitals NHS Foundation Trust

Warrington and Halton Hospitals NHS Foundation Trust Infection Control Sub-Committee Work Plan 2017 - 2018

DIVISION/DEPARTMENT	LEAD	Receipt of draft / approved minutes required	MAY	JUL	SEP	NOV	JAN	MAR
MRSA Preoperative Screening Audit	Matrons							
Other Departmental Reports								
Estates (Legionella management, theatre ventilation, capital projects)	OEM							
Facilities (Environmental hygiene, Laundry and waste management, Pest control)	Facilities Manager							
Workplace Health and Wellbeing	WHWB manager							
Policies/Guidelines for Ratification								
As and when reviewed/updated	IPCT							
Total reports received								
Reports received Total per meeting								

Legend

ADIPC	Associate Director of Infection Prevention and Control
AP	Antibiotic Pharmacist
CMM	Consultant Medical Microbiologist
IPCN	Infection Prevention and Control Nurse
IPCT	Infection Prevention and Control Team
OEM	Operational Estates Manager
WHWB	Workplace Health and Wellbeing Manager

Page 274 of 320

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Warrington and Halton Hospitals NHS
NHS Foundation Trust

Appendix 2 - Infection Prevention and Control Strategy

Infection Prevention and Control Strategy

2016 -2019

HIGH QUALITY, SAFE HEALTHCARE
QUALITY PEOPLE SUSTAINABILITY

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	*Partially 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

British Standards Institute (2014) Specification for the planning, application, measurement and review of cleanliness services in hospitals
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NICE (2013) Surgical site infection Quality Standard (QS49)
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https://www.nice.org.uk/guidance/qs61?unlid=150625743201536104842

NICE (2016) Healthcare-associated infections Quality Standard (QS113)
https://www.nice.org.uk/guidance/qs113

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NHS Warrington and Halton Hospitals NHS Foundation Trust

Appendix 3 Orthopaedic Surgical Site Infection Surveillance (SSIS) April 2016 - March 2017

In June 2003 the Chief Medical Officer announced that surveillance of SSI in Orthopaedic surgery would become mandatory from April 2004 requiring each hospital performing Total Hip and Total Knee Replacement surgery to submit at least 3 months SSI data per year. From 2010 the Orthopaedic Department at Warrington and Halton NHS Foundation Trust have been undertaking continual surveillance as requested by the Control of Infection and Prevention Team and to ensure that we meet the NICE Quality Standard for Orthopaedic Surgical Site Surveillance.

Over the last few years there has been a continued reduction on the length of stay in hospital following elective surgery, as a result many SSI's do not become apparent until after the patient has been discharged and as such, the rate of SSI based on inpatient data alone underestimated the true rate of infection.

Patients who develop superficial infections of the surgical site post-discharge are less likely to be detected by readmission surveillance. Therefore the detection of SSI's by trained staff in an outpatient or review clinic appears to be the best method of detection, at WHH we utilise the Surgical Assistants who complete the forms and review many of the patients at follow up Arthroplasty appointments.

Data submission and reconciliation needs to be within 90 days of closure of the previous quarter and therefore it has become a continual collection and submission process.

There are 3 types of Surgical Site Infection Classification identified, these being:-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.

Infections acquired in hospital, including surgical site infection, can cause anxiety and discomfort, complicate illness and delay recovery. It has been estimated that the annual cost nationally is almost £1 billion. It has been estimated that each patient with a surgical site infection requires an additional hospital stay of 6.5 days and hospital costs are doubled (Plowman *et al* 2001).

The data submitted for both Hip and Knee replacement surgery is displayed in the tables below.

No. of surgical site infections (SSI) for Knee Replacement surgery April 2016 to March 2017

Type of Surgery	No. of forms submitted	No. of SSI's detected during initial surveillance	Type of SSI Organisms identified
Primary Total Knee	342	0	None
Bilateral total knee	19		
Revision Knee Surgery	17		
Unicondylar	19		
Total	**410**	**0**	

No. of surgical site infections (SSI's) for Hip Replacement surgery April 2016 to March 2017

Type of surgery	No. of forms submitted 2016	No. of SSI's detected during initial surveillance	Type of SSI Organisms identified
Cemented hip replacement	112	Surgical Site Infections for period = 9	**Apr – June x 3** **Case 1** Hip replacement, superficial opened by surgeon S. aureus
Uncemented hip replacement	26		**Case 2**Hip abscess aspirated. Localise pain/redness. Proteus vulgaris and Enterococcus
Hybrid	42		
Reverse Hybrid	90		**Case 3** Hip Superficial antibiotics prescribed by GP
Revision Hip	23		**July – Sept X 2**
Resurfacing	6		**Case 4** Hip Superficial Antibiotics prescribed by GP
Bilateral hip	3		**Case 5** Hip Superficial Localised pain and swelling
			Oct – Dec x 3 **Case 6** Superficial antibiotics prescribed by GP
			Case 7 superficial Heat & redness

Type of surgery	No. of forms submitted 2016	No. of SSI's detected during initial surveillance	Type of SSI Organisms identified
			Case 8 Hip replacement Deep incisional – clinical diagnosis S. aureus **Jan – Mar 17 x 1** **Case 9** Cemented total hip replacement - deep joint infection requiring incision and debridement. Intra operative swabs grew S. epidermidis treated with Teicoplanin and Rifampicin
Total	**302**		

Conclusion

The surveillance information collected during April 16- March 17 has indicated that the Orthopaedic joint replacement infections have remained minimal at 9, but a slight increase from 2015-2016 of which there were 7. It is important however to bear in mind that a total joint may become infected during the time of surgery, or anywhere from weeks to years after the surgery, meaning the patient may require further treatment, surgery or even revision surgery to remove and replace the infection prosthesis; this highlights the importance of joint replacement monitoring at specified times as per the BOA guidelines.

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NHS Warrington and Halton Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/17/07/90**
SUBJECT:	**Report of the Senior Information Risk Owner**
DATE OF MEETING:	26 July 2017
ACTION REQUIRED	**The Board is asked to note the contents of the 2016/17 SIRO (Senior Information Risk Owner) report**
AUTHOR(S):	Jason DaCosta, Director of IM&T
EXECUTIVE DIRECTOR SPONSOR:	Jason DaCosta, Director of IM&T Choose an item.
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
	BAF1.1: CQC Compliance for Quality
	BAF1.1: CQC Compliance for Quality
STRATEGIC CONTEXT	This report is designed to brief the Trust's SIRO (Senior Information Risk Owner) on performance against the current version of the NHS Digital Information Governance Toolkit, information risks faced by the organisation, the work of the Information Governance and Corporate Records Sub-Committee and actions taken to mitigate Information Governance risks. The Trust's Senior Information Risk Owner is the Director of IT. The SIRO must be an Executive Director or member of the senior management board of an organisation and has overall responsibility for information risk assurance.
EXECUTIVE SUMMARY (KEY ISSUES):	WHH faces significant Information Governance challenges in 2017/18 as a result of the enforcement of the GDPR (EU General Data Protection Regulation) from May 2018 and continuing challenges in the area of cyber-security. Key issues for 2017/18 include: • WHH must maintain a focus of the requisite work in readiness for the implementation of the new General Data Protection Regulations (GDPR) in May 2018. • Maintenance of effective cyber security controls remains a priority and achievement of certification to the Cyber Essentials standard is a tangible demonstration of a good baseline of cyber security. • The IT Department Information Security Management System may require rework in light of new cyber security controls introduced and potential changes which need to be made as a result of the cyber essentials certification project

	which the Trust will be assessed against as part of ongoing work in conjunction with NHS England. • Version 15 of the NHS Digital Information Governance Toolkit will be released in April 2018 and will contain the changes required to provide assurance on the Trust's arrangements in respect of the 10 data standards contained in the National Data Guardian Report *Review of Data Security, Consent and Opt-Outs* published in July 2016.	
RECOMMENDATION:	The Board is asked to note the contents of the SIRO report which details Information Governance Toolkit submissions and outlines the work undertaken and performance in relation to: • 2016/17 Mersey Internal IG Assurance Audit • Freedom of Information Act 2000 Performance during the 2016/17 calendar year • Subject Access Request performance during the 2016/17 financial year • Externally reported data loss incidents during the 2016/17 financial year • Work undertaken to update the Trust's Information Security Management System • Ongoing work which towards the objective of ending the use of unsupported software such as Windows XP in order to improve resilience to cyber attacks • Building awareness around, and initiating gap analysis work, in preparation for the introduction of the General Data Protection Regulations in May 2018 • Current controls to mitigate IT/Information risks identified in the Board Assurance Framework	
PREVIOUSLY CONSIDERED BY:	**Committee**	Finance and Sustainability Committee
	Agenda Ref.	
	Date of meeting	19/07/2017
	Summary of Outcome	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

SUBJECT	SIRO Report	AGENDA REF:	BM/17/07/90

1. BACKGROUND/CONTEXT

It is a requirement of the NHS Digital Information Governance Toolkit that the Trust's Senior Information Risk Owner is made aware of the information risk to enable him/her to act as an advocate for information Risk on the Trust board.

2. KEY ELEMENTS

The report details performance in key areas of the Information Governance agenda during 2016/17. Performance against this agenda is annually audited by Mersey Internal Audit Agency and is reported three times annually to NHS Digital.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

The SIRO should ensure that focus on maintaining and improving strong cyber security controls is a priority during 2017/18. The implementation of controls, policies and procedures to ensure compliance with the General Data Protection Regulation which becomes enforceable in May 2018 is also and Information Governance priority.

4. IMPACT ON QPS?

Quality: the effectiveness of cyber security and information risk controls is fundamental to the quality and integrity of the person identifiable and clinical data that WHH holds and processes in relation to its service users.

People: The people (WHH staff) that handle person identifiable and sensitive data should be effectively trained and briefed on key Information Governance issues in order to minimise information risks when handling data.

Sustainability: The delivery of sustainable clinical services is dependent upon maintenance of the confidentiality, integrity and availability of quality data and ensuring that clinical systems have robust levels of resilience to cyber- attacks and downtime in order to provide continuity of service.

5. MEASUREMENTS/EVALUATIONS

Monitoring of compliance with NHS Digital Information Governance policy takes place as part of audits conducted on an annual basis as part of the Trust's internal audit programme.

The Trust was audited on the validity of its proposed scoring of 15 of the standards contained within version 14 of the NHS Digital IG Toolkit in March 2017. This constitutes one-third of the current acute services IG Toolkit which contains 45 standards

6. TRAJECTORIES/OBJECTIVES AGREED

August 2017-liaise with and conduct work in conjunction with NHS Digital to assess cyber security preparedness against the *cyber essentials plus* standard

August 2017-liaise with Mersey Internal Audit Agency to complete General Data Protection Regulation gap analysis

October 2017-IG Toolkit Self-Assessment Submission to NHS Digital

7. MONITORING/REPORTING ROUTES

The Information Governance and Corporate Records Sub-Committee meets on a bi-monthly basis and reports routinely to the Finance and Sustainability Committee and Quality Committee.

Monitoring of compliance with NHS Digital Information Governance policy takes place as part of audits conducted by Mersey Internal Audit Agency as part of the Trust's internal audit programme

The WHH IT Team are currently engaging with NHS England to assess cyber security defences which are deployed. A report will be authored by NHS England and will be made available to the SIRO on completion.

8. TIMELINES

May 2018-Completion of WHH policy and process changes relevant to the General Data Protection Regulation for May 2018 enforceability.

April 2018-Completion of the requisite work in time for release of version 15 of the Information Governance Toolkit containing standards to gain assurance on the 10 data standards contained within the National Data Guardian Report.

9. ASSURANCE COMMITTEE

Finance and Sustainability Committee

10. RECOMMENDATIONS

The Board is asked to note the contents of the report and the work carried out to minimise information risk and to respond to the requirements of the burgeoning Information Governance agenda during 2016/17.

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

Date of Information Governance and Corporate Records Group meeting	10/07/2017
Report from	Information Governance and Corporate Records Manager
Prepared by	Mark Ashton
Title	SIRO (Senior Information Risk Owner) Report 2017
Purpose	Report on the progress of key areas of the Information Governance agenda at WHH and risks faced by WHH in this area.
Findings	WHH faces significant Information Governance challenges in 2017/18 as a result of the enforcement of the GDPR (EU General Data Protection Regulation) from May 2018 and continuing challenges in the area of cyber-security. The ever changing digital landscape, increased information sharing and NHS aspirations to operate in a paperless environment will also create unprecedented Information Governance and Information Security challenges.

1. **INTRODUCTION**
2. **INFORMATION GOVERNANCE MANAGEMENT**
3. **KEY POINTS FOR 2017/18**
4. **2017 MIAA IG ASSURANCE REVIEW**
5. **IG ASSURANCE AUDIT CONCLUSION**
6. **2016/17 FREEDOM OF INFORMATION PERFORMANCE**
7. **SUBJECT ACCESS PERFORMANCE (ACCESS TO HEALTH RECORDS VIA DATA PROTECTION ACT 1998 AND ACCESS TO HEALTH RECORDS ACT 1990)**
8. **EXTERNALLY REPORTABLE DATA LOSS INCIDENTS 2016/17**
9. **ISMS AND MAY 2017 CYBER ATTACK**
10. **GDPR-OVERVIEW OF POTENTIAL KEY CHANGES IN THE NHS**
11. **PROPOSED NHS DIGITAL IG TOOLKIT SUBMISSION JULY 2017**
12. **CURRENT BOARD ASSURANCE FRAMEWORK AND CIRIS SYSTEM IG RISKS**
13. **CONCLUSION**
14. **APPENDICES**

1. INTRODUCTION

This assurance report is provided for the Senior Information Risk Owner who has executive responsibility for information risk and information assets. In order to demonstrate compliance with IG Toolkit standards and to ensure the Board is adequately briefed on information risks it is necessary to provide a report detailing identified information risks and progress against the IG Toolkit standards more generally. The Senior Information Risk Owner is required to act as an advocate for information risk on the Trust Board and is responsible for providing appropriate IG content for inclusion in the Quality Account Statement and the Annual Report.

2. INFORMATION GOVERNANCE MANAGEMENT

The Information Governance and Corporate Records Sub-Committee (IGCRSC), which is chaired by the Director of IT (SIRO), and is attended by the Caldicott Guardian, makes recommendations, produces policy and procedural documentation and agrees the annual IG work programme. The IG and Corporate Records Sub-Committee reports to both the Finance and Sustainability and Quality Committees respectively.

The Trust's most recent IG annual work plan was approved by the Information Governance and Corporate Records Sub-Committee in January 2017. The IG annual work plan, which details work carried out and a timetable for reporting to the IG and Corporate Records Sub-Committee is available in Appendix 1.

3. KEY POINTS FOR 2017/18

- WHH must maintain a strong focus on completion of the requisite work in readiness for the implementation of the new General Data Protection Regulations (GDPR) in May 2018.
- Maintenance and improvement of effective cyber security controls should be a corporate priority and certification to the Cyber Essentials standard is a tangible demonstration of a good baseline of cyber security.
- None of the data loss incidents reported to NHS Digital in the 2016/17 financial year were of a severity which necessitated escalation to the Information Commissioner's Office.
- As of May 2017 82.02% of WHH staff had completed mandatory in-year Information Governance training.
- Version 15 of the NHS Digital Information Governance Toolkit is yet to be released and the refreshed Information Governance training materials are also still unavailable as of June 2017.
- The entire Information Governance policy suite will require re-drafting in 2017 in order to reflect changes required as part of the introduction of GDPR
- The IT Department Information Security Management System will require significant work in light of new cyber security controls introduced and potential changes which need to be made as a result of the cyber essentials certification project.

4. 2017 MIAA IG ASSURANCE REVIEW

The Trust is audited annually by the Mersey Internal Audit Agency on its management of the Information Governance agenda. In 2017 Mersey Internal Audit Agency awarded the Trust a significant assurance rating against the proposed attainment levels scheduled for submission against version 14 of the NHS Digital Information Governance Toolkit in March 2017. During the IG assurance review the Trust was audited on the validity of the returns it intended to make for 15 of the NHS Digital IG Toolkit requirements. The audit sample used in this year's audit constitutes an audit of 33% of the total IG Toolkit requirements for Acute Trusts.

Three of the fifteen proposed scores for the requirements audited could not be adequately evidenced and as a result MIAA were provided with a management response describing actions undertaken to improve available evidence. Progress against these actions is routinely reported at the Information Governance and Corporate Records Sub-Committee.

A recent communique from NHS Digital informed all Trusts that there will be a delay to the start of 2017/18 IG Toolkit assessments. It is anticipated that version 15 of the IG Toolkit will be released during June 2017. The new version may contain significant changes particularly in light of the recent cyber-attack which affected many NHS organisations and the impending changes to UK Data Protection law due to the directly effective nature of the General Data Protection Regulations (GDPR).

The results of the 2017 IG assurance audit are summarised in the table below.

Self-Assessment Score	Our Opinion		
	Agreed	Unsubstantiated	Overstated
Not Relevant	-	-	-
0	-	-	-
1	-	-	-
2	11	3	-
3	1	-	-

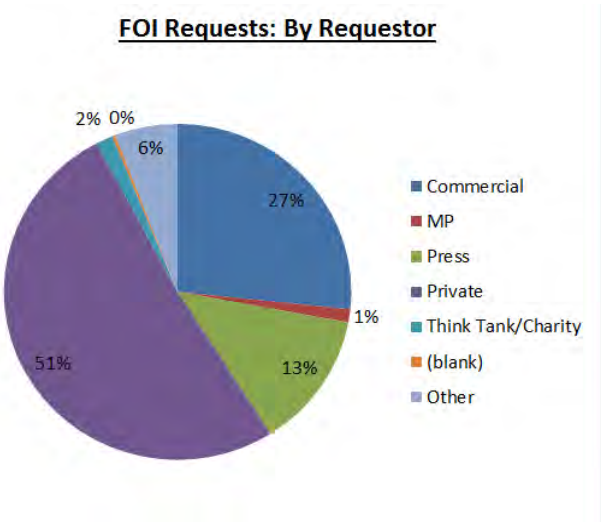
5. IG ASSURANCE AUDIT CONCLUSION

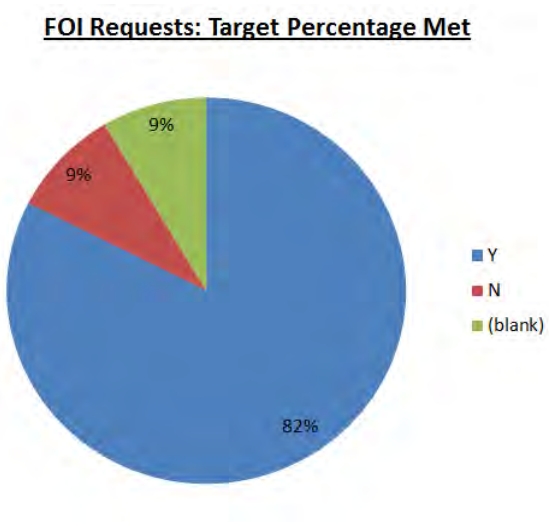
There are some weaknesses in the design and/or operation of controls which could impair the achievement of the objectives of the system, function or process. However, either their impact would be minimal or they would be unlikely to occur.

Significant Assurance

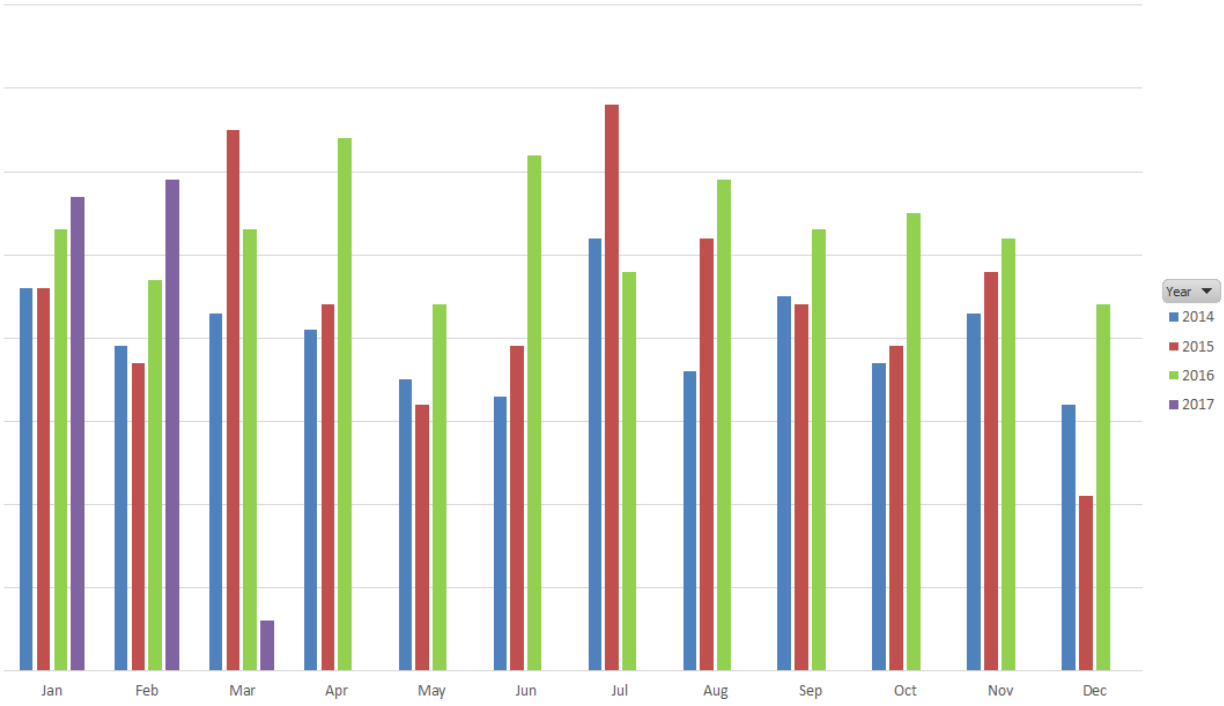
6. 2016/17 FREEDOM OF INFORMATION PERFORMANCE

The Trust received 635 Freedom of Information requests in 2016 which represents an 18% increase in requests received under the FoIA when compared with 2015. This is the highest total of requests received by the Trust since the introduction of the legislation in 2005. During the 2016 calendar year 82% of FOI requests were responded to within the 20 working day statutory timescale.





FOI REQUESTS YEARLY COMPARISON



The Trust must continue to maintain strong performance in order to demonstrate compliance with the FoIA 2000, particularly in light of an increased ICO trigger threshold whereby public authorities may now be considered for monitoring if fewer than 90% of FOI responses fall within the 20 day statutory timescale. The level of requests received continues to rise which means that compliance will present significant challenges if the trend of year-on-year increases in the volume of requests received continues.

In June 2017 an increase in the volume of FOI requests breaching the 20 day statutory response timescale was identified. This is primarily due to slow response times from staff within WHH, an under-resourced Information Team that have prioritised other reporting work above the FOIA agenda and late responses from requesters when clarification on the questions posed was sought.

7. 2016 SUBJECT ACCESS PERFORMANCE

Subject Access Requests (requests for access to person identifiable data made under the Data Protection Act 1998 and Access to Health Records Act 1990) are handled by the Trust's Medico-Legal Team based in the Medical Records department.

During the period 01/04/2016 to 31/03/2017 1,790 Subject Access Requests were received. 1,731 of the subject access requests received were completed within the statutory timescales.

The Trust's Outpatients and Health Records staff and Business Change teams within the IT Department are currently working with DXC in reviewing the end-to-end Subject Access Request functionality within the Lorenzo system. The Trust's Medico-legal team are using legacy systems to meet the legal requirements of the Data Protection Act 1998 in relation to the subject access process and generation of the requisite correspondence. Use of this system to generate correspondence is a risk because the system does not interface with the PDS or other systems which means that personal demographic details within this standalone system (Meditech) are not updated.

The Medico-legal service will face further risks in 2017 due to the inability of the service to levy a standard fee for access to health records due to the implementation of the new General Data Protection Regulations in May 2018.

8. EXTERNALLY REPORTABLE DATA LOSS INCIDENTS

Incidents reported externally to NHS Digital during the 2016/17 financial year are contained in the below table. None of the incidents were graded at the level 2 SIRI level which triggers reporting to the Information Commissioner's Office. Three of the incidents reported externally are still under investigation.

Date of Incident	ID	IG SIRI Level	Status	Summary of Incident
06-Jun-17	IGI/12022	1	Open	label attached to medication order sent external to Trust
07-Apr-17	IGI/11632	0	Open	subject access letter posted to deceased former patient
17-Feb-17	IGI/11637	1	Open	Access to Radiology systems by Doctor for non-business purposes
26-Jan-17	IGI/8113	1	Closed	A number of Radiology/theatre staff who wear a badge have had some personal information leaked. This includes their date of birth and national insurance numbers.
16-Dec-16	IGI/7895	1	Closed	unencrypted transmission of PID via email
23-Sep-16	IGI/6396	0	Closed	letters sent to GP surgery sent in an envelope with wrong GP practice name on the envelope. The GP practice is housed in a building that contains multiple GP practices.
18-Jul-16	IGI/5975	0	Closed	incorrect, secure destruction of records
07-Jul-16	IGI/5943	1	Closed	Trust governor disseminated person identifiable data via insecure email without the consent of the data subjects concerned
20-May-16	IGI/5685	0	Closed	mortality review and associated documentation sent to an incorrect nhsmail address in error

9. ISMS AND CYBER ATTACK

It was reported at the Information Governance and Corporate Records Sub-Committee in May 2017 that all documentation that forms part of the ISMS has been reviewed. At the time of reporting all but three of the documents were deemed current.

The Information Security Management System will be updated to reflect the improvement in controls necessitated by the cyber-attack which took place on 12th May 2017 and the results of the cyber essentials certification project. The remote security scan of the WHH network which is required as part 3 of the work in scope of the cyber essentials certification will be conducted when the Lorenzo testing programme is complete in late July 2017.

The requisite work to cease the use of Windows XP at WHH and therefore reduce exposure in the event of further cyber-attacks is ongoing but a number of developments have occurred.

- Reliance on Windows XP in the Pathology department reduced to one PC which runs the Mastascan. A replacement machine has been ordered.
- Windows XP use in the Pharmacy department continues for the Aseptic (Radio Pharmacy) system. RLUH operate this service and as a result of the move to their new facility their IT service have informed users that PCs that are running Windows XP will not be permitted on site. On this basis a new system must be procured which means that the Windows XP machine in the Pharmacy department can be replaced.

- Two Medcon reporting stations in the Cardiac Catheter lab are running Windows XP. A business case to upgrade the Medcon system has been drafted. As the system is upgraded the use of XP in this area will cease.
- Medical devices group to set future direction to address the issue of devices that are running Windows XP and are connected to the WHH network but are not controlled by WHH. In order to mitigate risk in this area the relevant departments are notified as patches are released by Microsoft. It is anticipated that the Medical Devices group may advocate taking a tougher stance in relation to the responsibility of suppliers to upgrade machines to later versions of Microsoft operating systems that security updates are available for if they are connected to the WHH network.

The controls and gaps in assurance in relation to WHH vulnerability to further cyber-attacks are expanded upon in section 12.

10. GDPR-OVERVIEW OF POTENTIAL KEY CHANGES IN THE NHS

The new General Data Protection Regulation (GDPR) is a regulation by which the European Parliament, the European Council and the European Commission will strengthen data protection provisions for individuals within the European Union. The GDPR will be in force from May 25th 2018 and will require organisations to comply with a strict data protection regime.

Brief Description	Potential Impact
Expansion of the definitions of: • Personal data • Health data • Genetic data • Biometric data	Key staff should familiarise themselves with the new definitions and the impact on WHH
Now an obligation for data controllers to demonstrate compliance with the Regulation	Demonstrating compliance with regulations will require (as a minimum) • Potential sign-up to regulatory code of conduct • More robust system audit trails • Routinely conducted Privacy Impact Assessments
Lawful Processing-reliance on 'legitimate interests' to process data no longer possible	Establish legal basis for processing of data. If consent is the legal basis we must be able to demonstrate that: • Consent has been freely given And that: • Processing data for secondary purposes has a legal basis
Greater emphasis on recording of consent to process special (sensitive) categories of data such as health data	• WHH must be able to demonstrate that explicit consent has been given
Greater data subjects rights (access to personal health data)	• Robust processes for correcting inaccuracies must be in place

	• Data portability requirements to allow service users to move data to other healthcare providers • Modified fair processing information • Impact on Medico-Legal service's ability to provide service due to removal of standard £10.00 access fee
Other general obligations and 'data protection by design'	• Performance of data protection impact assessments will be required • Data Protection Officer (IG lead) and new incident reporting mechanisms

11. PROPOSED NHS DIGITAL IG TOOLKIT SUBMISSION JULY 2017

The Trust undertook a self-assessment against version 14 of the NHS Digital Information Governance Toolkit in March 2017 and submitted a score of 68% rated 'satisfactory'.

The proposed scores for submission in July 2017 are detailed below. Two requirements within the Information Governance Management initiative will be raised to level 3 standard based on assessment of the available supporting evidence.

The requirements which will show an increased score and the rationale for raising them are contained in the table below.

Toolkit requirement number	Description	Actions required for maintenance/improvement
14-101	There is an adequate Information Governance Management Framework to support the current and evolving Information Governance agenda	• IG Framework for 2016/17 approved in November 2016. Framework should be reviewed and amended during 2017 to reflect changes made (use heading in IGT guidance • Review terms of reference of key bodies during 2017 • Increase to level 3 in July 2017 based on routine reporting to FSC and Quality Committee
14-105	There are approved and comprehensive Information Governance Policies with associated strategies and/or improvement plans	• IG Policies due for review in January 2018. Review as per IG Annual Work plan and present updated policies at November 2017 IGCRSC • Continue to include

		improvement plans in 2017 as per IG Annual Work Plan • Increase to level 3 on the basis of reporting to FSC and Quality Committee and improvement plans for each initiative as included on IGCRSC Annual Work Plan

Version 14.0 NHS Digital IG Toolkit

14-101	There is an adequate Information Governance Management Framework to support the current and evolving Information Governance agenda	**Level 3**
14-105	There are approved and comprehensive Information Governance Policies with associated strategies and/or improvement plans	**Level 3**
14-110	Formal contractual arrangements that include compliance with information governance requirements, are in place with all contractors and support organisations	**Level 2**
14-111	Employment contracts which include compliance with information governance standards are in place for all individuals carrying out work on behalf of the organisation	**Level 2**
14-112	Information Governance awareness and mandatory training procedures are in place and all staff are appropriately trained	**Level 2**
14-200	The Information Governance agenda is supported by adequate confidentiality and data protection skills, knowledge and experience which meet the organisation's assessed needs	**Level 2**
14-201	The organisation ensures that arrangements are in place to support and promote information sharing for coordinated and integrated care, and staff are provided with clear guidance on sharing information for care in an effective, secure and safe manner	**Level 2**
14-202	Confidential personal information is only shared and used in a lawful manner and objections to the disclosure or use of this information are appropriately respected	**Level 2**
14-203	Patients, service users and the public understand how personal information is used and shared for both direct and non-direct care, and are fully informed of their rights in relation to such use	**Level 2**
14-205	There are appropriate procedures for recognising and responding to individuals' requests for access to their personal data	**Level 2**
14-206	Staff access to confidential personal information is monitored and audited. Where care records are held electronically, audit trail details about access to a record can be made available to the individual concerned on request	**Level 2**
14-207	Where required, protocols governing the routine sharing of personal information have been agreed with other organisations	**Level 2**
14-209	All person identifiable data processed outside of the UK complies with the Data Protection Act 1998 and Department of Health guidelines	**Level 2**
14-210	All new processes, services, information systems, and other relevant information assets are developed and implemented in a secure and structured manner, and comply with IG security accreditation, information quality and confidentiality and data protection requirements	**Level 2**

14-300	The Information Governance agenda is supported by adequate information security skills, knowledge and experience which meet the organisation's assessed needs	**Level 2**
14-301	A formal information security risk assessment and management programme for key Information Assets has been documented, implemented and reviewed	**Level 2**
14-302	There are documented information security incident / event reporting and management procedures that are accessible to all staff	**Level 2**
14-303	There are established business processes and procedures that satisfy the organisation's obligations as a Registration Authority	**Level 2**
14-304	Monitoring and enforcement processes are in place to ensure NHS national application Smartcard users comply with the terms and conditions of use	**Level 2**
14-305	Operating and application information systems (under the organisation's control) support appropriate access control functionality and documented and managed access rights are in place for all users of these systems	**Level 2**
14-307	An effectively supported Senior Information Risk Owner takes ownership of the organisation's information risk policy and information risk management strategy	**Level 2**
14-308	All transfers of hardcopy and digital person identifiable and sensitive information have been identified, mapped and risk assessed; technical and organisational measures adequately secure these transfers	**Level 2**
14-309	Business continuity plans are up to date and tested for all critical information assets (data processing facilities, communications services and data) and service - specific measures are in place	**Level 2**
14-310	Procedures are in place to prevent information processing being interrupted or disrupted through equipment failure, environmental hazard or human error	**Level 2**
14-311	Information Assets with computer components are capable of the rapid detection, isolation and removal of malicious code and unauthorised mobile code	**Level 2**
14-313	Policy and procedures are in place to ensure that Information Communication Technology (ICT) networks operate securely	**Level 2**
14-314	Policy and procedures ensure that mobile computing and teleworking are secure	**Level 2**
14-323	All information assets that hold, or are, personal data are protected by appropriate organisational and technical measures	**Level 2**
14-324	The confidentiality of service user information is protected through use of pseudonymisation and anonymisation techniques where appropriate	**Level 2**
14-400	The Information Governance agenda is supported by adequate information quality and records management skills, knowledge and experience	**Level 3**
14-401	There is consistent and comprehensive use of the NHS Number in line with National Patient Safety Agency requirements	**Level 2**
14-402	Procedures are in place to ensure the accuracy of service user information on all systems and /or records that support the provision of care	**Level 2**
14-404	A multi-professional audit of clinical records across all specialties has been undertaken	**Level 2**
14-406	Procedures are in place for monitoring the availability of paper health/care records and tracing missing records	**Level 2**
14-501	National data definitions, standards, values and data quality checks are incorporated within key systems and local documentation is updated as standards develop	**Level 2**
14-502	External data quality reports are used for monitoring and improving data quality	**Level 2**
14-504	Documented procedures are in place for using both local and national benchmarking to identify data quality issues and analyse trends in information over time, ensuring that	**Level 2**

	large changes are investigated and explained	
14-505	An audit of clinical coding, based on national standards, has been undertaken by a Clinical Classifications Service (CCS) approved clinical coding auditor within the last 12 months	**Level 2**
14-506	A documented procedure and a regular audit cycle for accuracy checks on service user data is in place	**Level 2**
14-507	The secondary uses data quality assurance checks have been completed	**Level 2**
14-508	Clinical/care staff are involved in quality checking information derived from the recording of clinical/care activity	**Level 2**
14-510	Training programmes for clinical coding staff entering coded clinical data are comprehensive and conform to national clinical coding standards	**Level 3**
14-601	Documented and implemented procedures are in place for the effective management of corporate records	**Level 2**
14-603	Documented and publicly available procedures are in place to ensure compliance with the Freedom of Information Act 2000	**Level 3**
14-604	As part of the information lifecycle management strategy, an audit of corporate records has been undertaken	**Level 2**

12. CURRENT BOARD ASSURANCE FRAMEWORK AND CIRIS SYSTEM IG RISKS

Strategic Objective (Select from below)	**Risk: Risk of data loss and inability to deliver essential services due to a cyber-attack which results in loss of vital IT systems and reputational damage**
1. 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. **2. To have a committed, skilled and highly engaged workforce who feel valued, supported and developed and who work together to care for our patients.** **3. To deliver well managed, value for money, sustainable services** **4. To work with our partners to consolidate and develop sustainable, high quality care as part of a thriving health economy for the future.**	**Exec Lead: Jason DaCosta** **Operational Lead: Stephen Deacon** **Assurance Committee: ePR Programme Board/Event Planning Group** **Date to be reviewed: 09/07/2017**
Initial Risk Rating (1-25)	**12**

Impact (1-5)	**4**
Likelihood (1-5)	**3**

Controls: *(What are we doing about the risk?)*	**Gaps in Assurance** *(What additional assurances should we seek?)*
• Anti-virus/anti-spam measures deployed on servers and desktops. The McAfee product used is due for review/renewal in September 2017. Capital funds allocated for this purpose. • Firewall deployed to protect the network by filtering the traffic that is permitted in and out of the WHH network. The Stonegate Firewall product is due for renewal in March 2018. Capital funds being sought as part of improvements to the overall security suite. • Blocking file extensions recommended by NHS Digital on WHH Fileshare areas. CareCert bulletins containing information security measures which need to be implemented are produced by NHS Digital and measures taken to implement their requirements are documented at IT Seniors meeting on a weekly basis. • Information Security Management System (ISMS) in use to protect WHH IT assets. The ISMS is based on the principles contained within the ISO27001 standard in use to control physical and network access and the controls required to protect said assets. • Daily backups and 4 hour replication to the Halton site which replicates data on the Halton site storage area network (SAN). Data loss in the event of a Cyber-attack would be minimised due to the replication of data. • Achievement of Cyber essentials certification and completion of the requisite network penetration testing. Certification to the Cyber Essentials standard has been recommended for all Trusts and compliance with its requirements can enhance protection against circa 80% of Cyber-attacks. • Removal of obsolete operating systems (eg Windows XP) and automatic patching of critical updates offered by Microsoft. Removal of XP operating system across WHH continues and three tier patching regime is proposed	• **Implement security 'bubble' around the medical VLAN. The 'bubble' will protect medical devices (eg MRI and CT scanners which run the Windows XP operating system) with a firewall. Replacement of Windows XP will necessitate replacement of some medical equipment.** • **Act on recommendations made in the Cyber essentials report to ensure improved cyber security.** • **Ensure upgrade of security systems such as web filtering, anti-virus and firewalls.** • **Routine, quarterly reporting of attacks to the Information Governance and Corporate Records Sub-Committee**

Assurances *(How do we know if the things we are doing are having an impact and can we validate or evidence e.g. Inspections; Committees; Working Groups; Reports; Monitoring Returns etc)*	**Mitigating Actions** *(What more should we do?)*
• Cyber Essentials network penetration testing to be completed as soon as possible. This will provide evidence that robust protection is in place. • Evidence that the WHH network wasn't infected during the recent Cryptolocker cyber-attack can be provided • MIAA have been provided with evidence that patching of operating systems is carried out. Significant assurance awarded. • MIAA Information Governance assurance audit 2017-significant assurance awarded.	• **Ensure capital monies are available in 2018/19 for upgrade of vital security software and hardware** • **Ensure that Information Governance messages around safe use of IT assets are reiterated via corporate induction and training** • **Report serious cyber-attacks and a trend demonstrating increases in attacks on the Datix system**

Residual Risk Rating (1-25)	**8**
Impact (1-5)	**4**
Likelihood (1-5)	**2**
Target Risk Rating (1-25)	**8**
Impact (1-5)	**4**
Likelihood (1-5)	**2**

Strategic Objective (Select from below)	**Risk: Risk of inability to deliver a comprehensive IT service due to single points of failure**	
5. **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.** 6. **To have a committed, skilled and highly engaged workforce who feel valued, supported and developed and who work together to care for our patients.** 7. **To deliver well managed, value for money, sustainable services** 8. **To work with our partners to consolidate and develop sustainable, high quality care as part of a thriving health economy for the future.**		**Exec Lead: Jason DaCosta** **Operational Lead: Jason DaCosta** **Assurance Committee: ePR Programme Board** **Date to be reviewed: 09/07/2017**

Initial Risk Rating (1-25)	**12**
Impact (1-5)	**3**
Likelihood (1-5)	**4**

Controls: *(What are we doing about the risk?)* • IT Succession plan in place to replace leavers in key posts • Risk of IT systems failure is mitigated by documented disaster recovery plan which involves robust backups, dual site replication and virtual infrastructure • Phase 1 of the introduction of universal power support (UPS) for key clinical areas has been completed	**Gaps in Assurance** *(What additional assurances should we seek?)* • **Disaster recovery plan, and it's relevance to key IT systems, to be reviewed** • **Non-critical areas to be targeted in Phase 2 of UPS introduction programme**
Assurances *(How do we know if the things we are doing are having an impact and can we validate or evidence e.g. Inspections; Committees; Working Groups; Reports; Monitoring Returns etc)* • Engaged with BT (work to be carried out in September 17) to test the efficiency of the failover process whereby connection to the secondary N3 connection is tested in the event that the primary connection fails • Backups tested in live environment in early 2017 on a virtual server	**Mitigating Actions** *(What more should we do?)* • **Quarterly test of backups are now scheduled and results will be documented and reported on**

Residual Risk Rating (1-25)	**6**
Impact (1-5)	**3**
Likelihood (1-5)	**2**
Target Risk Rating (1-25)	**3**
Impact (1-5)	**3**
Likelihood (1-5)	**1**

Strategic Objective (Select from below)	**Risk: Risk of unavailability of key IT systems, both clinical and non-clinical, due to lack of regular testing of disaster recovery and business continuity plans**
9. **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.** 10. **To have a committed, skilled and highly engaged workforce who feel valued, supported and developed and who work together to care for our patients.** 11. **To deliver well managed, value for money, sustainable services** 12. **To work with our partners to consolidate and develop sustainable, high quality care as part of a thriving health economy for the future.**	**Exec Lead: Jason DaCosta** **Operational Lead: Jason DaCosta/Stephen Deacon** **Assurance Committee: ePR Programme Board**

		Date to be reviewed: 09/07/2017
Initial Risk Rating (1-25)	**12**	
Impact (1-5)	**3**	
Likelihood (1-5)	**4**	
Controls: *(What are we doing about the risk?)* • Business continuity plans for key systems documented • IT infrastructure disaster recovery plan is documented • Event planning group regularly review business continuity plans with operational teams	**Gaps in Assurance** *(What additional assurances should we seek?)* • **Update on disaster recovery/business continuity arrangements to be authored by IT Manager and reported on at Information Governance and Corporate Records Sub-Committee** • **New template for Information Asset Owner reporting on the arrangements for their systems to be reviewed by IG Manager** • **Systems are routinely taken down to test the continuity plans.**	
Assurances *(How do we know if the things we are doing are having an impact and can we validate or evidence e.g. Inspections; Committees; Working Groups; Reports; Monitoring Returns etc)* • Business Continuity arrangements utilised during Lorenzo patching post cyber-attack in May 2017 • Use of disaster recovery has been successful when utilised in the past • Information Governance Assurance Audits carried out by MIAA in 2017 have validated scoring in relation to business continuity arrangements	**Mitigating Actions** *(What more should we do?)* • **Disaster recovery plan, and it's relevance to key IT systems, to be reviewed** • **Quarterly test of backups are now scheduled and results will be documented and reported on** • **Improve the disaster recovery for the ICE system (currently hosed on a physical server with limited resilience)**	
Residual Risk Rating (1-25)	**6**	
Impact (1-5)	**3**	
Likelihood (1-5)	**2**	
Target Risk Rating (1-25)	**6**	
Impact (1-5)	**3**	
Likelihood (1-5)	**2**	
Strategic Objective (Select from below)	**Risk: Risk that the business requirements of WHH will not be met as a result of not correctly implementing the Trust's IT strategy**	

<table>
<tr><td colspan="2">13. 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.
14. To have a committed, skilled and highly engaged workforce who feel valued, supported and developed and who work together to care for our patients.
15. To deliver well managed, value for money, sustainable services
16. To work with our partners to consolidate and develop sustainable, high quality care as part of a thriving health economy for the future.</td><td>Exec Lead: Jason DaCosta</td></tr>
<tr><td colspan="2"></td><td>Operational Lead: Jason DaCosta</td></tr>
<tr><td colspan="2"></td><td>Assurance Committee: ePR Programme Board</td></tr>
<tr><td colspan="2"></td><td>Date to be reviewed: 09/07/2017</td></tr>
<tr><td>Initial Risk Rating (1-25)</td><td colspan="2">16</td></tr>
<tr><td>Impact (1-5)</td><td colspan="2">4</td></tr>
<tr><td>Likelihood (1-5)</td><td colspan="2">4</td></tr>
<tr><td>Controls: (What are we doing about the risk?)

• IT Strategy in place, reviewed in 16/17
• Routine RAG reporting of IM&T operational projects progress to ePR Programme Board and upwards to Finance and Sustainability Committee
• IMT Operational plan shared with clinical and operational teams to confirm priorities ahead of implementation
• Capital and revenue plans identified to support the operational plans
• Key systems continually evaluated to ensure they remain fit for purpose through establishment of Digital Optimisation Group and super user group.</td><td colspan="2">Gaps in Assurance (What additional assurances should we seek?)

• Failure of IMT systems to be available 24*7 or performing as expected increasing slowing the user uptake and loss of confidence.
• Failure to provide IMT system rollout support caused by lack of staff or single points of expertise in the structure. Impact on trust access, quality of care and financial targets with potential for reputational damage
• Failure to secure Trust's IM&T systems due to limited and out-of-date security systems meaning loss of confidence and potential data breaches.</td></tr>
</table>

Assurances *(How do we know if the things we are doing are having an impact and can we validate or evidence e.g. Inspections; Committees; Working Groups; Reports; Monitoring Returns etc)*	**Mitigating Actions** *(What more should we do?)*
• The Director of IT has undertaken a review regarding IT risks, which may impact upon 24/7 availability of key services and systems and the capital programme has been updated to reflect these risks. • Capital programme spend reviewed by Capital group and F&S, hardware inventory maintained to ensure end user equipment remains fit for purpose • Implementation progress assured through ePR board reporting to the F&S board committee. • Benefits of implementation being tracked through ICIC.	• **Invest in additional IMT staffing as workload increases, restructures based on work being reviewed with IM&T management** • **Work with other Trusts to share resources.** • **Continual market assessment to ensure we implement the correct solutions.** • **Work with existing suppliers to understand upgrade paths and opportunities for future benefits.**

Residual Risk Rating (1-25)	**8**
Impact (1-5)	**4**
Likelihood (1-5)	**2**
Target Risk Rating (1-25)	**8**
Impact (1-5)	**4**
Likelihood (1-5)	**2**

Risks – Divisional / Departmental 11 Items

Organisation Group equals: "Information Governance"

Risk ID	Risk Title	Division / Department	Source of the Risk	Date Identified	Initial Risk Score	Managerial Lead	Date of last review	Impact Rating	Residual Risk Score	Action Plan / Status	Date for Review	Target Date for Completion	Strategic Aim Risk Score
Organisation Group: Information Governance													
005171	Risk of poor preparation for GDPR implementation Due to failure to engage with external experts during gap analysis process	Information Governance	Committee Review	07/06/2017	High risk 12	Ashton, Mark; Information Governance and Corporate Records Manager; IG	07/06/2017	4	High risk 12	Risk Mitigation Action Plan [In progress - 07/06/2017]	31/07/2017	27/04/2018	Moderate risk 4
000146	Risk of non-compliance with NHS Digital IG Toolkit requirements resulting in regulatory action	Information Governance	Audit	01/02/2012	High risk 9	Ashton, Mark; Information Governance and Corporate Records Manager; IG	24/05/2017	3	High risk 9	Action plan to mitigate the risks of non-compliance at level 2 with all 45 standards contained within the Connecting for Health IG Toolkit. [In progress - 08/06/2017]	30/06/2017	31/03/2018	Moderate risk 6
000123	Risk of unauthorised access to person identifiable data due to Password and Smartcard Sharing	Information Governance	External Review	01/02/2012	High risk 12	Ashton, Mark; Information Governance and Corporate Records Manager; IG	24/05/2017	3	High risk 9	Action plan to reduce password sharing includes an awareness programme regarding issues relating to adherance to policy in relation to password use. [In progress - 08/06/2017]	30/06/2017	31/03/2018	Moderate risk 6
000153	Risks associated with failure to implement Business Continuity Plans for critical information assets.	Information Governance	Audit	01/02/2012	High risk 8	Ashton, Mark; Information Governance and Corporate Records Manager; IG	24/05/2017	4	High risk 8	Trust wide BCP and BC Manager to report to IG and Corporate Records Group on status of BCP's for identified assets. [In progress - 08/06/2017]	30/06/2017	31/03/2018	Moderate risk 4
002671	Risk of loss of sensitive person identifiable data Due to the use of paper records in multiple off-site settings	Information Governance	Risk Assessment	07/07/2016	High risk 8	Ashton, Mark; Information Governance and Corporate Records Manager; IG	24/05/2017	4	High risk 8	Risk Mitigation Action Plan [In progress - 08/06/2017]	30/06/2017	31/03/2018	Moderate risk 4
000193	Risk of Regulatory Action due to low levels of IG training	Information Governance	Committee Review	01/02/2012	High risk 9	Ashton, Mark; Information Governance and Corporate Records Manager; IG	24/05/2017	2	High risk 8	Action plan to remedy low training levels in Information Governance & plan to distribute learning materials to increase levels of traning [In progress - 08/06/2017]	31/03/2018	31/03/2018	Moderate risk 6
000192	Risk of delay in receipt of clinical information by GP Surgery staff due to patient correspondence delivery errors.	Information Governance	Incident	01/02/2012	High risk 8	Ashton, Mark; Information Governance and Corporate Records Manager; IG	24/05/2017	2	Moderate risk 6	Action plan to reduce correspondence errors [In progress - 08/06/2017]	30/06/2017	31/03/2018	Low risk 3

000136	Risk of patient care delay due to non-compliance with case note tracking resulting in missing records affecting patient safety	Information Governance	Incident	01/02/2012	High risk 12	Ashton, Mark; Information Governance and Corporate Records Manager; IG	24/05/2017	2	Moderate risk 6	Action plan to maintain adherance with correct casenote tracking procedures [In progress - 08/06/2017]	30/06/2017	31/03/2018	Moderate risk 6
000154	Risk of patient confidentiality breach due to patient correspondence delivery errors	Information Governance	Incident	01/02/2012	High risk 8	Ashton, Mark; Information Governance and Corporate Records Manager; IG	24/05/2017	2	Moderate risk 6	Action plan to reduce correspondence delivery errors [In progress - 08/06/2017]	30/06/2017	31/03/2018	Moderate risk 6
000207	Risk associated with generic network access accounts	Information Governance	Risk Assessment	20/11/2012	Moderate risk 6	Ashton, Mark; Information Governance and Corporate Records Manager; IG	24/05/2017	2	Moderate risk 6	restrictions placed upon generic accounts [In progress - 08/06/2017]	30/06/2017	31/03/2018	Moderate risk 4
000145	Risk of major information governance breach due to loss of PID-person identifiable data	Information Governance	Incident	01/02/2012	High risk 8	Ashton, Mark; Information Governance and Corporate Records Manager; IG	24/05/2017	2	Moderate risk 4	Plan to minimise the risk of loss of device or media containing person identifiable data. [In progress - 08/06/2017]	30/06/2017	31/03/2018	Moderate risk 4

13. CONCLUSION

The Sub-Committee is asked to note the contents of the annual SIRO (Senior Information Risk Owner) report and the Information Governance challenges identified including the implementation of robust controls to combat further cyber-attacks and the implementation of policies, processes and procedures required to satisfy the requirements of the new General Data Protection Regulations. The most significant change to UK Data Protection legislation since the 1990s will take place in 2018 and the challenges which face the NHS in this regard should not be underestimated.

14. APPENDIX 1

Agenda Item	LEAD	ASSURANCE REQUIRED	Jan 17	Mar 17	May 17	Jul 17	Sep 17	Nov 17
Freedom of Information Report	Information Governance Manager	Compliance with Statutory Response Periods						
IG and Smartcard Incidents Datix Report	Information Governance Manager	Review of IG and smartcard loss incidents reported on Datix						
SIRO Report	Information Governance Manager	Annual report for the SIRO detailing key information risks, data loss incidents and the work of the IG Sub-Committee						
ISMS Documentation Review	IT Manager	Report to provide assurance on the status of the content of ISMS documentation						

Agenda Item	LEAD	ASSURANCE REQUIRED	Jan 17	Mar 17	May 17	Jul 17	Sep 17	Nov 17
IG Toolkit Initiative Action Plan	Information Governance Manager	One initiative per IGCRSC meeting with action plan for maintenance and improvement						
IG Risk Register Review	Information Governance Manager	Review of IG Risk Register						
IG Toolkit Initiative Evidence Review	Information Governance Manage	Review of evidence by IG Toolkit initiative						
Corporate Records Report	Information Governance Manager	Compliance report for storage and retention of paper records						
Medical Records KPIs incl (casenote tracking, casenote availability and subject access performance)	Outpatients/Medical Records Service Manager	Casenote tracking accuracy and subject access/medico legal performance						
Information Mapping and Identified Risks	Information Governance Manager	Risks identified during mapping of information flows and actions to mitigate risks						
Review of Data Protection and Fair Processing Materials	Information Governance Manager	Results of review of materials supplied to service users via WHH website and in paper form						
Key Systems Report (incl Business Continuity Plans, IAO Risk assessments)	Information Governance Manager	Report indicating the status of information risk management in relation to key IT systems						
IG Toolkit Scores and Evidence Review	Information Governance Manager	Proposed IG Toolkit scores for validity checking and evidence base review						
IG Leads Approval	Information Governance Manager	Confirmation that leads for all IG Toolkit standards have been identified						
IG Policies Review	Information Governance Manager	Details of IG policies reviewed in year and amendments made						
Totals			3	6	8	5	7	7

We are WHH

Warrington and Halton Hospitals NHS
NHS Foundation Trust

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/17/07/91/**	
SUBJECT:	**Progress on Carter Report Recommendations**	
DATE OF MEETING:	26th July 2017	
ACTION REQUIRED	**For Discussion**	
AUTHOR(S):	Steve Barrow, Deputy Director of Finance	
EXECUTIVE DIRECTOR SPONSOR:	Andrea Chadwick, Director of Finance & Commercial Development Choose an item.	
LINK TO STRATEGIC OBJECTIVES:	All	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	BAF1.3: National & Local Mandatory, Operational Targets	
	BAF1.4: Business Continuity	
	BAF3.3: Clinical & Business Information Systems	
STRATEGIC CONTEXT	The purpose of this report is to update the Trust Board on the latest position regarding the progress made against the recommendations contained in Lord Carter's report "Operational productivity and performance in English NHS acute hospitals" issued in February 2016.	
EXECUTIVE SUMMARY (KEY ISSUES):	The Carter recommendations have been assigned to Executive leads. Updates are provided quarterly.	
RECOMMENDATION:	The Board of Directors is requested to note the contents of the report.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

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Warrington and Halton Hospitals NHS
NHS Foundation Trust

PROGRESS ON THE CARTER REPORT RECOMMENDATIONS

1. PURPOSE

The purpose of this report is to update the Trust Board on the latest position regarding the progress made against the recommendations contained in Lord Carter's report "Operational productivity and performance in English NHS acute hospitals" issued in February 2016.

2. BACKGROUND

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

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

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

Table: The breakdown of the £5 billion savings:

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

This paper is the next quarterly update report since the initial response to the Lord Carter Report presented to the Trust Board on 27th July 2016.

3. PROGRESS AGAINST LORD CARTER RECOMMENDATIONS

Recommendation 1

NHS Improvement should develop a national people strategy and implementation plan by October 2016 that sets targets for simplifying system structures, raising people management capacity, building greater engagement and inclusive for all colleagues by

significantly improving leadership capability from "ward to board" so that transformational change can be planned more effectively, managed and sustained in all Trusts.

Lead Director: Director of Human Resources (HR) and Organisational Development (OD).

Current Position:

The Trust has an approved People Strategy and Dashboard which focuses activities on 5 key priorities:

- Engage — Creating a progressive, collaborative and healthy working environment, that is conducive to both staff and patient experience
- Attract — Attracting and recruiting the best staff is crucial to the future sustainability and success of our organisation. We must recruit the highest quality employees that align to our culture and workforce plan
- Retain — We want to create an environment in which our staff can see (and are rewarded for) an alignment between their overall contribution and the quality of patient care
- Develop — WHH is committed to developing a culture of lifelong learning to support patient safety and quality care delivery
- Perform — Enable the delivery of high quality and safe healthcare

The Strategic People Committee receives the People Strategy Dashboard bi-monthly to gain assurance that these priorities are being operationalised within Clinical Business Units and are having an impact on our ambition to be an employer of choice for Warrington and Halton.

A revised Absence Management Policy was implemented from 1st December 2016, with the intention of reducing sickness absence levels through reduced trigger points and tighter management controls. The Trust has an absence target of 3.75%. The year to date sickness absence as at 30th June 2017 is 4.4% which is generally better than the same 5 month period in 2016 with the exception of the month of June. Stress remains the number one reason for absence with 24% of all sickness absence due to stress.

In response to the national CQUIN for Health & Wellbeing the Health and Wellbeing Strategy 'Fit to Care' continues to support a range of wellbeing approaches aimed at supporting staff back into work as soon as possible following any episode of sick leave or avoiding sick leave in the first place, including:

- Counselling Services
- Exercises Classes, and
- Fast Track Physio Services

The Trust continues to work with colleagues across the North West on a Workforce streamlining programme, to ensure that we have unified ways of working across organisations, reduce unnecessary bureaucracy, support the seamless movement of staff between organisations, provide assurance that all appropriate employment checks are

completed and maximise the use of ESR to enable their transfer between organisations. Specific progress is being made in the Trust of Core Skills training records to reduce time to corporately induct new staff. In addition, the Trust has developed the Streamlining Benefits Calculator and as a consequence of this was used as an example of good practice at the recent North West Streamlining Year One evaluation event.

On behalf of the Alliance, the Trust is leading on working collaboratively to review the delivery of back office functions. A Visioning Workshop is scheduled for 21 July 2017 with a focus on Finance, Procurement and HR (Training, Occupational Health, Recruitment and Workforce Informatics) with attendees expected from each organisation within the Alliance.

The Trust has reviewed the results of the Staff Opinion Survey (SOS) and will be working towards a programme of engagement aimed at improving our staffs' views around recommending the Trust as a place to work and to receive care. Clinical Business Units have all received their SOS results and have developed tailored action plans to address the issues raised by staff working in their areas.

Following a restructure within the HR Directorate the intention is to move the HR Business Partners and their teams into the clinical divisions in order to improve the HR & OD support provided, including the People Performance metrics. Monthly meetings continue with a review of the levels of support needed in line with the Performance regime agreed in 2016.

Recommendation 2

NHS Improvement should develop and implement measures for analysing deployment during 2016, including metrics such as Care Hours per Patient Day (CHPPD) and consultant job planning analysis, so that the right teams are in the right place at the right time collaborating to deliver high quality, efficient patient care.

Lead Directors: Medical Director and Chief Nurse

Current position:

The Trust continues to systematically collect and submit Care Hours per Patient Day (CHPPD) data since the national changes in April 2016. This data is submitted monthly to the Department of Health (DoH) and is presented to the Board of Directors on a monthly basis. In addition detail of mitigation and the actions taken to ensure safe staffing is presented. The Trust continues to implement the electronic roster along with the Safe Care module which provides us with real-time CHPPD data. The Corporate Nursing department has taken over the line management and leadership of the E Rostering Team; all core wards are now live on both the E Roster and Safe Care systems. A six monthly review of the acuity and dependency of patients has been undertaken utilising the Safer Nursing Care Tool, results of which have been presented to the Trust Quality Committee and the Board of Directors.

The 2017/18 consultant job planning round for job plans commencing 1st April 2017 is now underway (the second job-planning round with Allocate software), and includes, for the first time, all Specialty and Associate Specialist (SAS). Progress with regards to job plans for each

CBU is now being monitored on a weekly basis. We are at 19% completed job plans for 2017/18. This situation has been discussed at the Medical Cabinet on 12th July 2017. The Deputy Medical Director will be sending out this report weekly to keep Clinical Directors appraised of progress. The absolute job plan sign off deadline was agreed to be 29th September 2017. An updated draft job planning policy will be circulated to the Medical Cabinet in September taking into account comments from consistency panels this year. In order to reduce the 'back to discussion' option and time spent on job planning, it is proposed that we have only 2 sign offs for job plans for 2018/19: i) First sign off CBU managers/Clinical Directors (Jan/Feb 2018) and ii) second sign off CD/CBU manager/Consistency panel (March 2018). The project around a corporate budget for programmed activities medical leadership, education and research, quality governance and appraisal and revalidation is nearing conclusion with all non-core SPA and non-direct clinical care PAs being transferred from the CBUS/Divisions to one of four medical budgets.

Recommendation 3

Trusts should through the Hospital Pharmacy Transformation Programme (HPTP), develop plans by April 2017 to ensure hospital pharmacies achieve their benchmarks such as increasing pharmacist prescribers, e-prescribing and administration, accurate cost coding of medicines and consolidating stock holding, in agreement with NHS Improvement and NHS England by April 2020; so that their pharmacists and clinical pharmacy technicians spend more time on patient facing medicine optimisation activities.

Lead Directors: Medical Director and Chief Operating Officer.

Current Position:

A detailed paper highlighting the progress made was presented to the Trust Board in May. A table setting out the key areas being monitored by NHS Improvement and Trust performance against these are set out in Appendix 1.

Recommendation 4

Trusts should ensure their pathology and imaging departments achieve their benchmarks as agreed with NHS Improvement by April 2017, so that there is a consistent approach to the quality and cost of diagnostic services across the NHS. If benchmarks for pathology are unlikely to be achieved, Trusts should have agreed plans for consolidation with, or outsourcing to, other providers by January 2017.

Lead Director: Chief Operating Officer and Director of Transformation.

Current Position:

A working group has been established covering the three Acute Hospital Trusts within the local economy to seek a shared solution for the provision of pathology and imaging services.

The pathology team is developing service specification and will explore options to deliver to this new specification.

Recommendation 5

All Trusts should report their procurement information monthly to NHS Improvement to create a NHS Purchasing Price Index commencing April 2016, collaborate with other Trusts and NHS Supply Chain with immediate effect, and commit to DH's NHS Procurement Transformation Programme (PTP) so that there is an increase in transparency and a reduction of at least 10% in non pay costs is delivered across the NHS by April 2018.

Lead Director: Director of Finance and Commercial Development.

Current Position:

The procurement team continues to provide the data to NHSI for the NHS Purchasing Price Index benchmarking tool on a monthly basis. The evaluation of this data is embedded into the department as a tool for identifying additional savings. Additionally, work has been undertaken with the Alliance around the benchmarking of prices with savings both identified and delivered and progress continues to be made for both the Trust and the Alliance.

Following the publication of the results of a national procurement benchmarking exercise by NHSI the Procurement team has been working on areas for improvement to improve the Trust's ranking of 46 out of 136 Trusts. This placed the Trust in the middle upper quartile.

The Procurement Transformation Plan has been drafted and submitted to NHSI. To support this, a Procurement Dashboard has been established to measure Trust performance against the Carter metrics.

The Trust adoption plan for Scan4Safety (formally the Global Standard: GS1) and pan European Public Procurement Online (PEPPOL) standards is currently being updated that will require approval by the Trust Board. The procurement department is currently in the process of restructuring with part of this restructure established to support, develop and implement the requirements of Scan4Safety.

The Procurement team continues to collaborate with the Alliance, wider STP and wider NHS via Health Trust Europe's Procurement Partnership Board of which the Trust co-chairs. Monthly Alliance procurement meetings have been established along with an STP wide theatre group. A Corporate Services Collaborative Board has also been established.

The Trust has achieved NHS Standards of Procurement Level 1 accreditation and is working towards the achievement of Level 2 for review in December 2017.

Recommendation 6

All Trusts and estates and facilities departments should operate at or above the median benchmarks for the operational management of their estates and facilities functions by April 2017 (as set out by NHS Improvement in April 2016); with all Trusts (where appropriate) having a plan to operate with a maximum of 35% of non clinical floor space and 2.5% of unoccupied or under used space by April 2017 and delivering this benchmark by April 2020, so that estates and facilities resources are used in a cost effective manner.

Lead Directors: Director of Finance & Commercial Development and Chief Operating Officer.

Current Position:

The Board has recently been updated on the 2015/16 Model hospital metrics and is green on all cost efficiency metric except Water and Sewerage.

It is not possible to influence the water and sewerage charges as these are set by The Water Services Regulation Authority (OFWAT) and are not subject to challenge. It should be noted that the Trust water consumption per bed space is in the lower quartile nationally which shows that this is not a case of profligate use of water. The Trust will continue to review the effectiveness of the estate and monitor cost efficiency metrics to ensure value for money and to take actions for any deviation from the benchmark values. When the 2016/17 Model Hospital metrics are available an update will be provided.

Recommendation 7

All Trusts corporate and administration functions should rationalise to ensure their costs do not exceed 7% of their income by April 2018 and 6% of their income by 2020 (or have plans in place for shared service consolidation with, or outsourcing to, other providers by January 2017), so that resources are used in a cost effective manner.

Lead Director: Chief Operating Officer and Director of Transformation.

Current position:

All corporate divisions have been assigned costs savings targets in 2017/18 of £1.5m. The cost savings being delivered either reduce costs or increase income, thereby improving their respective percentage cost figures.

In addition to the direct cost savings targets for the corporate divisions a number of further “proxy targets” have been allocated in 2017/18. These proxy targets include enabler targets of £1.5m for Procurement and £0.75m for Information Technology.

These savings will be made by clinical and other corporate divisions but will be driven largely by the services that own the proxy target. These savings will contribute towards delivery of the Trust’s overall cost savings target of £10.5m for 2017/18.

Recommendation 8

NHS Improvement and NHS England should establish joint clinical governance by April 2016 to set standards of best practice for all specialties, which will analyse and produce assessments of clinical variation, so that unwarranted variation is reduced, quality outcomes improve, the performance of specialist medical teams is assessed accordingly to how well they meet the needs of patients and efficiency and productivity increase along the entire care pathway.

Lead Directors: Chief Operating Officer and Director of Transformation.

Current Position:

Any unwarranted variation within theatres and outpatients is being addressed through the theatres and outpatient work streams of the transformation programme and is closely monitored through the "grip and control" meetings by the Director of Transformation.

The Trust is also working with the Emergency Care Improvement Programme around efficiencies in patient flow and has agreed a number of key work streams across mid Mersey following a systems review. Progress will be monitored through the A&E Delivery Board.

The Trust is leading on a series of specialty level reviews across the Local Delivery System (LDS). A key element of these reviews is to agree and implement plans to reduce variation within pathways across the LDS. Initial specialty reviews have now been held in urology, trauma & orthopaedics and ophthalmology. A programme of workshops across priority specialties has been agreed, led by the LDS Director of Service Redesign. The Transformation Team is supporting the development of PIDs following individual workshops to enable delivery of improvements identified.

Recommendation 9

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

Lead Directors: Director of Information Management and Technology

Current Position:

The Trust has plans to be fully digitised by 2018 (subject to the availability of funding), with our strategy and digital roadmap implementation improving our digital maturity assessment. Plans to improve our already mature base include Electronic Documents and Records Management System, ePrescribing and structured clinical notes. We will take an active part in the Warrington health economy in the development of digital plans including the implementation of a care record to enhance the integration of care across all providers.

Recommendation 10

DH, NHS England and NHS Improvement, working with local government representatives, to provide a strategy for Trusts to ensure that patient care is focused equally upon their recovery and how they can leave acute hospital beds, or transfer to a suitable step down facility as soon as their clinical needs allow so they are cared for in the appropriate setting for themselves, their families and their carers.

Lead Director: Not applicable.

Current Position: Further information from national bodies is awaited.

Recommendation 11

Trust Boards should work with NHS Improvement and NHS England to identify where there are quality and efficiency opportunities for better collaboration and coordination of their clinical services across their local health economies, so that they can better meet the clinical needs of the local community.

Lead Director: Not applicable.

Current Position (no change from position reported in previous quarterly report):

The Trust is working in collaboration with external providers and commissioners within the STP and LDS to seek to address clinical and financial constraints through service, productivity and rationalisation opportunities.

Pathway Integration and efficiency through the local health economy will be digitally enabled through the use of Care Record, risk stratification and patients accessing personal health records.

Recommendation 12

NHS Improvement should develop the model hospital and the underlying metrics, to identify what good looks like, so that there is one source of data, benchmarks and good practice.

Lead Directors: Not applicable

Current Position (no change from position reported in previous quarterly report):

NHS Improvement has now published the model hospital data and the Trust is focussing on the use of the information to drive forward clinical and corporate practices so that outputs and financial performances can be improved. A report that extracts all key metrics from the Model Hospital portal that enables our individual services to review, analyse and respond will be prepared.

Recommendation 13

NHS Improvement should, in partnership with NHS England by July 2016, develop an integrated performance framework to ensure there is one set of metrics and approach to reporting, so that the focus of the NHS is on improvement and the reporting burden is reduced to allow Trusts to focus on quality and efficiency.

Lead Director: Not applicable.

Current Position (no change from position reported in previous quarterly report):

In September NHS Improvement published the document Single Oversight Framework (SOF) for all NHS Trusts and Foundation Trusts. This replaced the Monitor Risk Assessment Framework and the Trust Development Authority Accountability Framework from the provider sector and was effective from 1st October 2016.

Each Trust was allocated to a segment which reflects the level of support required. The Trust is in segment 3 (in breach of licence and requires formal action) and therefore mandated support as determined by NHSI. The breach of licence is currently being reviewed by NHSI and will be presented to their Board in August.

Recommendation 14

All acute Trusts should make preparations to implement the recommendations of this report by the dates indicated, so that productivity and efficiency improvement plans for each year until 2020/21 can be expeditiously achieved.

Lead Directors: All Executive Directors.

Current Position: See individual recommendations.

Recommendation 15

National bodies should engage with Trusts to develop their timetable of efficiency and productivity improvements up until 2020/21, and overlay a benefits realisation system to track the delivery of savings, so that there is a shared understanding of what needs to be achieved.

Lead Director: Not applicable.

Current Position: Further information from national bodies is awaited.

4. CONCLUSION

The Trust has embraced the recommendations and already complies with some of the key targets and performance indicators and is making progress on those applicable to the organisation.

It is important to recognise that NHS Improvement considers progress and implementation of the Lord Carter recommendations as mandatory and compliance is a key feature of future governance standards as indicated in the *Single Oversight Framework*.

5. RECOMMENDATION

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

Andrea Chadwick
Director of Finance and Commercial Development
19th July 2017

Appendix 1

Metric	Trust Performance	National Median or Target	Progress / Assessment
Money and Resources			
Pharmacy staff & medicines costs per WAU (15/16)	£296	£350	Strong performer
Medicines cost per WAU (15/16)	£232	£312	Strong performer
High cost medicines per WAU (15/16)	£ 75	£112	Strong performer
In tariff medicines per WAU (15/16)	£158	£196	Strong performer
Choice of paracetamol formulation (IV/Total) (15/16)	54%	56%	Strong performer
% spend on sevoflurane (15/16)	89%	66%	Strong performer
Safe			
Total antibiotic consumption (DDD/1,000 admission) (15/16)	4,074	4,512	Strong performer, maintaining focus
% diclofenac vs ibuprofen & naproxen (Jun 16)	23%	9%	Plan in place to improve
% eChemotherapy (14/15)	0%	50%	iQEMO implemented, outpatient & day case chemotherapy prescribing now electronic
% ePxing inpatient (15/16)	0%	50%	Business case to be reviewed
% ePxing OP (14/15)	0%	50%	100% in ED, roll out to OP is in the Lorenzo optimization plan
% ePxing at discharge (14/15)	100%	60%	Fully implemented
Effective			
Clinical Pharmacy activity (Pharmacist Time on direct medicines optimization activities/governance/safety) (15/16)	79%	67%	Currently close to 80% with pharmacists but under achieving with technicians (40%) & pharmacy assistants (33%) Adjusting work processes to have more technical staff on the wards **Target: 85%**
% Pharmacists actively prescribing (15/16)	23%	20%	2 more pharmacists in training & plan in place **Target: 85%**
% medicines reconciliation within 24hrs (15/16)	40%	73%	Currently assessing working arrangements and reviewing working over weekends **Target: 85%**
% use of SCR (Aug 16)	132%	52%	Electronic notes linked in to SCR so easily accessible
% soluble prednisolone/total prednisolone (Sep 16)	11.4%	3.4%	Working to reduce our %
% biosimilar infliximab (Sep 16)	91%	100%	All patients switched that are

			suitable for switching
% biosimilar etanercept (Aug 16)	0%	100%	New patients being started on biosimilar currently 10%
Dose banded chemotherapy (15/16)	0%	42%	Currently achieving 100% (CQUIN)
No. medication incidents reported to NRLS per 100,000 FCE (Mar 16)	395	286	Strong performer for pharmacy/nursing incidents, work required on prescribing incidents as shown by intervention audit
% medication incidents reported as causing harm or death/all medication errors	26.7%	9.7%	Outlier – review of incidents completed – % does not reflect the true picture. Prior to appointment of MSO there was over-reporting of 'no harm' incidents as 'harm' incidents one factor being the choice of incident type. If delay in treatment chosen for omitted medicines then this only allows harm to be reported. Action: In future MSO will review incidents utilizing the MSO rating tools & for type
Number of days stockholding	11 days	18.8 days	Already achieving – maintain and improve where able
Deliveries received into pharmacy	16 Warrington 3 Halton	15	2 year implementation - Working with other Trusts and Specialised Pharmacy Services to improve
e-Commerce	71% Alliance 62% AAH	90% 82%	True position is 100% of wholesalers , 2 year improvement plan in relation to other suppliers
Data quality of NHSE submissions (Nov 16)	20	20	NHSE have procured Blueteq software which will drive improvement as new indications/ medicines are added; CCGs are intending to implement Blueteq software in 2017/18
Caring			
National Inpatient Survey – medicines related questions (15/16)	76.8%	73.1%	Strong performer, as Pharmacy time spent on wards increases it is expected/intended that this % will increase
Responsive			
Sunday on ward clinical pharmacy hours of service (15/16)	0	7	Requires improvement. Bid submitted to transformation/for improvement funding; pilot underway to assess impact of Sunday working on medicine reconciliation figures
People, Management & Culture: Well-led			
% sickness absence rate (15/16)	4%	3.1%	Currently 3.5%, Dept. manages staff in accordance with the Trust Attendance Management Policy

Appendix 1

% Staff with Appraisals completed (15/16)	85%	85%	Currently 91%, ongoing focus on completing PDRs
% staff with statutory & mandatory training (15/16)	95%	91%	Ongoing focus on training
% Staff turnover (15/16)	9%	14%	Currently 14% trend is downwards after a difficult year
% Staff vacancy rate	6%	6%	Currently 10%, vacancies held to avoid redundancies due to contract termination of 2 SLAs and reduction in 2 others with another 2 under review. By July 17 some infrastructure services will have reduced in line with Lord Carter recommendations which will improve the position