We are WHH

Warrington and Halton Hospitals NHS
NHS Foundation Trust

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

Wednesday 27th July 2016, time 13:00 –15:45
Trust Conference Room, Warrington Hospital

REF BM/16	ITEM	PRESENTER	PURPOSE	TIME	
	Presentation: Specialist Surgery Peter Barrett , Clinical Director - Sheila Fields-Delaney, CBU Manager - Allen Hornby, Lead Nurse		Information	13:00	N/A
/144	Welcome, Apologies & Declarations of Interest	Steve McGuirk, Chairman	N/A	13:20	Verbal
/145	Minutes of the previous meeting held on 29th June 2016	Steve McGuirk, Chairman	Decision	13:22	Encl
/146	Actions & Matters Arising	Steve McGuirk, Chairman	Assurance	13:25	Encl
/147	Chief Executive's Report	Mel Pickup, Chief Executive	Assurance	13:30	Verbal
/148	Chairman's Report	Steve McGuirk, Chairman	Information	13:45	Verbal
	Quality People Sustainability				
/149	Integrated Performance Dashboard M3 2016-17	All Executive Directors	Assurance	13:50	Encl.
	Quality				
/150	Key Issues Report July Quality Committee	Margaret Bamforth, Committee Chair	Assurance	14:10	Encl.
/151	Safeguarding Annual Report 2015-16	Karen Dawber, Director of Nursing & Governance	Assurance	14:20	Encl.
/152	Director of Infection Prevention and Control – Healthcare Associated Infection - Annual Report April 2015 – March 2016	Simon Constable, Medical Director	Assurance	14:30	Encl.
/153	Part 1 Risk Register Q1 2016-17	Karen Dawber, Director of Nursing & Governance	Assurance	14:40	Encl.
	People				
/154	Safe Staffing Levels Review	Karen Dawber, Director of Nursing & Governance	Decision	14:50	Encl.
	Sustainability				
/155	Key Issues Report July Finance & Sustainability Committee	Terry Atherton, Committee Chair	Assurance	15:00	Encl.
/156	Key Issues Report July Audit Committee	Ian Jones, Committee Chair	Assurance	15:10	Encl.
/157	Response to Lord Carter Report Q1 2016-17	Andrea Chadwick, Director of Finance & Commercial Development	Assurance	15:20	Encl.
/158	NHS Improvement Governance Declaration Q1 2016-17	Andrea Chadwick, Director of Finance & Commercial Development	Decision	15:30	Encl.

/159	**Any Other Business**	**Steve McGuirk, Chairman**	**N/A**	**15:40**	**Verbal**
	Date of next meeting: Wednesday 31st August 2016				

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Warrington and Halton Hospitals NHS
NHS Foundation Trust

Warrington and Halton Hospitals NHS Foundation Trust
Minutes of the Board of Directors meeting held in public on Wednesday 29th June 2016
Trust Conference Room, Warrington Hospital

Present: **BM/16/145**

Steve McGuirk	Chairman
Mel Pickup	Chief Executive
Terry Atherton	Non-Executive Director
Margaret Bamforth	Non-Executive Director
Andrea Chadwick	Director of Finance & Commercial Development
Simon Constable	Medical Director & Deputy Chief Executive
Karen Dawber	Director of Nursing & Governance
Sharon Gilligan	Chief Operating Officer
Ian Jones	Non-Executive Director / Senior Independent Director
Lynne Lobley	Non-Executive Director & Deputy Chair
Anita Wainwright	Non-Executive Director

In Attendance:

Jason DaCosta	Director of IM&T
Lucy Gardner	Director of Transformation
Pat McLaren	Director of Community Engagement
Angela Wetton	Company Secretary
Roger Wilson	Director of Human Resources and Organisational Development
Kimberley Salmon-Jamieson	Deputy Director of Nursing, Pennine Acute Hospitals Trust

Apologies

None

Agenda Ref BM/	
	The Board Meeting opened with a presentation from Dr Liz O'Brien, Consultant in Palliative Medicine and Gwen Waller, Matron for Palliative Care giving the Board an overview of the work of the End of Life Care (EOLC) team over the previous twelve months. A request was made for a Non-Executive Director EOLC representative which the Board agreed to consider.
16/126	**Welcome, Apologies & Declarations of Interest** The Chair opened the meeting and welcomed those attending the meeting, including Governors and Kimberley Salmon-Jamieson who would be taking up the post of Director of Nursing & Governance with the Trust from 7th September 2016. Apologies: none received. Declarations of Interest: none declared.
16/127	**Minutes of the Previous Meeting Held on 25th May 2016** The minutes of the previous meeting were approved as a true and accurate record of the meeting.

16/128	**Action Plan** All actions were reviewed and progress was noted.
16/129	**Chief Executive Report** The Chief Executive updated the Board on items that had occurred or progressed since the last meeting at the end of May: • Cheshire & Merseyside Sustainability & Transformation Plans would be submitted on 30th June 2016. • Given the speed with which the plans had to be developed unfortunately engagement with local partners was not as comprehensive as we would have liked and during the month the Trust attended the Health Policy Board to answer their questions. • Four cardiology consultants have been appointed- two are joint appointments with Liverpool Heart & Chest Hospital NHS FT and one with Manchester Royal Infirmary • The first cohort of nine student Physician Associates has been welcomed to the Trust and six Physician Associates have been appointed from the USA where the role has been in place for some time • The cost of car parking to staff is being considered and engagement with staff is underway on this, with over 1000 responses to the survey having been received. The overwhelming feedback is to support the staff tariff divided by income bandings (as is currently in place), whereby the highest earners pay more. In comparison to other local trusts, WHH costs to staff are lower, significantly so when compared to some trusts. The Board noted the report.
16/130	**Chairman's Report** The Chairman gave the Board an update of events since the previous Board meeting stating he had met with the Chief Executive of St Helen's & Knowsley as part of the work of the Alliance Joint Oversight Group. The Board discussed the fact that as a Trust, our focus remained on patient care within the work of the STP. The Board noted the report.
16/131	**Integrated Performance Dashboard M2 2016-17** The Executive Directors each presented the metrics relating to their portfolios and the following points were highlighted: **Quality** • Major incidents – eight incidents currently under review which may or may not result in downgrading • Hospital Standardised Mortality Ratios – the Mortality Review Group are currently looking at the increase seen in this area • Pressure Ulcers – three have been reported but not yet confirmed. These are considered to be Serious Untoward Incidents (SUI) and are subject to level 2 investigations. **Finance** • Cash balance £1.4m – this is managed on a daily basis. • FSRR of 2 due to the financial position being slightly ahead of plan

- Control target – received revised proposal from the Regulator which was agreed based on a planned deficit of £7.9m.
- Better Payment Practice Code – the poor performance against the 95% national standard was highlighted and discussed. The Finance & Sustainability Committee had scrutinised the creditor position and the Board recognised that this performance was driven by the current financial position of the Trust, more specifically by the cash position. It was confirmed to the Board that this performance is unlikely to improve until the cash position improves significantly.
- The Capital Programme of £6.779m which was scrutinised by the June Finance & Sustainability Committee and recommended for Board approval, was presented to the Board. This was approved.

Performance

- A&E 4 hour target – whilst the national target of 95% was not being met, the Trust was meeting the improvement trajectory target set in agreement with the Regulator. The Chair of the Finance & Sustainability Committee reminded the Board of an earlier decision to review the A&E position once the figures for April and May were available and that this remained within the Committee's remit. The Chief Operating Officer advised that this performance data had been submitted to NHS Improvement four times and because the Trust had met the trajectory, the data submissions could cease but would restart should the Trust fail to continue to meet the targets set and agreed.
- RTT – following a query from a Non-Executive Director regarding the performance of General Surgery, the Chief Operating Officer acknowledged the performance and advised that a recovery plan was in place. She also explained that there had been issues with erroneous data following the implementation of Lorenzo which had been traced to the Outpatients department. Consequently the Finance & Sustainability Committee had requested more information and further scrutiny would be carried out at the July Committee.
- 62 Day Cancer target – the Chief Operating Officer reminded the Board that although this was a quarterly reported figure which the Trust always achieved, the monthly figures were constantly under surveillance.
- It was agreed that the Ambulance Handover figures which are scrutinised at the Finance & Sustainability Committee, would be added to this dashboard as fines are attached to this particular KPI. The Chief Operating Officer explained that she was currently working through a data reconciliation exercise with our partners, the North West Ambulance Service NHS Trust (NWAS).

The Board noted the report and agreed that this dashboard was an excellent improvement in the way the information was presented and would be used for the Council of Governor meetings too.

16/132

Key Issues Report from June Quality Committee

Margaret Bamforth reported that the Committee business had covered the following items at its June meeting:

- All items on the annual work plan were reported as expected, there were no reports from the Health and Safety or Patient experience committee as there had been no meetings.
- The CQC operational policy was agreed and ratified, the committee also had a verbal update on work within the CBU's to provide future assurance against the CQC report 2015.

- The Health and Safety annual report was reviewed and thanks given to the H&S team, it was noted though that there remains a trend of needlestick injuries – Infection Control Committee is leading on a piece of work to look at reductions.
- The palliative care end of year report was presented and the committee noted that the team have moved to a 365 day per year cover with on average two new patients referred every day.
- On reviewing the quality dashboard a detailed discussion was held around the potential never event relating to wrong site surgery
- The committee heard an update relating to Mary's Story and the quality summit held in June. The committee recommends that the executive meet with Mary's family to follow up their presentation at Board.
- The committee looked at benchmarking data across Cheshire and Merseyside for the reporting of SUI's and was assured that we are reporting similar themes and numbers as similar sized organisations. It was agreed to present this report as and when it is updated regionally.
- The Director of Nursing updated on the National Nursing framework and advised that the incoming Director of Nursing intends to submit a revised draft nursing strategy to the Board in October.
- The risk register was reviewed and it was pleased to note that the numbers of mitigated risks has reduced. An environmental risk to note was the flooring on B14 and an urgent plan is in place to close the ward to allow works to be completed.
- Discussion of the risks relating to the implementation of Lorenzo and electronic chemotherapy prescribing. It was noted that a clinical summit is planned to review the Lorenzo risks and a business case for the ichemo has now been resubmitted and funded.
- Under AOB we discussed the Deanery report in relation to patient safety incidents, it was agreed that this should be discussed at Quality Committee and this has been added to the annual work plan.

The Board noted the report.

16/133

Quality Dashboard M2 2016-17

The Director of Nursing and Governance presented her report and highlighted the following, confirming that trend data was now included in the report:

- **VTE Risk Assessment**
  Target : 95%
  April (90.25%)
  May (88.83%)
  Work is continuing to ensure effective systems are in place to accurately capture these assessments.
- **VTE Prophylaxis**
  In April 2016's safety thermometer survey, 3 out of the 415 patients who required prophylaxis had not received it but should have done by the time of the survey. In May 2016, this figure was 2 out of 590. The 100% target was narrowly missed in each month.
- **Hospital Standardised Mortality Ratio (HSMR)**
  The HSMR has been rising but within expected numbers, until the period April 2015 – March 2016, for which it is 'higher than expected' at 115.
  Crude mortality rose to 2.8% in Q4 2015/16. This has reduced to 2.1% for Q1 2016/17

	so far. The compliance for mortality peer review has fallen in April 2016, however these reviews are on-going and the figure will increase. On-going developments to the IT system used to support this will make the process more streamline and user friendly. Further detail is available in monthly mortality reports which are considered at the Mortality Review Group. • **Always Events** Although the target of 100% is not yet being met, an improvement was seen throughout 2015/16 with compliance for each quarter at 90%, 93% 95% and 94%. For the first 2 months of Q1 2016/17, compliance is above 95%. • **Complaints** The target of 94% was achieved in every month of 2015/16 except March 2016 (91.7%). May 2016 : 91.18% (31 of 34) April 2016: 91.67% (22 of 24) These recent consecutive 2 months in which the target was narrowly missed relate to an unusual period of significant staffing changes within the patient experience team. The Board noted the report and following a query from the Director of Nursing & Governance, confirmed that they did not require this additional dashboard provided all the agreed metrics were included in the integrated dashboard as previously seen.
16/134	**Complaints, Concerns & Compliments Annual Report 2015-16** The Director of Nursing and Governance presented her report and highlighted the following: • During 2015/2016, there were 613,936 attendances at the Trust. • The Trust received a total of 404 formal complaints between 1 April 2015 and 31 March 2016, which is a decrease of 70 on the previous year. • 13 cases have been closed by the PHSO during the year. There are 8 cases on-going at the moment. • 2,558 people contacted PALS during the year; this is an increase of 637 contacts on previous year. • 74 formal compliment letters were sent to the Chief Executive. • 98.03% of complaints were closed within agreed timescales. The Director of Nursing & Governance confirmed that the blank areas were new metric relating to CQUINs and that outside the meeting; she would circulate slides recently received from NHSE benchmarking the Trust. Improvements planned for 2016/2017 include: • The implementation of a robust process of monitoring the 72 hour reviews for complaints graded as high risk • The implementation of the new CBU structure, which will provide the patient experience team with key contacts from a nursing, medical and operational point of view • The implementation of a new format for complaint response letters • A re-launch of the PALS service, to include new posters for all wards and departments and working with the CBU leaders and ward / department managers to promote staff trying to resolve issues at the time they occur • Recruiting to and embedding the new team within the department

	The Board noted the report.
16/135	**Key Issues Report from the June Charitable Funds Committee & Revised Terms of Reference** Lynne Lobley, Chair of the Committee presented a summary of the Committee business: • Finance Report to 31st March 2016 • Fundraising Report • Key Risks Review • Development of WHH Legacies programme • Fundraising Work Plan 2016-17 • Introduction of a WHH Lottery • Developing Corporate Relationships • Revised Terms of Reference • New Charities Commission Guidance for Trustees • Approval of Bid Applications A copy of the New Charity Commission Guidance for Trustees was included with the report for Board members to read and it was confirmed that the checklist compiled by the Charities Commission would be completed on behalf of the Corporate Trustee and a report would be presented to the Board in due course. The revised Terms of Reference were recommended to the Board for ratification. The Board noted the report and approved the revised Terms of Reference. ***Action: Director of Community Engagement to present position report referring to checklist issued by Charities Commission to September Board.***
16/136	**National Nursing Framework Presentation** The Director of Nursing & Governance gave a short presentation to the Board on the 2016 Nursing Framework and confirmed that a revised Nursing Strategy would be presented to the Board by the incoming Director of Nursing in October 2016. The Board noted the content of the framework. ***Action: Director of Nursing to present revised Nursing Strategy to October Board.***
16/137	**Key Issues Report from the June Strategic People Committee and Revised Terms of Reference** Anita Wainwright presented the key items of business from the June Strategic People Committee which included: • Clarified sub-committee structure reporting into Strategic People Committee with discussion about roles and accountabilities • Director of Nursing and Governance gave an update on the Allocate Safer Staffing Acuity tool and provided assurance on both the cost and application • The outline People Strategy and agreed timescales to seek Trust Board Approval – August Board. • The HR & OD KPI report was also agreed as part of the recut organisational dashboard. • The Trust Exclusion Report

	• The NHS Workforce Race Equality Standard Report • The Health Education North West & General Medical Council Monitoring Visit 2016 report • Revised governance arrangements for the ratification of policies • Operational People Sub Committee meeting minutes from May 2016 The revised Terms of Reference were also presented for Board ratification. The Board noted the report and approved the Terms of Reference. ***Action: Director of HR & OD to present revised People Strategy to August Board.***
16/138	**Workforce Dashboard M2 2016-17** The Director of HR & OD provided an update to the Board on the Workforce Dashboard and highlighted the following: • Sickness absence performance has improved again in month. RTW rates have increased in month, but still lower than required. A revised Absence Management Policy is currently under discussion with Staff Side. • Both the turnover and stability rates have increased but the vacancy rate is at one of its lowest levels. • In month, the number of starters and leavers was roughly the same • In terms of pay bill, the Trust is £106k under budget in the month of May 2016, this included a reduction of £217k on temporary staffing spend in comparison with April 2016 • Trust is taking a system leadership role in relation to compliance with capped agency rates. The Trust is discussing with NHSI, a locality summit. • The Trust now has 19 Romanian nurses from the two international recruitment cohorts • A very successful advertising campaign using Facebook and Twitter has resulted in the appointment of at least 25 nurses with approximately another 5 where we are awaiting confirmation of offers • Recruitment times continue to fall and new ambitious stretch targets have been set • Employee Relations – 49 live cases, these are being managed through the appropriate governance structures It was confirmed that PDR and mandatory training data can now be seen per Clinical Business Unit (CBU) at CBU level in the organisation and that a further discussion around the agency cap and spend will be held at the July Finance & Sustainability Committee. The Board noted the report.
16/139	**Engagement Dashboard M2 2016-17** The Director of Community Engagement provided the Board with a high level overview of how well the Trust is engaging and involving with key stakeholder groups: • Staff • Patient • Other Key Stakeholders • Charity

	The following points were highlighted: • Overall positive month media wise • Social media – almost 10,000 engagements • Mobile enabled Extranet now live and figures show staff are spending time on the site • 'Facebook the Midwife' – another local Trust is keen to understand how we did this so they can look to implement something similar • Facebook recruitment campaign • Attendance at team brief was being monitored as a way of staff engagement • GP engagement dashboard – can be drilled down to data by practice The Board noted the report.
16/140	**HENW Monitoring Visit Results Presentation** Dr Richard Briggs, Director of Medical Education and Lesley Kinsey, Medical Education Business Manager gave a presentation detailing the outcome of the monitoring visits by the Junior Doctor Advisory Team (JDAT) from Health Education England (HEE) and the GMC. The Board noted the thirteen requirements and three recommendations from the visits; the governance structure around medical education which ultimately reports up to the Strategic People Committee (a Board Assurance Committee) and the response date of 13th August 2016.
16/141	**Key Issues Report from the June Finance & Sustainability Committee & Annual Report for 2015-16** Terry Atherton presented the key items of business from the June Finance & Sustainability Committee which reflected the information seen on the Integrated Performance Dashboard earlier in the meeting: • Month 2 of the 2016/17 financial year including cash position • The position with regard to fines and penalties • Elements of income and expenditure including where not on track together with the recovery plans; for example an Outpatients Recovery Plan will be presented to the July Finance and Sustainability Committee to include DNA management. • The revised Control Total offered by NHS Improvement and our response was considered alongside the need for reforecasting both our financial run rate and cash flow, once the position has been finalised. • The Capital Programme for 2016/17 • Robustness of Business Case approval processes • The 2016/17 CIP Target of £10m (but see later) and delivery of £8m • The revised Control Total offered (and accepted) from NHS Improvement • The 95% National 4 hour A&E standard and the trajectory agreed with NHS Improvement • The Finance and Sustainability Committee recommend that Board review of ED performance now takes place now that the data for the first part of the year is available. • RTT targets and indicators for Cancer • It had been the intention to consider WLIs at this meeting but this has been deferred to a large extent to the July meeting. • The Finance and Sustainability Committee continues to acknowledge the extensive effort in continuing to improve Corporate Performance. • The Finance and Sustainability Committee reviewed and agreed the Integrated

	Performance Dashboard Metrics in so far as they applied to the remit of the committee. • IM&T activities were reviewed in line with the report presented. • Lorenzo financial position and stabilisation were noted and the committee agreed that the Lorenzo Board Overview Group has been a useful additional element in overall governance of the programme and should now be stepped down. • A verbal update was received from the Director of HR&OD in respect of Agency Caps together with graphs of Price Cap Breaches across Medical and Nursing Prices. The Finance and Sustainability Committee were particularly concerned to note Nursing Price Cap Breaches at a rate of 100% of shifts since the Cap was lowered in April. It was agreed that a deep dive should take place at the July Finance and Sustainability Committee with the appropriate Executives present. The Finance and Sustainability Committee were mindful of the cross committee responsibilities in this area. • A report on the Trust's reference costs for 2015/16 was received and approved ahead of submission to the Department of Health by 28th July 2016. • A quarterly update on Service Line Reporting was received and considered extremely valuable in the current circumstances. The Committee's annual report detailing the work carried out during 2015-16 was also presented. The Board noted the reports and approved the decision to disestablish the Lorenzo Board Overview Group.
16/142	**Emergency Preparedness Annual Report 2015-16** The Chief Operating Officer presented the report as Executive lead and reminded the Board that all NHS organisations are required to deliver their responsibilities for Emergency Planning via the Civil Contingencies Act 2004. As a Category 1 responder under the Act, the Trust has a duty to develop robust plans to respond effectively to emergencies, to assess risks and develop plans in order to maintain the continuity of services in the event of a disruption. The report provided the Board with an overview of the emergency preparedness arrangements within Warrington and Halton Hospitals NHS Foundation Trust; outlined the work that has been undertaken in the area during the past twelve months; described the Trust response to incidents which occurred during 2015-16 and summarised our planned work streams and priorities for the year ahead, which will be monitored by the Event Planning Group and monthly updates to the Quality Committee, as follows: • Develop Trust CBRN/HAZMAT Plan, which will include Runcorn Urgent Care Centre and be based around the new Initial Operating Response (IOR) for dry decontamination. Deliver training and undertake a desk top exercise to test the plan. • A complete review of the Trust Business Continuity planning process in light of new clinical business unit structure. • Agree changes to Trust Escalation Plan which includes the revised Trust Full Capacity Policy and scoring matrix. • Review Trust Pandemic Influenza Plan including service business continuity plans and then undertake desktop exercise. • Further develop management on-call documentation and ensure training and support is provided to on-call staff. • Participate in multi-agency exercises and training with partner organisations in accordance with priorities identified by the LHRP.

	• Participate in multi-agency EPRR training and exercises in collaboration with partner organisations and the LHRP. • Support the planning process for future junior doctor's industrial action. • Jointly lead on the implementation of the Prevent agenda, raising awareness and ensuring staff receive appropriate training within the organisation. The Board noted the report and assurance reporting structure.
16/143	**Monitor Declaration - Annual Corporate Governance Statement** The Company Secretary presented her paper and proposed that the Board declare a 'Confirmed' response to the self-assessments, supported by the risks and mitigations detailed in the paper. The Board confirmed the declarations to the self-assessment statements and requested the Company Secretary to ensure submission to the Regulator before the deadline of 30th June 2016.
16/144	**Any Other Business** The Director of Community Engagement reminded Board members about the Open Day on 2nd July and confirmed that a briefing note would be issued. There being no further business to discuss, the meeting closed. **Next Meeting:** Wednesday 27th July 2016 in the Trust Conference Room

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Warrington and Halton Hospitals NHS
NHS Foundation Trust

BM/16/146

PUBLIC TRUST BOARD
ACTION PLAN – JULY 2016

Meeting Date	Minute Ref BM/	Action	Lead	Date	Status
29th June 2016	16/137	Director of HR & OD to present revised People Strategy to August Board.	HRD	August Board	Ongoing
29th June 2016	16/136	Director of Nursing to present revised Nursing Strategy to October Board.	DoN&G	October Board	Ongoing
29th June 2016	16/135	Director of Community Engagement to present position report referring to checklist issued by Charities Commission to September Board.	DoCE	September Board	Ongoing
27th April 2016	16/096	The Director of Nursing & Governance to establish a working group (including Non-Executive Directors) to agree the format of the quarterly risk register report.	DoN&G		Completed
27 January 2016	16/16	With regard to a Patient story, the Quality Committee to assure itself of the learning and improvement made to the service. Directors to meet with the family in July 2016 to discuss the Trust's response.	DoN&G.	July 2016	Completed

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Warrington and Halton Hospitals NHS
NHS Foundation Trust

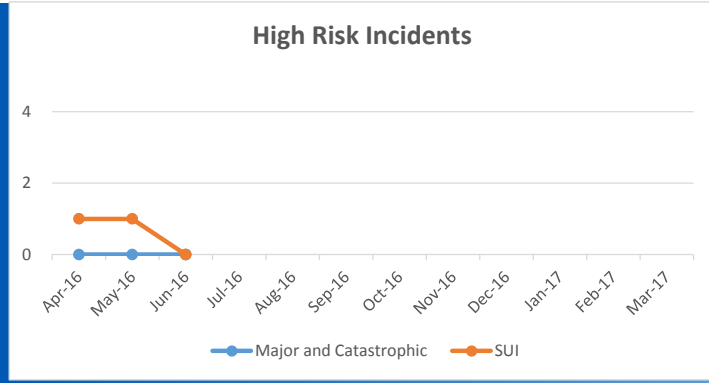
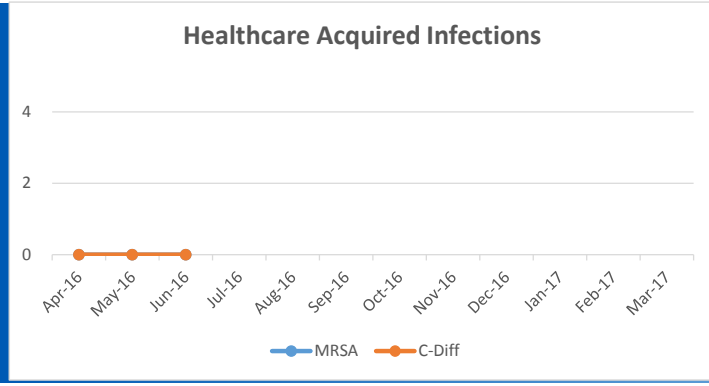
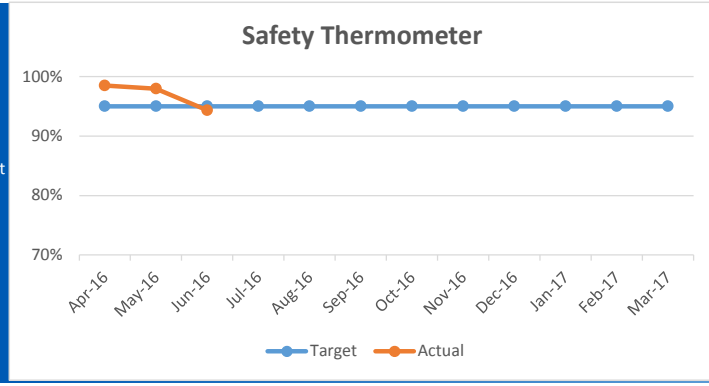
BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/16/149**	
SUBJECT:	**Integrated Performance Dashboard M3 2016-17**	
DATE OF MEETING:	**27th July 2016**	
ACTION REQUIRED	**For Assurance**	
AUTHOR(S):	**Various Executives and Senior Managers**	
EXECUTIVE DIRECTOR SPONSOR:	**All Executive Directors**	
LINK TO STRATEGIC OBJECTIVES:	**All**	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	**All**	
FREEDOM OF INFORMATION STATUS (FOIA):	**Release Document in Full**	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	**None**	
EXECUTIVE SUMMARY (KEY ISSUES):	**The Integrated Performance Dashboard will continue to be an iterative process with the potential for new metrics to be added.** **This dashboard contains the following areas:** • **Quality** • **People** • **Sustainability including operational activity & performance and finance** **With a separate dashboard for Engagement**	
RECOMMENDATION:	**The Trust Board is asked to note the trust performance as at M3 2016-17**	
PREVIOUSLY CONSIDERED BY:	**Committee**	
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - June 16

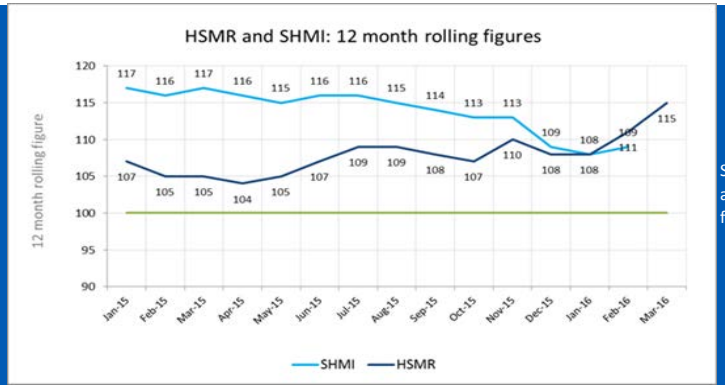
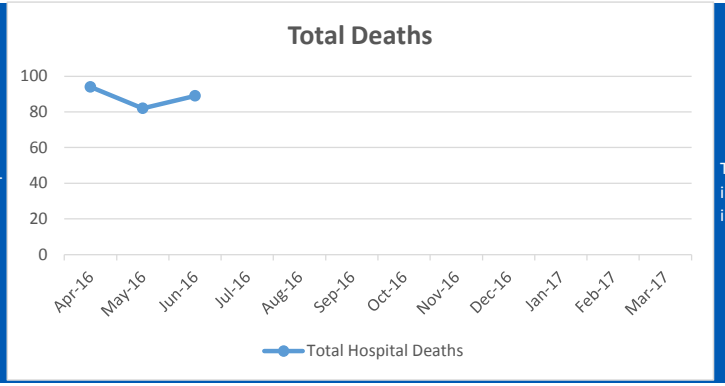
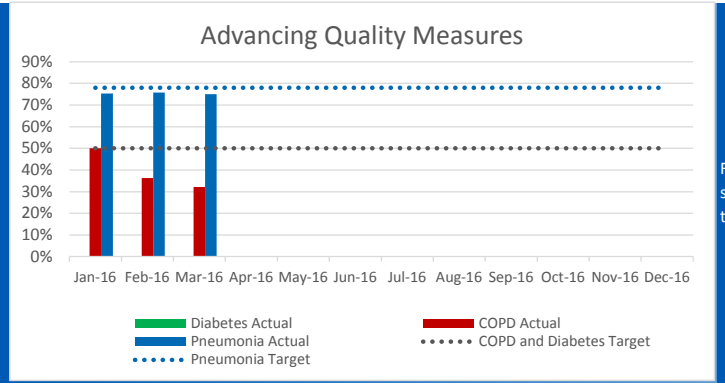
Quality Improvement

	Description	Aggregate Position	Trend	Variation
High Risk Incidents	Major and Catastrophic Incidents and Serious untoward incidents (SUIs) Level 3	There are no approved incidents of major or catastrophic harm for June 2016		There are 8 incidents of major or catastrophic harm under review
Healthcare Acquired Infections	MRSA and CLOSTRIDIUM DIFFICILE (due to lapses in care)	There were no cases of MRSA in Quarter 1. There have been 4 cases of hospital acquired Clostridium Difficile in Q1 however they are still under review so we cannot confirm if they are due to lapses in care.		
Safety Thermometer	% of patients free from harm (Safety Thermometer)	Based on monthly snapshot audit of all inpatients, just over 6% had a fall, pressure ulcer, VTE or catheter acquired infection in June 2016.		

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - June 16

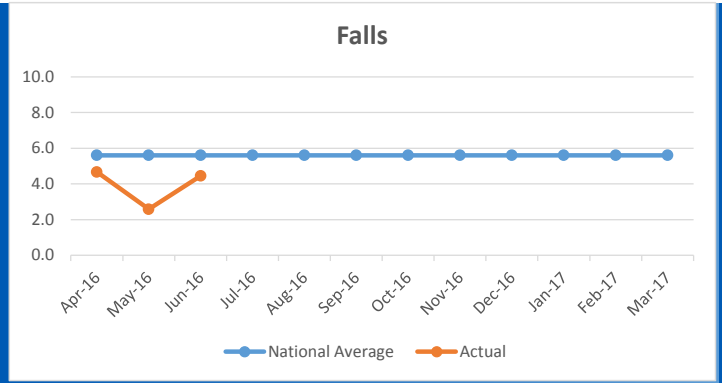
Quality Improvement

	Description	Aggregate Position	Trend	Variation
Mortality Ratios	HSMR (12 month rolling) SHMI (12 month rolling)	The latest HSMR is 'higher than expected' at 115 for April 2015 - March 2016 The latest SHMI is ' as expected' at 109 for March 2015 to February 2016. Following a seasonal rise in deaths in January, February and March, the figures have reduced to 94 in April ,82 in May and89 in June.		SHMI, however, we are in the 'as expected' range. We are currently awaiting data for HSMR - April and SHMI for March.
Total Deaths	Total Deaths in Hospital	The death rate was 2.8% for Q4 2015/16. It is 2.1% for 01/04/16 to 16/06/2016		The Mortality Review Group is tasked with interpreting the data for the above and driving improvements
Diabetes Pneumonia COPD	Chronic Obstructive Pulmonary Disease (COPD), Diabetes and Pneumonia	The data for Diabetes will be collected from April 2016. Possible issues with compliance for COPD include smoking cessation / review inhaler technique measures. The Trust now has a smoking cessation advisor who could support this measure.		For pneumonia we have introduced a quarterly sliding scale to the thresholds and Quarter 1 is 75%. We have therefore met the threshold.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - June 16

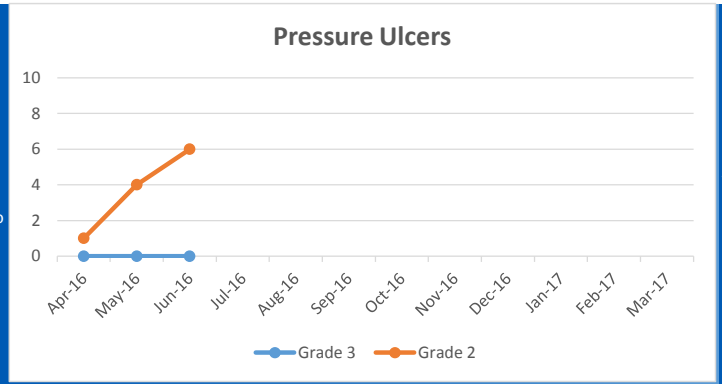
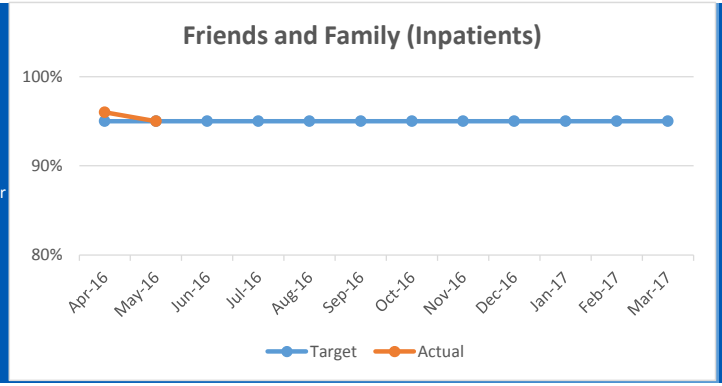
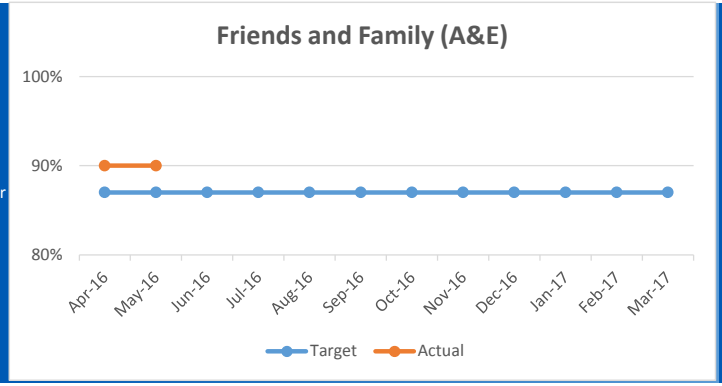
Quality Improvement

	Description	Aggregate Position	Trend	Variation
Sepsis	Screening of all eligible patients - acute inpatients (*to be validated). Screening of all eligible patients admitted to emergency areas (*to be validated). Inpatient received treatments and empiric review within three days of prescribing antibiotics. Emergency patients received treatment and emperic review within three days of prescribing the antibiotics.	This data is not yet available for any of the measures. There are a number of data collection and resource issues and a meeting is due to take place on 25th July to identify solutions going forward. The Trust is due to submit data by 12th August 2016.	Awaiting Data	
Antimicrobial Resistance and Stewardship	Antimicrobial Resistance and Stewardship - Reduction in antibiotic consumption per 1,000 admissions. Antimicrobial Resistance and Stewardship- Empiric Review of antibiotic prescriptions within 72 hours	The Trust has submitted the baseline data as required for 2013/2014 - 2015/2016. The 2016/2017 Q1 usage report will be available when the pharmacist has received data from the Homecare Company. This will be submitted in approximately one weeks time and will be available for the next dashboard.	Awaiting Data	
Falls	Falls per 1000 bed days	We are below the national average of 5.6 approved falls per 1000 bed days in Quarter 1.		

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - June 16

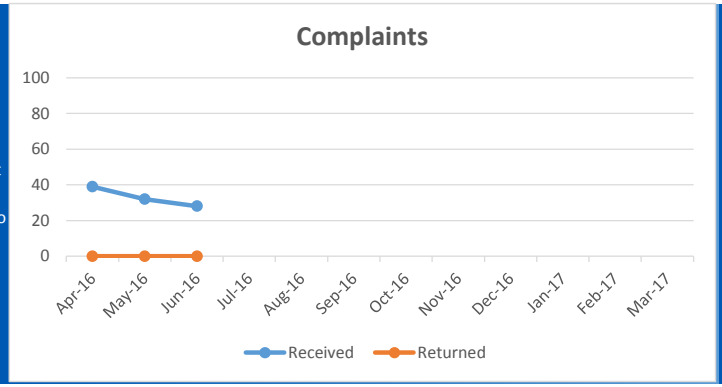
Quality Improvement

	Description	Aggregate Position	Trend	Variation
Pressure Ulcers	Grade 3 hospital acquired (avoidable). Grade 2 hospital acquired (avoidable and unavoidable)	We have no confirmed grade 3 or 4 pressure ulcers. We have 12 approved grade 2 pressure ulcers for Quarter 1. The threshold of 82 for the year equates to 6 per month and 20.5 per quarter.		There are 4 cases of Grade 3 or 4 pressure ulcers under review for Quarter 1
Friends and Family (Inpatients)	% recommending the Trust : Inpatients.	This data is sourced from NHS England and is one month in arrears. We have met the monthly target for April and May 2016		
Friends and Family (A&E)	% recommending the Trust : A & E	This data is sourced from NHS England and is one month in arrears. We have met the monthly target for April and May 2016		

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - June 16

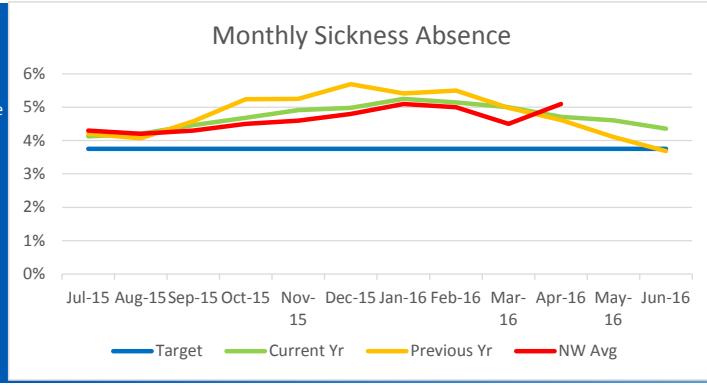
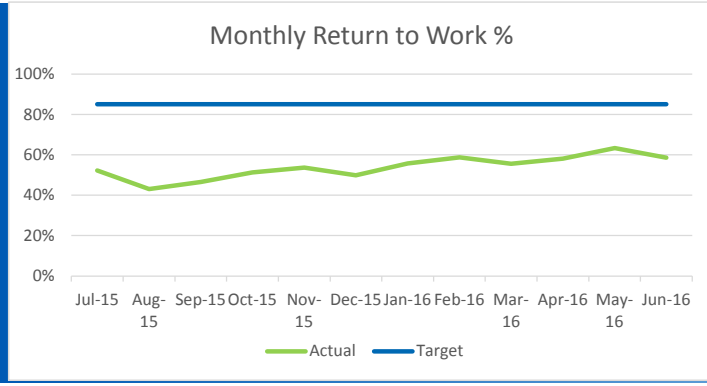
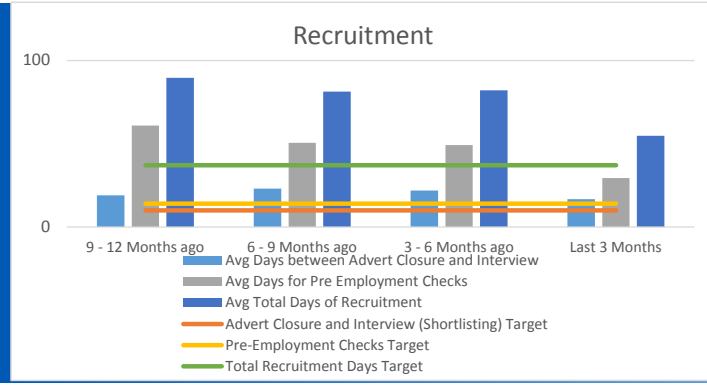
Quality Improvement

	Description	Aggregate Position	Trend	Variation
Complaints	Total complaints received. Total returned complaints	The Trust received 99 complaints in Quarter 1. No complaints have been returned in Quarter 1 (NB this data collection started in May 2016). Please note that the data for the number of complaints and concerns are reviewed on a monthly basis and can be subject to change as complaints can become concerns (and vice versa), with the agreement of complainants.		We started to collect data in May 2016 for complaints returned.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - June 16

Workforce

	Description	Aggregate Position	Trend	Variation
Sickness Absence	Comparing the monthly sickness absence % with the Trust Target (3.75%) previous year, and North West average	Sickness absence for June 2016 was 4.36%, a decrease in the previous month's performance however 0.68% higher than the same period last year. The latest figures for the North West absence performance currently stands at 5.1%. The YTD sickness % is 4.6% against a target of 3.75%		June 2015 was the only month in the last 24 where the Trust was below the 3.75% target, however early signs suggest that WHH are below the North West Average. The Attendance Management policy is close to being signed off which is expected to enhance the methods by which the Trust manages sickness. Stress remains the number one reason for absence with 23% of all sickness absence due to stress. ACS - Jun-16 = 5%, YTD = 4.9% SWC - Jun-16 = 4.3%, YTD = 4.7% Corp - Jun-16 = 3.3%, YTD = 3.8%
Return to Work	A review of the completed monthly Return to Work Interviews	RTW compliance continues to be below the Trust Target and has followed a similar pattern of reducing following two months of positive movement.		Completion of RTWs is considered key to good sickness management and therefore we continue to encourage all managers to ensure completion. For the avoidance of doubt, the RTW can be recorded in either ESR or E-Rostering, there is no need to record the date in both. HRBPs continue to support their managers to increase compliance.
Recruitment	A measurement of the average number of days it is taking to recruit into posts. It also shows the average number of days between the advert closing and the interview (target 10) to measure if we are taking too long to complete shortlisting and also highlights the number of days for which it takes successful candidates to complete their pre-employment checks	Recruitment times continue to reduce but disappointingly as a Trust we are still taking 6.7 days longer between advert closure and Interview date than the 10 day target.		The team continue to improve their processes to ensure the pre-employment stage is as efficient as possible. Currently e-Forms are being explored - this may require investment. All recruiting managers are encouraged to plan their shortlisting and interview dates ahead of time, by sticking to the agreed targets recruitment times could be reduced by a week.

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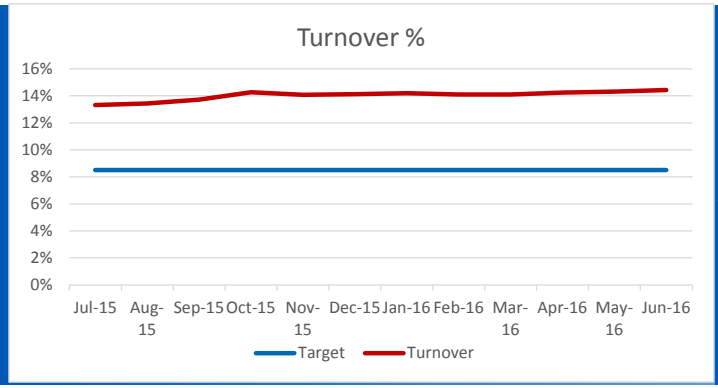
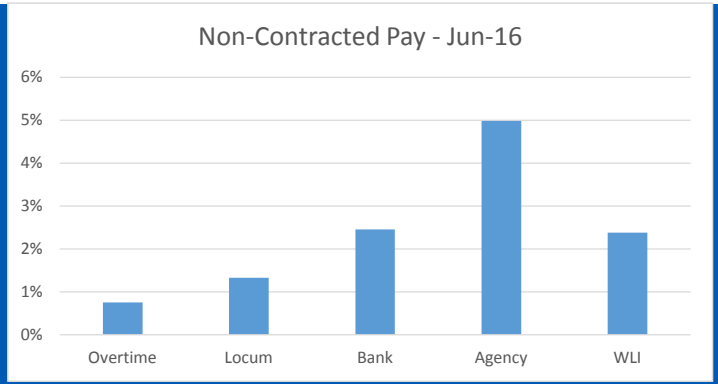
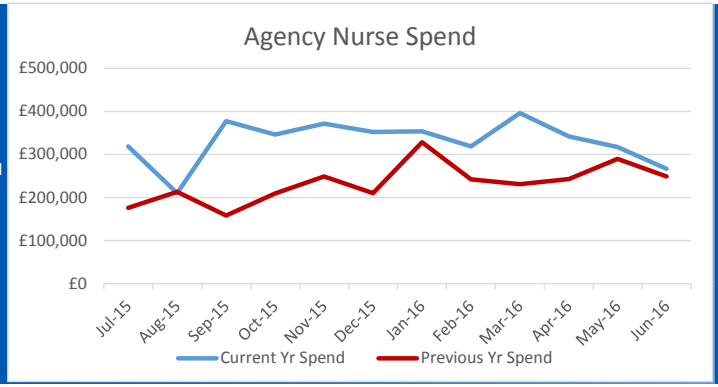
Integrated Dashboard - Board of Directors - June 16

Workforce

	Description	Aggregate Position	Trend	Variation
Turnover	A review of the turnover percentage over the last 12 months	Turnover, now 14.44% isn't moving much and continues to be above the Trust target of 8.5%.		During the last three months the number of leavers and new starters have been very similar and in the past 12 months we have averaged 39.9 FTE new starters and 39.7 FTE leavers. The main reasons people are leaving WHH is for an improved Work Life Balance (94 people in the last 12 months). Work continues within the CBUs to address this.
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 5% of the Trusts overall pay bill year to date. This has however reduced from 6% in April 2016. WLI spend now accounts for 2.38% of the pay bill compared to 1.93% in April 2016. Overall Non-Contracted pay now makes up 11.9% of the pay bill compared the 13.02% in April 2016 - moving in the right direction.		Work continues on implementing the action plan developed alongside E&Y. Chief operating officer currently reviewing options for future WLI payments.
Agency Nurse Spend	A review of the monthly spend on Agency Nurses	Agency Nurse spend continues to reduce this Financial year, however the Trust is still spending more than it was this time last year.		On-going work continues to reduce the reliance of Agency Nurses and it is hoped this reduction will continue. On Thursday 21st July, the Trusts second Staff Nurse recruitment morning will be held and we're hoping for similar results to last time where 31 Nurses have been offered roles. Trust working with NHS Employers to setup an agency spend summit meeting

Warrington and Halton Hospitals NHS
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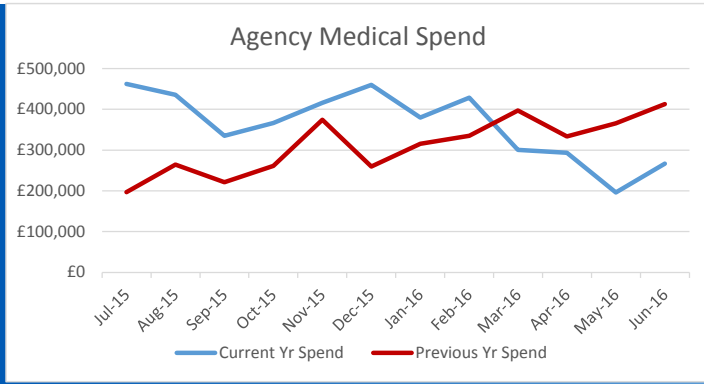
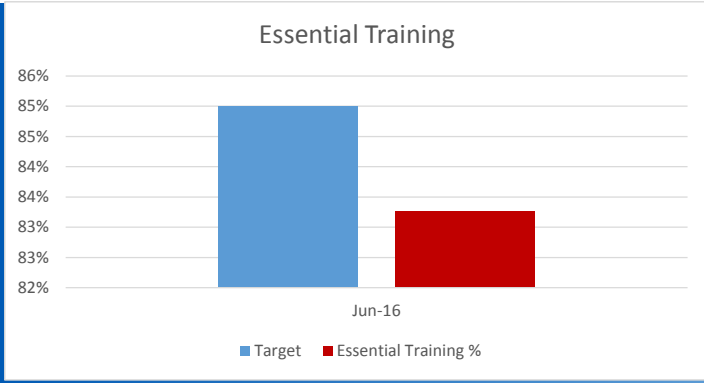
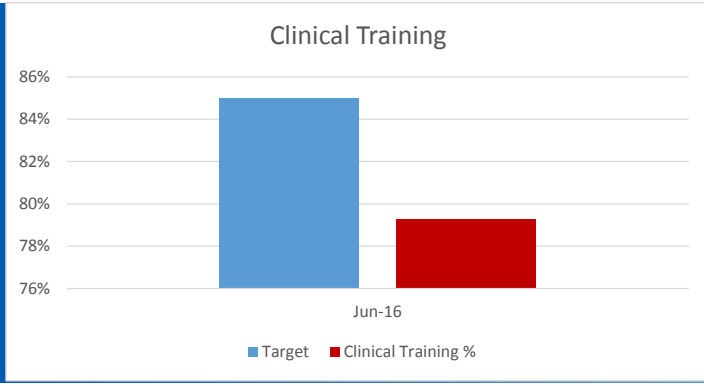
Integrated Dashboard - Board of Directors - June 16

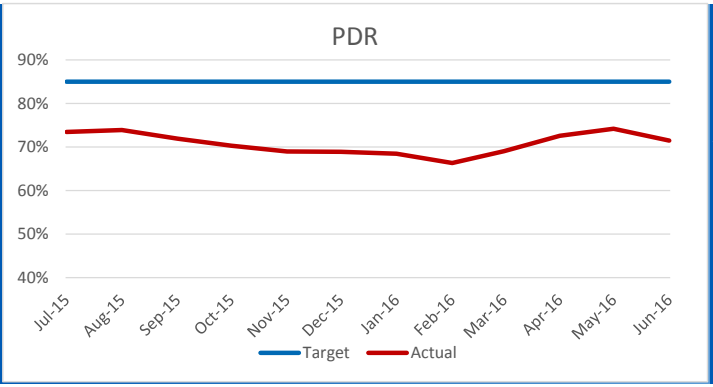
Workforce

	Description	Aggregate Position	Trend	Variation
Agency Medical Spend	A review of the monthly spend on Agency Locums	Agency Medical spend increased for the first time since Feb-16 but we're still spending less than last year.		The Trust continues attempts to enforce the Price Cap rules, however it's proving difficult and currently around 80% of our shifts worked each week breach the Price Cap. The extra scrutiny by the Chiefs of Service however has seen a reduction in the number of Locum shifts required through increased Grip and Control Trust working with NHS Employers to setup an agency spend summit meeting
Essential Training	A summary of the Essential Mandatory Training Compliance, this includes: Corporate Induction Dementia Awareness, Fire Safety Health and Safety Moving and Handling	The current compliance for June-16 is 83.26%		Grouping the Mandatory Training in this method is new way of reporting compliance, historic figures are however not yet available.
Clinical Training	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 current compliance for June-16 is 79.3%		Grouping the Mandatory Training in this method is new way of reporting compliance, historic figures are however not yet available.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - June 16

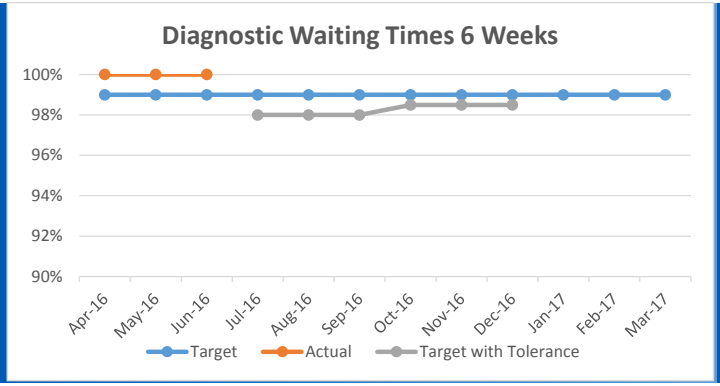
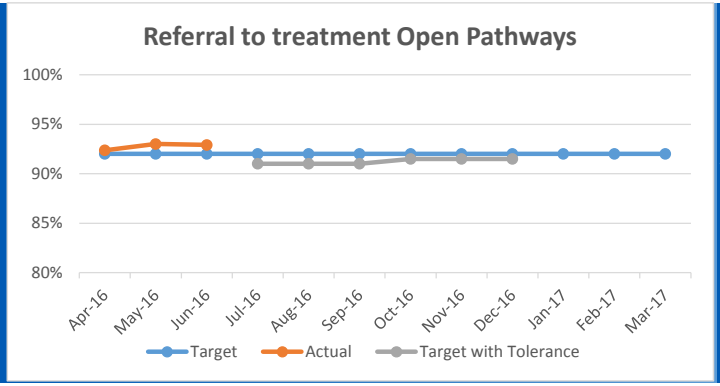
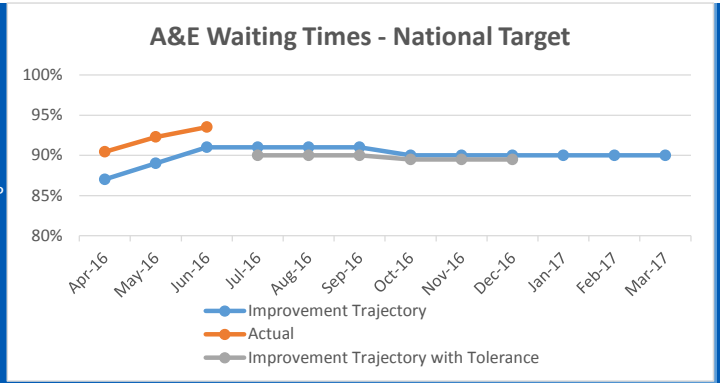
Workforce

	Description	Aggregate Position	Trend	Variation
PDR	A summary of the PDR Compliance rate	Disappointingly the PDR rate dipped for the first time since Feb-16 in Jun-16. The Compliance rate is currently 71.48%, which is still someway off the Trusts target.		The HR team are offering further support to managers who are struggling with their PDR Compliance. We are currently reviewing our response to non compliance with operational managers.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - June 16

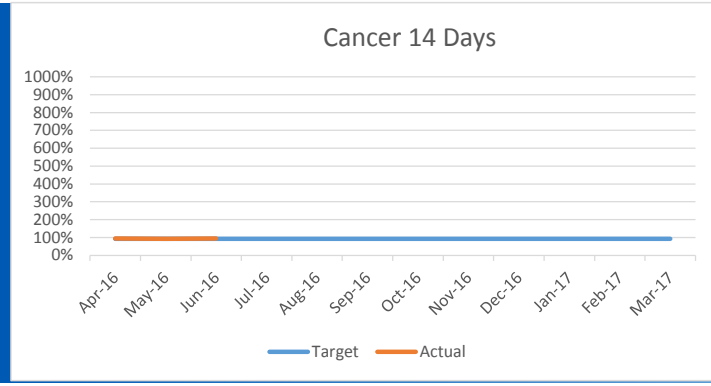
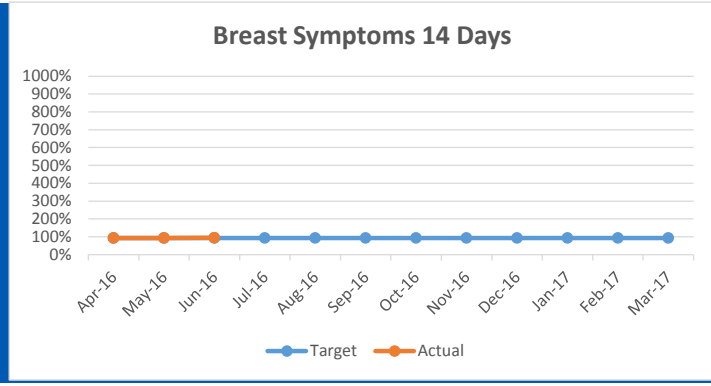
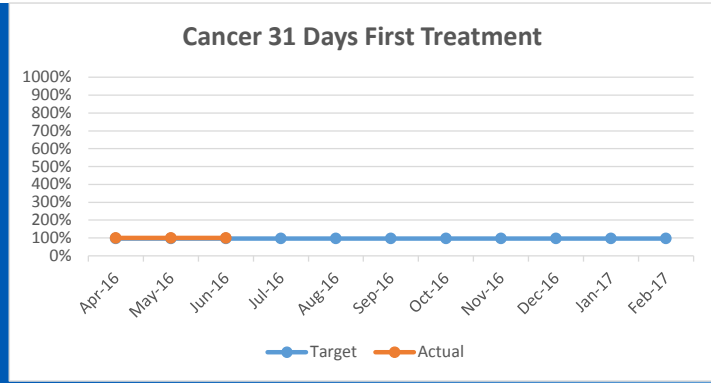
Mandatory Standards - Access & Performance

	Description	Aggregate Position	Trend	Variation
Diagnostic Waiting Times 6 Weeks	All diagnostic tests need to be carried out within 6 weeks of the request for the test being made. The national target is 99% or over within 6 weeks. This metric also forms part of the Trust's Sustainability and Transformation Plan (STP) Improvement trajectory. The proposed tolerance levels applied to the improvement trajectories are also illustrated.	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.		0 breaches of the 6 week standard
Referral to treatment Open Pathways Number of patients waiting 52+ weeks	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 but there are 2 x 52 week breaches. The Trust has also met the STP improvement trajectory.		One Spinal patient and one ENT patient have been waiting 52+ weeks. The only specialities not to achieve the target are: • General Surgery – 87.99% • Urology – 90.91% • T&O – 86.95%
A&E Waiting Times - National Target A&E Waiting Times - STP Trajectory	All patients who attend A&E should wait no more than 4 hours from arrival to admission, transfer or discharge. The national target is 95% This metric also forms part of the Trust's STP improvement trajectory. The proposed tolerance levels applied to the improvement trajectories are also illustrated.	The Trust is not achieving the 95% national 4 hour target. However the Trust is achieving against the STP improvement trajectory.		Whilst the Trust is not achieving the 95% national target improvement in performance continues with the Trust meeting the STP Improvement trajectory.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - June 16

Mandatory Standards - Access & Performance

	Description	Aggregate Position	Trend	Variation
Cancer 14 Days	All patients need to receive first appointment for cancer within 14 days of urgent referral. The national target is 93%. This target is measured and reported on a quarterly basis.			
Breast Symptoms 14 Days	All patients need to receive first appointment for any breast symptom (except suspected cancer) within 14 days of urgent referral. The national target is 93%. This target is measured and reported on a quarterly basis.			This target is becoming more and more challenging each month due to patient choice.
Cancer 31 Days First Treatment	All patients to receive first treatment for cancer within 31 days of decision to treat. This national target is 96%. This target is measured and reported on a quarterly basis.			

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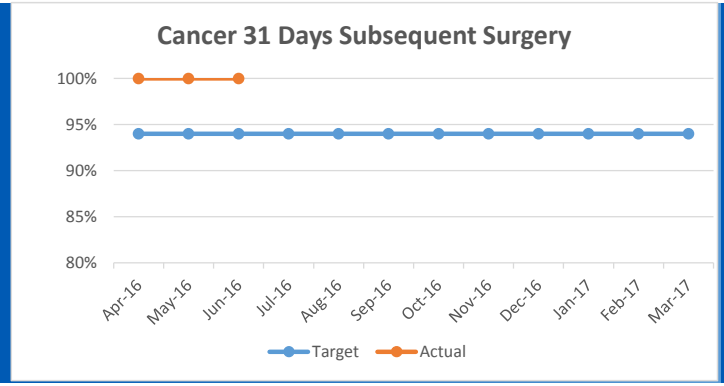
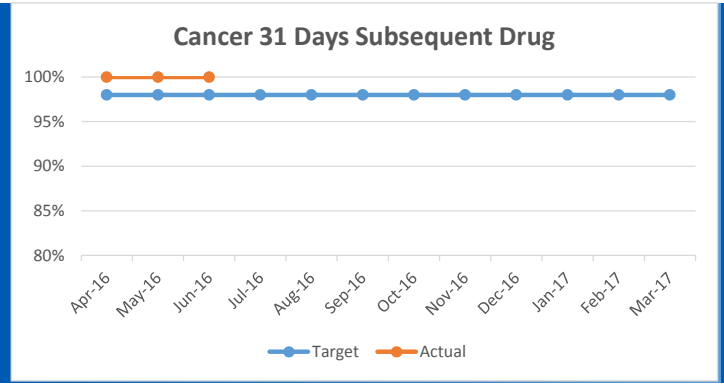
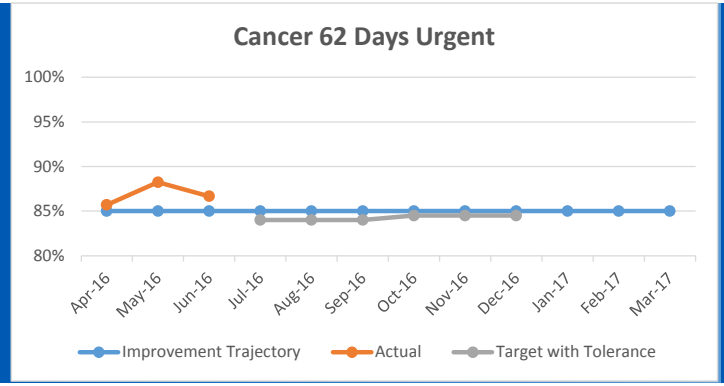
NHS Foundation Trust

Integrated Dashboard - Board of Directors - June 16

Mandatory Standards - Access & Performance

	Description	Aggregate Position	Trend	Variation
Cancer 31 Days Subsequent Surgery	All patients to receive a second or subsequent treatment for cancer within 31 days of decision to treat/surgery. The national target is 94%. This target is measured and reported on a quarterly basis.			
Cancer 31 Days Subsequent Drug	All patients to receive a second or subsequent treatment for cancer within 31 days of decision to treat – anti cancer drug treatments. The national target is 98%. This target is measured and reported on a quarterly basis.			
Cancer 62 Days Urgent	All patients to receive first treatment for cancer within 62 days of urgent referral. The national target is 85%. This metric also forms part of the Trust's STP Improvement trajectory. The proposed tolerance levels applied to the improvement trajectories are also illustrated.			

Warrington and Halton Hospitals NHS
NHS Foundation Trust

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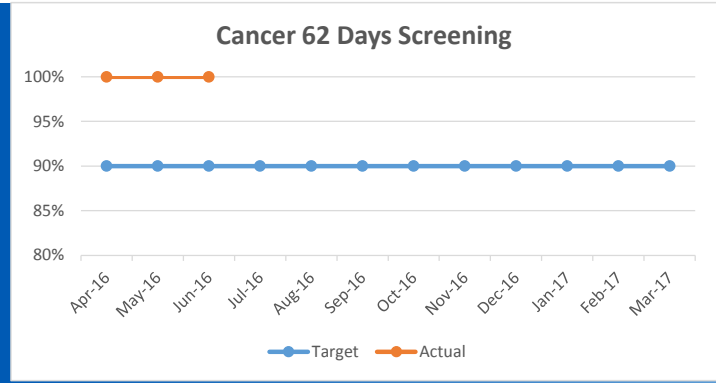
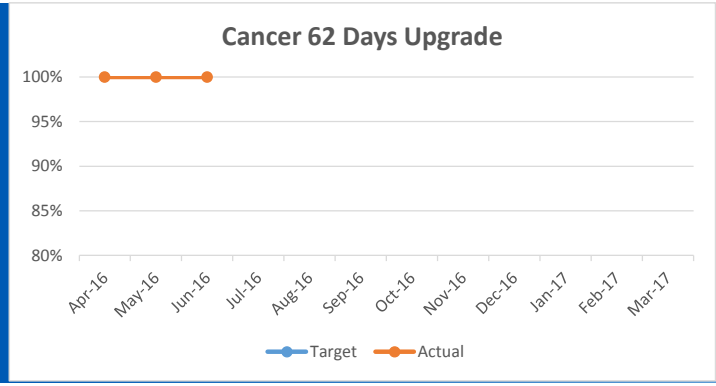
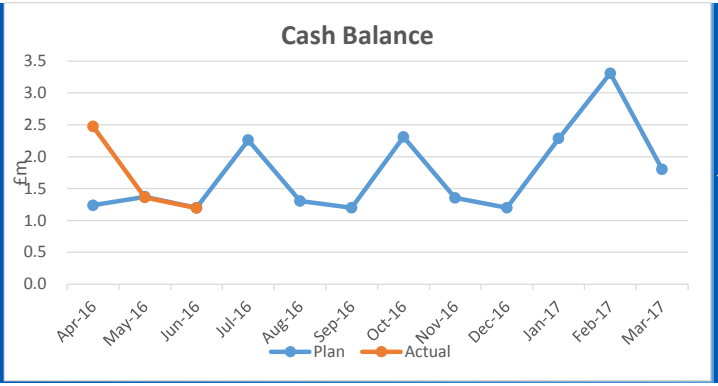
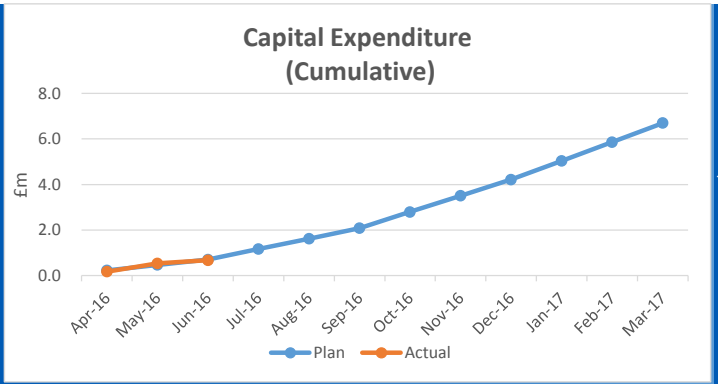
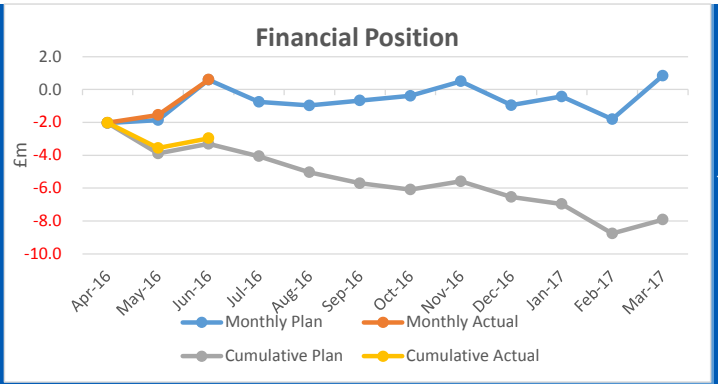
Mandatory Standards - Access & Performance

	Description	Aggregate Position	Trend	Variation
Cancer 62 Days Screening	All patients must wait no more than 62 days from referral from an NHS screening service to first definitive treatment for all cancers. The national target is 90%. This target is measured and reported on a quarterly basis			
Cancer 62 Days Upgrade	62 day upgrade			

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - June 16

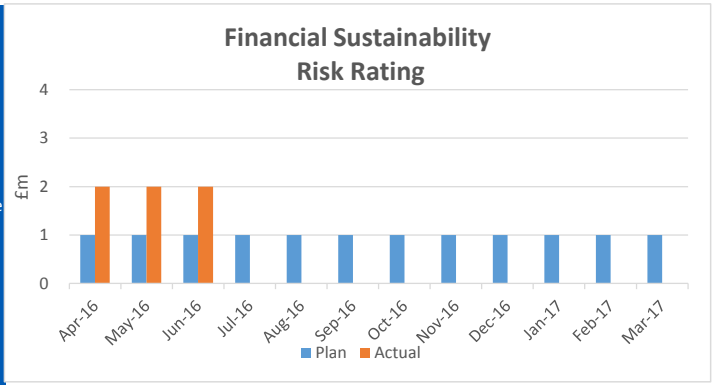
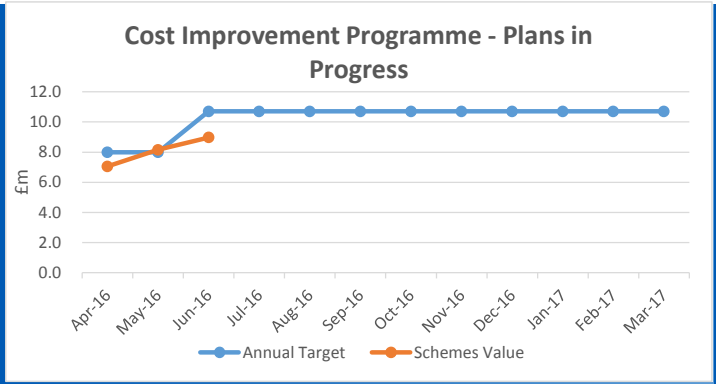
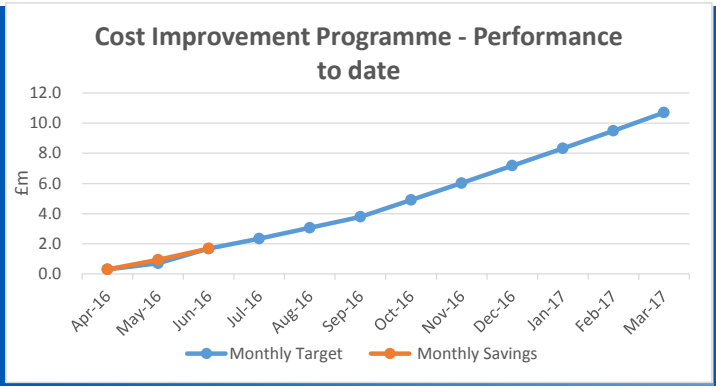
Safely Reducing Costs & Mandatory Standards - Finance

	Description	Aggregate Position	Trend	Variation
Cash Balance	Cash held in our Government Services Bank Account	Under the terms of the working capital loan the Trust is required to have a minimum cash balance during the month of £1.2m. The current cash balance of £1.2m equates to circa 2 days operational cash.		The current cash balance of £1.2m is in line with the planned cash balance.
Capital Expenditure (Cumulative)	Year to date capital expenditure	The annual capital programme for the year is £6.7m and to date £0.7m has been spent.		The current capital spend of £0.7m is in line with the planned spend.
Financial Position	Net income and expenditure position	The actual surplus in the month is £0.6m which reduces the cumulative deficit to £3.0m		The cumulative deficit of £3.0m is £0.3m below the planned deficit of £3.3m

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - Board of Directors - June 16

Safely Reducing Costs & Mandatory Standards - Finance

	Description	Aggregate Position	Trend	Variation
Financial Sustainability Risk Rating	NHSI metric of financial risk.	The Financial Sustainability Risk Rating for the year to date is a rating of 2. Capital servicing capacity, Liquidity and I&E margin are all at the highest risk (Level 1) whilst I&E margin as a percentage of plan is at the lowest risk (Level 4).		The current Financial Sustainability Risk Rating of 2 is better than the planned rating of 1.
Cost Improvement Programme - Plans in Progress	Planned improvements in productivity and efficiency.	The Trust has a CIP target of £11m and delivery of £10.7m is currently assumed in the reforecast financial plan. To date the Trust has developed schemes worth £9.0m in year (£9.9m recurrently).		The value of the planned savings is £9.0m which is £1.7m below the annual target included in the reforecast annual plan.
Cost Improvement Programme - Performance to date	Performance against the cost savings target	In month the Trust has delivered savings of £0.7m which increases the cumulative savings to £1.7m.		The cumulative savings of £1.7m are in line with the planned savings of £1.7m

Warrington and Halton Hospitals NHS
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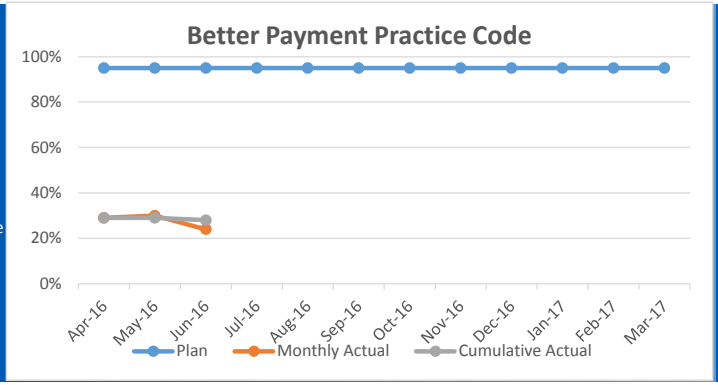
Integrated Dashboard - Board of Directors - June 16

Safely Reducing Costs & Mandatory Standards - Finance

	Description	Aggregate Position	Trend	Variation
Better Payment Practice Code	Payment of trade invoices within 30 days of invoice date.	In month the Trust has paid 24% of suppliers withiin 30 days and the cumulative performance is 28%. The reduction in compliance in the month is due to the fact that more invoices over 30 days overdue have been paid.		The cumulative position of 28% is 67% below the national standard of 95%

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Trust Engagement Dashboard June 2016

Director of Community Engagement

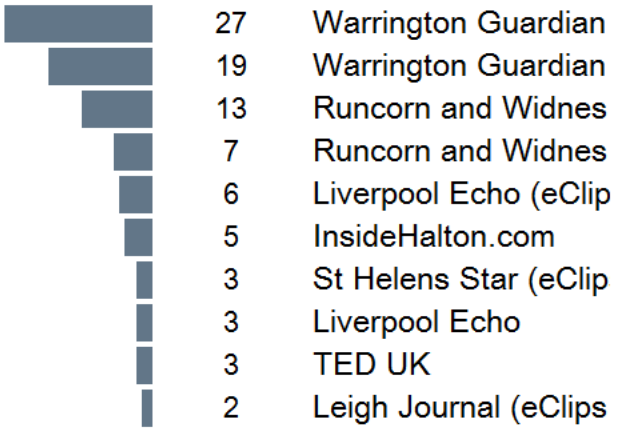
HIGH QUALITY, SAFE HEALTHCARE
QUALITY PEOPLE SUSTAINABILITY

We are WHH

Media Dashboard (Public Engagement)
1-30th June 2016

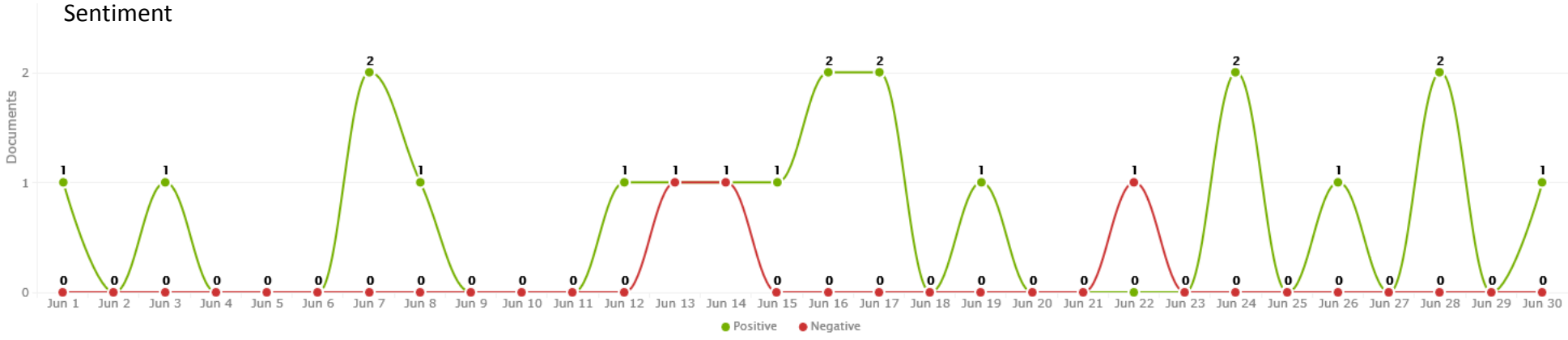
Warrington and Halton Hospitals

Top 10 Publications by Volume



Total media coverage = 123 reports

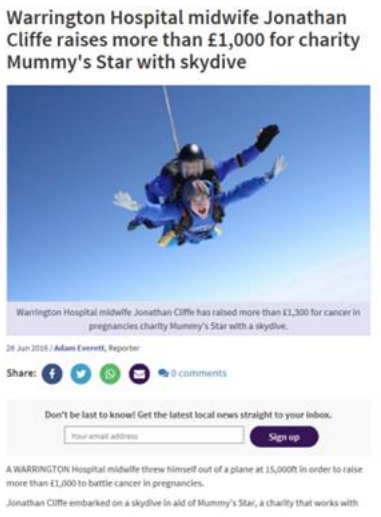
Sentiment



We are WHH

Media Dashboard (Public Engagement)/2

Top positive stories	Publication	Total Reach
Patient's £125,000 gift funds new hospital restaurant and equipment	R&WW print and online	106,096
Halton's unsung heroes honoured	R&WW print and online	106,096
'Little miracle' who survived four heart attacks to begin teaching at high school	WG print and online	116,422
A&E nurse retires after more than 35 years working at Warrington Hospital	WG print and online	116,422
REVEALED: Warrington Hospital's new birthing unit	WG print and online	116,422
Warrington swimmer Judy Brown speaks about defying cancer to win two medals at the European Masters Championships	WG print and online	116,422
Warrington Hospital midwife Jonathan Cliffe raises more than £1,000 for charity Mummy's Star with skydive	WG print and online	116,422
Dr Graham Barton retires after more than 35 years of service to Warrington Hospital	WG print and online	116,422
Pupil saves mum from choking after learning school first aid skills	WG print	61,875
999 What's Your Emergency? episodes filmed in Warrington to begin airing next week	WG print	61,875
Runcorn man's amazing legacy for hospital	Liverpool Echo online	168,559
Walking group founders receive gongs at Halton's Get Active awards	Liverpool Echo online	168,559
Cost-effective recruitment methods for a large randomised trial in people with diabetes: A Study of Cardiovascular Events iN Diabetes (ASCEND)	Bio Med Central	1,235,932


Warrington Hospital midwife Jonathan Cliffe raises more than £1,000 for charity Mummy's Star with skydive

Warrington Hospital midwife Jonathan Cliffe has raised more than £1,300 for cancer in pregnancies charity Mummy's Star with a skydive.

28 Jun 2016 / Adam Everett, Reporter

Share: 0 comments

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A WARRINGTON Hospital midwife threw himself out of a plane at 15,000ft in order to raise more than £1,000 to battle cancer in pregnancies.

Jonathan Cliffe embarked on a skydive in aid of Mummy's Star, a charity that works with


Patient's £125,000 gift funds new hospital restaurant and equipment

Hospital chairman Steve McGuirk, Mayor of Halton Cllr Ged Philbin, George Lloyd's wife Ina and his cousin Alan Bratt at the opening of the restaurant

7 Jun 2016 / Barbara Jordan, Chief Reporter / @worldbarbara

Share: 1 comment

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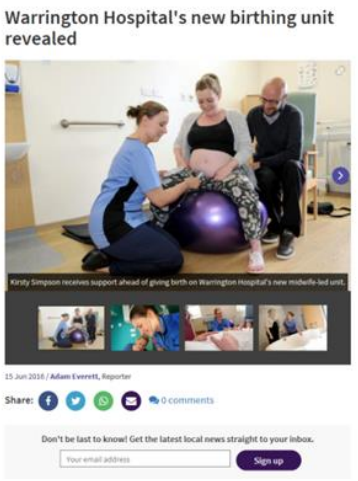
CATERING facilities at Halton Hospital have been given an £80,000 makeover, thanks to a legacy from a former patient

Media Dashboard

Overall a positive month in the media, highlights being our skydiving midwife Jonathan Cliffe, the George Lloyd Legacy and the opening of the new Midwifery-led unit .

Negative media included NHS hospitals income from parking fines


Warrington Hospital's new birthing unit revealed

Kirsty Simpson receives support ahead of giving birth on Warrington Hospital's new midwife-led unit.

15 Jun 2016 / Adam Everett, Reporter

Share: 0 comments

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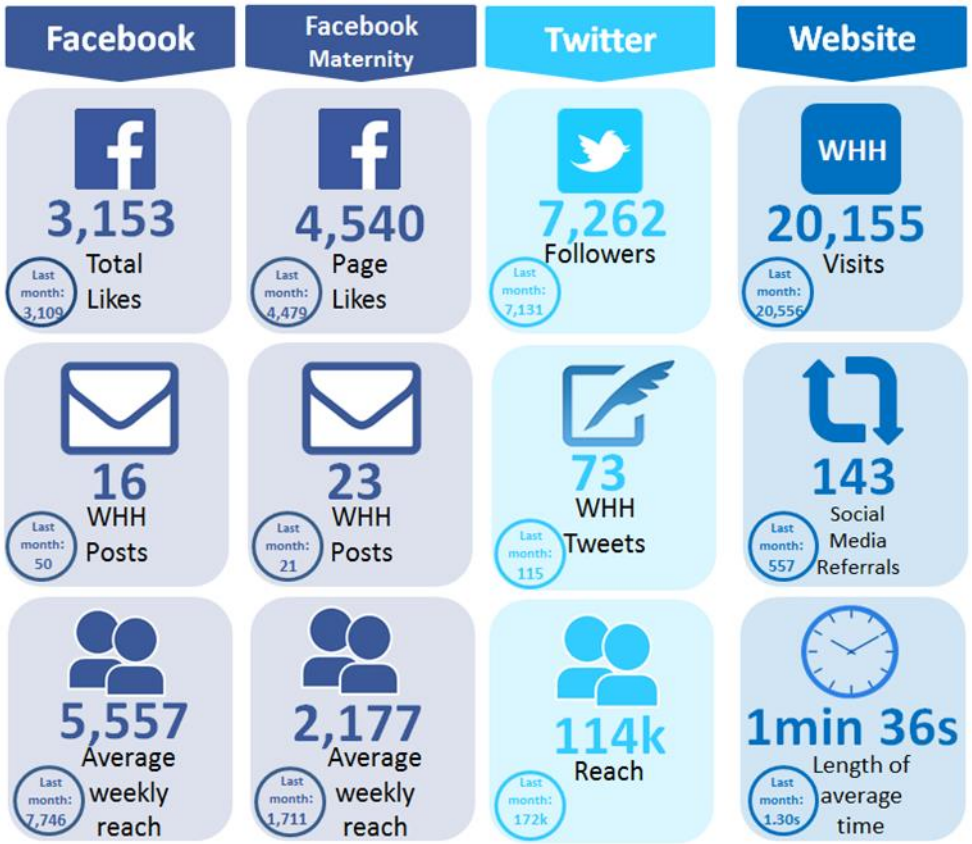
All negative stories	Publication	Total Reach
Letter: Affordability now seems to be the byword for hospital care	Shropshire Star	106,286
Hospitals feeling just fine collecting millions in car park charges	UK	1,242,157
NHS's £350m parking goldmine: Trusts collect average of £950,000 each in the past three years while receiving £2.8m in fines	Daily Mail Online	44,677,679

Social/Digital Media (Public Engagement)/3

We are WHH

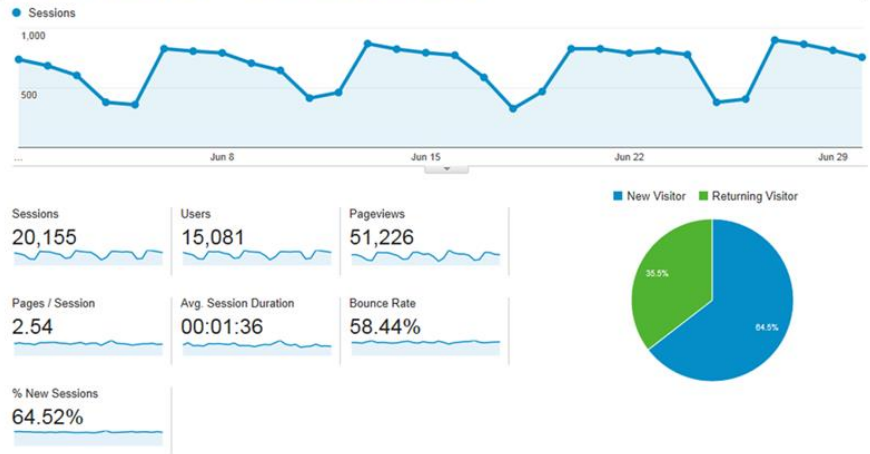


Top Landing Pages	%	Visits
Home page	22.39	4,512
Contact us	9.10	1,835
Current vacancies	8.93	1,800
Hospital shuttle bus	5.82	1,173
Urgent Care Centre - Runcorn	4.27	861
Warrington Hospital	3.72	750

WEBSITE ACTIVITY

- → Website traffic was stable at around 20K visits
- ↓ Social media referrals decreased (to normal levels – there was an unusually high volume of condition awareness campaigning in May)
- → Dwell time was roughly static
- → New visitors continued to account for two thirds of all traffic
- → Most visitors land at the beginning of the week, tailing off towards the weekend

Google analytics – WHH website visits



Social Media Dashboard JUNE 2016

- ↑ Facebook likes increased in month by 44
- ↓ Average weekly FB reach reduced to 5.6K from 7.8K.
- ↑ Maternity Facebook community continues to thrive with increase in likes by 61 and increased activity
- ↑ Twitter followers increased by 131 in month
- ↓ Tweets decreased to 73 in month, reach was slightly down to 114K followers

We are WHH

Patient Engagement

NHS Choices
↑ Increase in comments in month by 5
→ Star Rating remains unchanged in month

Friends and Family Test (Adult services)

↓ Responses decreased by 224 in month
↓ Star rating reduced by 0.02
↑ % likely to recommend increased by 1.7%
↑ % unlikely to recommend increased by 0.4%

NHS Choices

16
No. of comments posted
Last month: 11

100%
No. of comments responded to within five working days
Last month: 100%

Halton – 5 stars
CMTC - 5 stars
Warr – 3.5 stars

Warrington and Halton Hospitals NHS Foundation Trust

Date: 01 June - 30 June

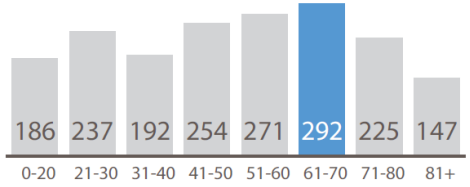
Your average score for all questions this period: 4.76

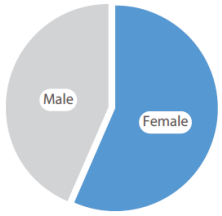
Reviews this period: 1929

Your recommend scores

5 Star Score	% Likely to recommend	% Unlikely to recommend
4.75	95.8%	1.3%

Reviews by patient's age





Top three services (with 5 reviews or more)	
Ward A4	5.00
Oral Surgery Department Warrington	4.98
Catheter Lab Warrington	4.95

Bottom three services (with 5 reviews or more)	
Clinical Decisions Unit	4.37
Ward B12	4.32
Ward A3	4.07

Friends and Family Test (Adult services)

Staff Engagement

Extranet engagement:

↑ 1,854 staff registered on the new extranet since launch 24.2.16 (increase in month of 233 new registrants)
↑ Bounce rate 30.7% (Bounce rate is indication of interaction with site: (Good is 26% – 40%, average is 40% – 55%, bad is 56-80%)

Team Brief Attendances

❑ Staff nominating colleagues for :
- ↑ Employee of Month = 7 (no change month on month)
- ↑ Team of Month = 3 (no change month on month)

Quarterly Data (latest quarter is Q1 – data is incomplete at time of reporting)

❑ Q1 Staff FFT responses (online results only) 102 (Q4– 315 responses)
- **Staff FFT Recommend for Care / treatment**
  - ↑ 72% extremely likely or likely (Q4 70%)
  - ↑ 16% extremely unlikely or unlikely (Q4 16%)
- **Staff FFT Recommend as Place of Work**
  - ↑ 66% extremely likely or likely (Q4 64%)
  - ↑ 24% extremely unlikely or unlikely (Q4 21%)

❑ Q4 Staff attending 'Big Conversations' – Bright Ideas = 60

Annual Data:

❑ NHS Staff Survey 2015 – Engagement score 3.74 (worse than similar Trusts)

We are WHH

Other Stakeholder Engagement

GPs

- GP Engagement Dashboard developing to capture feedback, escalate issues and enable better planning
- Practice visits programme in month:
  - Padgate Medical Centre
  - **Castlefields Health Centre**
- **New directory of Services** – to complete in July 2016 – on track
- **WHH Clinical and non clinical education programmes offered to primary care colleagues:**
  - **Basic Life Support Skills training for Primary Care Clinicians** delivered by Deputy Medical Director and Emergency Care specialist Dr Nick Jenkins on Weds 31st August at Halton Hospital Education Centre and on Weds 12th October at Warrington
  - **Current trends in the management of the diabetic foot.** Conference chaired by Mr Thomas Nicholas, Consultant Vascular Surgeon and Mr Colin Chan, Consultant Vascular Surgeon Thursday 15th September

FT Governors and Membership

- *Your Hospitals* (via News Quest) Latest issue published 22 June 2016 Audience reach >80K in print and >300K on line
- Annual open day held 2nd July at Warrington, overall well received
- Your Health events planned for members:
  - Diabetes awareness - Tuesday 19th July 2016
  - Take a closer look at Ophthalmology – Wed 14th September 2016

WHH Charity

Warrington & Halton Hospitals' Charity

Donor Relationships/ Management

↑ Donors total on system 520 (Individuals 441, Corporate 79)
↑ Individual donations – 49 donations =totalling £17,599.55 (ex Gift Aid)

- **New Corporate relationships**
- Swinton Insurance– engaging Swinton's staff to support events and spend a day volunteering.
- Doncaster Racecourse – donation of tickets

Community Fundraising

- School & Clubs campaign – colouring competition r Sept – December raising funds for Making Waves campaign
- **Staff Fundraisers**
- Fundraising – Reverend Phil Turner London to Paris Cycle
- Ward fundraising – Neonatal/Children's Ward continues
- **Partnership working**
- New relationship with Brainwave Charity – joint Comedy night planned for March 30th 2017

Events:

- Recruiting now for the Capesthorne Hall Born Survivor 10K race with 30 obstacles on 24th September - a fierce challenge not for the faint hearted!
- **WHH Charity Abseil –** 25th September

Campaigns

- Making Waves campaign – target £100K
- To launch: Autumn Forget me Not Appeal for extension of FMN Garden

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/16/150**	
SUBJECT:	**Key Issues Report from the Quality Committee July 2016**	
DATE OF MEETING:	**27th July 2016**	
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 MONTH meeting. The revised Terms of Reference are also attached for ratification by the Board.**	
RECOMMENDATION:	**The Board note the report and that there are no matters arising for escalation.** **The Board satisfies itself that the revised Terms of Reference will ensure the Committee delivers the assurance It requires and either makes amendments or ratifies accordingly.**	
PREVIOUSLY CONSIDERED BY:	**Committee**	**Not Applicable**
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	

KEY ISSUES REPORT
QUALITY COMMITTEE

Date of meeting:	
Standing Agenda Items	The meeting was quorate. Minutes of the meeting held on 7th June 2016 were approved as a correct record.
Formal Business	The Committee considered the Quality Summit undertaken to review the practice and quality standards on B14. The background to this includes a red rating on the DAWES and a serious patient complaint. The paper presented was a self-assessment that focussed mainly on the nursing care. Suggestions were made regarding additional information that could be included to give the report a more multi-disciplinary perspective. Overall the exercise was positive in both the process and providing reassurance that care is of a high quality. One important outcome has been some reorganisation of the staffing and the teams. A high level MAZARS Enquiry summary report, produced following an investigation into the poor practice at Southern Health NHS Foundation Trust regarding the failure to investigate unexpected deaths, was discussed. This led to a more general discussion about how patients with learning disability are cared for at WHH and the process of review in the event of a death. Any deaths of a patient with LD would be formally reviewed at the mortality reviews that take place for all deaths. An important issue that was highlighted is the need to consider adult safe-guarding issues when managing vulnerable patients and the CCG representatives present made several helpful suggestions about how WHH could link with the wider system. The Quality Dashboard was reviewed. There have been 3 Grade 3 pressure sores, one of which is expected to be hospital acquired. The Must score is green for the first time for a while. HSMR is higher than expected but this is likely to be due to a coding error. This is currently being investigated and will be reported on at the next Quality Committee in August. Goddard Enquiry report was discussed. This relates to historical abuse. There is a significant checklist for organisations to work through. This was reviewed at the committee but work is still at an early stage and it will

	come back for further consideration. The NHS Safety Thermometer Benchmarking Data and the National Patient Inpatient Survey were reviewed. Both show the Trust to be performing well in comparison to other organisations. For the Patient In-patient survey WHH is in the same range (about the same) as most Trusts but WHH compares well to local Trusts. SUIs – 3 new incidents in June, one involving a delay in diagnosis in a gastro-intestinal presentation. The new management arrangements will enhance working arrangements between the physicians and surgeons and should encourage early referral for a surgical opinion. Medicines management Stanford Workshops – project group for medicines management 3 main recommendations • EPM (electronic prescribing) • Improving prescribing knowledge of frontline staff • Whole system transformation Need for a wider business case for medicines management. Corporate Risk Register • Flooring B14 – there is a plan in place for this to be replaced. • The Lorenzo risk was discussed. A clinical risk summit has been requested by the Exec Team and was due to take place on the 15th July. Update and feedback from the summit to be given at the next QC.
Local Policies and Guidance Approved:	WHHFT Escalation Plan – approved. However, should it be audited to assure effectiveness? On-call Guidance - approved
Any Learning and Improvement identified from within the meeting:	None
Any other relevant items the Committee wishes to escalate?	Audit of WHHFT Escalation Plan to Audit Committee (This was discussed at the Audit Committee on 13th July. Not appropriate for MIAA programme so will be considered by the QC at the next meeting.)

We are WHH

Warrington and Halton Hospitals NHS
NHS Foundation Trust

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/16/151**	
SUBJECT:	**Safeguarding Children Annual Report**	
DATE OF MEETING:	**27th July 2016**	
ACTION REQUIRED	**For Assurance**	
AUTHOR(S):	**Katie Clarke, Matron / Named Nurse For Safeguarding Children**	
EXECUTIVE DIRECTOR SPONSOR:	**Karen Dawber, Director of Nursing and Governance**	
LINK TO STRATEGIC OBJECTIVES:	**All**	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	**BAF1.1: CQC Compliance for Quality**	
	BAF1.3: National & Local Mandatory, Operational Targets	
	BAF3.3: Clinical & Business Information Systems	
FREEDOM OF INFORMATION STATUS (FOIA):	**Release Document in Full**	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	**None**	
EXECUTIVE SUMMARY (KEY ISSUES):	**This is the 12th annual report on Child Protection /Safeguarding Children. 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.**	
RECOMMENDATION:	**The Board note the report and the key objectives for 2016-17.**	
PREVIOUSLY CONSIDERED BY:	**Committee**	**Not Applicable**
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Child Protection / Safeguarding Children

Annual Report
April 2015 – March 2016
Report compiled by

Katie Clarke – Matron / Named Nurse
Safeguarding Children

Contents:-

Appendix

1. Purpose of Report

This is the 12th annual report on Child Protection /Safeguarding Children. 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 g All staff of Warrington and Halton Hospitals NHS Foundation Trust 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).

Definition of 'children'
Child is defined under Children Act 1989 (H.M.Gov. 2015) as any person who has not yet reached their 18th birthday. The fact that a child has reached sixteen years of age, is living independently, is in Further Education, is a member of the armed forces, is in hospital, or in prison or a young offenders institution does not change their status or their entitlement to services or protection.

The Children Act also places a duty of care on the Local Authority to offers services up to the age of 21yrs when the young adult has been a 'looked after child' preferably referred to as a *child in care.*

The document 'Working together to safeguard children' sets out the responsibilities of agencies to ensure their staff have adequate child protection training (H.M. Gov. 2015). The Intercollegiate document 3rd edition (2014) identifies roles and competencies for health care staff that specifies what constitutes training.

Recently there has been an increased concern about Child Sexual Exploitation (CSE) following several high profile cases coming to light. CSE and Female Genital Mutilation (FGM) are recent additions to the policy.

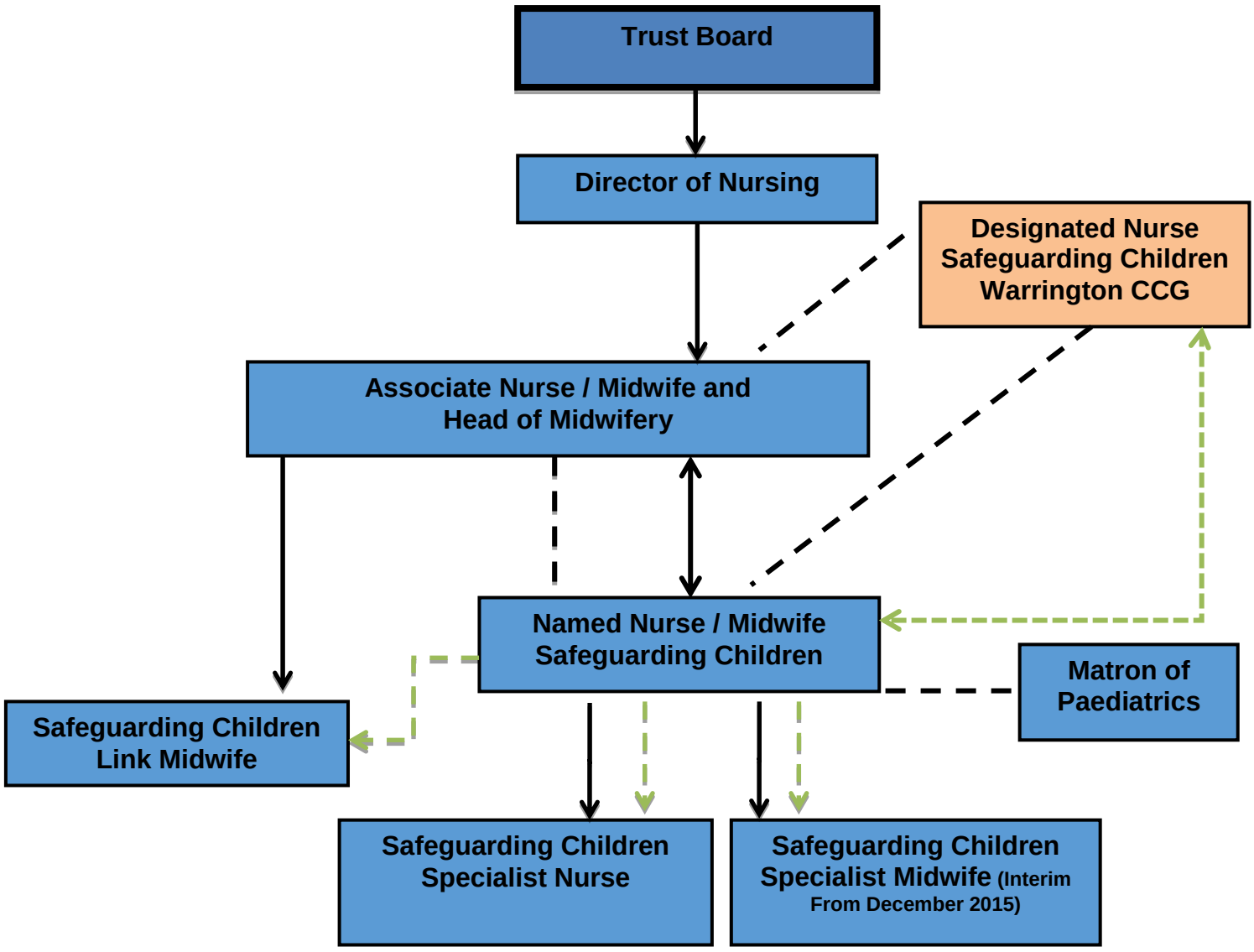
Safeguarding children is the responsibility of everyone and as such, we are duty bound to always act in the best interest of the child. Safeguarding Children is a high-risk area for health organisations. Chief Executives have a responsibility to ensure their staff receive relevant child protection training.

The LSCB Section 11 audit had to be updated in 2015/16 with updated evidence. The tool was scrutinised by the LSCB and an action plan was implemented.
Following the new and updated Working Together to Safeguarding Children 2015, the hospital safeguarding policy was updated and ratified in September 2015. Changes to the policy included:

- New sections on Children who undergo female genital mutilation (FGM) or who may have been or may be radicalised: The LA is also now required, in compliance with the Counter-Terrorism and Security Act 2015, to ensure Channel panels are in place from April 2015.
- Child Sexual Exploitation: LSCB's are required to conduct regular assessments on the effectiveness of Board Partners' responses to child sexual exploitation and include information on the outcome of these assessments in the Annual Report. This should also include how partners have used their data to promote service improvement to vulnerable children and their families with respect to sexual abuse. LSCB's are required to conduct regular assessments of the effectiveness of partners' responses to CSE including reporting on the outcomes from these assessments. The Trust Policy is currently being reviewed to take account of all these changes. See glossary of terms for any abbreviations – *See Appendix 1*

2.0 Structure

WHH NHS Foundation Trust Safeguarding Children Structure 2015/2016 (The structure changed in December 2015 due to the retirement of the Named Nurse/ Midwife)



1 WTE x 8A –Named Nurse Safeguarding Children	1 WTE x 7 – Specialist Nurse	0.1 WTE – Safeguarding Children Link Midwife
Bridgewater Warrington employ 0.53 WTE band 7 and 0.48WTE band 5 nurse =1.01 WTE Liaison service their remit is purely Liaison service		

Warrington Structure – equivalent of 2.1 WTE qualified nurses of grades 7 and 8A (excluding the 8c strategic lead and head of Midwifery Midwife).

3.0 External and Internal Assurance

The LSCB Section 11 audit had to be updated in 2015/16 with updated evidence. The tool was scrutinised by the LSCB and an action plan was implemented.
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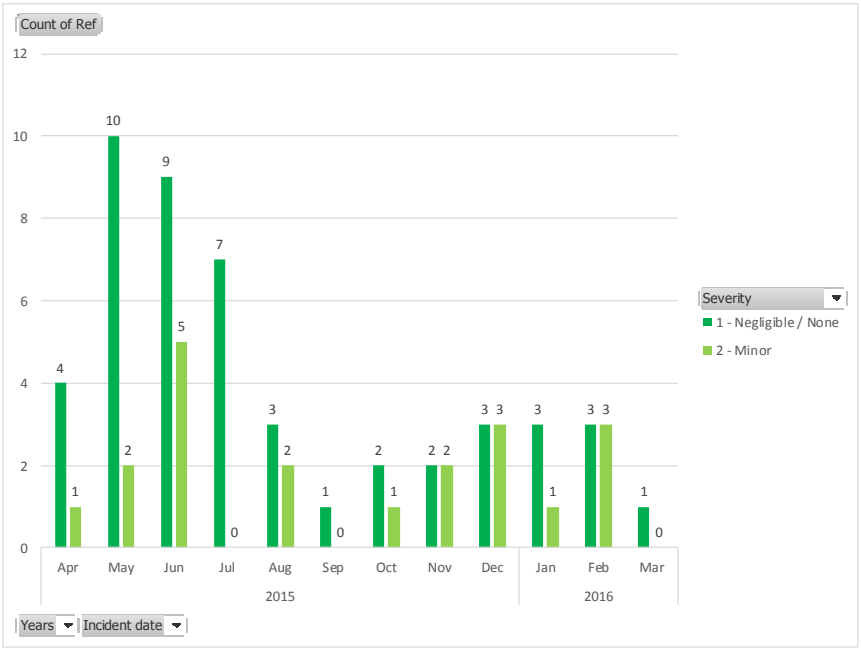
Internal

Incident reporting (Datix)

Over the past 12 months there have been 68 incidents with a safeguarding children element. These have been reviewed by the Named Nurse /Midwife.
Incidents are reviewed and deemed: Appropriate action taken; Additional information required or incident needs further investigation.

Figure 1: Incidents by Severity and Month – 01/04/15 to 31/03/16



Audits

Physical Harm cases and concerns forms

This will be the 12th annual audit is due to be completed to review the standards of the hospital when a child has a Safeguarding concern of a physical injury being caused. This is a high risk area and there is concern that best practice is not being followed.
The sample was taken from the Safeguarding Children data base and the list of medical reports completed in 2015-2016. The database is populated by staff raising an order entry and picking the physical harm category. The sample was determined by reviewing the notes that were readily available in medical records from the cases identified. Findings from this audit will be available later in the year.

DNA audit

Neglect is amongst the most pervasive forms of child abuse, with the power to blight children's lives in the short and long term. It can seriously affect their education, physical and emotional development, as well as their behaviour and friendships. Dubowitz, (2013)
The UK National Service Framework for Children, Young People and Maternity Services (DfES and DH, 2004: 10) highlights that children or young people failing to attend health appointments may trigger concern, given that they are reliant on their parent or carer to take them to the appointment.
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. 2015/2016 saw the first DNA audit completed. 27 sets of notes were audited. From the 27 cases identified, 22 should have triggered the DNA pathway.

Conclusion

- Poor compliance across the trust
- Need to tighten up on recognising missed essential health appointments
- Practice across all consultants and specialities were not consistent.

Recommendations

- Update the DNA pathway within the safeguarding children policy to change from 2 DNAs to 3 DNAs.
- Re-visit neglect during in-house safeguarding training
- On-going education required.

Peer review meetings- Dr D. Webb- Named Doctor for child protection.

Monthly peer review meetings of child protection medical reports based on the RCPCH structure continue to be well attended by paediatric consultants. All child protection cases are discussed in a non-judgemental learning environment. Between 4 and 10 cases are discussed at each meeting. The source of referral is now monitored in the peer review meeting as there was a concern that a significant number of children were being referred who may have been more suitably assessed by the community paediatric team –i.e. were less urgent and did not need to be seen out of hours. There were 52 cases discussed in 2015/2016.

External audit

A DASH Board continues to be completed on a quarterly basis and is submitted to the Designated Nurse quarterly.

- Submission includes a short case study from that quarter looking at a range of safeguarding children issues where hospital staff or the Safeguarding children team have

identified or acted on a concern to demonstrate some qualitative aspects of safeguarding children.

- Tracking of any reviews (SCR and domestic homicide reviews) and any serious untoward incidents.
- An action plan for the DASH Board that are not scoring in the green zone.

Steering group and strategic group for safeguarding children and adults which has now been replaced after April 2015 with a separate Safeguarding children group and then Safeguarding reporting into PESC meeting (from May 2015 onwards).

Multiagency note audit
Midwives have taken part in 2 multiagency note audits during 2014 -15. No actions were recommended for the Trust. Overall learning for all agencies continue to be around multi agency communication and working together.

Case reviews
Reports have been completed for 7 cases for consideration for review. This is a significant increase from 2 the previous year. Three of the cases went on to be a Case review involving the Trust. 1 Action plan is complete, and 2 action plans remain outstanding. See Appendix 2

CAF
The CAF team and partner agencies audited 2 CAFs completed by hospital staff as part of the Warrington CAF team audit process. One CAF was audited as good whilst the other was graded as needs improvement. Feedback from the CAFs were shared with the practitioners and the safeguarding children forum group. See Appendix 3.

4.0 Learning from Serious Case Reviews, Domestic Homicide Reviews, Child Deaths and other Serious Incidents.

The trusts were not part of any Serious Case Reviews in 2015/2016.

There has been one domestic homicide that the trust became involved in following the incident. The action plan and final report for this domestic homicide remains outstanding with the LSCB however it is not anticipated that there will be any specific learning's for the trust.

Child Deaths 2015 –
Dr Nisar Mir- Lead Paediatrician for Child Deaths and CONI Paediatrician

The Regulations relating to child death reviews – Working Together to Safeguard Children 2015
The Local Safeguarding Children Board (LSCB) functions in relation to child deaths are set out in Regulation 6 of the Local Safeguarding Children Boards Regulations 2006, made under section 14(2) of the Children Act 2004. The LSCB is responsible for:
a) collecting and analysing information about each death with a view to identifying -
(i) any case giving rise to the need for a review mentioned in regulation 5(1)(e);
(ii) any matters of concern affecting the safety and welfare of children in the area of the authority;
(iii) any wider public health or safety concerns arising from a particular death or from a pattern of deaths in that area; and

(b) putting in place procedures for ensuring that there is a coordinated response by the authority, their Board partners and other relevant persons to an unexpected death.

Specific responsibilities of relevant professionals when responding rapidly to the unexpected death of a child	
Designated paediatrician for unexpected deaths in childhood	Ensure that relevant professionals (i.e. coroner, police and local authority social care) are informed of the death; coordinate the team of professionals (involved before and/or after the death) which is convened when a child dies unexpectedly (accessing professionals from specialist agencies as necessary to support the core team). Convene multi-agency discussions after the initial and final initial post-mortem examination results are available.

Child death reports are for the calendar year 2015.

During 2015 there were a total of 12 deaths that required SUDIC input. Unlike the previous year there were more females (7) than males (5).

Number	Category
Expected deaths	
1-3	Prematurity (< 26 week gestation)
4	Congenital Brain Tumour (F, 2d)
Unexpected - Accidental Death	
5	Road Traffic Collision (M, 17y)
6	Severe Scalds (in Pakistan) presented with Septicaemia (F, 3y)
7	Attempted Suicide by hanging Died of HIE (F, 16)
SUDIC	
8	SUDI, Unascertained (F, 3 months)
9	SUDI Pneumonia on autopsy (F, 19 months)
10	Severe Developmental Delay, West Syndrome, Epilepsy, SUDI, Pneumonia (M, 9yrs)
11	Dravit Syndrome Refractory Epilepsy , SUEP (M, 5yrs)
12	Neonatal HIE, LRTI, Pneumonia (F, 22 months)

5.0 Review of objectives set for 2014/15 and Key achievements

Objectives for Safeguarding children	outcome	Explanation
Training compliance at level 1 and 2 to be 85%		Level 1 - training figures are 84% which is an increase by 10% from the same time last year. Commissioners accepted level 1 reading material update for staff which has made a large impact on the training compliance. Level 2 – training figures are currently 61% which has increased from 52%. *(see appendix 4)*
Maintain and improve on level 3 training figures		Level 3 - has declined slightly from 78% to 76%
Work load / Nursing Safeguarding Children requirements to be reviewed in light of additional pressures.		A 'statement of Need' was completed as well as a business case being completed for additional Nursing time for the team. This went to the bilateral meeting in March and was not progressed. In November 2015 the Named Nurse / Midwife retired. A specialist Midwife was placed within the team as a development role.

This is the 3rd year that all objectives were not fully achieved. There was increased activity and Trust pressures that have impacted on performance.

The Safeguarding team has worked with the Training department over the last year to devise innovative ways of increasing training compliance. However other methods have failed to produce the desired results. All training action plans have been completed however training events have been poorly attended. The Trust has been under pressure over the last year in order to cover workloads. The training department continues to work with managers across the trust to ensure training figures improve for all mandatory training. Reports are collated quarterly and reviewed by Safeguarding where action plans are in place to allow for improved training compliance.

6.0 Safeguarding Activity Analysis

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’.

Needs analysis about changes since last year -

2014/15 appeared to have a dip in concerns forms commenced. In 2015/16 figures have increased up to 395 which is a similar trend to 2013/2014. In November 2015 ICE, a new electronic referral system was introduced. ICE referrals are now being used instead of MEDITECH order entries to update the safeguarding team on ongoing cases and also to ask for further advice on specific cases. This has continued to generate more work for the safeguarding team however it is highlighting that staff appear to be recognising and considering families that need lower level support and early help before it reaches child protection level . Unfortunately the number of CAFs completed does not reflect this. Some families have required single agency intervention and a CAF was not the most appropriate course of action to take at that time. Interestingly the number of referrals to children social care has increased by 85%. The increase in referrals is partly related to the change in safeguarding children team process when dealing with domestic abuse referrals. Living in a home where there’s domestic abuse is harmful and can have a serious impact on a child's behaviour and wellbeing. Parents or carers’ may underestimate the effects of the abuse on their children because they don’t see what’s happening. Children witnessing domestic abuse is recognised as 'significant harm' in law. All referrals of domestic abuse where children lived in the household were referred to children’s social care due to concerns of emotional harm.

Child protection medicals are carried out in the community however should a child protection medical should be required out of hours it is the responsibility of the hospital pediatricians. There had been a number of cases that were discussed at peer review whereby the hospital had completed child protection medicals within working hours when in fact it should have been completed within the community. The process was reiterated to hospital and community staff and the numbers of hospital child protection medicals within the hospital have appropriately reduced.

Domestic abuse referrals have decreased by 11 this year. The IDVA (Independent Domestic Violence Advocate) is well established within the trust it was predicted that the number of domestic referrals would increase. Recognising domestic abuse continues to be an area that requires significant improvement. A domestic abuse training program has been produced with 6 sessions being delivered in 2016. 2015/16 has seen a significant increase in staff disclosing domestic abuse. Specific number of staff referrals will be collected in 2016/17. It is thought that the increase is due to the introduction of the IDVA and raising awareness with managers.

The number of Maternity special circumstance forms being commenced has remained static. There is no clear explanation for this however positively there have been very few inappropriate referrals. It has however been identified that there has been an increase in level 4 cases. An increase in level 4 cases has impacted on the safeguarding team and also the community midwifery service. An increase in level 4 cases has led to a significant increase in safeguarding meeting and child protection conferences which both require structured reports.

Completion of pre-CAF / CAFs has reduced by -20%. The reduction was noted mid 2015 by the safeguarding team. Due to this the CAF team was invited to deliver a refresher session to community midwives. The community midwives reported that following this session they felt more confident in completing the CAFs. It is predicted that there will be an increase in CAFs in 2016/17.

7.0 Domestic Abuse

In 2015/2016 a total of 178 domestic abuse forms were completed and sent to the Safeguarding team.

- 8% were pregnant at the time
- 44% had children in the family

There has been a steady increase (over 100%) in the numbers of DA referrals /cases identified over the last 8 years. years. The impact of abuse and neglect on teenagers is often not recognised, the link between domestic abuse, running away and sexual exploitation is becoming more evident. The DA victims attending the Trust come from mainly three geographical areas to which each has a MARAC (Multiagency Risk assessment conference). Initially these were held monthly and had 5-8 cases discussed. This has now increased to every two weeks with 12-18 cases discussed. In total there are 6 MARAC meetings per month for which WHH have to provide information.

It has become increasingly difficult to maintain the work around the MARAC reports as the numbers of cases have increased as well as the meeting become more frequent. A statement of need and business case was completed in April 2015 however this was not progressed and the safeguarding children team have continued to struggle to maintain the work load surrounding domestic abuse. In late 2015 the Safeguarding Adult team became more involved in supporting the safeguarding children team however this was to replace the service (attendance at local MARAC) that the Emergency Department had withdrawn.

8.0 Child Sexual Exploitation

Child sexual exploitation (CSE) is a type of sexual abuse in which children are sexually exploited for money, power or status. Children or young people may be tricked into believing they're in a loving, consensual relationship. They might be invited to parties and given drugs and alcohol. They may also be groomed online. Some children and young people are trafficked into or within the UK for the purpose of sexual exploitation. Sexual exploitation can also happen to young people in gangs.

In March 2016 the Safeguarding Children team participated in the National Child Sexual Exploitation Awareness. Information packs were provided to departments across the trust and a stall was set up in the main entrance. The day was a success with staff, patients and visitors and was well supported by the hospital communication team.

In August 2014 Professor Alexis Jay published a review of child sexual exploitation in Rotherham. It showed that organised child sexual exploitation had been happening on a massive scale over many years. Local agencies had dismissed concerns or put in place an inadequate response. Shockingly, Louise Casey's report of 4 February 2015 showed that even since the Jay report, many in the council and its local partners had continued to deny the scale of the problem, and not enough action had been taken to stop the abuse.

Tackling child sexual exploitation must be a shared effort. Government can lead the national response. Local authorities, police, children's and health services have a statutory duty to work together to identify and stamp it out in their area. Communities must help to tackle the problem, rather than assume victims bring it on themselves. We must eradicate the culture of denial that allows organisations and individuals to avoid the issue, blame others, or distract themselves with endless planning rather than making sure they actually make a difference. Changing culture requires strong leadership, clear accountability, engagement

with victims and staff, and unequivocal feedback on what is working well and what is not across the whole local area.

Warrington and Halton Hospitals NHS Foundation Trust developed and implemented a CSE screening tool to be used on all young people who fall into criteria for CSE screening. On-going work is required to raise awareness. Engaging with 2 LSCB'S regarding CSE and flagging children who are at risk of CSE is an additional pressure for the safeguarding children team.

9.0 Safer Working Practices:-

MIAA (Mersey Internal Audit Authority) audited the Trust's recruitment practices in July 2015. The trust received an overall rating of significant assurance. Part of their audit also looked at pre-employment checks (including DBS checks) and their findings state that generally, comprehensive evidence was documented to demonstrate that the checks undertaken prior to the appointment of individuals were sufficient, appropriate to the post and provided adequate assurance for the suitability of the individual.

10.0 Any Organisational Specific issues

- Both Local Safeguarding Children Boards have undergone Ofsted Inspections. The Trust was involved in preparation of cases but inspectors did not visit the Trust as part of these inspections. The Executive lead was involved as she sits on the board for the LSCB's.

- The Section 11 audit was completed during the year. The Trust achieved:-
    - 100% for sections:- 11.2, 11.3, 11.4, 11.7, 11.10
    - 96% for sections:- 11.12
    - 94% for section 11.11
    - 92% for section 11.8
    - 88% for section 11.1
    - 82% for section 11.9
    - 75% for sections:- 11.5 and 11.6

The section 11 audit was presented at the scrutiny panel in late 2015. The panel confirmed that the evidence presented within the completed e-audit tool by Warrington and Halton Hospitals Trust was robust. The documents attached by the Trust to the tool, including policies and procedures and other evidence, supported their judgements. The representative also gave further verbal reassurances and explanations evidencing the judgements for each of indicators. The audit tool scored 91%, with a monitored action plan in place.

A particular strength noted by the panel was that all teams work well together to deliver cohesive and comprehensive support to vulnerable children and young people that protects them and keeps them safe.

An action plan had been developed and put in place to address areas identified that require further development. See Appendix 6.

<u>Female Genital Mutilation</u>

Female Genital Mutilation reporting became compulsory from September 2014. The data set and process to record was established in Spring 2015. The Trust has now commenced

quarterly up loading of information. In 2015/2016 there were 6 recorded cases of identified FGM. All 6 cases were historic cases and support was offered. There were no new concerns identified in all 6 cases.

Graded Care Profile

In November 2015 WHHFT supported the LSCBs decision to adopt and implement The Graded Care Profile and the Home Conditions Assessment tool. The tools are for families where neglect is an area of concern for a child's welfare. The 'tools' can be used across the Children's Continuum of Need and by practitioners from various agencies.

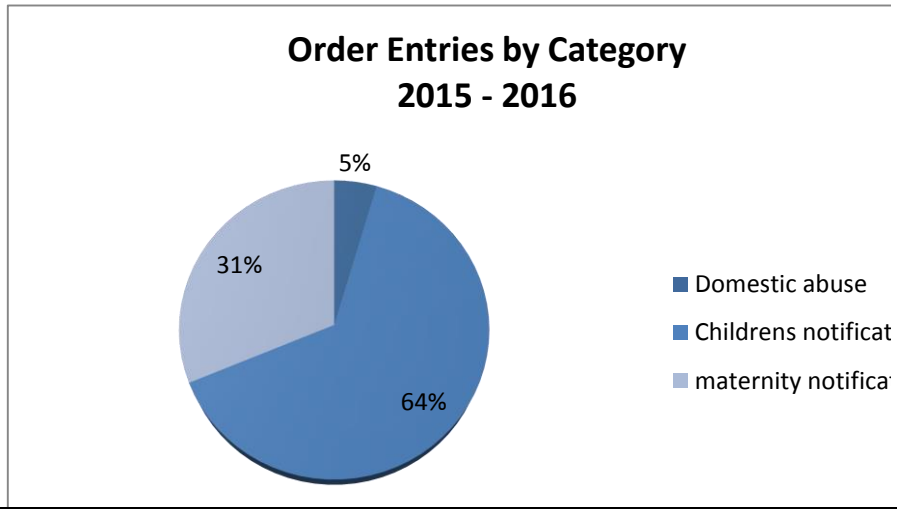
Neglect is difficult to define and agencies have varied views about what constitutes neglect. These and the lack of a common language cause difficulties.

WHH commenced training session in January 2016 for the community midwives and appropriate specialist nurses. Take up of the tool will be monitored by the LSCB. There have been no completed tools to date however with education and safeguarding supervision it is predicted that there will be significant increase in 2016/2017.

11.0 Key Objectives for forthcoming year

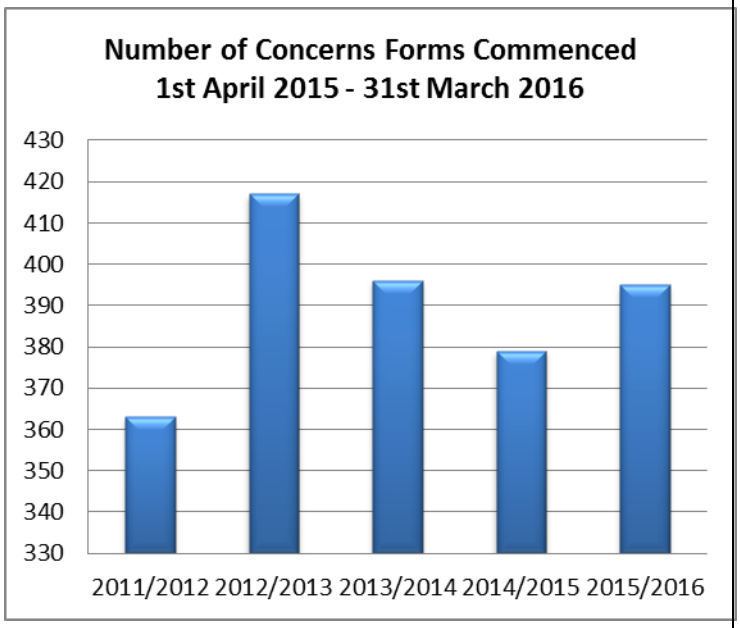
- Training compliance at level 1 and 2 to be 85%
- Maintain and improve on level 3 training figures
- Work load and Capacity to be reviewed for the team
- Safeguarding Supervision to be more robust and embedded across the trust.
- Number of CAFS to be increased.

12.0 Activity Report

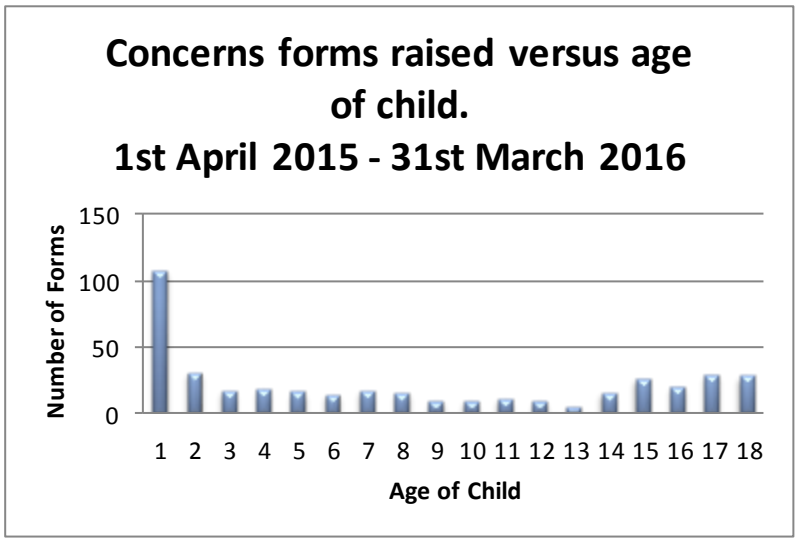


2015/2016 there was a total of 2237, this is a steady 6% increase from the previous year. Order entries / ICE referrals are used to pass information about special circumstance forms, concerns forms or domestic abuse cases coming to light.

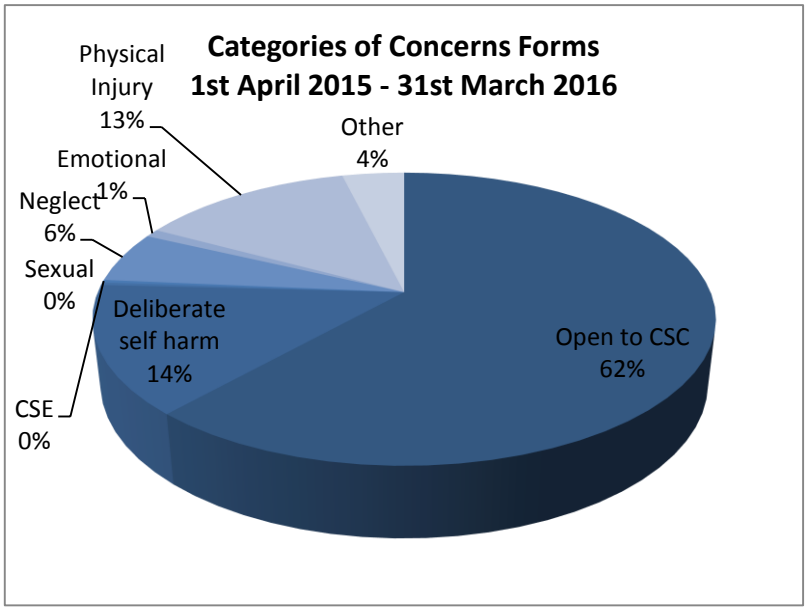
Concerns forms - Children



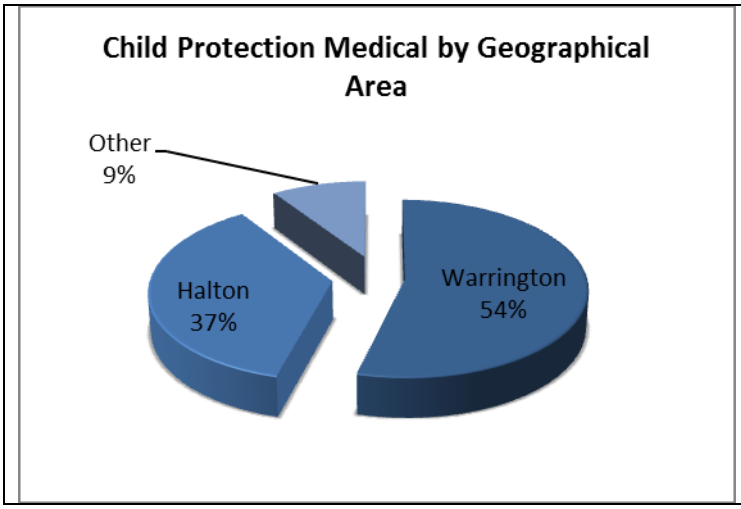
Year	Forms commenced	% of forms commenced for Suspected Physical abuse
2007	192	30 %
2008	178	45 %
2009	240	29 %
2010	283	28 %
2011 -12	363	20 %
2012 -13	417	16.5 %
2013 -14	396	15 %
2014 -15	379	22%
2015 - 16	395	13%



This shows a similar distribution to previous years; however the number of teenagers has reduced slightly.

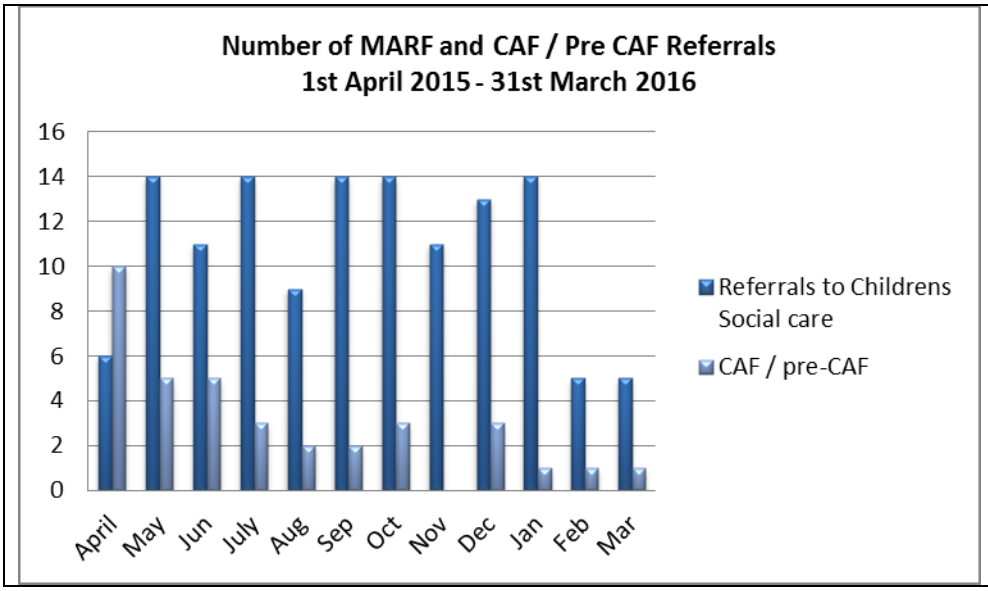


Children attending hospital who are known to children's services have increased by 29%. Concerns of physical injury have reduced by 50%.



44 child protection medicals were completed. This is a significant decrease from last year.

The process for accepting referrals for child protection medicals has been updated; this has resulted in a reduction of inappropriate referrals.

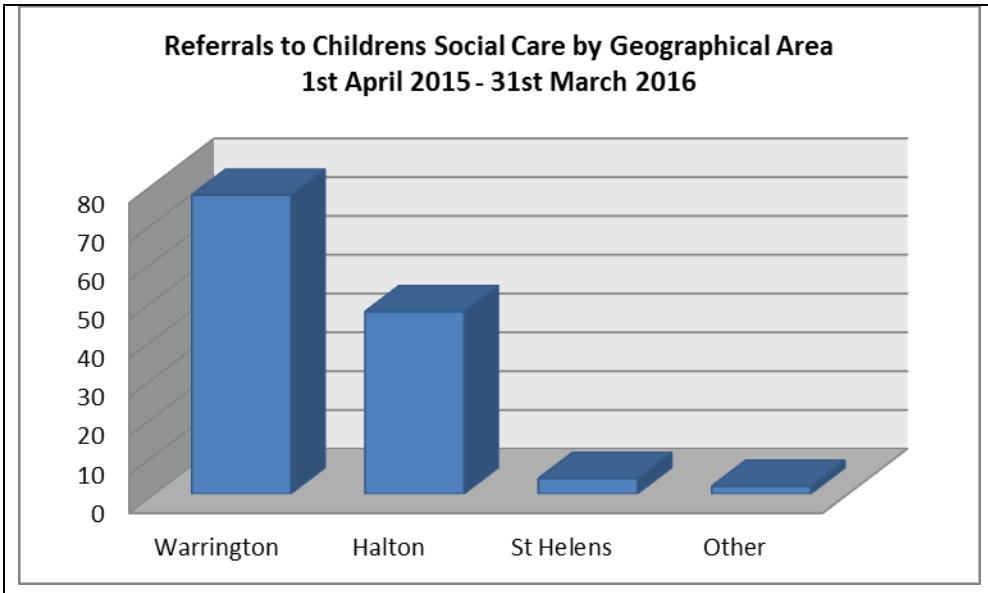


Referrals to CSC 130

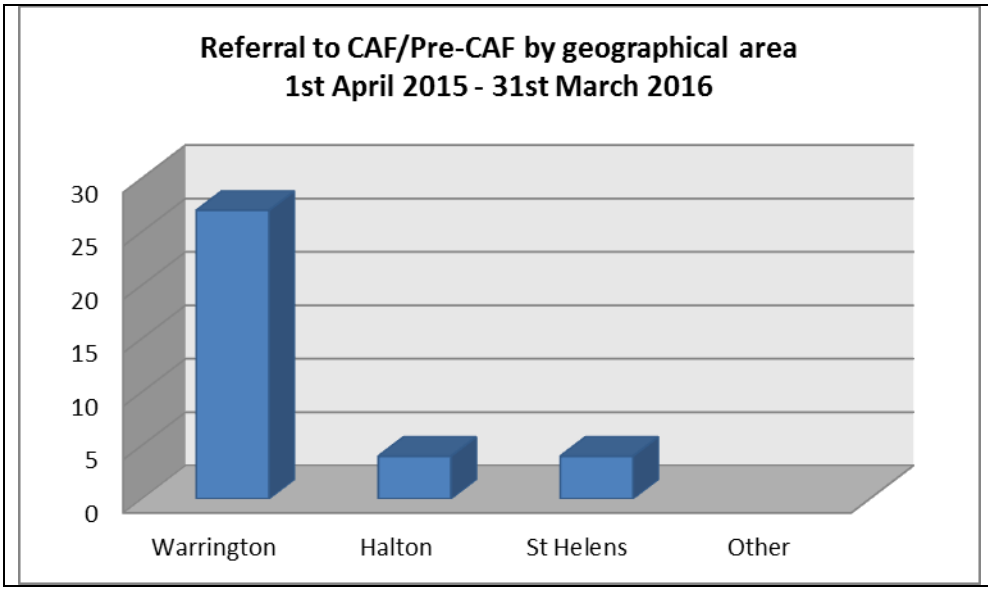
CAF and Pre CAF 36

Increase of 85% in social care referrals.

CAF / Pre-caf saw a decline by -20%

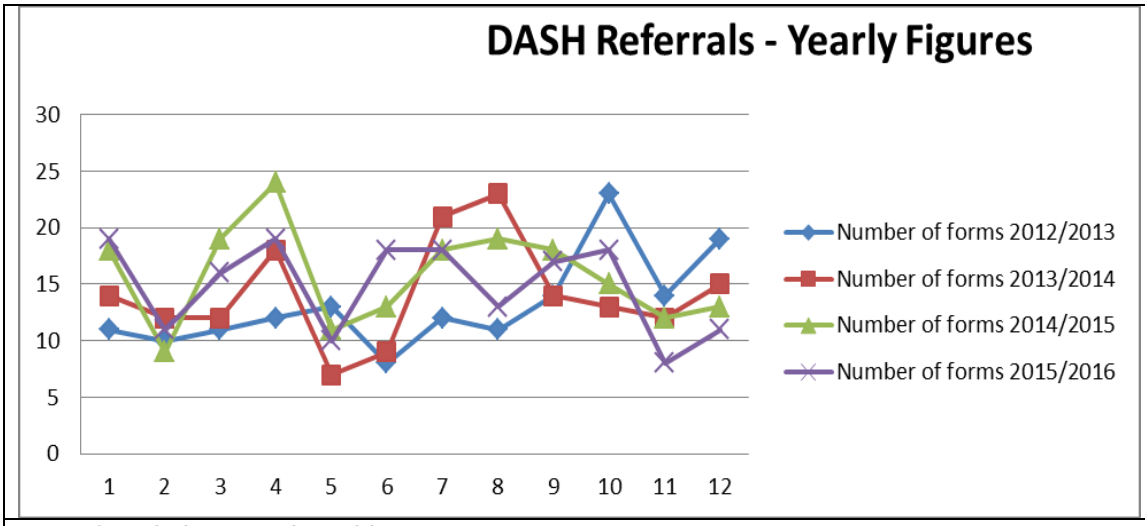


This graph demonstrates the number of referrals that have been notified to the safeguarding children team or that have been identified by the safeguarding Childrens team. It is evident that not all referrals are followed up with a written referral or notified to the office.

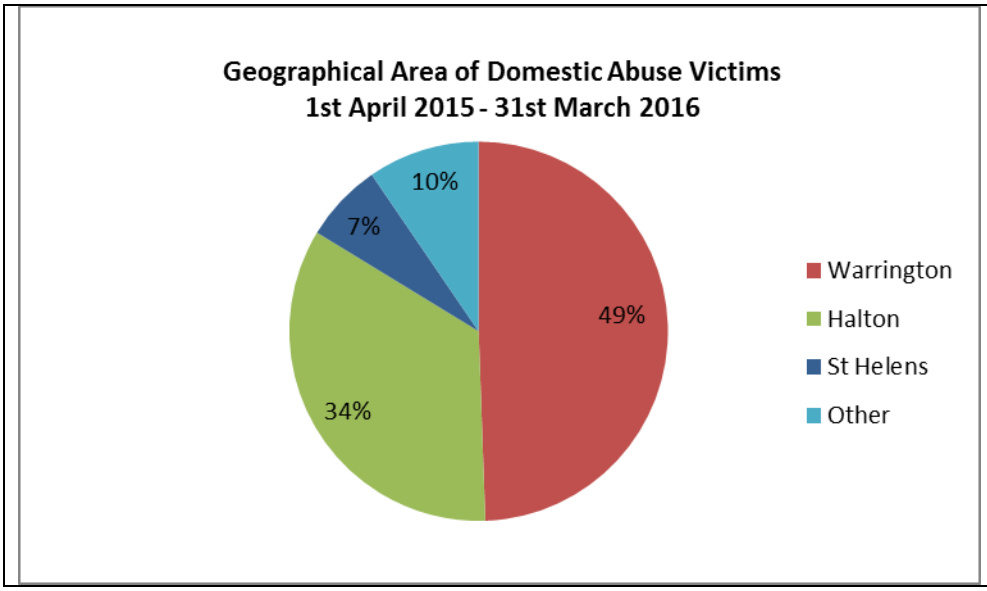


This remains static with the majority of CAFs completed by midwives.

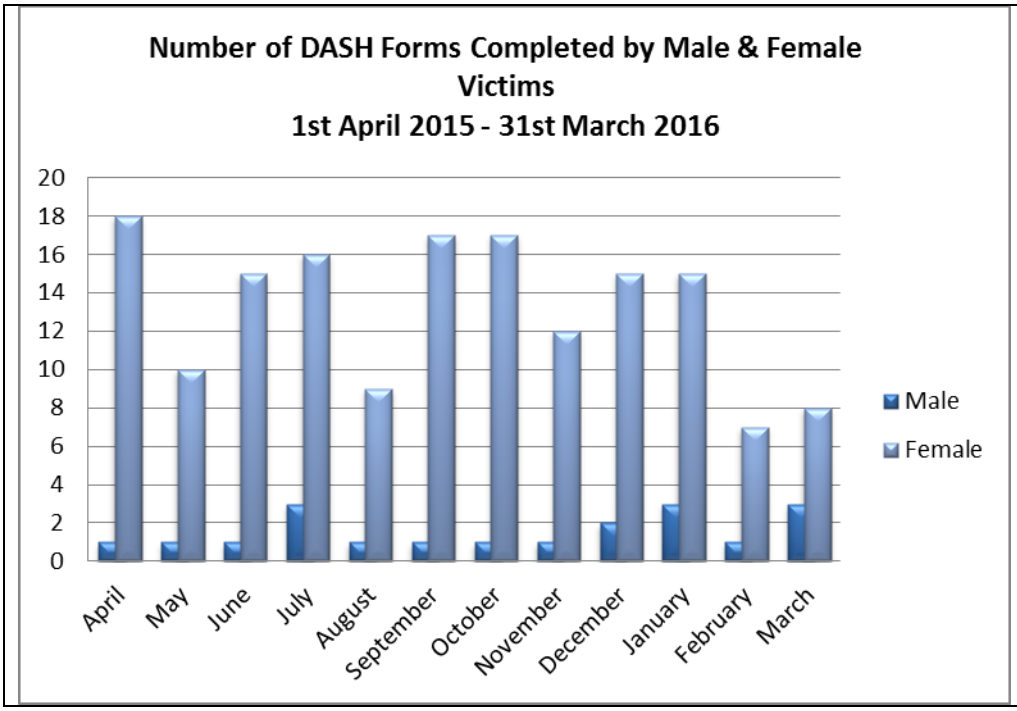
Domestic Abuse - Referrals



DA referrals have reduced by 11.

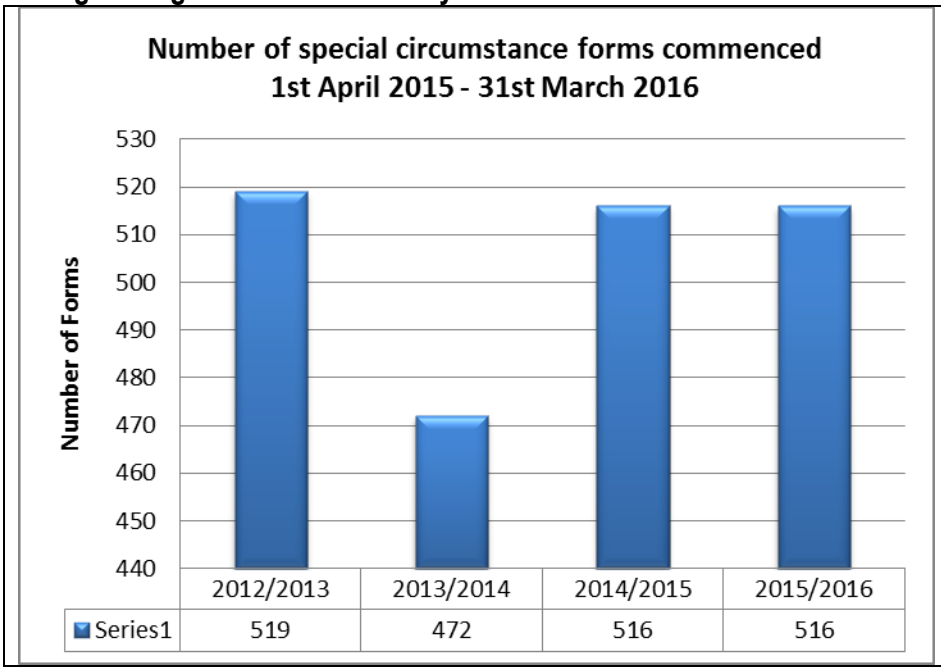


This remains a similar distribution.

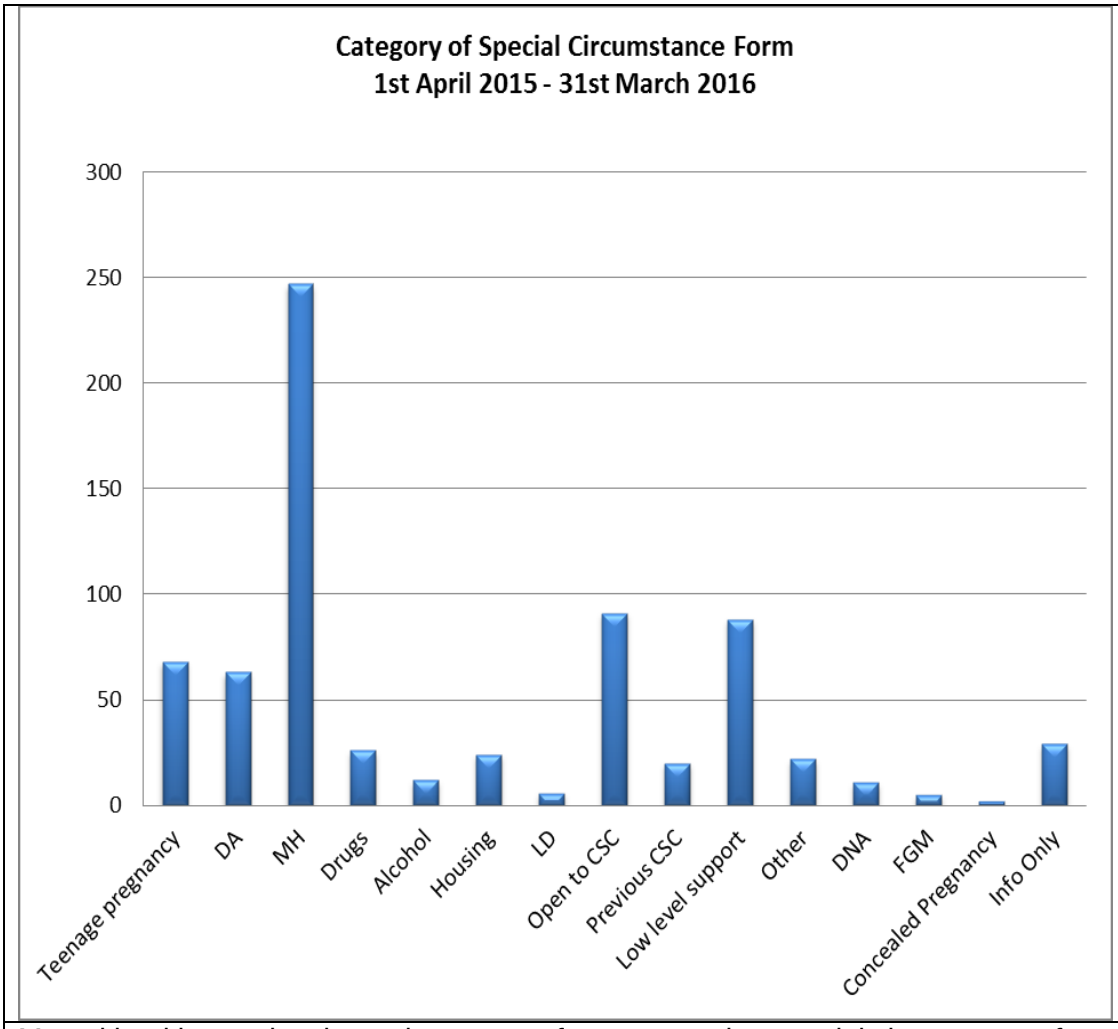


Male / female mix remains similar

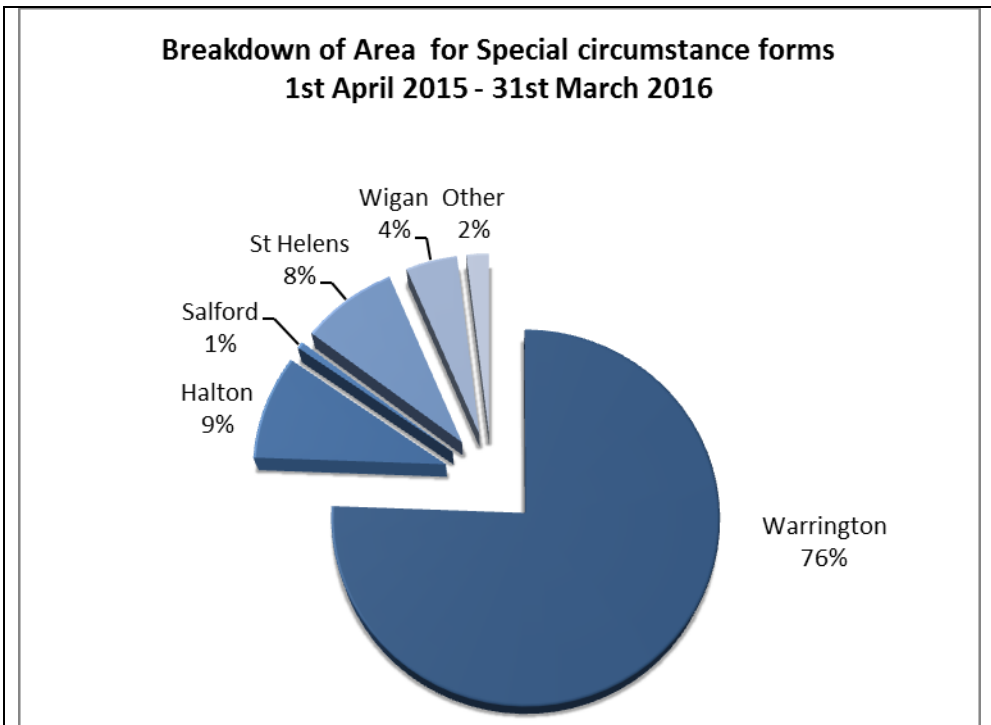
Safeguarding Children in Maternity



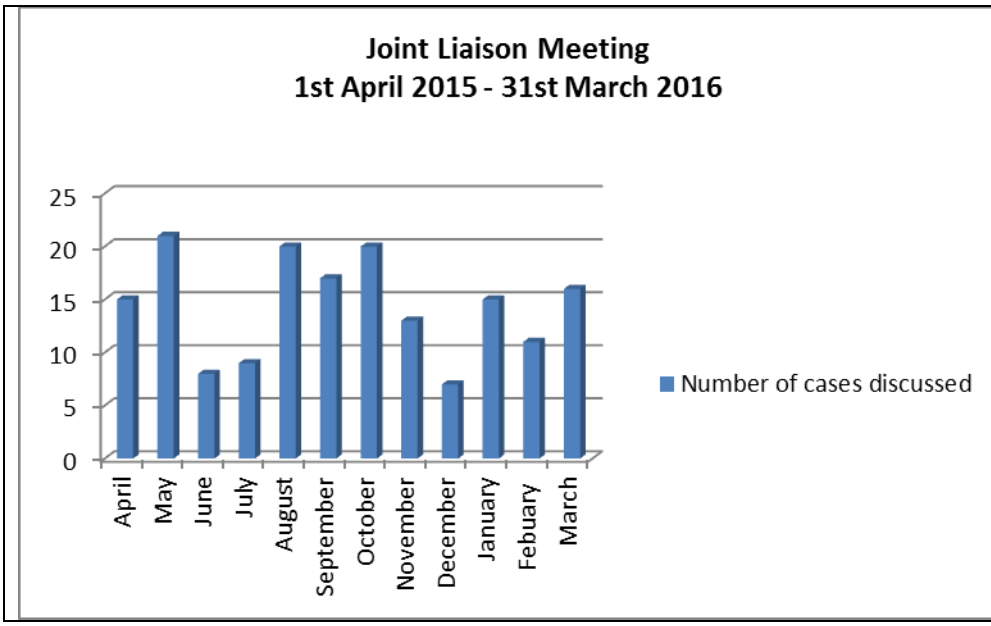
The number of referrals remain the same.



Mental health remains the main category for commencing special circumstance forms with the second highest being the family already being open to children's social care.
The number of cases identified due to lower level support has increased. This demonstrates that midwives are recognising lower level concerns however with the reduction of CAFs being completed this identifies that the appropriate action may not be being taken.



This remains a similar distribution to previous years.

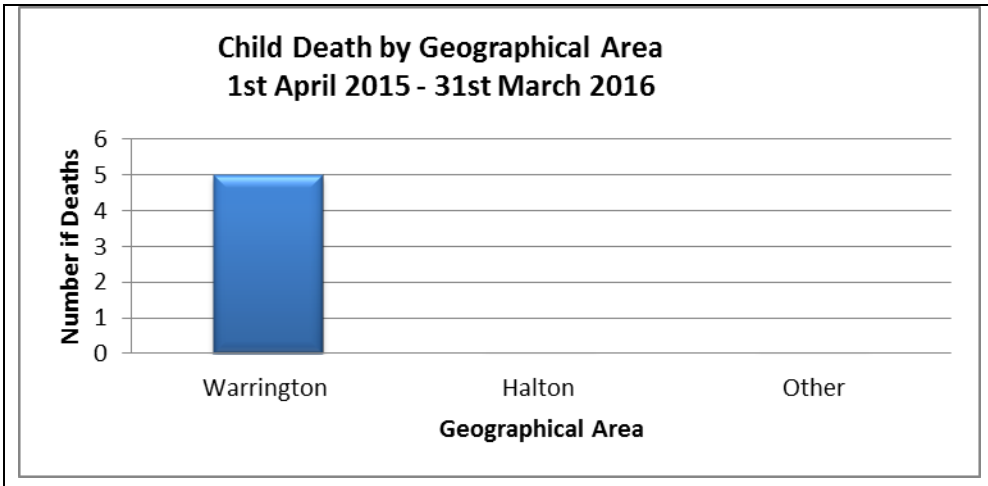


172 cases were discussed which remains similar to previous years.

Medical History Forms forwarded to the hospital for children that are in care

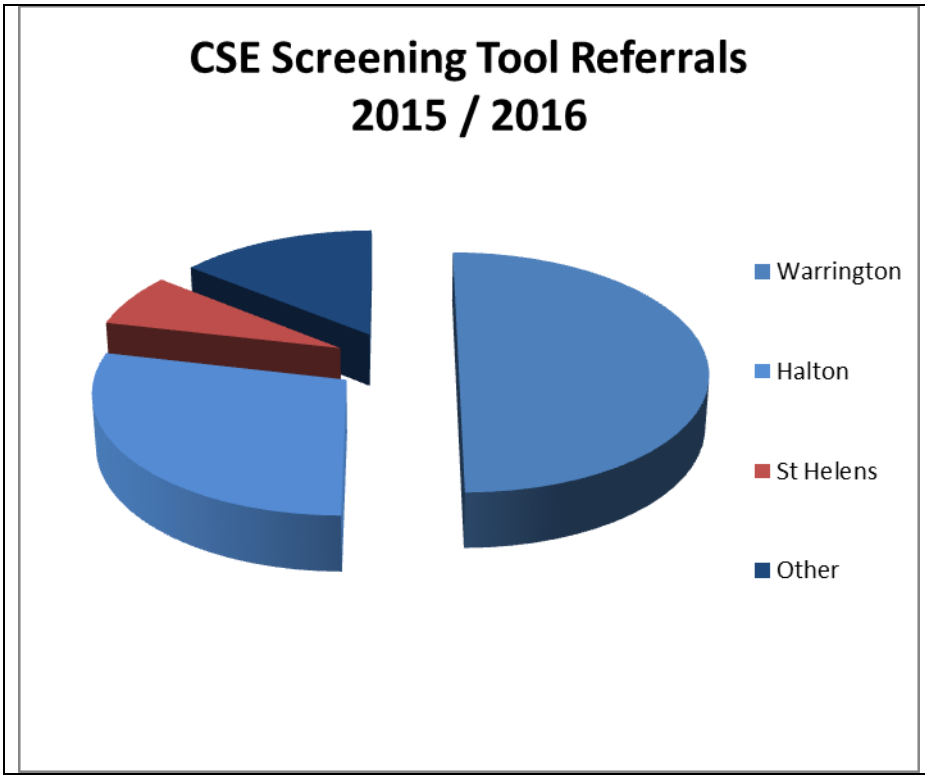
	2010	*2011-12*	*2012-13*	*2013 – 14*	*2014-15*	*2015-2016*
Medical history - Forms completed	55	94	39	103	102	265

There has been a significant increase in these requests. There is no clear explanation for this other than increased activity in children in care. National figures have not yet been released for 2015/2016 of children in care / adopted



Unexpected and explained – 3
Unexpected and unexplained – 2

Unexpected deaths numbers have reduced by 2. Unlike previous years, all of the deaths occurred were Warrington children.



There were 28 hospital CSE screening tools completed.

Appendix 1

Glossary of terms and abbreviations

	Term	Description/ definition
Safeguarding	Safeguarding and promoting the welfare of Children:	• Protecting children from maltreatment; • Preventing impairment of children's health or development; • Ensuring that children are growing up in circumstances consistent with the provision of safe and effective care; and • Taking action to enable children in need to have optimum life chances
CSC	Children's Social Care	Children's social care services
CSE	Child Sexual Exploitation	
CAF	Common Assessment Framework	Is a shared assessment tool for use across all agencies. It aims to help early identification of need and promote coordinated service provision.
PreCAF	Pre Common Assessment Framework	Referral form for a CAF – which is forwarded to a practitioner in health (usually a Midwife/ Health Visitor or School Health advisor)
DA	Domestic abuse	
MARAC	Multi Agency Risk Assessment Conference	Is a victim focused meeting where information is shared on the highest risk cases of domestic abuse between criminal justice, health, child protection, housing, IDVA's as well as other specialities from the statutory and voluntary sector.
IDVA	Independent domestic Violence adviser	Trained specialists who provide a service to victims, who are at risk of harm from intimate partners or family.
CP	Child Protection	
NAI	Non Accidental Injury	
CIN	Child In Need	Under section 17 of the Child Act – A child who is unlikely to reach or maintain a satisfactory level of health or development, or their health or development will be significantly impaired, without the provision of services, or a child who is disabled.
CHIC	Child In Care	Child in the care of the local authority
LSCB	Local Safeguarding Children's Board	WSCB- Warrington Safeguarding Children's Board HSCB - Halton Safeguarding Children's Board
ESR	Electronic Staff Record	
SUDIC	Sudden Unexpected Death in Infants and Children	

Appendix 2

Extract from WSCB action plan for Child J case review – actions pertinent to Warrington and Halton Hospital.

There is a need to ensure that local Midwife practitioners are operating within Trust Guidance to ensure support and guidance is given to families to reduce the risk of Sudden Unexpected Death in Infants(SUDIC)						
No		**Actions**	**Evidence**	**Leads**	**By When**	**Expected Outcome**
1	The Board should require Warrington and Halton Hospital Trust to provide assurance that there is clear guidance in place for midwives with regard to referral for Care of the Next Infant (CONI)scheme and that this is complied with	1.1 Warrington and Halton Hospital Trust evidences the guidance has been developed and issued 1.2 CONI protocol to be reviewed to ensure that it is up to date and includes all empirical evidence in relation to care of the next infant. 1.3 An audit is undertaken six months after launch of the protocol to evidence compliance 1.4 Report on audit presented to the Board		Protocol and guidance: Dr Mir SUDIC Paediatrician Warrington and Halton Hospital Trust Audit: Mel Hudson Head of Midwifery and Jane Scott Paediatric Matron Warrington and Halton Hospital Trust	April 16	Babies are protected because expectant mothers are referred to the CONI programme appropriately and consistently as soon as risk is identified. Update 21/03/2016 – The guidelines have been reviewed – DRAFT copy enclosed. Dr Mir advises that there have been changes in the community set up and he is currently liaising with Bridgewater to share the guidelines. It is therefore expected that a further revision of the guidelines will be available in coming months. However it should be noted that this would not alter our management at the Trust.
	The Board should require Warrington and Halton Hospital Trust to take affirmative action to ensure that all Midwifes are	1.5 Warrington and Halton Hospital Trust evidences that supervision is		Mel Hudson Head of Midwifery and Jane Scott Paediatric Matron	Sept 15	Evidence of Strong consistent communication between midwives and parents around safe sleep reduce the harm to babies

	operating in accordance with Trust policy with regard to safe sleeping arrangements for babies.	used to ensure all Midwifes are operating in accordance with Trust policy with regard to safe sleeping arrangements for babies		Warrington and Halton Hospital Trust		Updated 21/03/16 – Audit completed of safe sleep.  Safe Sleep Audit Nov 2015.docx
That the community GP services and acute hospital paediatric services review together the adequacy of current observation formats with regard to neonatal babies and report as to whether a single format is recommended.						
No		**Actions**	**Progress**	**Leads**	**By When**	**Expected Outcome**
3	That the Board require Bridgewater Trust and the Acute Hospital Trust to report back to the Board of the above issue within a three month period	3.1 GP services including out of hours and acute hospital paediatric services review together the adequacy of the two tools (NICE guidance on the acutely ill child and the Paediatric Early Warning SCORE (PEWS) tool) with regard to neonatal babies and children and report to the Board whether the use of a single tool or both tools will ensure that any acutely ill neonate or child receives the appropriate intervention	12.08.15 Dr Fisher and relevant Clinical Leads from Warrington CCG Met to discuss the PEWS's and NICE Guidance. following the meeting a further meeting to take place with Dr Mir and the relevant paediatricians at WHHT to discuss the tool and Planned for September 2015. A communication for All GP's working in primary care to be disseminated by the Named GP by 30.09.2015	Dr Mir SUDIC Paediatrician Warrington and Halton Hospital Trust Dr Neil Fisher Interim Medical Director Bridgewater Community NHS Foundation Trust Dr Ipsita Chatterjee Paediatric Clinical Lead Warrington	Oct 2015	Neo natal babies are protected because professionals with specialist medical services have an agreed consistent process for recording their observations

				Clinical Commissioning Group (CCG)		
	In the meantime, the Out of Hours GP service should adopt a risk minimisation approach by ensuring that any red alert score for a neonatal baby results in a referral for paediatric oversight.	3.2. Interim Medical Director Bridgewater Community NHS Foundation Trust ensures out of hours GP's are aware of action and refer all neo natal babies that have a red alert score for paediatric oversight	**Completed confirmed on 13.08.20015** Communication from Dr Fisher has been disseminated to all out of hours GP's in relation to reminding all GP's to refer all neonatal babies and indeed all babies who score red on the screening tool to be referred for a paediatric assessment Action Complete	Dr Neil Fisher Interim Medical Director Bridgewater Community NHS Foundation Trust	End August 15	All neonatal babies that attend out of hours GP services who score red on the NICE Guidance for the acutely ill child are referred for a paediatric review

Appendix 3 – CAF feedback

Graded	Comments
Requires improvement	• Good attempt to update the CAF following the birth of baby. • Needs clarity on reasons for the CAF relating to child rather than mum e.g. mum's drug misuse and mental health could affect ability to care for child. What are long term risks? E.g. Impact on child if mum cannot attend appointments, baby groups, etc. Risks of being premature – will parents have added health appointments and will the child need more support? Will parents be able to cope? • Include your professional opinion on the situation. Risks are explored (substance misuse) however this is not linked to parenting ability or impact on baby. Given the baby is a new born, can you comment upon their relationship? How are parents interacting with baby on NNU? Do you have any concerns re: attachment, bonding? • Consider wider risks for the baby if mum does not stop using Methadone. Is the greater risk mum's substance misuse or her mental health? Will mum be able to take the baby to appointments? • Include some information on wider family. Mum has other children so the baby has siblings. What has their experience been? Have parents demonstrated positive parenting ability with these children? • In future, a stronger focus on the child and the impact of parenting issues on the child will help to produce a 'good' quality CAF.
Good	• Overall, this is a very well written and informative assessment. This assessment would have been judged as 'outstanding' if: o professional contributions and analysis was clearly recorded o protective factors were clearly identified o the views of parents were included - do they feel prepared and ready to parent? o parenting ability were explored in more detail. • Although parents' needs and changes they will face are explored, it would have been helpful if it was recorded how those issues will impact upon them as carers for a newborn baby e.g. what mother can do or will be able to do. Will the child be safe? • Throughout the assessment, remember to keep focused on the unborn baby. At times, it seemed the CAF was for mum rather than baby. Although mum's needs will impact upon her ability to parent (so it is important to include these), the assessment should reflect on what this means for unborn. • A 'good' CAF assessment, with a strong professional analysis to conclude on findings.

Appendix 4 – Training report

	Safeguarding Procedures (Children) - Level 1 1st March 2013 - 31st March 2016			Safeguarding Procedures (Children) - Level 2 1st March 2013 - 31st March 2016			Safeguarding Procedures (Children) - Level 3 1st March 2013 - 31st March 2016		
	Heads	Number Completed	% Completed	Heads	Number Completed	% Completed	Heads	Number Completed	% Completed
CORPORATE SERVICES									
370 Finance RWW208	69	68	98.55%	0	0	#DIV/0!	0	0	#DIV/0!
370 FIN FSD RWW340	7	7	100.00%	0	0	#DIV/0!	0	0	#DIV/0!
370 Finance & Supplies RWW339	62	61	98.39%	0	0	#DIV/0!	0	0	#DIV/0!
370 HR & OD RWW210	115	110	95.65%	24	17	70.83%	0	0	#DIV/0!
370 HR & Payroll RWW334	53	50	94.34%	3	2	66.67%	0	0	#DIV/0!
370 ODG Education RWW331	62	60	96.77%	21	15	71.43%	0	0	#DIV/0!
370 IT RWW213	74	45	60.81%	1	0	0.00%	0	0	#DIV/0!
370 IT RWW3	74	45	60.81%	1	0	0.00%	0	0	#DIV/0!
370 Nursing & Governance RWW209	68	56	82.35%	44	29	65.91%	0	0	#DIV/0!
370 Governance RWW333	17	16	94.12%	3	3	100.00%	0	0	#DIV/0!
370 Nursing RWW341	51	40	78.43%	41	26	63.41%	0	0	#DIV/0!
370 Research & Development RWW314	9	6	66.67%	8	6	75.00%	0	0	#DIV/0!
370 R&D RWW414	9	6	66.67%	8	6	75.00%	0	0	#DIV/0!
370 Strategy Partnerships & Communications RWW307	9	9	100.00%	0	0	#DIV/0!	0	0	#DIV/0!
370 SPC RWW407	9	9	100.00%	0	0	#DIV/0!	0	0	#DIV/0!
370 Trust Execs RWW211	24	14	58.33%	4	1	25.00%	0	0	#DIV/0!
370 Trust Executives RWW314	24	14	58.33%	4	1	25.00%	0	0	#DIV/0!
OPERATIONS									
370 CHARITABLE FUNDS RWW106	1	1	100.00%	0	0	#DIV/0!	0	0	#DIV/0!
370 Charity Development Fund	1	1	100.00%	0	0	#DIV/0!	0	0	#DIV/0!
370 Estates RWW326	61	60	98.36%	0	0	#DIV/0!	0	0	#DIV/0!
370 Estates RWW4	61	60	98.36%	0	0	#DIV/0!	0	0	#DIV/0!
370 Facilities RWW327	380	350	92.11%	0	0	#DIV/0!	0	0	#DIV/0!
370 Facilities RWW4	380	350	92.11%	0	0	#DIV/0!	0	0	#DIV/0!
370 OPS Central Operations RWW337	6	4	66.67%	0	0	#DIV/0!	0	0	#DIV/0!
370 OPS Central Operations RWW418	6	4	66.67%	0	0	#DIV/0!	0	0	#DIV/0!
370 Scheduled Care RWW323	858	728	84.85%	715	438	61.26%	0	0	#DIV/0!
370 Critical Care RWW405	313	290	92.65%	291	229	78.69%	0	0	#DIV/0!
370 General Surgery RWW406	224	178	79.46%	161	71	44.10%	0	0	#DIV/0!
370 Scheduled Care Divisional Management RWW404	17	16	94.12%	10	6	60.00%	0	0	#DIV/0!
370 Special Surgery RWW422	124	112	90.32%	107	75	70.09%	0	0	#DIV/0!
370 Trauma Orthopaedics & Cancer RWW407	180	132	73.33%	146	57	39.04%	0	0	#DIV/0!
370 Unscheduled Care RWW324	881	666	75.60%	725	344	47.45%	97	60	61.86%
370 Acute Medicine RWW428	110	57	51.82%	86	29	33.72%	0	0	#DIV/0!
370 Discharge & Palliative Care RWW429	16	8	50.00%	14	6	42.86%	0	0	#DIV/0!
370 Emergency Care RWW416	162	109	67.28%	122	79	64.75%	96	59	61.46%
370 Medicine, Elderly & Stroke RWW417	304	250	82.24%	283	132	46.64%	1	1	100.00%
370 Specialty Medicine RWW423	227	191	84.14%	213	93	43.66%	0	0	#DIV/0!
370 Unscheduled Care Divisional Management RWW424	62	51	82.26%	7	5	71.43%	0	0	#DIV/0!
370 Womens, Childrens & Supporting Services RWW325	1360	1185	87.13%	879	631	71.79%	280	226	80.71%
370 Audiology RWW415	22	16	72.73%	19	9	47.37%	0	0	#DIV/0!
370 Child Health RWW409	132	120	90.91%	125	105	84.00%	106	88	83.02%
370 Pathology RWW419	145	135	93.10%	50	30	60.00%	0	0	#DIV/0!
370 Pharmacy RWW421	141	125	88.65%	6	5	83.33%	0	0	#DIV/0!
370 Radiology RWW420	181	155	85.64%	141	96	68.09%	0	0	#DIV/0!
370 Therapies RWW413	291	246	84.54%	270	189	70.00%	0	0	#DIV/0!
370 WCSS Divisional Managment & Admin RWW414	78	62	79.49%	17	8	47.06%	6	4	66.67%
370 WCSS Outpatient Department RWW425	163	149	91.41%	54	27	50.00%	2	1	50.00%
370 Womens Health RWW408	207	177	85.51%	197	162	82.23%	166	133	80.12%
TRUST TOTAL	**3915**	**3302**	**84.34%**	**2400**	**1466**	**61.08%**	**377**	**286**	**75.86%**

Appendix 5 - Action plan 2015/2016

ACTION PLAN

Title: **Safeguarding Procedures (Children) Mandatory Training Compliance**

Key

1 – Agreed but not yet actioned

2 – Action in progress

3 – Made partial implementation

4 – Full implementation completed

	Actions	Responsible Person	Change stage (see Key)	Date Action(s) to be Completed
1	Named Nurse/Midwife Safeguarding Children to review the quarterly compliance reports for all levels of training, in order to ascertain which staff require specific levels of training.	Matron / Named Nurse, Safeguarding Children	4	**Completed**
2	Named Nurse/Midwife Safeguarding Children to ensure facilitation of specific 'stand-alone' Level 1 Safeguarding Procedures (Children) in order to target specific staff groups and increase training compliance.	Matron / Named Nurse, Safeguarding Children	4	**Completed**
3	Named Nurse/Midwife Safeguarding Children, together with Training Team, to devise a staff handout / leaflet for Safeguarding Procedures (Children) Level 1, with staff to sign to state they are happy with the content and the procedures to follow. All staff signed sheets to be returned to the Training Team for inputting onto ESR.	Matron / Named Nurse, Safeguarding Children	4	**Completed**
4	Named Nurse / Safeguarding Children to meet with A&E Nurse Educator Trudi Lowe and review the action plan formulated by A&E	Matron / Named Nurse, Safeguarding Children	4	**Completed**
5	The Trust is currently working towards a competency based workforce which is a large scale project over the next few years. A self-assessment tool for ward managers has been developed which has within it a safeguarding element and will be rolled out.	Director of Nursing and OD	2	On-going
6	Named Nurse / Midwife Safeguarding Children to review copy of the detailed report to identify staff groups that are out of date with training and to contact Managers / Divisional Nurses for assistance regarding improving training compliance in their areas of influence	Matron / Named Nurse, Safeguarding Children	4	**Completed**

	from Level 3 downwards.			
7	Training compliance for Safeguarding Children placed on Risk Register (Corporate) – Score 12.	Matron / Named Nurse, Safeguarding Children	4	**Completed**
8	A matrons/ ward managers and specialist Nurses to complete Level 2 e learning if not already up to date	Ward Managers /Specialist nurse	3	**Completed**
9	Level 1 briefings to be cascaded – all briefed to sign and lists to go to training department.	Matrons / ward managers / Safeguarding office	3	**Completed**
10	Quarter 4 data 2015/16 to be reviewed, all level 2 out of date practitioners to be notified by email.	Matron / Named Nurse, Safeguarding Children	4	**Completed**
11	Quarter 4 data 2015/2016 to be reviewed, all level 3 out of date practitioners' managers to be notified by email.	Matron / Named Nurse, Safeguarding Children	4	**Completed**
12	All safeguarding children link people to be trained in CSE	Matron / Named Nurse, Safeguarding Children and catch 22.	3	June 2016
13	6 sessions of Domestic Abuse training to be arranged for the trust.	Matron / Named Nurse, Safeguarding Children	3	June 2016 October 2016 November 2016 (2 sessions per month)

Appendix 6

Pan Cheshire Section 11 Audit Audit Summary

Allocation Name: Allocation: Pan Cheshire Section 11 Audit Warrington and Halton Hospitals Trust

Organisations: Warrington and Halton Hospitals Trust

Exported on 07-Jul-2016 13:24

Progress: 99 % Score: 91 % Status: In Progress Grade: Grade 3 Start Date: 06-Jun-2014 Deadline Date: No Deadline

	Title	Progress	Status	Score	Grade
1	Section 11.1	92 %	In Progress	88 %	Grade 3
1.1	1.1 There is a named senior manager who champions safeguarding throughout your organisation		Complete	100 %	Grade 4
1.2	1.2 There is a named or designated person with a clearly defined role and responsibilities in relation to safeguarding, including child protection and early help		Complete	100 %	Grade 4
1.3	1.3 Everyone in the organisation knows whom the designated or lead person for safeguarding is.		Complete	100 %	Grade 4
1.4	1.4 Children are listened to, taken seriously and responded to appropriately		Complete	75 %	Grade 3
1.5	1.5 There is a designated or lead person for child sexual exploitation who provides a single point of contact re CSE for the agency.		In Progress	50 %	Grade 2
1.6	1.6 There is a locally agreed definition of 'early help' which is disseminated across the organisation. All staff are aware of their role in early help and actively support children, young people and their families at the earliest opportunity.		Complete	100 %	Grade 4
2	Section 11.2	96 %	In Progress	100 %	Grade 4
2.1	2.1 The organisation has a written policy and procedure for safeguarding and protecting children		Complete	100 %	Grade 4
2.2	2.2 The above policy and procedure is available to all staff		Complete	100 %	Grade 4
2.3	2.3 The policy and procedures have been reviewed since the introduction of Working Together in 2013.		Complete	100 %	Grade 4
2.4	2.4 The policy and procedure is reviewed on a regular basis to maintain compliance with new legislation and service and personnel changes.		Complete	100 %	Grade 4
2.5	2.5 All staff are aware of their own roles and responsibilities and those of the organisation for safeguarding and protecting children		Complete	100 %	Grade 4
2.6	2.6 The policy and procedures help staff to recognise the additional vulnerability		Complete	100 %	Grade 4
2.7	2.7 The organisation has effective complaint policies and systems in place for professionals and service users, which are compatible with LSCB Procedure and Guidance		Complete	100 %	Grade 4
2.8	2.8 The organisation has effective whistle blowing policies and systems in place for professionals and service users, which are compatible with LSCB Procedure and Guidance		Complete	100 %	Grade 4

	Title	Progress	Status	Score	Grade
2.9	2.9 The organisation has effective allegation policies and systems in place for professionals and service users, which is compatible with LSCB Procedure and Guidance		Complete	100 %	Grade 4
2.10	2.10 The above policies are mandatory for staff and volunteers		Complete	100 %	Grade 4
2.11	2.11 All incidents, allegations of abuse and complaints are recorded, monitored and available for internal and external audit.		Complete	100 %	Grade 4
2.12	2.12 All incidents, allegations of abuse and complaints are dealt with in an appropriate manner in line with policy and procedure.		In Progress	100 %	Grade 4
3	Section 11.3	100 %	Complete	100 %	Grade 4
3.1	3.1 The organisation has a clear written accountability framework, which covers individual, professional and organisational accountability		Complete	100 %	Grade 4
3.2	3.2 Staff understand to whom they are accountable and what level of accountability they have		Complete	100 %	Grade 4
3.3	3.3 Staff working with children receive regular reflective supervision and appraisals		Complete	100 %	Grade 4
4	Section 11.4	100 %	Complete	100 %	Grade 4
4.1	4.1 Service plans consider how the delivery of services will take account of the need to safeguard and promote the welfare of children.		Complete	100 %	Grade 4
4.2	4. 2 Organisational policies and procedures and all service developments take into account e safety and reflect the actions necessary to address this		Complete	100 %	Grade 4
5	Section 11.5	100 %	Complete	75 %	Grade 3
5.1	5.1 Learning and Improvement Professionals and organisations protecting children need to reflect on the quality of their services and learn from their own practice and that of others.		Complete	75 %	Grade 3
5.2	5.2 Service development plans are informed by the views of children and families.		Complete	75 %	Grade 3
5.3	5.3.Organisation can demonstrate a culture of listening		Complete	75 %	Grade 3
6	Section 11.6	100 %	Complete	75 %	Grade 3
6.1	6.1 Individual case decisions are informed by the views of children and families		Complete	75 %	Grade 3
7	Section 11.7	100 %	Complete	100 %	Grade 4
7.1	7.1 Children are made aware of their right to be safe from abuse. This is achieved through information made available, for children, young people and parents about where to go for help in relation to maltreatment and abuse.		Complete	100 %	Grade 4
7.2	7.2 Information provided is in a format and language that can be easily understood by all service users.		Complete	100 %	Grade 4
8	Section 11.8	100 %	Complete	92 %	Grade 3
8.1	8.1 The organisation has an induction process for all staff and volunteers that includes familiarisation with safeguarding policy and procedures.		Complete	100 %	Grade 4

	Title	Progress	Status	Score	Grade
8.2	8.2 Appropriate staff and volunteers who work with or have contact with children and families receive training on their professional roles and responsibilities and those of their organisation		Complete	75 %	Grade 3
8.3	8.3 Appropriate staff and volunteers are trained to recognise signs of abuse and neglect		Complete	100 %	Grade 4
8.4	8.4 Outcomes and findings from reviews and inspections are disseminated to staff and volunteers, and the learning becomes embedded in practice		Complete	100 %	Grade 4
8.5	8.5 All staff who work directly with children are trained in e safety working practices, for example regarding contact and professional boundaries		Complete	75 %	Grade 3
8.6	8.6 Senior Managers monitor the effectiveness of training and identify gaps and issues		Complete	100 %	Grade 4
9	Section 11.9	100 %	Complete	82 %	Grade 3
9.1	9.1 Safer Recruitment The organisation has a safer recruitment policy in effect which ensures professional and character references are always taken up		Complete	75 %	Grade 3
9.2	9.2 Any anomalies are resolved		Complete	100 %	Grade 4
9.3	9.3 Identity and qualifications are verified		Complete	50 %	Grade 2
9.4	9.4 Where appropriate DBS checks are completed on all those staff and volunteers who work primarily or directly with children and young people and their managers...		Complete	100 %	Grade 4
9.5	9.5 Face-to-face interviews are carried out.		Complete	100 %	Grade 4
9.6	9.6 Previous employment history and experience are checked and satisfactory references are affirmed		Complete	75 %	Grade 3
9.7	9.7 Employees involved in the recruitment of staff to work with children have received training as part of the "safer recruitment training" programme.		Complete	75 %	Grade 3
10	Section 11.10	100 %	Complete	100 %	Grade 4
10.1	10.1 The organisation has identified principles of working with children and their families for all staff to work within.		Complete	100 %	Grade 4
10.2	10.2 Staff understand when to discuss a concern about a child's welfare with a manager.		Complete	100 %	Grade 4
10.3	10.3 Staff understand the threshold for making a referral to Children's Services or initiating an Early Help Assessment (CAF/TAF)		Complete	100 %	Grade 4
10.4	10.4 Staff have access to Local Safeguarding Children Board inter-agency guidance and procedures.		Complete	100 %	Grade 4
10.5	10.5 Staff participate in multi-agency meetings and forums to consider individual children		Complete	100 %	Grade 4
10.6	10.6 Contractors to the organisation who work with Children and are delivering statutory services are Section 11 compliant and have been audited.		Complete	100 %	Grade 4
11	Section 11.11	100 %	Complete	88 %	Grade 3
11.1	11.1 Staff know how and when to share information in a way that is both legal and ethical to safeguard and protect children.		Complete	100 %	Grade 4

	Title	Progress	Status	Score	Grade
11.2	11.2 Data collected is made available to LSCB, practitioners, users and commissioners.		Complete	100 %	Grade 4
11.3	11.3 As a minimum the organisation evaluates outcomes from the perspective of the child or young person.		Complete	75 %	Grade 3
11.4	11.4 The organisation has in place a programme of internal audit and review that enables them to continuously improve the protection of children and young people from harm or neglect.		Complete	75 %	Grade 3
12	Section 11.12 ADDITIONAL QUESTIONS ONLY FOR COMPLETION BY HEALTH PROVIDER ORGANISATIONS	100 %	Complete	97 %	Grade 3
12.1	12.1 There is a named lead for MCA implementation – the focus for named professionals is MCA implementation within their own organisations (MCA Best Practice Tool DH 2006)		Complete	100 %	Grade 4
12.2	12.2 The board regularly reviews MCA implementation across the organisation		Complete	100 %	Grade 4
12.3	12.3 There is an operational strategy for safeguarding children in place which includes quality indicators to evidence best practice in safeguarding		Complete	100 %	Grade 4
12.4	12.4 There is a process for ensuring that patients are routinely asked about dependents such as children, or about any caring responsibilities		Complete	75 %	Grade 3
12.5	12.5 The provider complies with the principles in Prevent and the Prevent guidance toolkit.		Complete	75 %	Grade 3
12.6	12.6 Pathways are in place to ensure safeguarding during transition to adult services are met.		Complete	100 %	Grade 4
12.7	12.7 There is a process for following up children who do not attend an appointment for specialist care		Complete	100 %	Grade 4
12.8	12.8 There is a system for flagging children for whom there are safeguarding concerns		Complete	100 %	Grade 4
12.9	12.9 There is clear guidance in relation to Children in Care as to the requirements necessary for the completion of health action plans, including regular health assessments, medicals and reviews.		Complete	100 %	Grade 4
12.10	12.10 The NWAS Safeguarding Communication Pathway is in place.		Complete	100 %	Grade 4
12.11	12.11 To help prevent the fragmentation of records health organisations are to ensure that within a given location, health professionals work from a single set of records for each child (recommendation 78, Victoria Climbié Inquiry Report, CM 5730, 2003)		Complete	75 %	Grade 3
12.12	12.12 There is clear guidance on the management of children admitted to adult wards which ensures that care is delivered in a safe environment		Complete	100 %	Grade 4
12.13	12.13 There is clear guidance as to the discharge of children for whom there are child protection concerns.		Complete	100 %	Grade 4
12.14	12.14 Specialist paediatric advice is available at all times		Complete	100 %	Grade 4
12.15	12.15 The child's GP and health visitor/school nurse is notified of admissions/discharges		Complete	100 %	Grade 4
12.16	12.16 Clinical Commissioning Group and Local Authority shall be notified of any child (normally resident in Clinical Commissioning Group area likely to be accommodated for a consecutive period of at least 3 months...		Complete	100 %	Grade 4
12.17	12.17 As part of the assessment and care planning, child and mental health professionals should identify whether abuse or neglect, or domestic abuse, are factors in a child's mental health problems		Complete	100 %	Grade 4

	Title	Progress	Status	Score	Grade
12.18	12.18 There are clear procedures for staff to follow in situations when inpatient beds are required but not immediately available within the relevant service.		Complete	100 %	Grade 4
12.19	12.19 The use of restraint is always appropriate, reasonable, proportionate and justifiable to that individual		Complete	100 %	Grade 4
12.20	12.20 Rapid tranquilisation will only be used in accordance with NICE clinical guidelines on Violence		Complete	75 %	Grade 3
12.21	12.21 Practitioners working within adult mental health services should routinely record details of patient's responsibilities in relation to children...		Complete	100 %	Grade 4
12.22	12.22 All inpatient mental health services must have policies and procedures relating to children visiting inpatients as set out in the Guidance on the Visiting of Psychiatric Patents by Children (HS 1999/222:LAC (99)32), to NHS Trusts		Complete	100 %	Grade 4
12.23	12.23 Staff routinely assess the risk and history of abuse and the person's vulnerability to abuse, including predatory behaviour or sexual vulnerability and manage any identified risks		Complete	100 %	Grade 4
12.24	12.24 A consultant psychiatrist should be directly involved in all clinical decision making for service users who may pose a risk to children		Complete	100 %	Grade 4
12.25	12.25 All assessment, CPA monitoring, review, and discharge planning documentation and procedures should prompt staff to consider if the service user is likely to have or resume contact with their own child or other children in their network of family...		Complete	100 %	Grade 4
12.26	12.26 Safeguarding training specifically includes the risks posed to children from parents with delusional beliefs involving their children or who might harm their children as part of a suicide plan		Complete	100 %	Grade 4
12.27	12.27 All staff working in A&E Departments, Ambulance Care Units, Urgent Care Units and Minor Injury Units should be able to:		Complete	100 %	Grade 4
12.28	12.28 All attendances for children under 18 years to A&E, ambulatory care units, walk in centres and minor injury units should be notified to the child's GP....		Complete	100 %	Grade 4
12.29	12.29 There are clear guidelines for the management of sudden unexpected deaths in childhood in line with those of the Local Safeguarding Children Board.		Complete	100 %	Grade 4
12.30	12.30 Emergency Departments receiving children have a Registered Nurse (children) lead nurse for the care of children and young people and a lead nurse responsible for safeguarding within the department.		Complete	100 %	Grade 4
12.31	12.31 There is a lead consultant and lead nurse within the A&E Department with responsibility for safeguarding.		Complete	100 %	Grade 4
12.32	12.32 The A&E Department has a minimum of 1 Registered Nurse (children) present at all times.		Complete	100 %	Grade 4
12.33	12.33 As part of the Healthy Child Programme, regular health reviews are undertaken which provide the opportunity to weigh up risk and protective factors that make children more likely to experience poorer outcomes.		Complete	100 %	Grade 4
12.34	12.34 All professionals delivering primary care should know when it is appropriate to refer a child to children's social care for help as a 'child in need', and know how to act on concerns a child may be at risk of significant harm.		Complete	100 %	Grade 4
12.35	12.35 Community health practitioners should have a clear means of identifying in records those children (together with their parents and siblings) who are subject to a child protection plan		Complete	100 %	Grade 4
12.36	12.36 There is good communication between GPs, community nursing services (i.e. health visiting, school nursing and community midwifery services) in respect of children for whom there are concerns.		Complete	100 %	Grade 4

We are WHH

Warrington and Halton Hospitals NHS
NHS Foundation Trust

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/16/152**	
SUBJECT:	**Director of Infection Prevention and Control – Healthcare Associated Infection - Annual Report April 2015 – March 2016**	
DATE OF MEETING:	**27th July 2016**	
ACTION REQUIRED	**For Assurance**	
AUTHOR(S):	**Lesley McKay Associate Director of Infection Prevention & Control**	
EXECUTIVE DIRECTOR SPONSOR:	**Simon Constable, Medical Director & Deputy CEO**	
LINK TO STRATEGIC OBJECTIVES:	**SO1: To ensure that all care is rated amongst the top quartile in the North West of England for patient safety, clinical outcomes and patient experience**	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	**BAF1.1: CQC Compliance for Quality**	
	BAF1.2: Health & Safety	
	BAF1.3: National & Local Mandatory, Operational Targets	
FREEDOM OF INFORMATION STATUS (FOIA):	**Release Document in Full**	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	**None**	
EXECUTIVE SUMMARY (KEY ISSUES):	**This report outlines the arrangements, activities and achievements of the Trust relating to infection prevention and control for the April 2015 to March 2016 financial year.**	
RECOMMENDATION:	**The Board note the contents of the report.**	
PREVIOUSLY CONSIDERED BY:	**Committee**	**Not Applicable**
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	

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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 the surrounding areas. The Trust operates across two sites, has approximately 600 inpatient beds, an annual budget in the region of £215 million, employs over 4,200 staff and provides access to healthcare for over 500,000 patients as an outpatient and/or inpatient.

The Trust's vision is to ensure that all care is rated amongst the top quartile in the North West of England for patient safety, clinical outcomes and patient experience. This places both quality and safety as the highest priorities for the organisation.

Good infection prevention and control practices are essential to ensure that people who use healthcare services receive safe care. The 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 2015 to March 2016 financial year.

Infection prevention and control action 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. There has been a delay in completing some policy reviews and the audit programme was not fully completed.

A robust work plan (appendix 1) has been devised for the 2016/17 financial year. This 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.

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 and related guidance (2015)
- Meticillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia reduction
- Meticillin-sensitive *Staphylococcus aureus* (MSSA) bacteraemia reduction (fully completed)
- Clostridium difficile reduction (and additional recovery plan)

Total hospital apportioned cases of Clostridium difficile rose slightly. However, 48% (16) of the cases were deemed unavoidable. MRSA bacteraemia cases reduced slightly. Cases of hospital apportioned MSSA bacteraemia reduced significantly and this action plan was completed.

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)
18th July 2016

Acknowledgements

Lesley McKay	Associate Director of Infection Prevention and Control
George Creswell	Associate Director of Estates and Facilities
Julie McGreal	Facilities Manager
Marcia Anthony	Facilities Manager
Rachel Cameron	Antibiotic Pharmacist
Cathy Johnson	Matron CMTC & Halton (Scheduled Care)
Dr Thamara Nawimana	Consultant Medical Microbiologist/Infection Control Doctor
Dr Zaman Qazzafi	Consultant Medical Microbiologist
Natalie Crosby	Matron Intensive care
Karen Smith	Infection Prevention and Control Nurse
Andrew Sargent	Infection Prevention and Control Nurse
Glynn Marriott	Infection Prevention and Control Nurse

DESCRIPTION OF INFECTION CONTROL ARRANGEMENTS

Infection Prevention & Control Team

The Infection Prevention & Control Team meets weekly. Membership includes:-

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

- Consultant Medical Microbiologists:-
    - Dr Zaman Qazzafi
    - Dr Thamara Nawimana

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

- Infection Prevention & Control Nurses:-
    - Karen Smith
    - Glynn Marriott (from October 2015)
    - Andrew Sargent (0.4WTE)

- Antibiotics Pharmacist (part time):-
    - Rachel Cameron (0.4 WTE)

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

Infection Control Sub-Committee

The Trust's Infection Control Sub-Committee meets 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 & Control Nurse Specialists
- Antibiotics Pharmacist
- Practice Educators (specialist interest in IV management)
- Divisional Infection Control Lead Consultant - Scheduled Care
- Divisional Infection Control Lead Consultant - Unscheduled Care
- Divisional Infection Control Lead Consultant - Women, Children and Clinical Support Services
- Associate Directors of Nursing/Head of Midwifery (infection prevention and control leads)
- Matrons Scheduled Care

- Matrons Unscheduled Care
- Matrons Women, Children and Clinical Support 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 Governance Sub-Committee

Links to Drugs and Therapeutics Committee

The links are via:-

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

Links to Quality Governance Sub-Committee and Safety and Risk Sub-Committee

The links are via:-

- Director of Infection Prevention and Control
- Associate Director of Infection Prevention & Control
- Director of Nursing
- Minutes of Infection Control Sub-Committee/high level briefing papers
- Infection prevention & 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 bacteraemia cases
- Post infection review of hospital apportioned MSSA bacteraemia cases
- Divisional 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 2015
- June 2015 (Clostridium difficile exception report)
- July 2015
- September 2015 (Annual Report on previous years activity)
- October 2015
- January 2016

Annual action 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 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 robust 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 Governance Sub-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.

Compliance at the end of March 2016 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*
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 & volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection	*Partially compliant*	*A performance management policy has been implemented to drive improvements in attendance at mandatory training (including infection prevention and control)*
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*	*Some policies are beyond review date – a recovery plan is in place*
10. Providers have a system in place to manage the occupational health needs of staff in relation to infection	*Compliant*	

MRSA bacteraemia reduction action plan

This action plan sets out the work required to reduce the risks of MRSA bacteraemia. The Trust reported 4 MRSA bacteraemia cases (2 hospital apportioned and 2 community apportioned). This is an improvement to the previous financial year where 3 hospital apportioned cases were reported.

All hospital apportioned MRSA bacteraemia cases are incident reported and undergo a post infection review (PIR). This is particularly useful in identifying areas requiring improvement. The findings from the PIRs are detailed in table 2.

Table 2 – MRSA bacteraemia investigation findings

Case	Root cause(s)	Areas for care improvement
1	Antibiotic choice did not cover MRSA	Compliance with MRSA admission screening ensuring invasive device sites are included as per policy Use of longer term IV access devices for patients requiring daily bloods and IV fluid infusion
2	Antibiotic selection pressure due to prophylaxis for spontaneous bacterial peritonitis	Use of longer term IV access devices for patients requiring daily bloods and IV fluid infusion Wound management for patients with pruritus

Both the MRSA bacteraemia cases occurred on the same ward with a three week period. Due to the close timescale the specimens were referred for further typing. The results showed different SPA types therefore this was concluded as a cluster of cases and not an outbreak.

A number of actions have been undertaken to address some of the common themes identified in the investigations. These include:-

- Highlighting the need to refer patients for insertion of longer term IV access devices
- Education on MRSA screening in line with Trust policy

Currently the Trust does not have a clinical IV insertion service. A limited service is provided by the Clinical Education Team. There is a plan to review clinical nurse specialist posts and look at the feasibility of introducing this type of service.

MSSA bacteraemia reduction action plan

This action plan sets out the work required to reduce the risks of meticillin sensitive *Staphylococcus aureus (*MSSA) bacteraemia. The Trust was previously identified as an outlier for MSSA bacteraemia cases (higher than the average rate) both nationally and in the northwest region during 2012/2013.

During 2015-2016 the Trust reported 31 MSSA bacteraemia cases (4 hospital apportioned and 27 community apportioned). This is a decrease of 8 hospital apportioned cases from the previous financial year and a reduction of 22 cases since the 2012/2013 year, demonstrating continuous improvement. The findings from the PIRs are detailed in table 3.

Table 3 – MSSA bacteraemia investigation findings

Case	Root cause(s)/ contributory factors	Areas for care improvement
1	Septic on admission	Admitted from neighbouring mental health Trust, clearly septic on admission however, blood cultures were taken on 2nd day after admission. Low dose antibiotics were prescribed in AED due to poor renal function (however would have been sub-therapeutic level)
2	Unknown but possibly from community acquired pressure sores	Blood cultures were taken on 2nd day after admission. The infection was likely present on admission Ensuring medically accepted patients are reviewed post take if remaining in CDU at times of bed pressures
3	VAP/ Surgical tracheostomy; long dwell time for a peripheral cannula (9 days)	Protocol required for tracheostomy insertion which includes assessing the requirement for antibiotic prophylaxis
4	Psoriasis skin/soft tissue infection (candida) / possible hospital acquired pneumonia (HAP)	IV device selection- peripheral cannula with long dwell time (7 days) due to poor access although VIP = 0

The PIRs identified late sampling resulted in 2 of these 4 cases being apportioned to the Trust. Work is in place to increase training for staff in AED to promote timely and appropriate blood culture sampling on admission.

Clostridium difficile reduction action plan

The Clostridium difficile objective for the 2015-2016 financial year was 27 cases. The Trust reported a total of 63 cases of Clostridium difficile, 33 of which were initially apportioned to the Trust. Compared to the previous financial year this equates to an increase of 2 hospital apportioned cases. All 33 cases were referred to the CCG for review. This resulted in 16 cases being assessed as unavoidable, leaving 17 cases attributed to the Trust.

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

- Participation in a peer review by a neighbouring Trust
- Development of a recovery plan focussing on 5 key action areas

- Surveillance of cases/monitoring for increased incidences in defined locations
- Cohort facility review by option appraisal and maintained for this purpose
- 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

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

Case 1 – (April 2015) GP Assessment Unit (GPAU)

A female patient was admitted to the GPAU with a rash – thought to be an allergy to the whooping cough vaccine. The patient was 34 weeks pregnant, reported a previous history of chickenpox and therefore this was not initially suspected. Serology confirmed current chickenpox. 7 staff and 22 patient contacts and were identified. From the patient contacts, 8 were inpatients that required investigation to determine immunity. Two patients had risk factors that may lead to complications but were immune.

Liaison took place with the Midwifery Team to ensure the risk of neonatal chickenpox was highlighted in case of early delivery. Education took place with GPAU staff in relation to isolating patients with rash illness. A patient notification exercise was completed and none of the contacts were reported to have developed chickenpox.

Case 2 – (May 2015) AED

A female patient who was 25 weeks pregnant attended AED with rash illness. The patient was reviewed at triage and then returned to the waiting room for a period of approximately 4 hours. The patient was considered infectious at the time of the visit. The patient was discharged when medically reviewed.

There were 120 contacts in the AED, 12 of these were admitted to the Trust but not deemed to be at high risk of complications. 8 patients gave a history of chickenpox. 2 of the contacts that were discharged were noted to be pregnant. The Community Midwifery Team was contacted to arrange testing which showed immunity. A patient notification exercise was completed and none of the contacts were reported to have developed chickenpox.

Case 3 – (October 2015) Paediatric OPD

A paediatric patient attended Paediatric Outpatients Department on the day of rash onset (therefore considered infectious) and a diagnosis of chickenpox was made by the consultant Paediatrician. 5

paediatric contacts were identified (between ages 3 months and 10 years). No significant immunosuppression was identified in any of the paediatric contacts. A patient notification exercise was completed. The Infection prevention & Control Team were not informed of any of the cases developing chickenpox.

Pseudomonas aeruginosa (August 2015) Neonatal Unit (NNU))

A cluster of Pseudomonas aeruginosa cases was identified on the NNU. This incident was managed with support from the local Public Health England (PHE) Unit. Molecular testing showed:-

- Case 1 & 2 were identical indicating transmission has occurred - thought to be associated with inadequate decontamination of ventilator temperature probes
- Case 3 & 4 were genetically different from cases 1 & 2 and each other

Case 3 and 4 were identified from the additional screening implemented as part of the incident management plan and were concluded to be sporadic cases. All the cases were subsequently discharged home.

A number of actions have been implemented in terms of NNU design against the health building note, improving hand washing facilities, review of laundering and review of feeding bottle disinfection.

Vancomycin-resistant enterococcus (October 2015) Ward B19

A patient on ward B19 was identified to have Vancomycin-resistant enterococcus (VRE) from a clinical site. Contact screening was undertaken and a further 4 patients were identified with VRE colonisation. From the 5 cases 4 cases were E. faecalis; 1 case was E. faecium.

Additional testing of the isolates showed that the isolates shared similar profiles but were not identical. Therefore this was concluded as a cluster of cases not an outbreak.

A number of actions were taken including:-

- Ward closure (as advised by PHE)
- STEIS notification
- Enhanced environmental hygiene and equipment cleaning (chlorine-based products)
- Segregation of toilet facilities from non-affected patients
- Augmented hand hygiene (washing followed by alcohol-based hand rub)
- Antibiotic review for colonized patients

The ward was re-opened following 6 days closure.

Clostridium difficile periods of increased incidence

The Infection Prevention & 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, 4 periods of increased incidence were investigated. Table 4 provides details of the PII findings.

Table 4 – Findings of Clostridium difficile PII investigations

Ward	Cases	Month	Year	Ribotyping	Comment/ areas of concern
A6	2 toxin positive cases	05	2015	015 ; 005	Ribotyping different therefore this was a cluster of 2 separate cases
C22	2 toxin positive cases	06	2015	070 ; 295	Ribotyping different therefore this was a cluster of 2 separate cases
A4	2 toxin positive cases	02	2016	126	Ribotyping was identical indicating transmission occurred between the 2 cases
A9	2 toxin positive cases	02	2016	002 ; 005	Ribotyping different therefore this was a cluster of 2 separate cases

Viral gastroenteritis (Norovirus)

Viral gastroenteritis infections can occur at any time of the 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. The rapid implementation of infection control measures and support from Operational Management to keep wards/bays closed to admissions, until 48 hours after the last symptoms, assisted in ensuring the outbreaks within the Trust were not prolonged. This demonstrates the close working relationships within the Trust between the Infection Prevention & Control Team; the Patient Flow Team and Matrons. This is critical in managing outbreaks effectively. It is recognized that closure of beds; bays and wards places significant pressure on operational teams and there has been no hesitation in accepting the Infection Prevention & 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 organism identified as Norovirus. Table 5 provides details of the number of reported incidents by month and findings.

Table 5 – Viral gastroenteritis incidents

Month	Year	No of wards affected	Causative organism(s)
Apr	2015	5	Not identified
May	2015	4	Not identified
Jun	2015	2	Not identified
Jul	2015	3	Not identified
Aug	2015	4	Not identified
Sep	2015	2	Not identified
Oct	2015	1	Not identified
Nov	2015	0	N/A
Dec	2015	3	Norovirus 1 ward
Jan	2016	8	Not identified
Feb	2016	13	Norovirus 3 wards
Mar	2016	9	Not identified

The Infection Prevention & Control Team takes a pragmatic escalatory approach to diarrhea and vomiting outbreak management. This involves closing only affected bays and escalating to full ward closures only when appropriate. During the year only 5 wards were fully closed.

The Microbiology laboratory conducted a trial on in-house testing for viral gastroenteritis pathogens. This approach to testing provides results in a timely manner which supports appropriate decision making on ward closure/re-opening. A business case is in production to support the introduction of in-house testing following the positive outcome of the trial.

The increase in wards reporting diarrhea and vomiting from January to March 2016 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 & 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.

CPE 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 & Control Team has implemented national guidance to isolate and conducting CPE (3 specimens) screening for all patients admitted by inter hospital transfer. In addition screening (1 specimen) for Vancomycin resistant enterococci (VRE) is also performed.

During the reporting period the following screening was carried out:-

- 219 patients were screened for CPE/VRE carriage
    - 4 patients were positive for Klebsiella pneumoniae. These were confirmed by the reference laboratory as:
        - 1 OXA 48
        - 1 GES
        - 2 non-metallo
    - 31 patients were positive for VRE

In addition to the 31 patients identified with VRE carriage on screening, a further 28 patients were identified with VRE from clinical specimens.

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

BUDGET ALLOCATION TO INFECTION CONTROL ACTIVITIES

The budget allocation to infection control includes:-

- Staff - Nursing
    - 1 WTE Nurse band 8b
    - 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

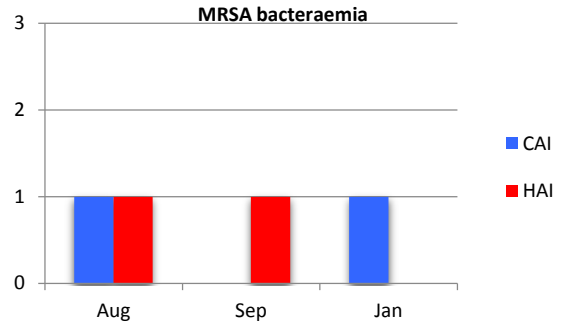
The Trust participates in the mandatory reporting of the following healthcare associated infections.

MRSA bacteraemia

The Trust reported 4 cases of MRSA bacteraemia (2 community apportioned [CAI] and 2 hospital apportioned [HAI]). The number of hospital apportioned cases has reduced by 1 case compared to the

previous financial year. Figure 1 depicts the MRSA bacteraemia cases by month detected and source of acquisition e.g. hospital or community. Details of the PIR findings are included on page 10.

Figure 1 - MRSA bacteraemia cases/source of acquisition

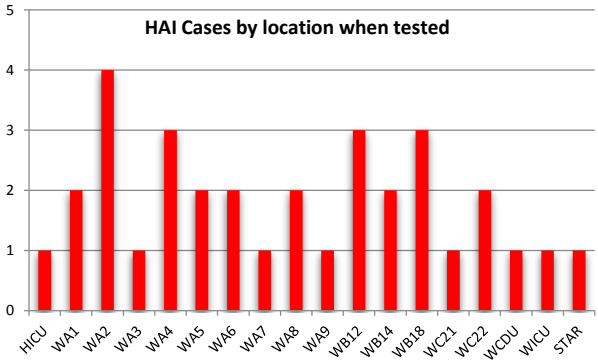


Clostridium difficile (toxin positive)

The Trust reported 63 Clostridium difficile toxin positive cases (30 community apportioned; 33 hospital apportioned). The number of hospital apportioned cases has remained similar to the previous financial year. The number of patients affected is equal to 31 as 2 patients had repeat positive tests (after 28 days of the initial sample) and were reported in line with mandatory requirements.

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

Figure 2 - 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 with input from the patients' consultants. Completed investigations were forwarded to the CCG for review. The final position was removal of 16 cases (48%) from those counted for contractual purposes. This is an improvement from the previous FY where only 1 case was removed. Figure 3 depicts the Clostridium difficile toxin positive case review outcomes by month.

Figure 3 – 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	3	5	4	1	0	4	3	2	0	0	9	2	**33**
Cases under Review	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Not due to lapse in care	3	4	1	0	0	1	2	1	0	0	4	0	16
Due to lapses in care	0	1	3	1	0	3	1	1	0	0	5	2	**17**

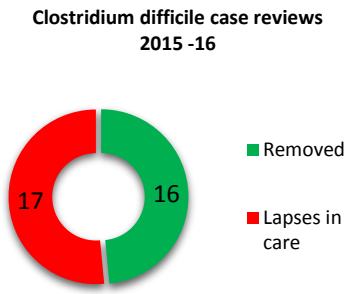
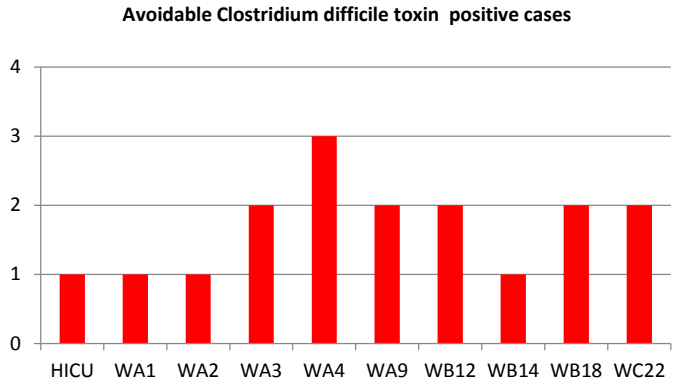


Figure 4 provides adjusted data on the 17 Trust apportioned cases (by revised location) following decisions taken by the CCG review panel.

Figure 4 - Avoidable Hospital apportioned Clostridium difficile <u>toxin positive</u> cases by location



Common themes emerging from the incident meetings include:-

- reviews of proton pump inhibitor medications are not being undertaken
- microbiological samples are not being received in the laboratory that would support presumptive diagnoses
- documented diagnoses in relation to antibiotic choice does not always match
- stools are not always documented
- specimen labelling does not meet minimum standard of 3 identifiers leading to testing delays

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

Clostridium difficile (toxin negative/PCR positive)

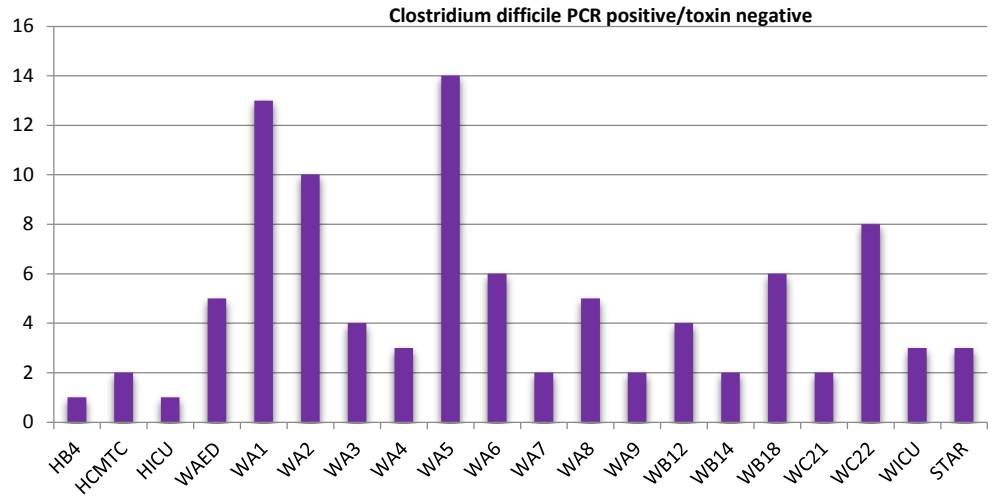
Diagnostic testing methods for Clostridium difficile infection distinguished between patients who are colonised with Clostridium difficile (PCR positive), and those with Clostridium difficile toxins present which indicates infection is more likely.

The Infection Prevention & 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 & Control Team. Patients exhibiting symptoms are nursed in isolation and treatment advice is provided.

Figure 5 demonstrates the results for all patients (no apportionment) who were Clostridium difficile toxin negative/PCR positive and at the time of testing. Some of these patients have subsequently tested positive for Clostridium diffcile toxins or have had a previous history with toxins present.

Figure 5 - Clostridium difficile <u>PCR positive/toxin</u> 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.

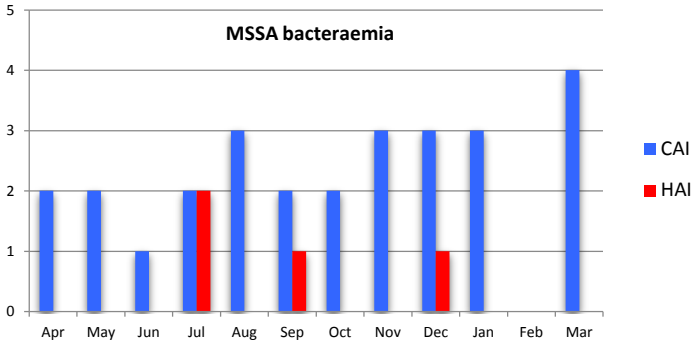
Glycopeptide resistant enterococci (GRE) bacteraemia

The Trust has reported 2 cases of 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 meticillin sensitive Staphylococcus aureus (MSSA) bacteraemia. Figure 6 shows the cases of MSSA bacteraemia identified within the Trust. There was a reduction of 8 hospital apportioned cases compared to the previous financial year. PIR findings are included on page 11.

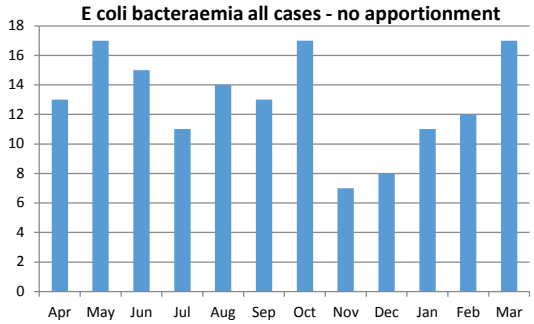
Figure 6 - MSSA bacteraemia cases/source of acquisition



Escherichia coli (E. coli) bacteraemia

The Department of Health has not set targets for the reduction of E. coli bacteraemia. Data is being collated for surveillance purposes only. The data capture system does not make a distinction between hospital/community apportioned cases. Figure 7 displays the total number of cases (155) reported by month between April 2015 and March 2016.

Figure 7 - E. coli bacteraemia cases April 2015 – March 2016



All E. coli bacteraemia cases are reviewed by the Consultant medical Microbiologists. Of the 155 cases reported:-

- 130 were not likely to be associated with healthcare
- 2 were source unknown
- 4 were likely to be associated with healthcare with source urinary tract
- 19 were possibly associated with healthcare:-

- 10 with possible urinary source
- 3 with possible hepatobiliary source
- 3 with possible respiratory tract source
- 2 with possible gastrointestinal source
- 1 other – no clear source but more likely gastrointestinal

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 minimal & mainly superficial infections. One deep seated infection was noted requiring referral for specialist management. Due to the nature of implant surgery infections can manifest themselves beyond this surveillance period. Surveillance data is provided in more detail in appendix 2.

HAND HYGIENE AND ASEPTIC PROTOCOLS

Audits of compliance with the Hand Hygiene Policy are undertaken weekly at ward and department level. The hand hygiene average compliance rate for the year was 97%.

Trust scores from the National Inpatient Management Survey 2015 included questions on:-

- availability of hand-wash gels for patients and visitors
  - 97% (n=491) respondents said these were available
  - 1% (n=3) stated dispensers were empty
  - 2% (n=12) stated they did not see any hand-wash gels

- Cleanliness of hospital rooms/wards
  - 76% (n=395) stated very clean
  - 22% (n=113) stated fairly clean
  - 3% (n=14) stated not very clean

- Cleanliness of toilets and bathrooms
  - 70% (n=348) stated very clean
  - 25% stated (126) fairly clean
  - 3% (n=17) stated not very clean
  - 1% (n=7) stated not at all clean

The Environmental hygiene group has been 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 did not met. A lead has now been appointed and the Terms of Reference revised with the first meeting scheduled in July 2016.

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.

Decontamination incident – (July 2015) CMTC Theatres

A decontamination incident occurred at CMTC theatres associated with an arthroscopy procedure. During the procedure a marking was noted on the internal lumen of the trocar. A Datix and Duty of Candour were completed. There was a delay in reporting this incident to the Infection Prevention & Control Team. An incident meeting was held and reassurance provided there was no risk of blood borne virus transmission as the instruments had been autoclaved. However a recommendation was made to follow-up the patient for 12 months. An inspection was carried out at the Trust's instrument decontamination service provider and compliance with sterilisation standards was confirmed.

CLEANING SERVICES

Management arrangements

All of the domestic staff working across Warrington and Halton Hospital sites 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 24/7 cover, including out of hours support at Halton site by the Portering Team and are supported by "as and when" staff who cover for vacancies and partially 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 infection outbreaks. They also form the core team progressing deep cleans in clinical areas.

Budget allocation

The budget allocation for domestic services for 2015/16 was £3.36m with 154.7 whole time equivalent 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, ICU, Endoscopy
High Risk Areas	Wards, Accident & Emergency, Public areas, Pharmacy, Ward Kitchens
Significant Risk Areas	OPD, external entrances
Low Risk Areas	Chapel, Offices

Copies of the monitoring reports are circulated to the Matrons, Ward Managers, Domestic and Portering Manager 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 frequencies of monitoring are increased to address any problem areas.

To positively encourage high standards, the Domestic Team working on an area which achieves 100%, will be given 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 Prevention & Control Nurse and attended by an Estates Manager, Facilities Manager, Associate Director of Infection Prevention & 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
- establish a rolling programme for use of hydrogen peroxide vapour for decontamination of side rooms
- ensure roles and responsibilities for cleaning and disinfection of re-usable equipment are made clear
- ensure mattresses are inspected as per SOP and appropriately disposed of when no longer fit for purpose
- ensure cleanliness standards in Ward Kitchens are of an acceptable high standard
- promote water safety by ensuring flushing of underused outlets is carried out in line with the legionella policy and reported centrally to Estates
- review cleanliness monitoring standards and agree methods
- 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 2015/16 staff responded to 2,901 terminal cleaning requests, a 13% increase on the previous year and curtain changes increased by 10% in the same period.

Table 6 –Terminal cleans 2013 - 2016

Terminal cleans	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Total**
2013/14	94	55	60	47	59	59	70	72	53	48	62	55	734
2014/15	100	93	92	88	47	97	110	117	150	187	114	111	1306
2015/16	278	281	235	254	224	212	236	199	235	208	233	306	2901

Table 7 - Curtain changes 2013 - 2016

Curtain changes	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Total**
2013/14	72	66	67	62	40	69	79	80	113	120	69	79	**916**
2014/15	111	169	108	79	134	155	173	169	153	190	217	153	**1700**
2015/16	179	188	151	167	124	123	175	114	178	134	157	184	**1874**

Cleanliness scores

The 2015/16 cleanliness monitoring scores were:

- Halton: 95%
- Warrington: 94%

Table 8 - Warrington Cleanliness scores

Warrington	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Annual Average**
2013/14	95%	94%	95%	96%	94%	93%	93%	93%	94%	93%	93%	92%	**94%**
2014/15	94%	96%	97%	92%	90%	92%	96%	93%	94%	91%	91%	95%	**93%**
2015/16	96%	92%	94%	95%	93%	94%	95%	94%	94%	95%	93%	92%	**94%**

Table 9 - Halton Cleanliness scores

Halton	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Annual Average**
2013/14	92%	90%	96%	92%	93%	94%	94%	92%	94%	98%	97%	93%	**94%**
2014/15	94%	95%	94%	95%	96%	94%	95%	96%	92%	94%	95%	95%	**95%**
2015/16	94%	95%	95%	94%	95%	96%	95%	94%	97%	95%	96%	94%	**95%**

***PLACE** (Patient Led Assessments of the Care Environment)*

In 2015 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 2014 and 2015 assessments are detailed in table 10, along with National averages.

Table 10 PLACE assessment results

Year	**Criteria**	**Halton**	**Warrington**	**National Average**
2014	Cleanliness	98.93%	99.42%	97.25%
2015	Cleanliness	99.68%	99.23%	97.25%
2014	Condition, appearance & maintenance	94.91%	95.35%	91.97%
2015	Condition, appearance and maintenance	92.21%	89.66%	90.11%

Following the assessments, Place Action Plans were produced to address any issues identified and were circulated to the Divisions to address. This information is also circulated to the patient assessors.

The Infection Control Sub-Committee receives updates on a monthly basis regarding the progress of the PLACE Action Plan.

Corporate reporting

A report is submitted by Facilities to the Infection Control Sub Committee on a monthly basis regarding cleanliness standards scores, number of terminal cleans/curtain changes, process audits regarding cleaning hand wash sinks and personal protective equipment (PPE), ward kitchen monitoring, linen and pest control and waste.

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 PPE when cleaning hand-wash sinks.

PAS 5748:2014

In 2015 the Facilities and the Infection Control Team completed an action plan to comply with the above best practice document. This document details the specification for the planning, application, measurement and review of cleanliness services in hospitals.

Clinical access/responsibility

The domestic staff are centrally managed by Facilities, however, the Ward Managers and the Housekeepers are able to direct the domestic staff based on the wards 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 liaises closely with the Infection Prevention & Control Team 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.

In 2015 the Trust Cleaning Standards Policy and the Domestic Manual were updated, ratified and placed on CIRIS.

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.

The audits are carried out by the Infection Prevention and Control Nurses using an approved Infection Control Nurses Association (ICNA) 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. Due to the 6 month period of reduced staffing within the Infection prevention & Control Team only a limited number of audits were completed during the financial year.

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.

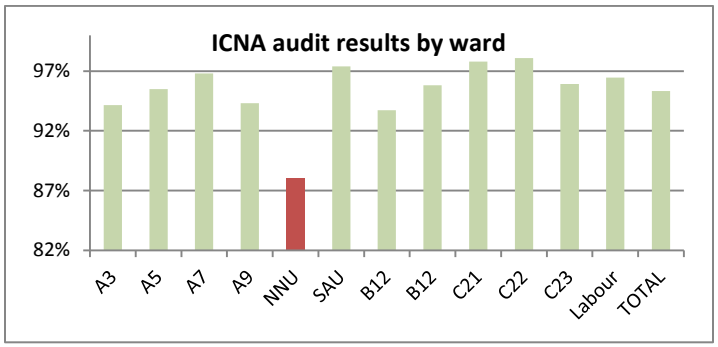
If compliance scores are lower than acceptable levels the audit will be repeated following implementation of action plans. This occurred for ward B12 (figure 8).

The compliance results from all audits are added to an excel spreadsheet to provide an overall compliance score for the Trust.

Results

A total of 12 inpatient areas were audited during the financial year 2015-2016. The majority of areas attained 94% or above. The exception to this occurred in the neonatal unit who achieved 88% compliance. Overall Trust compliance was 95%.

Figure 8 - ICNA audit results by ward/department



The NNU (Neo-natal) unit was the only clinical area to show less than 90% compliance. The audit was conducted in response to a cluster of cases of Pseudomonas aeruginosa. A number of improvement actions have been implemented and a repeat audit will be undertaken once upgrade work has been completed. The total percentage compliance for each of the components is detailed in table 11.

Table 11 Audit Summary for each component

Assessment element	Total
Environment	90%
Ward Kitchens	90%
Handling/Disposal of Linen	92%
Departmental Waste handling	96%
Safe Handling Disposal of Sharps	93%
Patient Equipment (General)	99%
Hand Hygiene	96%

Assessment element	Total
Patient Equipment (Specialist)	100%
Personal Protective Equipment	97%
Short Term Catheter Management	100%
Enteral Feeding	99%
Care of Peripheral Intravenous Lines	97%
Non-Tunnelled Central Venous Catheters	100%
Isolation Precautions	97%
Overall Compliance	95%

The lowest scoring components were general ward environment and ward kitchens. In terms of general environment and ward kitchens, 58% (n=7) of areas scored 90% or less for compliance. The audits of ward kitchens, completed by the Facilities Manager have also shown low compliance. This auditing tool is under review.

Other areas of concern included:-

- Handling & disposal of linen - 25% (n=3) areas with 90% or less for compliance
- Safe handling & disposal of sharps - 33% (n=4) areas with 90% or less for compliance

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.

Due to concerns identified at the Infection Control Sub-Committee the environment group has been re-established with a specific remit to improve standards of cleanliness for in-patient areas and ward kitchens.

Partnership working with the Health & Safety Team and Workplace Health & Wellbeing is in place to address concerns about sharps safety. This work was instigated in response to a number of high risk exposure incidents.

Education has been strengthened within the annual mandatory training package on correct linen handling and disposal.

Limitations

The Infection Prevention and Control Team staffing was reduced due to a whole time equivalent vacancy for 6 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 a robust action plan that is followed through to completion to ensure improvement actions have been taken.

It is not possible to draw any conclusions in terms of Trust wide compliance with polices/guidelines from the low number of audits completed.

Recommendations

The programme of audit should 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 the other Trusts in the Alliance Local Delivery System. This may lead to a change in the auditing tool used.

The ward kitchen auditing tool should be reviewed to ensure the requirements of the Trust are met. Discussion has taken place with the Facilities Manager to achieve this.

Sharps audit

An external audit of compliance with good practice in relation to sharps management is conducted annually. The sharps bin supplier was invited (November 2015) 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 seventeen (117) wards/departments were visited during the audit and five Hundred and eighty nine (589) sharps containers were reviewed. The sharps containers were mainly from the company conducting the audit although there were some containers from 2 other suppliers. The audit results showed:-

- nil (0) sharps containers with protruding sharps
- one (1) sharps container that was not properly assembled, (this container was immediately assembled properly and staff were informed that sharps containers which were not assembled properly could lead to the lids coming off if dropped or during transportation)
- five (5) sharps containers that were more than three quarters full, (staff were advised to only fill to the line)

- Nil (0) sharps container had the wrong lid on the wrong base
- Nil (0) sharps containers were sited on the floor or at an unsuitable height or place
- Twenty six (26) were unlabelled. All staff were informed that the label on the sharps bin should be filled in at assembly and completed at final closure
- Sixteen (16) sharps containers had significant inappropriate non sharp contents. Staff were advised not to put packaging or non-sharp items in sharps containers
- Ninety four (94) sharps containers did not have the temporary closure in place when the container was left unattended or during movement
- Small sharps containers and trays were available to take to the bedside

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 recommendations included:-

- 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 has been rescheduled for November 2016.

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.

There is a recognised shortage of office space and a number of clinical areas have used patient facilities to accommodate staff. Recently, demand for isolation has increased for infection control reasons with the introduction of the Carbapenemase Producing Enterobacteriaceae (CPE) toolkit (Department of Health 2013) which requires all patients admitted by inter-hospital transfer to be isolated, until screening results are available to inform management.

A trust wide survey was conducted showing that 17 side rooms were being used for non-clinical functions (12 beds on the Warrington site and 5 beds on the Halton site). In addition Daresbury Unit function was converted to use for Intermediate Care patients.

The Estates Department are reviewing these areas to assess if any input is required in terms of replacing medical gas/suction and nurse call bells.

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.

Both Theatres and the Accident and Emergency Department have been reported to have reduced compliance. The Infection Prevention & Control Team has continued to support both of these areas with improvements noted.

Antibiotic Prescribing

Joint Consultant Microbiologist and Antibiotic Pharmacist Ward Rounds - Summary of Interventions from 1st April 2015 – 31st March 2016

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 and levofloxacin and the other ward round targets wards where there are higher rates of antibiotic prescribing or concerns about compliance with the Trust antibiotic formulary.

Table 12 - Total Number of Antibiotics Reviewed

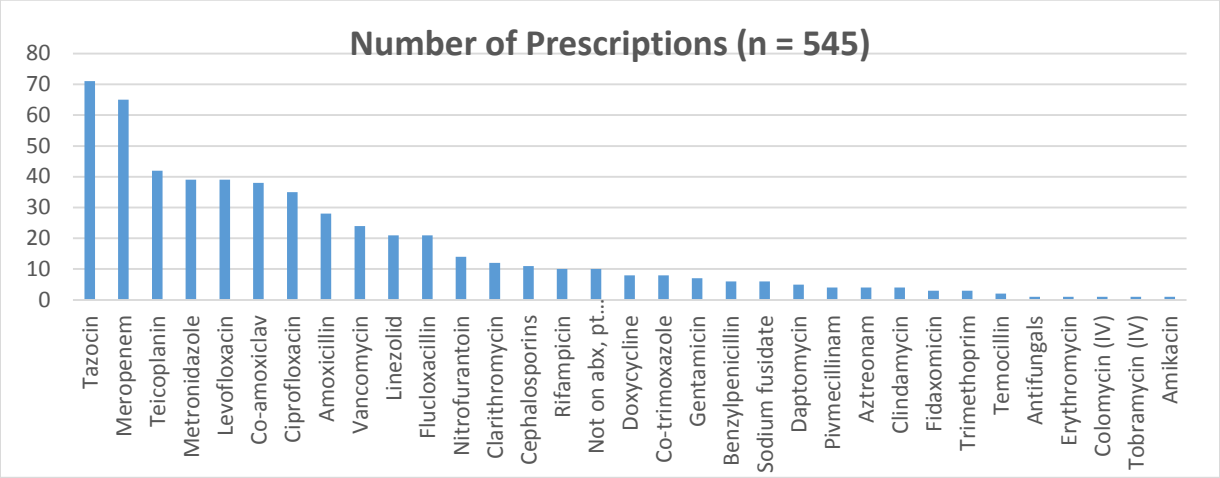
Time period	Number of patients reviewed	Number of antimicrobials reviewed
April 2013 – March 2014	592	770
April 2014 – March 2015	420	579
April 2015 – March 2016	395	545

A total of 395 patients and 545 antimicrobials were reviewed between April 2015 and March 2016. 378 antibiotics were reviewed on the Tuesday "target" round and 167 were reviewed on Friday ward round which targets specific wards. The difference in the numbers reviewed reflects the amount of time allocated to each round.

Summary of Antibiotics Reviewed

The graph below (graph 1) indicates which antibiotics were reviewed on the ward round. 48% of the antimicrobials which were reviewed were "target antibiotics," which is lower than the 85% last year which were from this group. This may reflect the wider range of antibiotics being used within the Trust. 10 patients were reviewed who were not on antibiotics but required intervention due to laboratory reports, and in 8 of the 10 cases antimicrobials were initiated after discussion with the clinical teams looking after these patients.

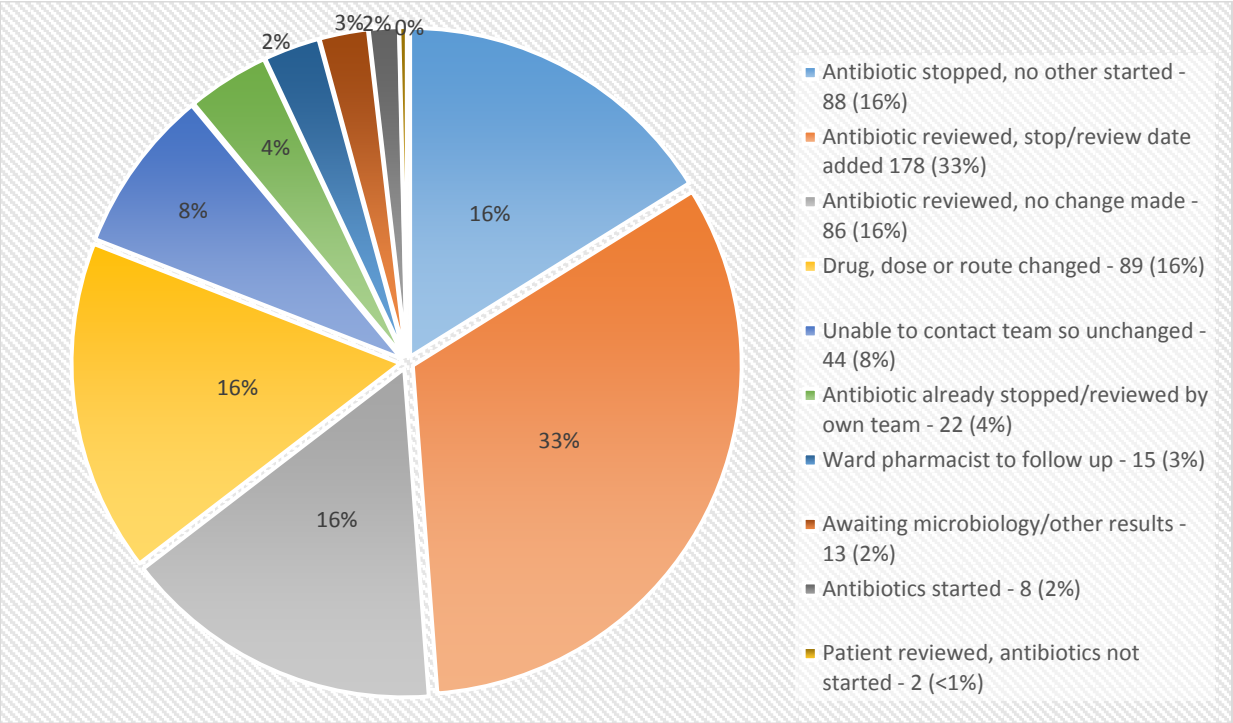
Figure 9 – Prescriptions reviewed on ward rounds



Summary of Ward Round Interventions

Of the 545 antibiotics reviewed, 177 antibiotics (33%) were either stopped or changed to a more appropriate antibiotic. Changes were only made if the team looking after the patient could be contacted. A further 178 antibiotics (33%) had a stop date added or a date for further review added. Figure 10 summarises the outcome of the antibiotic reviews in more detail.

Figure 10 – Outcome of antibiotic reviews



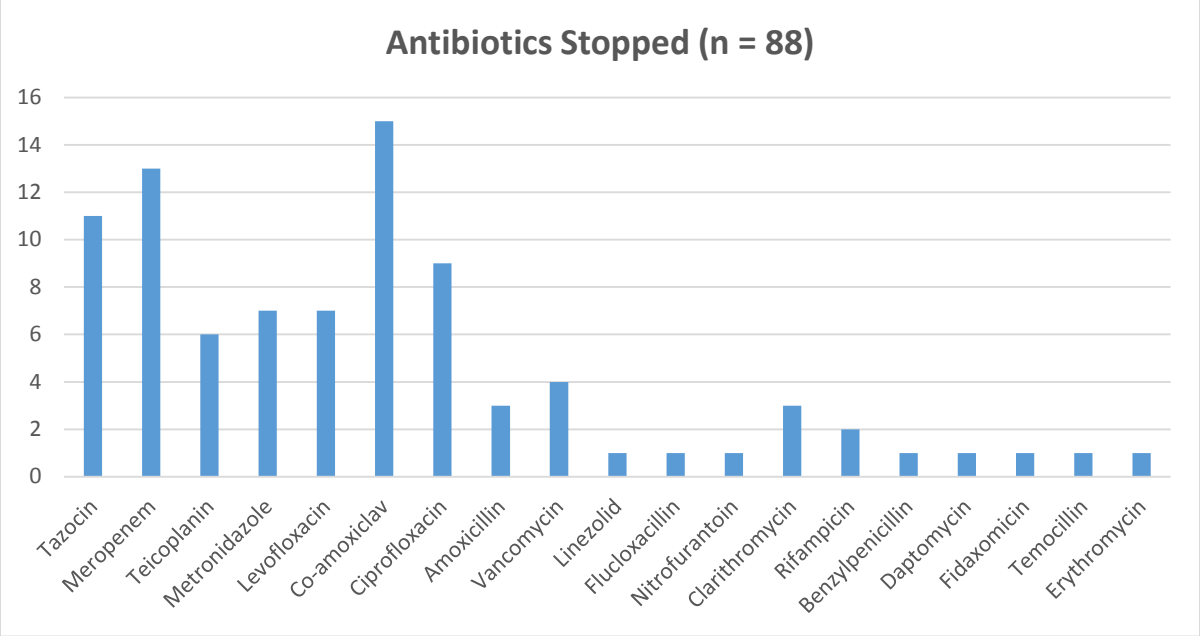
Summary of Antibiotics Stopped

88 (16%) of the antibiotics which were reviewed on the ward round were stopped and no further antibiotic treatment was considered appropriate at that point. The antibiotics which were stopped are detailed in figure 11.

Antibiotics were stopped only if the team with clinical responsibility for the patient could be contacted. In 44 (8%) of cases the team with clinical responsibility for the patient could not be contacted on the ward round so no changes were made at the time of the ward rounds. It was documented in the patient notes that a discussion with a Consultant Microbiologist was required, but these later changes were not included in the data collection.

The antibiotics which were stopped and not further treatment started are summarised in figure 11.

Figure 11 – Antibiotics stopped

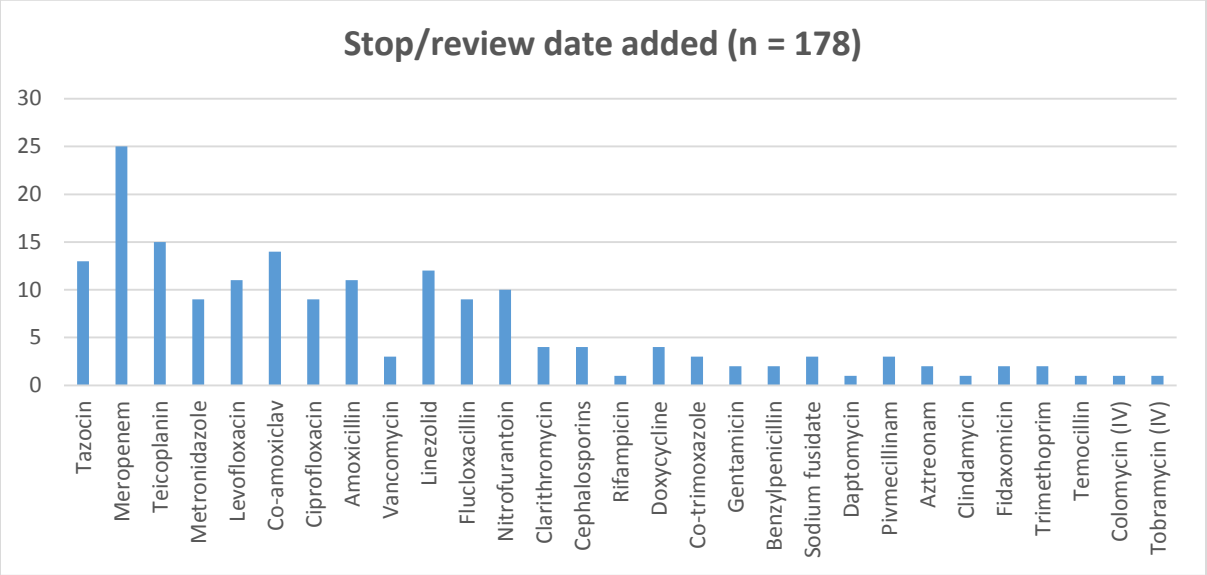


Summary of antibiotics with stop or review date added

178 (33%) of the antibiotics reviewed were considered to be appropriate but did not have a documented stop or review date on the prescription chart or in the notes.

This is an area for improvement, as all antibiotics should have a stop or review date documented when they are prescribed so as to monitor the patient and their response to treatment.

Figure 12 – Antibiotics stopped/reviewed date 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 before the patient is seen on the ward, which allows treatment to be changed if necessary. The ward rounds improve patient safety as it can reduce the risks associated with antibiotic treatment.

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 be saved by the appropriate stopping of antibiotic, particularly intravenous antibiotics. In addition 7 antibiotics which require therapeutic drug monitoring were stopped which also reduces nursing time and ward pharmacist time.

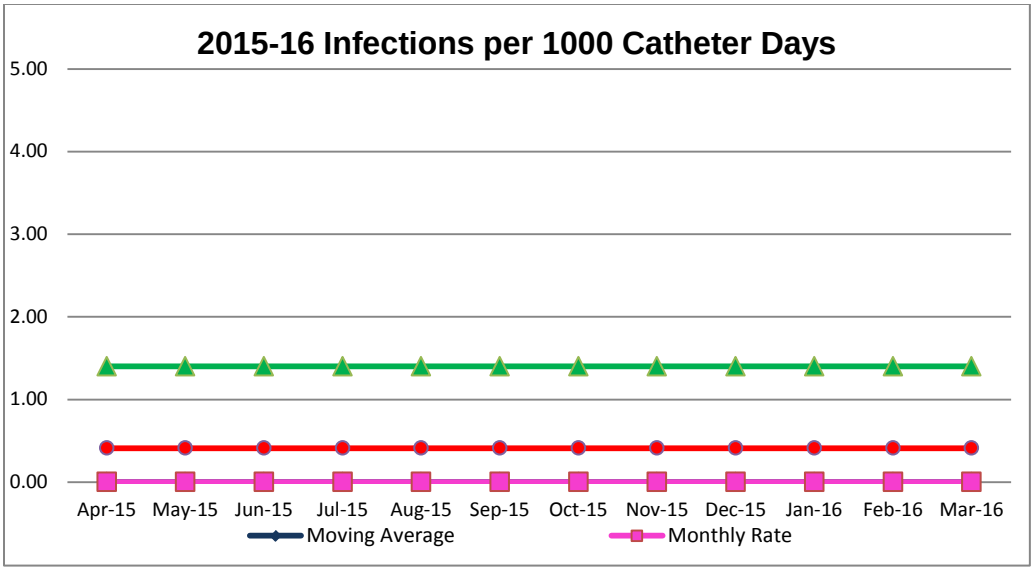
Future developments

Ideally the antimicrobial ward rounds could be expanded so that more patients on antibiotics are reviewed. At present, any patients who are reviewed on the ward round are not followed up again to review their progress unless the ward team contact the microbiologists directly. 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 2015 – 2016 financial year is displayed in figure 13.

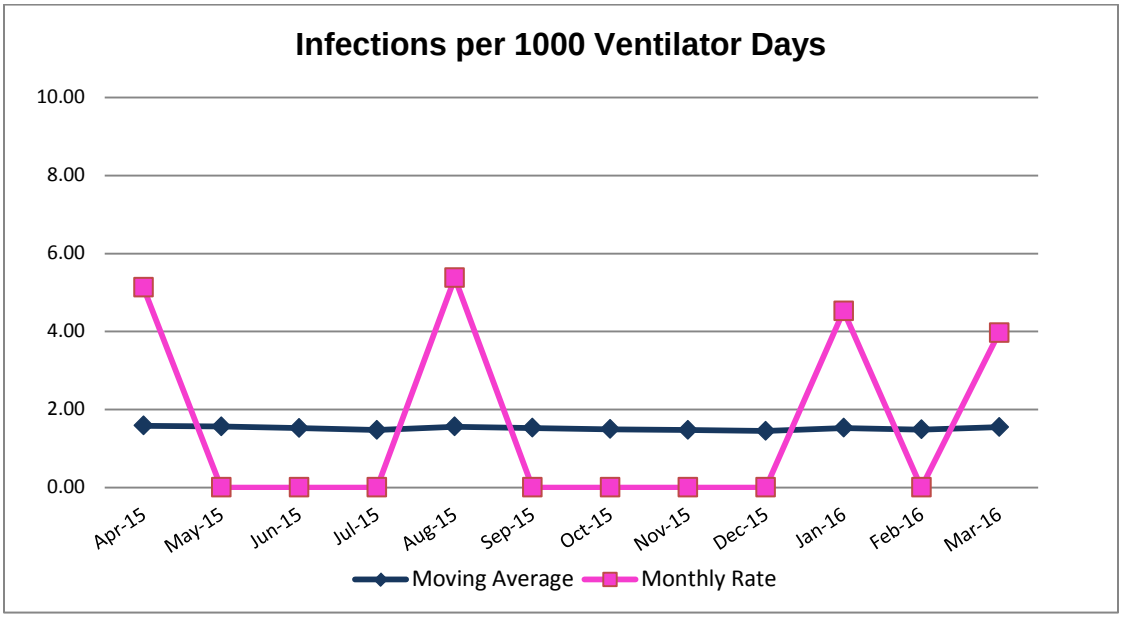
Figure 13 - Matching Michigan data



The Trust's overall rate has been consistently below that of Michigan since January 2011. Reductions were seen compared to the 2014 – 2015 data.

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 2015 – 2016 year is displayed in figure 14.

Figure 14 – VAP data



TARGETS AND OUTCOMES

Activities

The Infection Prevention & 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
- 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:-

- Blood and body fluid spillage guidelines
- Chickenpox/shingles guidelines
- Clostridium difficile guidelines
- Deceased patient guidelines
- Hand hygiene policy
- Isolation of immunosuppressed patient guidelines
- Infection prevention & control policy
- Isolation policy
- Major outbreak
- Notification policy
- Operational policy for the C. difficile cohort isolation facility
- Pest control policy
- Reporting infections conditions guidelines
- Standard precautions guidelines
- Terminal cleaning guidelines
- Viral gastroenteritis guidelines
- Ward/Department closure guidelines
- Waste handling guidelines
- Waste management policy
- SOP for HCAI incident investigation
    - Roles & responsibilities guidance

- SOP for mattress inspection and cleaning
- SOP for surveillance of surgical site infection

- Information leaflets
    - VRE
    - Infection Control for Contractors
    - CPE information for contacts
    - Surveillance of surgical site infection

- Clostridium difficile – toolkit for case investigation
- Assurance framework – Infection prevention & Control Team structure
- Terms of reference - Infection prevention & Control Sub-Committee
- Infection prevention & Control Work plan 2016/17

Updated proforma

- Data Capture System proforma
    - MRSA bacteraemia
    - MSSA bacteraemia

- Lorenzo notification forms
    - C difficile – toxin positive
    - C difficile PCR positive
    - MRSA
    - Drug resistant organisms

- Deceased patient identification and infection risk assessment form

Trust policies database

Revised and updated infection control policies, procedures and information leaflets are available on CIRIS which is accessed via the Trust's intranet.

Contribution to other initiatives

- Option appraisal for the C. difficile cohort isolation facility
- Development of a side room utilisation proforma for daily use

Capital Projects

The Infection Prevention & Control Team participated in Estates Safety & Risk Meetings. All areas that have undergone upgrade work have been reviewed and signed off by the Infection Prevention & Control Team prior to re-occupation by patients. The Infection Prevention and Control Team have been involved in discussions about the proposal to build a new Facilities Management building.

FMEA were completed for

- Combining CCU with ICU
- Moving SAU to the ARC

- Installation of IT equipment in theatres
- Moving Urgent Care centre to B2

Group documents

- Terms of reference Decontamination Group
- Terms of reference for Infection Prevention & 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 & Control sub Committee
    - Guidance notes for Matron's report completion
- Terms of reference Environment Group

- SBAR reports to DIGGs – re C difficile

Service tenders

- 0-19 service
- Community Midwifery tender
- Statement of need for in-house testing for viral gastroenteritis viruses

External reports

- Ward Closure summary report to the CCG

External groups

The Infection Prevention & 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

- Synergy – decontamination facility
- Highfield hospital audit

TRAINING ACTIVITIES

The Infection Prevention & Control Team continues 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. Attendance at training sessions is below the expected level and an action plan is in place to improve compliance.

Trust corporate induction

All new starters

Mandatory training

All staff

Infection Prevention & Control (and Sepsis) Link Staff

1 day placements/shadowing scheme

- F1 Doctors
- Student Nurses/ Medical Students

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 & 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
- GP Planned Learning Time - information on Clostridium difficile

Grand round presentation on Infection Control issues

- Missing the point – Prevention & Management of Sharps Injuries

Trust Open day

Volunteer Induction

Infection prevention & control activities

The Infection Prevention & Control Team has 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 by Infection Prevention & Control Team Members

Dr Zaman Qazzafi - Consultant Microbiologist

24 June 2015	Fosfomycin meeting
19 Oct 2015	Viral Infection in immunocompromised BSAC Educational Workshop
3 Nov 2015	NORWIC meeting
16 March 2016	BSAC education workshop Start Smart and then Focus
Apr 2015 – Mar 2016	Grand Rounds Warrington Hospital including topics such as Pneumonia (AQuA), Ebola and Flu

Co-author to a Poster Presentation on 'Incidence of Ventilator Acquired Pneumonia'
Co-author to a Poster Presentation on 'Better Outcomes – Procalcitonin'
Teaching Year 4 Medical Students and FY1 doctors (various topics)

Dr Thamara Nawimana – Consultant Microbiologist/Infection Control Doctor

17th April 2015	Antifungal conference
13th May 2015	E learning – BMJ module Ebola Virus
12th June 2015	Trust mandatory training
28th October 2015	Training & awareness session on the toolkit for managing CPE
5th November 2015	Vascular network – diabetic foot workshop
19th November 2015	North West peri-prosthetic joint infection meeting
Apr 2015 – Mar 2016	Grand Rounds Warrington Hospital

Lesley McKay – Associate Director for Infection Prevention & Control

2nd June 2015	PHE HCAI Forum
11th September	Grand Round Ebola and Flu
3rd Nov 2015	NORWIC meeting
2nd December 2015	AMR re-launch event
22nd February 2016	Clostridium difficile NHSE HCAI network

Karen Smith – Infection Prevention & Control Nurse

11th September	Grand Round Ebola and Flu
7th October 2015	*PHE Forum*

Glynn Marriott – Infection Prevention & Control Nurse

9th July 2015	*NWZG Annual Conference – Food Safety*
7th October 2015	*PHE Forum*

Rachel Cameron – Antibiotics Pharmacist

Quarterly	North West Antimicrobial Pharmacist Group educational session
March 2016	UKCPA Infection Management Masterclass

CONCLUSION

This has been a very challenging year for the Infection Prevention & 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 whilst maintaining attention to a demanding audit, education and training and surveillance work plan.

Assurance on the prevention and control of infections is provided by a matrix approach of updating policies in light of best practice/legislation; robust and regular auditing of policies and practice; spot checks and self-assessment. Although there was a reduction in auditing there was an appropriate 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 quarterly Board reports, these documents give the Trust Board assurance about infection control activities and outcomes.

Gratitude is extended to the Infection Prevention & Control Team for maintaining their proactive leadership of a challenging and extremely busy agenda. The Board is asked to receive the Infection Prevention & Control Annual Report and note the progress made.

Simon Constable
Executive Medical Director/Director of Infection Prevention and Control (DIPC)
July 2016

Appendix 1 - Infection Prevention and Control Work Plan 2016 - 2017

The Infection Control Work Programme 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 Infection Control Sub-Committee Work Plan 2016 - 2017

Division/Department	LEAD	RECEIPT OF APPROVED MINUTES REQUIRED	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
Infection Prevention and Control Team submissions (DIAGNOSTICS CBU)														
Action plans (S Drive – Action Plans)														
Health and Social Care Act	ADIPC													
Clostridium difficile Reduction	ADIPC													
MRSA/MSSA bacteraemia Reduction	ADIPC													
Infection Control Team Reports														
Antibiotic Prescribing Compliance Point Prevalence Audit Report	AP													
Antibiotic Ward Round annual report	AP													
HCAI surveillance data	ICNs													
C difficile CCG review panel feedback	ICNs													
Isolation Facilities Audit	ICNs													
Laboratory Mandatory Enhanced Surveillance Data	CMM													
Training statistics	ICNs/ Matrons													
Audit report	ICNs													

Warrington and Halton Hospitals NHS Foundation Trust Infection Control Sub-Committee Work Plan 2016 - 2017

Division/Department	LEAD	RECEIPT OF APPROVED MINUTES REQUIRED	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
DIPC Annual Report	ADIPC													
DIPC Board report	ADIPC													
Infection Control Risk Register	ICT													
CQC Hospital Intelligent Monitoring Report (As and when updated)	ADIPC													
Trust wide sharps audit (external)	ICNs													
IV Team report	CNS IV Therapy													
Terms of reference	ICT													
Annual Work plan	ICT													
ICT Assurance framework	ICT													
Other Committee/meeting minutes/action notes														
Decontamination Group	ICT	✓												
Water Safety Group (within Estates report)	ICT	✓												
Antimicrobial Management Steering Group	CMM	✓												

Warrington and Halton Hospitals NHS Foundation Trust Infection Control Sub-Committee Work Plan 2016 - 2017

Division/Department	LEAD	RECEIPT OF APPROVED MINUTES REQUIRED	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
Clostridium difficile Action Group	CMM	✓												
External Reports														
Primary Care Infection Control Report - Bridgewater	ICN													
3 Boroughs Public Health Commissioning Team	ICN													
Divisional Reports to be received and reviewed														
Acute Care														
Urgent & Emergency Care Emergency Medicine, Acute Medicine, General internal medicine	Lead Nurse Matron													
Airway Breathing & Circulation A7, CCU, C21,	Lead Nurse Matron													
Airway Breathing & Circulation ICU	Lead Nurse Matron													
Specialist medicine Wards A3, A4, A8, B12, B14, B18, STAR	Lead Nurse Matron													
Surgery and Women's and Children's Health														

Warrington and Halton Hospitals NHS Foundation Trust Infection Control Sub-Committee Work Plan 2016 - 2017

Division/Department	LEAD	RECEIPT OF APPROVED MINUTES REQUIRED	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
Digestive Diseases Wards A5, A6, C22, SAU, Endoscopy, Warrington Theatres	Lead Nurse Matron													
Musculoskeletal Care Wards A9, B19, CMTC	Lead Nurse Matron													
Musculoskeletal Care Halton Site wards B4, DCU, B1	Matron													
Musculoskeletal Care Halton Site Theatres	Lead Nurse Matron													
Womens Health Delivery Suite, C23, C20, Maternity	Matron													
Children's Health Paediatrics & NNU	Matron													
Specialist Surgery Ophthalmology, Orthodontics	Lead Nurse													
MRSA Preoperative Screening Audit	Matrons													
Other Departmental Reports														
Estates (Legionella management, theatre ventilation, capital projects)	Operational Estates Manager													
Facilities (Environmental hygiene, Laundry and waste management, Pest control)	Facilities Manager													
Workplace Health and Wellbeing	WHWB manager													

Warrington and Halton Hospitals NHS Foundation Trust Infection Control Sub-Committee Work Plan 2016 - 2017

Division/Department	LEAD	RECEIPT OF APPROVED MINUTES REQUIRED	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
Policies/Guidelines for Ratification														
As and when reviewed/updated	**ICT**													
Total reports received														
Reports received Total per meeting														

Legend

ADIPC	Associate Director of Infection Prevention and Control
AP	Antibiotics Pharmacist
CMM	Consultant Medical Microbiologist
ICN	Infection Prevention & Control Nurse
ICT	Infection Control Team
WHWB	Workplace Health & Wellbeing Manager

Appendix 2 - Orthopaedic Surgical Site Infection Surveillance (SSIS) April 2015 - March 2016

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 Infection Prevention and Control 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 marked reduction on the length of stay in hospital following elective surgery, as a result many SSIs 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 SSIs 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 2015 to March 2016

Type of Surgery	No. of forms submitted 2015/16	No. of SSI's detected during initial surveillance	Type of SSI Organisms identified
Primary Total Knee Bilateral total knee Revision Knee Surgery	333 7 (14 knee replacements) 16	4 in total (2 definite, 2 queries GP treated with antibiotics)	Case 1: Swab - Staphylococcus aureus Case 2: Patient reported only, antibiotics given by GP – no specimens received Case 3: Patient reported only, antibiotics given by GP. Staphylococcus aureus identified on wound swab Case 4: a) Staphylococcus epidermis b) Enterococcus faecalis c) Proteus Mirabilis
Total	**363**	**4**	

No. of surgical site infections (SSI's) for Hip Replacement surgery April 2015 to March 2016

Type of surgery	No. of forms submitted 2015/16	No. of SSI's Detected 2015/16	Type of SSI Organisms identified
Primary Hip Surgery Primary Hip following trauma Bilateral Hip replacements Revision Hip Surgery	269 7 6 (12 hip replacements) 21	3 in total (2 definite, 1 query GP treated with antibiotics)	Case 1: Pseudomonas Aeruginosa from wound swab Case 2: Tissue from hip Staphylococcus aureus Case 3: Patient reported only, antibiotics given by GP – no specimens received
Total	**309**	**3**	

Conclusion

The surveillance information collected during April 15 - March 16 has indicated that the Orthopaedic joint replacement infections have remained minimal and mainly superficial infections. 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.

Matron, Cathy Johnson

2016

We are WHH

Warrington and Halton Hospitals NHS
NHS Foundation Trust

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/16/**	
SUBJECT:	**Part 1 Risk Register Q1 2016-17**	
DATE OF MEETING:	**27th July 2016**	
ACTION REQUIRED	**For Assurance**	
AUTHOR(S):	**Millie Bradshaw, Associate Director of Governance**	
EXECUTIVE DIRECTOR SPONSOR:	**Karen Dawber, Director of Nursing and Governance**	
LINK TO STRATEGIC OBJECTIVES:	**All**	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	**BAF1.1: CQC Compliance for Quality**	
	BAF1.2: Health & Safety	
FREEDOM OF INFORMATION STATUS (FOIA):	**Release Document in Full**	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	**None**	
EXECUTIVE SUMMARY (KEY ISSUES):	**The Part 1 RR (risks of 15 and above) has been split into Clinical and non-clinical.** **Clinical risks (1) are reviewed by the Patient Safety and Effectiveness Sub-Committee.** **Non-Clinical risks (3) are reviewed by the Health and Safety Sub-Committee.** **The July 16 Quality Committee reviewed and discussed all the risks on behalf of the Board.**	
RECOMMENDATION:	**The Board note the current risks on the part 1 risk register and also the oversight process.**	
PREVIOUSLY CONSIDERED BY:	**Committee**	**Quality Committee**
	Agenda Ref.	
	Date of meeting	**July 2016**
	Summary of Outcome	

Insufficient staffing establishment to meet minimum service requirements affecting key objectives and patient safety Linked to 000347 and 000724

Patient Safety Sub-Committee Risk

Risk ID	000089
Risk Title	Insufficient staffing establishment to meet minimum service requirements affecting key objectives and patient safety Linked to 000347 and 000724
Further Information (If Required)	Affected key objectives include Governance activities (Departmental & Trust), NICE medicines reconciliation/ adherence, ward visiting, stock top up visits (CQC breach), external audit actions, licensing requirements (e.g MHRA), procurement processes including homecare.
Source of the risk	Risk Assessment
Risk Code	Clinical
Identified By	Matthew, Diane on 31/01/2011
Division / Department	Pharmacy
Managerial Lead	Matthew, Diane; Chief Pharmacist - Pharmacy; PHARM
Risk Status	Open as at 24/05/2016
Date for Next Review	24/08/2016

Control Measures 6 Items

Control ID	Control Title	Organisation	Owner	Compliance Rating	Assurance Rating	Risk Rating
018886	Risk assess level of risk to patients from prescription issues on wards to enable prioritisation and allocation of staff resources - may be assessed on a daily basis (acute staffing problem) or for ongoing gaps in capacity-demand	Warrington and Halton Hospitals NHS Foundation Trust	Matthew, Diane; Chief Pharmacist - Pharmacy; PHARM [From 14/07/2016]	Compliant [From 14/07/2016] The assessment is reviewed whenever staffing levels are such that ward visiting has to be reviewed.	Partially Assured [From 14/07/2016]	Extreme risk [From 14/07/2016]
021607	Pharmacist clinical review of patient at discharge	Women's, Children's and Support Services Division	Matthew, Diane; Chief Pharmacist - Pharmacy; PHARM [From 14/07/2016]	Partially Compliant [From 14/07/2016]	Partially Assured [From 14/07/2016]	Moderate risk [From 14/07/2016]
021608	Review of medicines incidents and provision of support for staff who make errors	Warrington and Halton Hospitals NHS Foundation Trust	Matthew, Diane; Chief Pharmacist - Pharmacy; PHARM [From 14/07/2016]	Compliant [From 14/07/2016]	Partially Assured [From 14/07/2016]	Moderate risk [From 14/07/2016]

Control ID	Control Title	Organisation	Owner	Compliance Rating	Assurance Rating	Risk Rating
021609	Quarterly Medicines Safety Assurance Reports are prepared for the Medicines Safety Committee, shared learning from incidents is taken back into the three divisions.	Warrington and Halton Hospitals NHS Foundation Trust	Matthew, Diane; Chief Pharmacist - Pharmacy; PHARM [From 14/07/2016]	Compliant [From 14/07/2016]	Partially Assured [From 14/07/2016]	Moderate risk [From 14/07/2016]
021610	Time is ring fenced for key governance activities	Pharmacy	Matthew, Diane; Chief Pharmacist - Pharmacy; PHARM [From 14/07/2016]	Compliant [From 14/07/2016]	Partially Assured [From 14/07/2016]	High risk [From 14/07/2016]
024750	Referral system in place	Pharmacy	Matthew, Diane; Chief Pharmacist - Pharmacy; PHARM [From 14/07/2016]	Compliant [From 14/07/2016]	Partially Assured [From 14/07/2016]	Moderate risk [From 14/07/2016]

Initial Risk Evaluation 1 Item

Review Date	Evaluator	Impact Category / Narrative	Impact Rating	Likelihood Rating	Risk Grade
31/01/2011	Matthew, Diane; Chief Pharmacist - Pharmacy; PHARM	Business objectives / projects -	4 - Major	4 - Likely	Extreme risk 16

Residual Risk Evaluation 1 Item

Review Date	Evaluator	Impact Category / Narrative	Impact Rating	Likelihood Rating	Risk Grade
14/07/2016	Matthew, Diane; Chief Pharmacist - Pharmacy; PHARM	Statutory duty / inspections -	4 - Major	4 - Likely	Extreme risk 16

Mitigation Action Plan 1 Item

Action Plan ID	Action Plan Due Date	Strategic Aim Risk Score	Action Plan Lead	Action Plan Status
020891	30/06/2016	High risk 8	Matthew, Diane; Chief Pharmacist - Pharmacy; PHARM	In progress as at 14/07/2016

Outstanding Action Points 5 Items

Action	ID	Action Lead	Priority	Action Status	F'cst Due Date	Last Review / Outcome
Exploratory visit to East Lancashire NHST to identify any resultant actions	TASK 40287	Hayes, Nicola; Deputy Chief Pharmacist - Pharmacy; PHARM		In progress as at 14/07/2016	31/10/2016	

Action	ID	Action Lead	Priority	Action Status	F'cst Due Date	Last Review / Outcome
Recruit to new posts e.g. Antibiotics Pharmacist, Medical Education/Safety Pharmacist (new funding); AMU Pharmacy Technician, A&E pharmacy Assistant (from budgets held by USC)	TASK 20926	Matthew, Diane; Chief Pharmacist - Pharmacy; PHARM		In progress as at 14/07/2016	31/10/2016	Update 24.5.16: Only the antimicrobial therapy pharmacist outstanding - due date adjusted accordingly Update 24.2.15: Still awaiting Finance funding approval for the medical Education/Medicines Safety Post; AMU technician interviews imminent, pharmacy assistant recruited and in post. Update 1.6.15 PA & PT recruited. Pharmacist recruitment stalled as funding not identified. Discussed with Finance Manager. AD for Clinical Education/OD is adding the Medical Education risk onto the risk register
Recruit to vacancies (existing posts)	TASK 20892	Matthew, Diane; Chief Pharmacist - Pharmacy; PHARM		In progress as at 14/07/2016	31/10/2016	24/5/16: Due to resignations currently recruiting to 7 pharmacy technician, 1 porter, 1 pharmacy assistant, 3 pharmacist posts (13% of Trust Pharmacy establishment). Due date updated accordingly 4 pharmacy technicians recruited-start date-April 15x1, August 15x3. Further recruitment needed into 1.6xnew technician vacancies (leaver/reduction in hours). 3 pharmacists recruited-start date April/ May/ June. Further recruitment needed into 1xnew vacancy (leaver). Update 1.6.15: PT recruitment successful-fully recruited to current vacancies start date ?Sept, pharmacist interviews arranged for early June
Review NHS benchmarking data alongside the System21 data and produce a staffing report	TASK 27146	Matthew, Diane; Chief Pharmacist - Pharmacy; PHARM	Low	In progress as at 14/07/2016	31/10/2016	Risk to be reviewed by NH/MK. Following implementation of new EPR, data from EPR reports is being analysed alongside activity data provided by staff
Staff to review their outstanding tasks and report back to senior management to allow these to be reviewed, re-prioritised and potentially re-allocated if required	TASK 35649	Hayes, Nicola; Deputy Chief Pharmacist - Pharmacy; PHARM		In progress as at 14/07/2016	31/10/2016	Due date extended, to be discussed with staff

HSSC Risk register (To be read in conjunction with accompanying report) 3 Items

Residual Risk Score greater than or equal to: "15"

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	Date for Review	Target Date for Completion	Strategic Aim Risk Score
Group Name: ACS - Specialist Medicine												
001365	Flooring on Ward B14 ripped and in poor state of repair.	Specialist Medicine	Risk Assessment	07/08/2015	High risk 12	Rouse, Janet; Ward Manager - B14; B14	13/07/2016	4 - Major	Extreme risk 16	27/07/2016	31/08/2016	3
Group Name: HR												
000269	Risk of expenditure on temporary staffing significantly exceeding budget/affecting future viability of the trust with reports to NHS Improvement	Human Resources and Organisational Development	Committee Review	01/04/2012	Extreme risk 20	Wilson, Roger; Director of Human Resources & OD; EXEC	05/07/2016	4 - Major	Extreme risk 16	04/08/2016	31/03/2017	8
Group Name: Trust Wide												
001045	Lack of an adequately resourced surveillance system	Warrington and Halton Hospitals NHS Foundation Trust	Risk Assessment	05/03/2015	Extreme risk 16	McKay, Lesley; Matron - Infection Control; INFCON	05/07/2016	4 - Major	Extreme risk 16	08/08/2016	31/03/2017	6

Flooring on Ward B14 ripped and in poor state of repair.

Health and Safety Sub-Committee Risk

Risk ID	001365
Risk Title	Flooring on Ward B14 ripped and in poor state of repair.
Further Information (If Required)	The erosion of the floor in the bays aswell as the nurses station is worsening causing a patient safety and reputational issue. This is also causing an environment that is not therapeutic to stroke rehab.
Source of the risk	Risk Assessment
Risk Code	
Identified By	Stone, Karen on 07/08/2015
Division / Department	Specialist Medicine
Managerial Lead	Rouse, Janet; Ward Manager - B14; B14
Risk Status	Open as at 14/07/2016
Date for Next Review	27/07/2016

Control Measures 2 Items

Control ID	Control Title	Organisation	Owner	Compliance Rating	Assurance Rating	Risk Rating
025739	Area to be cleaned daily, estates aware of the problem and taping to floor put in place by estates.	B14				
028199	Monitoring of erosion from flooring	Specialist Medicine		Compliant [From 27/04/2016]	Fully Assured [From 27/04/2016]	Moderate risk [From 27/04/2016]

Initial Risk Evaluation 1 Item

Review Date	Evaluator	Impact Category / Narrative	Impact Rating	Likelihood Rating	Risk Grade
07/08/2015	Stone, Karen; Staff Nurse; B14	Service / business interruption Environmental impact -	3 - Moderate	4 - Likely	High risk 12

Residual Risk Evaluation 1 Item

Review Date	Evaluator	Impact Category / Narrative	Impact Rating	Likelihood Rating	Risk Grade
13/07/2016	Prescott, Kathryn; Clinical Governance Manager - Acute Care Services; ACS	Service / business interruption Environmental impact -	4 - Major	4 - Likely	Extreme risk 16

Mitigation Action Plan 1 Item

Action Plan ID	Action Plan Due Date	Strategic Aim Risk Score	Action Plan Lead	Action Plan Status
029822	31/08/2016	Low risk 3	Rouse, Janet; Ward Manager - B14; B14	In progress as at 27/04/2016

Outstanding Action Points 3 Items

Action	ID	Action Lead	Priority	Action Status	F'cst Due Date	Last Review / Outcome
Close patient bay to replace flooring.	TASK 35387			Required as at 26/01/2016		
Health and Safety to complete a robust risk assessment of whole flooring in Ward B14 to assess the health and safety risk.	TASK 39640			In progress as at 11/05/2016	25/05/2016	
Matron to liaise with Infection Control to assess risk of worsening erosion in areas where patients are nursed.	TASK 39641			In progress as at 11/05/2016	18/05/2016	

Monitoring Parties 2 Items

Monitoring Party	Party Type	Monitoring Capacity	Lead Monitoring Party?	Comments
Health and Safety Sub-Committee	Committee		No	
Divisional Integrated Governance Group - Unscheduled Care	Committee		Yes	

Risk of expenditure on temporary staffing significantly exceeding budget/affecting future viability of the trust with reports to NHS Improvement

Health and Safety Sub-Committee Risk

Risk ID	000269
Risk Title	Risk of expenditure on temporary staffing significantly exceeding budget/affecting future viability of the trust with reports to NHS Improvement
Further Information (If Required)	Risk of expenditure on temporary staffing significantly exceeding budget and affecting the future viability of the trust with reports to NHS Improvement
Source of the risk	Committee Review
Risk Code	
Identified By	Dawber, Karen on 01/04/2012
Division / Department	Human Resources and Organisational Development
Managerial Lead	Wilson, Roger; Director of Human Resources & OD; EXEC
Risk Status	Open as at 05/07/2016
Date for Next Review	04/08/2016

Control Measures 1 Item

Control ID	Control Title	Organisation	Owner	Compliance Rating	Assurance Rating	Risk Rating
017965	Temporary Staffing expenditure monitored at the Trust Board, Strategic Workforce Committee and the Temporary Staffing Group	Human Resources and Organisational Development	Dawber, Karen; Director of Governance and Workforce; DODG [From 01/04/2012]	Not Compliant [From 01/04/2012]	Not Assured [From 01/04/2012]	High risk [From 30/05/2014]

Initial Risk Evaluation 1 Item

Review Date	Evaluator	Impact Category / Narrative	Impact Rating	Likelihood Rating	Risk Grade
04/05/2013	; Divisional Head of Nursing - WCSS; WCSS	Finance including claims -	5 - Catastrophic	4 - Likely	Extreme risk 20

Residual Risk Evaluation 1 Item

Review Date	Evaluator	Impact Category / Narrative	Impact Rating	Likelihood Rating	Risk Grade
05/07/2016	Wilson, Roger; Director of Human Resources & OD; EXEC	Finance including claims -	4 - Major	4 - Likely	Extreme risk 16

Mitigation Action Plan 1 Item

Action Plan ID	Action Plan Due Date	Strategic Aim Risk Score	Action Plan Lead	Action Plan Status
004219	31/03/2017	High risk 8	Wilson, Roger; Director of Human Resources & OD; EXEC	In progress as at 05/07/2016

Outstanding Action Points 5 Items

Action	ID	Action Lead	Priority	Action Status	F'cst Due Date	Last Review / Outcome
Plans should be put in place, if not already, to decide how the department will move forward in relation to the Consultant in Emergency Medicine vacancy.	TASK 12421	Holland, Neil; Divisional Director of Operations - Acute Care Services; ACS		In progress as at 13/06/2014	31/03/2015	
Regular contact with the agency must happen to ensure the Consultant locum in place within Diabetes and Endocrinology is given appropriate notice for their placement to cease.	TASK 12422	Holland, Neil; Divisional Director of Operations - Acute Care Services; ACS		In progress as at 12/02/2014	31/03/2015	
The division has already taken steps to try to reduce locum and agency spending. They have amended a trainee on-call rota to reduce the need for locums. LAS appointments have been made where this has been possible. Clinical Fellow posts have been introduced and are being utilised to fill some of the junior specialty trainee gaps. Wherever possible they use internal locums to reduce, but not eradicate, the need for agency locums. DRS Realtime has been purchased and is being utilised for rota management within the Medicine specialties. Although decisions have not been reached on all posts it is evident that recruitment to gaps is an on-going process within the division.	TASK 12416	Holland, Neil; Divisional Director of Operations - Acute Care Services; ACS		In progress as at 12/02/2014	31/03/2015	
There are two new Gastroenterology posts and one Palliative Care post which the Trust is in the process of gaining Royal College approval. This should be expedited if appropriate to avoid the need for continued Locum cover.	TASK 12423	Holland, Neil; Divisional Director of Operations - Acute Care Services; ACS		In progress as at 12/02/2014	31/03/2015	
With regard to the Elderly Care Consultant posts the Division need to decide how they wish these posts to progress.	TASK 12418	Holland, Neil; Divisional Director of Operations - Acute Care Services; ACS		In progress as at 12/02/2014	31/03/2015	

Monitoring Parties 2 Items

Monitoring Party	Party Type	Monitoring Capacity	Lead Monitoring Party?	Comments
Health and Safety Sub-Committee	Committee		No	
Strategic People Committee	Committee		No	

Lack of an adequately resourced surveillance system

Health and Safety Sub-Committee Risk

Risk ID	001045
Risk Title	Lack of an adequately resourced surveillance system
Further Information (If Required)	NICE QS 61 requires the Trust to have evidence of an adequately resourced surveillance system with specific, locally defined objectives and priorities for preventing and managing healthcare-associated infections
Source of the risk	Risk Assessment
Risk Code	
Identified By	McKay, Lesley on 05/03/2015
Division / Department	Warrington and Halton Hospitals NHS Foundation Trust
Managerial Lead	McKay, Lesley; Matron - Infection Control; INFCON
Risk Status	Open as at 05/03/2015
Date for Next Review	08/08/2016

Control Measures 1 Item

Control ID	Control Title	Organisation	Owner	Compliance Rating	Assurance Rating	Risk Rating
024804	Crystal reports	Warrington and Halton Hospitals NHS Foundation Trust	Constable, Simon; Medical Director; EXMD [From 07/05/2015]	Unknown [From 07/05/2015] NICE QS for infection control states there should be Evidence of an adequately resourced surveillance system with specific, locally defined objectives and priorities for preventing and managing healthcare-associated infections	Partially Assured [From No programme of surgical site infection. Problems with extracting data from the laboratory computer system due to limited personnel trained in IT coding. - new functionality within the Pathology computer system, MOLIS addresses this requirement	Low risk [From 02/06/2016]

Initial Risk Evaluation 1 Item

Review Date	Evaluator	Impact Category / Narrative	Impact Rating	Likelihood Rating	Risk Grade
05/03/2015	McKay, Lesley; Matron - Infection Control; INFCON	Impact on the safety of patients, staff or public (physical / psychological harm) -	4 - Major	4 - Likely	Extreme risk 16

Residual Risk Evaluation 1 Item

Review Date	Evaluator	Impact Category / Narrative	Impact Rating	Likelihood Rating	Risk Grade
05/07/2016	McKay, Lesley; Matron - Infection Control; INFCON	Impact on the safety of patients, staff or public (physical / psychological harm) -	4 - Major	4 - Likely	Extreme risk 16

Mitigation Action Plan 1 Item

Action Plan ID	Action Plan Due Date	Strategic Aim Risk Score	Action Plan Lead	Action Plan Status
024762	31/03/2017	Moderate risk 6	McKay, Lesley; Matron - Infection Control; INFCON	In progress as at 05/07/2016

Outstanding Action Points 1 Item

Action	ID	Action Lead	Priority	Action Status	F'cst Due Date	Last Review / Outcome
Review of surveillance systems	TASK 24771			In progress as at 05/07/2016	01/10/2016	

Monitoring Parties 3 Items

Monitoring Party	Party Type	Monitoring Capacity	Lead Monitoring Party?	Comments
Health and Safety Sub-Committee	Committee		Yes	
Corporate Nursing Team Meeting	Committee		No	
Infection Control Sub Commmittee	Committee		Yes	

We are WHH

Warrington and Halton Hospitals NHS
NHS Foundation Trust

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/16/154**
SUBJECT:	**Safe Staffing Levels Review**
DATE OF MEETING:	**27th July 2016**
ACTION REQUIRED	**For Decision**
AUTHOR(S):	**Karen Dawber, Director of Nursing and Governance**
EXECUTIVE DIRECTOR SPONSOR:	**Karen Dawber, Director of Nursing and Governance**
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**
	BAF2.2: Nurse Staffing
	BAF2.5: Right People, Right Skills in Workforce
FREEDOM OF INFORMATION STATUS (FOIA):	**Release Document in Full**
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	**None**
EXECUTIVE SUMMARY (KEY ISSUES):	**This is the second time we have used triangulation of SNCT information with professional judgement tool and quality indicators. Based on this information the shift in acuity on surgical wards and the need for increased 1 to 1 (specials), we are recommending additional investment is required in a number of areas.**
RECOMMENDATION:	**The Trust Board is asked to:** • **Note the content of this paper and agree that a robust methodology is in place to provide assurance of safe staffing across the organisation to ensure our hospitals can maintain safe patient care and improve patient and family experience.** • **Agree to the use of temporary expenditure on ward A7 on an ad hoc basis whilst further cost analysis is gathered regarding the income generated from additionally supported NIV beds. Proposal and full business case to be submitted to**

	Execs. • **Fund the additional investment of £419,130 - option 3:** **4.00 WTE band 5 circa £117427 A6** **WTE band 4 circa £25430 A5** **0.20 WTE band 2 circa £3955 A5** **11.0 WTE band 2 circa £217538 for pool** **2.80 WTE band 2 circa £54780 for B14 (Stroke Ward)** • **Review and evaluate implementation in six months, as part of the next planned staffing review, this will include an analysis of the benefits realised in relation to the band 2 pool.**	
PREVIOUSLY CONSIDERED BY:	**Committee**	**Strategic People Committee**
	Agenda Ref.	
	Date of meeting	**June 2016**
	Summary of Outcome	**Recommend to Board**

Introduction

This paper has been discussed and considered at Strategic People Committee in April 2016, following a discussion it was agreed that the Committee was supportive of the proposals. The Committee was mindful that it could not authorise any additional expenditure though.

Summary

Staffing establishments have received scrutiny over the past 12 months and monthly position statements on planned to actual staffing levels have been presented to the Board giving assurance that care is safe and effective even in times of extreme pressure.

This is the second time we have used triangulation of SNCT information with professional judgement tool and quality indicators. Based on this information the shift in acuity on surgical wards and the need for increased 1 to 1 (specials), we are recommending additional investment is required in a number of areas.

The safer nursing care tool data is currently collated on a manual basis, a separate business case has been submitted for an add on to E Rostering to allow this to be updated electronically on a twice daily basis, providing continuous and not snap shot data collection.

To ensure best value for money we are proposing a number of options to be considered these include: investment into individual wards in line with recommendations; a pool solution for 1 to 1 close observation / special; watch and wait for a further six months.

Going forward we will continue to review and produce a report on a 6 monthly basis to allow for trend analysis and early identification of any risks associated with nurse staffing. In addition we will be cognisant of any new guidance from the National Quality Board (expected April 2016).

The summary of the wards and departments is shown below (Table 1) – note all costs are at a mid-point with 20% uplift and no allowance made for unsociable hours payments:

Table 1 – Summary of Wards and Departments

WARD	BAND	WTE	TOTAL (£)	RATIONAL
A1				No Changes required
A2	2	5.54	109560	1 to 1
A3	2	5.54	109560	1 to 1
A3	5	1.2	35228	MDT Coordinator
A4				Recently reconfigured
A5	4	1.0	25430	AP instead of Band 5 theatre days
A5	2	0.2	3955	Cover for AP at band 2
A6	5	2.77	81319	Additional SN - Acuity
A7	5	5.54	162638	To support increase in NIV patients
A8				Recently reconfigured
A9				No Changes required
B12	2	5.54	109560	1 to 1
B14	2	2.77	54780	Additional duties stroke
B18				No Changes required
B19				No Changes required
C20				No Changes required
C21				No Changes required

C22				No Changes required
CCU				No Changes required
CDU	2	5.54	109560	1 to 1
AED				No Changes required
ITU				No Changes required
MATERNITY				Investment made as result BRP
PAEDIATRICS				No Changes required
CMTC				No Changes required
B1				No Changes required
B4				No Changes required
		30.1	801590	

Options

The balance of Quality, People and Sustainability (QPS) is our absolute focus; ward staffing levels are directly linked to patient quality and harm. However, there is a shortage of qualified staff and the lead in time for recruitment needs to be considered. Flexibility will be the key to ensuring we have the right staff to care for our patients at the right time. We also know that our current expenditure is higher than our income, resulting in a recurrent deficit that cannot continue; consequently any recommendations for staffing must be cognisant of providing best return on investment.

Option 1 – Review in a further six months

Although this appears to be a cost neutral option we will almost definitely incur additional staffing costs in two main areas: A7 when NIV beds are escalated and most areas when patients require close observation. 75% of additional spend for close observation is on six wards, April 15-Jan 16 we spent £281k for 18,500 hours equating to £15.20 per hour, see appendix II for breakdown.

In addition, we have had some concerns relating to the retention of staff and acuity on the surgical wards and levels of support staff on B14 (stroke Unit) during the day. This has been further quantified by the safer nursing care tool.

It must also be noted that on last receipt of the six monthly reviews it was agreed to review the data in a further 6 months, the picture is similar and not just a one off spike in acuity / activity.

This is not a preferred option for the reasons outlined above.

Option 2 – Investment as per table 1

Although on the face of it the evidence would suggest that there is a requirement to investment to the posts as described, the methodology used does not lend itself to economies of scale across a larger patch and would not be the most cost effective use of resources

Option 3 – Hybrid version with additional monitoring

There is a need to invest in some areas due to changes in acuity that has been evidenced over a 12 month period.

However, efficiencies have been made in other Trusts by adopting a close observation pool of staff. It is therefore suggested that the total staff requested for close observation are pooled into one team at an investment of 50%. This would result in a reduction on temporary staffing expenditure.

In addition, we have submitted a separate business case for an add on to allocate E Roster that will enable SNCT data and Nurse Hours per patient day (Carter metric) to be collated twice daily, allowing for any changes to staff to be highlighted and staff moved appropriately to the highest risk areas – mitigating the risk of not implementing option 2.

NIV workload on A7 is being reviewed by the division, looking at options to invest in A7 or move NIV to HDU, the Division needs to review the delivery model and present a revised model.

Recommendations

The Trust Board is asked to:

1. **Note the content of this paper and agree that a robust methodology is in place to provide assurance of safe staffing across the organisation to ensure our hospitals can maintain safe patient care and improve patient and family experience.**

2. **Agree to the use of temporary expenditure on ward A7 on an ad hoc basis whilst further cost analysis is gathered regarding the income generated from additionally supported NIV beds. Proposal and full business case to be submitted to Execs.**

3. **Fund the additional investment of £419,130 - option 3:**

    a. **4.00 WTE band 5 circa £117427 A6**
    b. **1.00 WTE band 4 circa £25430 A5**
    c. **0.20 WTE band 2 circa £3955 A5**
    d. **11.0 WTE band 2 circa £217538 for pool**
    e. **2.80 WTE band 2 circa £54780 for B14 (Stroke Ward)**

4. **Review and evaluate implementation in six months, as part of the next planned staffing review, this will include an analysis of the benefits realised in relation to the band 2 pool.**

We are WHH

Warrington and Halton Hospitals NHS
NHS Foundation Trust

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/16/155**	
SUBJECT:	**Key Issues Report July Finance & Sustainability Committee**	
DATE OF MEETING:	**27th July 2016**	
ACTION REQUIRED	**For Assurance**	
AUTHOR(S):	**Terry Atherton, Committee Chair**	
DIRECTOR SPONSOR:	**Terry Atherton, Committee Chair**	
LINK TO STRATEGIC OBJECTIVES:	**SO3: To deliver well managed, value for money, sustainable services**	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	**BAF1.3: National & Local Mandatory, Operational Targets**	
	BAF3.2: Monitor Undertakings: Corporate Governance & Financial Management	
	BAF3.3: Clinical & Business Information Systems	
FREEDOM OF INFORMATION STATUS (FOIA):	**Release Document in Full**	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	**None**	
EXECUTIVE SUMMARY (KEY ISSUES):	**A summary of the key issues discussed at July's committee meeting.**	
RECOMMENDATION:	**The Board note the contents of the discussions and that there are no matters arising for escalation**	
PREVIOUSLY CONSIDERED BY:	**Committee**	**Not Applicable**
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	

KEY ISSUES REPORT
JULY FINANCE AND SUSTAINABILITY COMMITTEE

Date of meeting:	**20th July 2016**
Standing Agenda Items	The meeting was quorate. Minutes of the meeting held on 22nd June 2016 were approved as a correct record.
Formal Business	Following the acceptance of the revised Control Total of £7.9m for 2016/17 the Reforecast Plan was considered allowing for the receipt of Sustainability and Transformation funding of £8m alongside additional costs savings to be achieved of £2.7m, to a total of £10.7m. This Plan was reviewed in the light of the criteria to access the Sustainability and Transformation funding which has recently been published. Payments will be made quarterly in arrears and wef Quarter 2, 70% will be weighted against achievement of the YTD financial control total with the balance around the achievement of RTT, A&E, Cancer and Diagnostics on a specific percentage basis (though there is no percentage allocation for us against Diagnostics) Our already tight cash position could well come under further strain and the Finance and Sustainability Committee considered a number of scenarios. It was recognised that the criteria provides scant flexibility for any underperformance. The Reforecast Plan does not take into account the financial impact of the new Junior Doctors contract which at this stage cannot be identified. The revised Financial and CIP targets are now imbedded in the Trusts forecasts. For Month 3, we have achieved a surplus of £0.6m, marginally above plan and an YTD deficit of £3.0m against a plan of £3.3m deficit. The Month 3 outturn takes into account Quarter 1 Sustainability and Transformation funding to be received and changes around the profile of the revised CIP plan. Capital expenditure remains on plan and the minutes of the Capital Planning Group of 24th June were reviewed. The Finance and Sustainability Committee spent some time looking at our creditor position as our Better Payment Practice Code remains poor at 28% – we are especially concerned around our non-NHS suppliers – and will undertake the more detailed 'Dive' regarding Creditors will now be in August Finance and Sustainability Committee.

	The Trust has applied for a working capital loan of £7.9m in 2016/17 and in the meantime have drawn £4.1m under an interim facility. Divisional Performance was considered from income and cost perspectives. As at 14th July CIP schemes to a total of £8.977m PYE and £9.934m have been developed. At the end of Month 3 the Trust has delivered £1.685m in actual CIP savings, which exceeds the revised plan for Quarter 1 by £2k. The revised CIP plan for 2016/17 was considered. July presents an immediate challenge – Finance and Sustainability Committee were reassured by the activity around this. CIP achievement in Womens and Children's Health is a challenge and other Divisions are having to step in with further savings plans. For the month of June against a trajectory of 91%, the Trust achieved 93.52% against the four hour standard. For Quarter 1 the outcome was 92.12%. Considerable effort has been made around Ambulance Handover times to the point where the Trust is being used as an example of good performance. Two 52 week waiters have emerged and the committee were reassured not only in relation to these specific cases but also the wider position. Outpatients were reviewed in a later agenda item. Performance otherwise remains robust. The Finance and Sustainability Committee received a presentation around the Outpatients Recovery Plan, not only to address historic issues but also issues arising out of the implementation of Lorenzo. The Finance and Sustainability Committee will now receive regular progress reports through the monthly Corporate Performance reports. An update was received around IM&T together with minutes of recent meetings of ePR Programme Board and Information Governance Corporate Records Sub Committee noted the intention to merge the Data Quality and Information Governance Committees which was supported but needs to be considered by the Trust Secretary. A presentation was received around Agency Caps from the Medical Director, the Deputy Medical Director and the Deputy Director of Nursing. This highlighted the historic position of the Trust, the current situation and the actions being taken to address our current challenges both within the Trust and the wider local Provider Network. The Finance and Sustainability Committee alongside Strategic People Committee both have a role to play in tracking progress towards CAP compliance and managing our overall pay bill.

	WLIs formed part of these discussions. The Finance and Sustainability Committee has not traditionally met in August; however a shorter agenda meeting will take place on 24th August around Financial, CIP and Corporate Performances for July and the outlook thereafter.
Local Policies and Guidance Approved:	None.
Any Learning and Improvement identified from within the meeting:	None.
Any other relevant items the Committee wishes to escalate?	None.

We are WHH

Warrington and Halton Hospitals NHS
NHS Foundation Trust

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/16/156**	
SUBJECT:	**Key Issues Report July 2016 Audit Committee**	
DATE OF MEETING:	**27th July 2016**	
ACTION REQUIRED	**For Assurance**	
AUTHOR(S):	**Ian Jones, Committee Chair**	
DIRECTOR SPONSOR:	**Ian Jones, Committee Chair**	
LINK TO STRATEGIC OBJECTIVES:	**All**	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	**BAF3.2: Monitor Undertakings: Corporate Governance & Financial Management**	
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 that there are no matters for escalation.**	
PREVIOUSLY CONSIDERED BY:	**Committee**	**Not Applicable**
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	

We are WHH

Warrington and Halton Hospitals NHS
NHS Foundation Trust

KEY ISSUES REPORT
AUDIT COMMITTEE

Date of meeting:	**13th July 2016**
Standing Agenda Items	The meeting was quorate. Minutes of the meeting held on 26th April 2016 were approved as a correct record.
Formal Business	• To ensure that we have no gaps in our assurance monitoring, it was agreed that we reinstate the meetings of Non-Executive Directors prior to each Board Meeting as a forum for the NEDs in their capacity as Committee Chairs to discuss issues relating to governance and control. • The Counter-Fraud Officer of MIAA presented his Anti-Fraud Annual Report. This reported no significant issues, with 21 out of 25 NHS Protect standards being fully achieved and 4 requiring some attention. • An updated Anti-Fraud, Bribery & Corruption Policy was approved and will be published on the Intranet. • The Director of Finance reported on steps she is taking to increase awareness of Financial Governance, initially via a workshop of Finance Department managers, then to be rolled out to CBU managers. • The DoF is also liaising with the Director of HR & OD with a view to improving the induction processes to increase awareness of financial processes and counter-fraud issues. • Internal Audit reported on 3 completed reviews. Firstly a review of the Phase 1 Implementation of Lorenzo provided limited assurance. The problems encountered to date are already well known to the Board, and relate to both system issues and internal processes, with remedial work ongoing. The second report related to Delayed Discharges and again provided limited assurance. As with Lorenzo, the problems were largely well known and were a mixture of some internal issues and some system wide Issues. These two Reviews provide useful reference points from which we will continue to monitor the effectiveness of the ongoing remedial action. The third review related to Performance Improvement compliance and provided significant assurance. • MIAA also presented their Summary of Internal Audit Recommendations Followed-Up. Whilst most recommendations have been accepted and implemented it was noticeable that there are a number of recommendations which for one reason or another have not been implemented, partially implemented or

	been rejected by managers. It was apparent that the monitoring of the recommendations emanating from the Internal Audit Reviews needs to be tightened up. The Director of Finance has already taken this on board and will institute a monitoring system, including an action log, which will be brought to Audit Committee at each meeting. • Audit Committee received a verbal update on Tender Waivers, advising that the trend is still in the right direction with fewer waivers but the number still remain higher than we would wish. Again the DoF is pushing hard to rectify the situation. • The Tender process for the appointment of External Auditors is on course, with tenders being invited prior to 15th August and an evaluation process to follow with completion expected by the end of August, with a recommendation to go to the Council of Governors thereafter.
Local Policies and Guidance Approved:	Anti-Fraud, Bribery & Corruption Policy
Any Learning and Improvement identified from within the meeting:	No
Any other relevant items the Committee wishes to escalate?	No

We are WHH

Warrington and Halton Hospitals NHS
NHS Foundation Trust

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/16/157**	
SUBJECT:	**Response to Lord Carter Report Q1 2016-17**	
DATE OF MEETING:	**27th July 2016**	
ACTION REQUIRED	**For Assurance**	
AUTHOR(S):	**Steve Barrow, Deputy Director of Finance**	
EXECUTIVE DIRECTOR SPONSOR:	**Andrea Chadwick, Director of Finance & Commercial Development**	
LINK TO STRATEGIC OBJECTIVES:	**All**	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	**BAF3.2: Monitor Undertakings: Corporate Governance & Financial Management**	
FREEDOM OF INFORMATION STATUS (FOIA):	**Release Document in Full**	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	**None**	
EXECUTIVE SUMMARY (KEY ISSUES):	**The purpose of this report is to update the Board of Directors on 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.**	
RECOMMENDATION:	**The Board of Directors is asked to note the contents of the report and the progress made against the recommendations**	
PREVIOUSLY CONSIDERED BY:	**Committee**	**Not Applicable**
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	

RESPONSE TO THE CARTER REPORT

1. PURPOSE

The purpose of this report is to update the Board of Directors on 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 summarized 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 optimization	1.0
Better estates management and optimization	1.0
Better procurement management	1.0
Total	**5.0**

Lead Directors have been identified internally to progress the recommendations that apply to the Trust as set out in Section 3 of this paper.

3. PROGRESS AGAINST 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 and Organisational Development.

Current Position:

The Trust is currently working on a revised Absence Management Policy with Staff Side colleagues. Ordinarily, the Trust performs favourably when compared with North West Acute Trusts, however we need to improve to deliver the 3.75% target.

The Trust is currently reviewing all policies to ensure necessity and clarity.

As part of our launch of Fit to Care – our Health and Well-Being Strategy, an increased focus is being placed on reducing Bullying and Harassment across our organisation. A new campaign to support this will commence in September 2016, fronted by our Chief Executive.

There is an on-going focus on the delivery of performance reviews for staff and the trust has established a link to incremental progression. The Trust is currently reviewing our Performance Review template to ensure congruence with our revised Values and Behaviours.

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 Director of Nursing & Governance.

Current position:

The Trust has started to record nurse hours per patient day and report nationally from the 1st April 2016. We have had notice from Lyn McIntyre MBE, Senior Nurse Advisor on the Carter Review regarding the roll-out of the Model Hospital Nursing Dashboard to all 136 acute trusts and we are in the process of collating a return back to the DH on ward level data. In addition, in late June we received revised guidance on rostering and good practice and we are in the process of benchmarking ourselves against the data. We are planning to take the detail to the next Strategic People Committee.

All of the consultants now have agreed job plans, in an electronic source document, that will now enable direct comparison between consultants and linked to the requirements of the service.

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 optimization activities.

Lead Directors: Medical Director and Chief Operating Officer.

Current Position:

The Trust is developing a Hospital Pharmacy Transformation Plan which will be finalised in line with the required timescale. This work is being looked at in partnership with our LDS partners. The benchmarking phase is underway at present. We have 8 prescribing pharmacists and are continuing to train at 2 per year. It is noteworthy that drug spend is extremely well managed – our high quality pharmacy service benchmarks well as part of the Carter review (our higher than normal staffing costs is offset by our lower drug spend). We have been unable to support e-prescribing and medicines administration in this financial year but will review as part of the plan and aim to bring forward another proposal in 2017/18 for implementation ahead of the April 2020 deadline. We are increasing the amount of patient-facing time our pharmacy staff have and we are currently building a bid to trial pharmacist and technician presence as part of the clinical team on the acute medical unit 7am - 9:30pm, seven days per week.

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:

The Trust has submitted the required dataset to the NHS Benchmarking Network for Radiology and is attending the Network conference in September to hear national findings and keep abreast of developments in this area.

Once the Pathology Quality Assurance Dashboard (PQAD) is published the Trust will introduce within the required timeframes.

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 & Commercial Development.

Current Position:

The Trust has produced and supplied NHSI with the information relating to the top 100 purchased products and will supply thereafter on a monthly basis.

The Trust is committed to the Procurement Transformation Programme (PTP) although further details on the scope of the work are awaited. The Director of Finance is the lead director for the programme and will work closely with the Head of Procurement to implement the changes.

The Trust is compiling an adoption plan for the Global Standard (GS1) and Pan European Public Procurement Online (PEPPOL) standards, including the introduction of an Inventory Management System (IMS) to improve product use, tracking and traceability. The Trust already has 385 electronic catalogues covering 61,772 product lines.

The Trust has made good progress against the April 2018 target for a number of key performance metrics, namely:

- 80% addressable spend transaction volume on catalogue – currently 90%.
- 90% addressable spend transaction volume with a purchase order – currently 70%. (Transactions are reviewed on a monthly basis to capture orders not raised via a PO to ensure that the appropriate rules and controls are put in place).
- 90% addressable spend by value under contract – currently 97%.

The Trust currently collaborates with a number of other organisations to improve procurement and reduce cost as much as possible, namely:

- A member of Health Trust Europe's Procurement Partnership Board in collaboration with 14 other NHS providers.
- A member of the Cheshire & Merseyside Agency Cluster along with 15 other member trusts that work in collaboration with HealthTrust Europe, Liaison and NHS Professionals. The Head of Procurement is the lead for the cluster.
- Members of the Procurement Team meet with NHS Supply Chain on a monthly basis to review all savings opportunities available.

The Trust has achieved NHS Standards of Procurement Level 1 accreditation and is working towards the achievement of Level 2 by October 2016. In addition the Head of Procurement sits on both the Procurement Staff Development Focus Group and the NHS Standards of Procurement Assessment Group.

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 Trust has completed its carbon energy plan, which includes the installation of Combined Heat and Power (CHP) at Warrington and Halton hospitals, motor and water controls, energy efficient luminaires, lighting controls and management systems. The Trust has undertaken Patient Level Costing and Service Line Reporting for a number of years and estates and facilities costs are an integral part of the costing to ensure that the outputs reflect as accurately as possible the true costs of service delivery. The Trust recently received the 2014/15 reference costs audit report which concluded that the Trust was materially compliant with Monitor's Costing Guidance (this is the highest level of compliance).

Based on the latest ERIC returns, compiled from the 6 facet survey data the non patient occupied floor area is as follows

Site	Percentage
Warrington Hospital	42.9%
Halton Hospital (including CMTC)	37.4%

The current Estates Strategy is on hold and will be incorporated within the strategic review of Estates as part of the strategic solutions for the Local Delivery System (the Alliance).

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:

The Trust has compared the 2016/17 budgets for each corporate service against the overall planned income as detailed below:

Function	**£m**
Central Operations	0.2
Finance, Procurement & Contracting (excluding CNST premium)	2.9
Human Resources & Organisational Development	4.3
IM&T	3.5

Nursing & Governance	1.5
Programme Management Office	0.4
Research & Development	0.1
Commercial Development (including clinical coding)	1.1
Trust Executives	2.6
Total	**16.6**

Corporate functions costs are 7.3% against the 16/17 planned income including S&T funding (£227.7m) and 7.6% excluding S&T funding (£219.7m).

The Carter report highlights Human Resources, Finance, IM&T and Procurement as functions that should test their existing services against shared service solutions. These services total for £10.7m and account for 4.7% of the 16/17 planned income (including the S&T funding).

The Trust continues to explore trust specific cost reduction opportunities as part of the continuous cost savings exercise and potential strategic solutions in collaboration with our Alliance Acute providers.

NHS Improvement is currently developing a national set of benchmarks to allow for comparisons of corporate / administrative workforce across Trusts but details are awaited.

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.

Detailed business plans, including KPIs are being developed for all specialties. These will form the basis of in depth service reviews for selected specialties as part of the transformation programme.

The Trust is participating in the NHSE Acute Medical Model programme to support the improvement of our acute medical model. The Trust has to date implemented ambulatory care and is currently trialing diagnostic discharge facilitators.

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 IM&T

Current Position:

The Trust has plans to be fully digitised by 2018, with our strategy and digital roadmap implementation improving our digital maturity assessment. Plans to improve already mature base include Electronic Documents and Records Management System, ePrescribing and structured clinical notes. We will take an active part in digital health economy with the implementation of a care record to bring all providers together.

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: Awaiting further information from national bodies.

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:

The Trust is actively engaged with Southport & Ormskirk Hospitals NHS Trust and St Helens & Knowsley Teaching Hospitals NHS Trust as part of the LDS Alliance and all providers and commissioners as part of the Cheshire & Mersey STP footprint to work in partnership and collaboration to address 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: Awaiting further information from national bodies.

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: Awaiting further information from national bodies.

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: Awaiting further information from national bodies.

4. CONCLUSION

The recommendations in the Lord Carter report are wide and varied and cover a five year time period. The Trust has embraced the recommendations and already complies with some of the key targets and performance indicators contained in the report as they seen as good

practice. For example procurement opportunities and collaborative working have been a key feature for many years.

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 consultation document *Single Oversight Framework*.

Progress reports will be provided to the Trust Board on a quarterly basis.

5. RECOMMENDATION

The Trust Board is asked to note the contents of the report.

We are WHH

Warrington and Halton Hospitals NHS
NHS Foundation Trust

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/16/158**	
SUBJECT:	**NHS Improvement Governance Declaration Q1 2016-17**	
DATE OF MEETING:	**27th July 2016**	
ACTION REQUIRED	**For Decision**	
AUTHOR(S):	**Steve Barrow, Deputy Director of Finance**	
EXECUTIVE DIRECTOR SPONSOR:	**Andrea Chadwick, Director of Finance & Commercial Development**	
LINK TO STRATEGIC OBJECTIVES:	**All**	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	**BAF1.1: CQC Compliance for Quality**	
	BAF1.3: National & Local Mandatory, Operational Targets	
	BAF3.2: Monitor Undertakings: Corporate Governance & Financial Management	
FREEDOM OF INFORMATION STATUS (FOIA):	**Release Document in Full**	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	**None**	
EXECUTIVE SUMMARY (KEY ISSUES):	**Based on 2016/17 actual and forecast performance the Trust can respond "confirmed" to the capital and the other statements but "not confirmed" to the financial sustainability risk rating and governance statements.**	
RECOMMENDATION:	**The Board of Directors is asked to approve the governance statement for submission to NHS Improvement.**	
PREVIOUSLY CONSIDERED BY:	**Committee**	**Not Applicable**
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	

WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST

NHS IMPROVEMENT GOVERNANCE STATEMENT

QUARTER 1 2016/17 (1st APRIL 2016 – 30th JUNE 2016)

1. BACKGROUND

In accordance with the Risk Assessment Framework published by Monitor on 27th August 2015, Boards of NHS Foundation Trusts are required to respond to the following statements.

2. STATEMENTS

2.1 FINANCE STATEMENTS

- The Board anticipates that the Trust will continue to maintain a financial sustainability risk rating of at least 3 over the next 12 months.
- The Board anticipates that the Trust's capital expenditure for the remainder of the financial year will not materially differ from the amended forecast in this financial return.

2.2 GOVERNANCE STATEMENT

The Board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds) as set out in Appendix A of the Risk Assessment Framework and a commitment to comply with all known targets going forwards.

2.3 OTHERWISE

The Board confirms that there are no matters arising in the quarter requiring an exception report to NHS Improvement (per the Risk Assessment Framework page 22 table 3) which have not already been reported (See attachment 1).

3. RECOMMENDATIONS

Finance

The 2016/17 reforecast annual plan submitted to NHS Improvement on 29th June 2016 concluded that the planned Financial Sustainability Risk Rating in each quarter was a rating of 1.

The actual Financial Sustainability Risk Rating for the period ending 30th June 2016 is a rating of 2, which is above the planned rating. The finance statement requires the Board

to confirm that it anticipates it will "maintain a financial sustainability risk rating of at least 3 over the next 12 months" which therefore runs to Quarter 4 2016/17.

Therefore based on current and planned performance it is recommended that the Board states that it cannot confirm that it anticipates maintaining a risk rating of at least 3 over the next 12 months.

The planned capital expenditure for the year is £6.7m funded from internally generated depreciation and a carry forward of the 15/16 capital underspend. As at 30th June 2016 the actual capital spend is £0.7m which is in line with plan and is forecasting annual spend of £6.7m which is in line with plan, managed through the Capital Planning Group.

Therefore based on the actual performance it is recommended that the Board states that it can confirm that it anticipates that the Trust's capital expenditure for the remainder of the financial year will not materially differ from the amended forecast in this financial return.

Governance

In Quarter 1 the Trust achieved all national targets with the exception of A&E Clinical Quality – total time in A&E under 4 hours and (therefore reported as not met) is in breach in relation to moderate and major CQC concerns or impacts regarding the safety of healthcare provision (per Corporate performance report).

The A&E Clinical Quality – total time in A&E under 4 hours performance for Quarter 1 is 92.1%, which is above the improvement trajectory agreed as part of the annual plan submission. However the declaration against healthcare targets and indicators is compared to the national target of 95% and NHS Improvement has confirmed that the declaration is against the national target not the improvement trajectory. NHS Improvement has also confirmed that Sustainability and Transformational funding will be focussed on performance against the improvement trajectory not the national target.

Therefore based on current and forecast performance it is recommended that the Board states that it cannot confirm that it is satisfied that plans in place are sufficient to ensure on-going compliance with all existing targets and a commitment to comply with all known targets going forwards.

Otherwise / Exception Reporting

There are no actual or prospective material changes which may affect the ability to comply with any aspect of authorisation and which have not been previously notified to NHS Improvement.

Therefore based on the fact there are no actual or prospective material changes it is recommended that the Board confirms there are no matters arising in the quarter

requiring an exception report which have not already been reported.

Appendices

The declaration of risks against healthcare targets and indicators is attached at Appendix A.

The in-year governance statement is attached at Appendix B.

Attachment 1

RISK ASSESSMENT FRAMEWORK (PAGE 22, TABLE 3)

EXAMPLES OF EXCEPTION REPORTS

CONTINUITY OF SERVICES

- Unplanned significant reductions in income or significant increases in costs
- Discussions with external auditors which may lead to a qualified audit report
- Future transactions potentially affecting the continuity of services risk rating
- Risk of a failure to maintain registration with the Care Quality Commission (CQC) for Commissioner Requested Services (CRS)
- Loss of accreditation of a CRS
- Proposals to vary CRS provision or dispose of assets including
  - cessation or suspension of CRS
  - variation of asset protection processes
- Proposed disposals of CRS related assets

FINANCIAL GOVERNANCE

- Requirements for additional working capital facilities
- Failure to comply with the statutory reporting guidance
- Adverse report from internal auditors
- Significant third party investigations that suggest potential material issues with governance
- CQC responsive or planned reviews and their outcomes
- Other patterns of patient safety issues which may reflect poor governance (eg serious incidents, complaints)
- Performance penalties to commissioners

GOVERNANCE

- Third party investigations that could suggest material issues with governance (eg fraud, CQC concerns, Medical Royal Colleges' reports)
- CQC responsive or planned reviews and its outcomes / findings
- Other patient safety issues which may impact compliance with the license (eg serious incidents)

OTHER RISKS

- Enforcement notices or sanctions from other bodies implying potential or actual significant breach of a license condition (eg Office of Fair Trading)
- Patient group concerns
- Concerns from whistleblowers or complaints

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Declaration of risks against healthcare targets and indicators for 201617 by Warrington and Halton Hospitals NHS Foundation Trust

Targets and indicators as set out in the Risk Assessment Framework (RAF) - definitions per RAF Appendix A
NOTE: If a particular indicator does not apply to your FT then please enter "Not relevant" for those lines.

Key:

must complete
may need to complete

Target or Indicator (per Risk Assessment Framework)		Threshold or target YTD	Scoring Per Risk Assessment Framework	Annual Plan: Risk declared	Annual Plan: Scoring Per Risk Assessment Framework	Quarter 1: Performance	Quarter 1: Declaration	Quarter 1: Comments / explanations	Quarter 1: Scoring Per Risk Assessment Framework
Referral to treatment time, 18 weeks in aggregate, incomplete pathways	i	92%	1.0	No	0	92.9%	Achieved		0
A&E Clinical Quality - Total Time in A&E under 4 hours	i	95%	1.0	Yes	1	92.1%	Not met		1
Cancer 62 Day Waits for first treatment (from urgent GP referral) - post local breach re-allocation	i	85%	1.0	No	0	86.8%	Achieved		0
Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral) - post local breach re-allocation	i	90%	1.0	No		100.0%	Achieved		
Cancer 62 Day Waits for first treatment (from urgent GP referral) - pre local breach re-allocation	i					86.1%			
Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral) - pre local breach re-allocation	i					100.0%			
Cancer 31 day wait for second or subsequent treatment - surgery	i	94%	1.0	No	0	100.0%	Achieved		0
Cancer 31 day wait for second or subsequent treatment - drug treatments	i	98%	1.0	No		100.0%	Achieved		
Cancer 31 day wait for second or subsequent treatment - radiotherapy	i	94%	1.0	No			Not relevant		
Cancer 31 day wait from diagnosis to first treatment	i	96%	1.0	No	0	100.0%	Achieved		0
Cancer 2 week (all cancers)	i	93%	1.0	No	0	93.5%	Achieved		0
Cancer 2 week (breast symptoms)	i	93%	1.0	No		93.7%	Achieved		
Care Programme Approach (CPA) follow up within 7 days of discharge	i	95%	1.0	N/A	0		Not relevant		0
Care Programme Approach (CPA) formal review within 12 months	i	95%	1.0	N/A			Not relevant		
Admissions had access to crisis resolution / home treatment teams	i	95%	1.0	N/A	0		Not relevant		0
Ambulance Category A 8 Minute Response Time - Red 1 Calls	i	75%	1.0	N/A	0		Not relevant		0
Ambulance Category A 8 Minute Response Time - Red 2 Calls	i	75%	1.0	N/A	0		Not relevant		0
Ambulance Category A 19 Minute Transportation Time	i	95%	1.0	N/A	0		Not relevant		0
C.Diff due to lapses in care (YTD)	i	6.75	1.0	No	0	0	Achieved		0
Total C.Diff YTD (including: cases deemed not to be due to lapse in care and cases under review)	i					4			
C.Diff cases under review	i					4			
Minimising MH delayed transfers of care	i	<=7.5%	1.0	N/A	0		Not relevant		0
Early intervention in psychosis: first experience treated with a NICE-approved package within 2 weeks	i	50%	1.0	N/A	0		Not relevant		0
Improving access to psychological therapies: % patients beginning treatment within 6 weeks of referral	i	75%	1.0	N/A	0		Not relevant		0
Improving access to psychological therapies: % patients beginning treatment within 18 weeks of referral	i	95%	1.0	N/A	0		Not relevant		0
Data completeness, MH: identifiers	i	97%	1.0	N/A	0		Not relevant		0
Data completeness, MH: outcomes	i	50%	1.0	N/A	0		Not relevant		0
Compliance with requirements regarding access to healthcare for people with a learning disability	i	N/A	1.0	No	0	N/A	Achieved		0
Community care - referral to treatment information completeness	i	50%	1.0	N/A	0		Not relevant		0
Community care - referral information completeness	i	50%	1.0	N/A			Not relevant		
Community care - activity information completeness	i	50%	1.0	N/A			Not relevant		
Risk of, or actual, failure to deliver Commissioner Requested Services		N/A	Report by Exception	No			No		
Date of last CQC inspection	i	N/A		N/A			26/01/2015		
CQC compliance action outstanding (as at time of submission)		N/A		No			No		
CQC enforcement action within last 12 months (as at time of submission)		N/A		No			No		
CQC enforcement action (including notices) currently in effect (as at time of submission)		N/A		No			No		
Moderate CQC concerns or impacts regarding the safety of healthcare provision (as at time of submission)	i	N/A		No			No		
Major CQC concerns or impacts regarding the safety of healthcare provision (as at time of submission)	i	N/A		No			No		
Overall rating from CQC inspection (as at time of submission)	i	N/A		N/A			Requires improvement		
CQC recommendation to place trust into Special Measures (as at time of submission)		N/A		N/A			No		
Trust unable to declare ongoing compliance with minimum standards of CQC registration		N/A		No			No		
Trust has not complied with the high secure services Directorate (High Secure MH trusts only)		N/A		N/A			N/A		
Results left to complete:	i						0		
Checks Count:	i								
Checks left to clear:	i						OK		
Service Performance Score	i				1				1

0
0
0

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In Year Governance Statement from the Board of Warrington and Halton Hospitals NHS Fo

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (see notes below)	Board Response
For finance, that: The board anticipates that the trust will continue to maintain a financial sustainability risk rating of at least 3 over the next 12 months.	Not Confirmed
The Board anticipates that the trust's capital expenditure for the remainder of the financial year will not materially differ from the amended forecast in this financial return.	Confirmed
For governance, that: The board is satisfied that plans in place are sufficient to ensure: ongoing compliance with all existing targets (after the application of thresholds) as set out in Appendix A of the Risk Assessment Framework; and a commitment to comply with all known targets going forwards.	Not Confirmed
Otherwise: The board confirms that there are no matters arising in the quarter requiring an exception report to NHS Improvement (per the Risk Assessment Framework, Table 3) which have not already been reported.	Confirmed
Consolidated subsidiaries: Number of subsidiaries included in the finances of this return. This template should not include the results of your NHS charitable funds.	0

Signed on behalf of the board of directors

Signature		Signature	
Name	Mel Pickup	Name	Andrea Chadwick
Capacity	Chief Executive	Capacity	Director of Finance
Date	29/07/2016	Date	29/07/2016

Responses still to complete: 0

Notes:
NHS Improvement will accept either 1) electronic signatures pasted into this worksheet or 2) hand written signatures on a paper printout of this declaration posted to NHS Improvement to arrive by the submission deadline.
In the event than an NHS foundation trust is unable to confirm these statements it should NOT select 'Confirmed' in the relevant box. It must provide a response (using the section below) explaining the reasons for the absence of a full certification and the action it proposes to take to address it.
This may include any significant prospective risks and concerns the foundation trust has in respect of delivering quality services and effective quality governance.
NHS Improvement may adjust the relevant risk rating if there are significant issues arising and this may increase the frequency and intensity of monitoring for the NHS foundation trust.

The board is unable to make one of more of the confirmations in the section above on this page and accordingly responds:

A The reforecast 16/17 annual plan concluded that the planned Financial Sustainability Risk Rating in each quarter was a rating of 1.The actual Financial Sustainability Risk Ratings for the period ending 30th June 2016 is a rating of 2.

Therefore the Board cannot confirm that it anticipates maintaining a risk rating of at least 3 over the next 12 months.

B The operational difficulties associated with managaing demand and patient flow, in part due to insufficient service provision in primary care and community care settings mean that the Trust is not able to met the national A&E target although plans are in place to ensure improve performance in line with the trajectory.

Therefore the Board cannot confirm that is satisfied that plans are in place sufficient to ensure ongoing compliance with all existing targets.

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We are
WHH

Warrington and Halton Hospitals NHS
NHS Foundation Trust

WHH Board of Directors Meeting Held in Public

Wednesday 27th July 2016
1:00pm – 3:45pm
Trust Conference Room