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NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

WHH Board of Directors Meeting Part 1

Wednesday 29 January 2020
9.45am-12.30pm
Trust Conference Room

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

Wednesday 29 January 2020 time 9.45am -12.30pm
Trust Conference Room, Warrington Hospital

REF BM/20	ITEM	PRESENTER	PURPOSE	TIME	
BM/20/01/01	**Board Engagement Story 15 Minutes –** Ambulance /NWAS Collaborative Board – Chris Evans , Chief Operating Officer			09.45	PPT
BM/20/01/02	Welcome, Apologies & Declarations of Interest	Steve McGuirk, Chairman	N/A	10.00	Verb
BM/20/01/03 PAGE 5	Minutes of the previous meeting held on 27 November 2019	Steve McGuirk, Chairman	*For decision*	10:02	Encl
BM/20/01/04 PAGE 13	Actions & Matters Arising	Steve McGuirk, Chairman	*For assurance*	10:05	Encl
BM/20/01/05 PAGE 14	Chief Executive's Report including - NHSE Responsible Officer Compliance - CQC Certificate - Summary of NHS Providers Board papers	Simon Constable, Chief Executive	*For info/update*	10:10	Verb
BM/20/01/06	Chairman's Report	Steve McGuirk, Chairman	*For info/update*	10:20	Verb

Quality People Sustainability

BM/20/01/07 PAGE 43	Integrated Performance Dashboard M9 and Assurance Committee Reports	All Executive Directors	*For assurance*	10:30	Enc
(a) PAGE 99	- Quality Dashboard including o Monthly Nurse Staffing Report – October, November	Kimberley Salmon-Jamieson Chief Nurse			Enc
(b) PAGE117	- Key Issues report Quality and Assurance Committee (7.01.2020)	Kimberley Salmon-Jamieson Chief Nurse – Executive Lead			Enc
(c) PAGE120	People Dashboard - Key Issues Strategic People Committee (22.1.202)	Michelle Cloney Director of HR & OD – Executive Lead			Enc
	- Sustainability Dashboard	Andrea McGee			
(d) PAG124	- Key Issues Finance and Sustainability Committee (18.12.2019 + 22.01.2020)	Director of Finance & CD – Executive Lead			Enc

Quality

BM/20/01 08PAGE129	Care Quality Commission (CQC) Action Plan & Moving to Outstanding Update	Kimberley Salmon-Jamieson Chief Nurse	*For assurance*	11.30	Enc

Sustainability

BM/20/01 09 PAGE 159	Quarterly Progress on Carter Report Recommendations + Use of Resource Assessment	Andrea McGee Director of Finance + Commercial Development	*For info/update*	11.40	Enc
BM/20/01 10 PAGE 197	Digital Strategy	Phill James Chief Information Officer & Alex Crowe Acting Executive Medical Director	*For decision*	11.50	PPT+ Enc

BM/20/0111 PAGE 226	**Quarterly Engagement Dashboard**	**Pat McLaren Director of Community Engagement + Fundraising**	***For info/update***	**12.15**	**Enc**

GOVERNANCE

BM/20/0112 PAGE234	**Strategic Risk Register + BAF**	**John Culshaw Trust Secretary**	***For assurance***	**12.20**	**Enc**

MATTERS FOR APPROVAL

	ITEM	Lead (s)				
BM/20/0113 PAGE 2	**WHH Charity Annual Report 2018-2019**	**Andrea McGee Director of Finance + Commercial Development**	**Committee**	Charitable Funds Committee		**Enc**
			Agenda Ref.	CFC/19/12/42		
			Date of meeting	5 December 2019		
			Summary of Outcome	CFC requested that changes to the annual report highlighted by PMcL actioned and a revised report be circulated electronically. Revised accounts approved by CFC Committee members by email on 17th January 2020.		
BM/20/0114 PAGE 30	**Terms of Reference and Cycle of Business – Quality Assurance Committee**	**John Culshaw Trust Secretary**	**Committee**	**Quality Assurance Committee**		**Enc**
			Agenda Ref.	QAC/20/01/16		
			Date of meeting	7 January 2020		
			Summary of Outcome	**Approved**		

MATTERS NOTING

	ITEM	Lead (s)				
BM/20/0115 PAGE 40	**Key Issues Audit Committee (21.11.219) Verbal update provided at Trust Board 27.11.2019**	**I Jones Committee Chair**	**Committee**	Trust Board		**Enc**
			Agenda Ref.	BM/19/11/108(e)		
			Date of meeting	27 November 2019		
			Summary of Outcome	**Noted**		
BM/20/0116 PAGE 42	**Guardian of Safe Working Q3 Report**	**Alex Crowe Acting Executive Medical Director**	**Committee**	**Strategic People Committee**		**Enc**
			Agenda Ref.	SPC/20/01/10		
			Date of meeting	22 January 2020		
			Summary of Outcome	**Noted**		
			Agenda Ref.	QAC/20/01/11		
			Date of meeting	7 January 2020		
			Summary of Outcome	**Noted**		
BM/20/01/17	**One Halton Place Based Plan 2019-2024**	**Chris Evans Chief Operating Officer**	**To note**		**12.30**	**Enc**

BM/20/01/18	**Any Other Business**	**Steve McGuirk, Chairman**	**N/A**		**Ver**

Conflicts of Interest

At any meeting where the subject matter leads a participant to believe that there could be a conflict of interest, this interest must be declared at the earliest convenient point in the meeting. This relates to their personal circumstances or anyone that they are of at the meeting.

- Chairs should begin each meeting by asking for declaration of relevant material interests.
- Members should take personal responsibility for declaring material interests at the beginning of each meeting and as they arise.
- Any new interests identified should be added to the organisation's register(s) on completion of a Declaration of Interest Form.
- The Vice Chair (or other non-conflicted member) should Chair all or part of the meeting if the Chair has an interest that may prejudice their judgement.

If a member has an actual or potential interest the Chair should consider the following approaches and ensure that the reason for the chosen action is documented in minutes or records:

- Requiring the member to not attend the meeting.
- Excluding the member from receiving meeting papers relating to their interest.
- Excluding the member from all or part of the relevant discussion and decision.
- Noting the nature and extent of the interest, but judging it appropriate to allow the member to remain and participate.
- Removing the member from the group or process altogether.

Staff may hold interests for which they cannot see potential conflict. However, caution is always advisable because others may see it differently and perceived conflicts of interest can be damaging. All interests should be declared where there is a risk of perceived improper conduct.

Interests fall into the following categories:

- **Financial interests:**
  Where an individual may get direct financial benefit[1] from the consequences of a decision they are involved in making.
- **Non-financial professional interests:**
  Where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making, such as increasing their professional reputation or promoting their professional career.
- **Non-financial personal interests:**
  Where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are involved in making in their professional career.
- **Indirect interests:**
  Where an individual has a close association[1] with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest and could stand to benefit from a decision they are involved in making.

DRAFT

Warrington and Halton Hospitals NHS Foundation Trust Minutes of the Board of Directors meeting held in Public (Part 1) on Wednesday 27 November 2019 Trust Conference Room, Warrington Hospital	
Present	
Steve McGuirk (SMcG)	Chairman
Terry Atherton (TA)	Deputy Chair, Non-Executive Director (Chair)
Margaret Bamforth (MB)	Non-Executive Director
Simon Constable (SC)	Chief Executive
Chris Evans (CE)	Chief Operating Officer
Ian Jones (IJ)	Non-Executive Director / Senior Independent Director
Andrea McGee (AMcG)	Director of Finance and Commercial Development
Cliff Richards (CR)	Non-Executive Director
Kimberley Salmon-Jamieson (KSJ)	Chief Nurse
Anita Wainwright (AW)	Non-Executive Director
In Attendance	
John Culshaw (JC)	Head of Corporate Affairs
Phillip James (PJ)	Chief Information Officer
Julie Burke (JB)	Secretary to Trust Board (Minutes)
Pat McLaren (PMcL)	Director of Community Engagement + Fundraising
Judith Burgess (JBu)	Lead Nurse Integrated Medicine + Community *(Item BM/19/11/102)*
Jill Wright (JW)	Clinical Specialist Physiotherapist (*Item BM/19/11/102)*
Apologies	
Alex Crowe (AC)	Acting Executive Medical Director, WHH and Bridgewater CHFT
Lucy Gardner (LG)	Director of Strategy
Observing	
Norman Holding	Public Governor
John Williams	Partner Governor, University of Chester
Alison Kinross	Public Governor
Laura Churchill	Corporation Secretary Warrington + Vale Royal College

BM/19/11/102	Patient Story The Board welcomed Judith and Jill who shared a story and learning from a patient who had suffered a stroke and had received treatment and support in hospital and in the Community including reablement services and care and support at home with continuing support in out-patients following discharge. The story highlighted some isolation felt by the patient not having access to familiar everyday activities during a lengthy stay and areas for improvement in care and communication. A number of improvements that had been put in place were explained including increased HCA support on the wards to improve the response time when patients call for help and working with MDT teams to ensure that all aspects of care and support is in place, as well as ward rounds with nurses and therapists, a weekly liaison meeting with families and support from volunteers on wards to provide support especially at meal times. Opportunities are being explored to provide patients with access to other media through Apps with a successful bid to the Charitable Funds Committee for cognitive therapy aids. In addition opportunities are being explored through Be The Change for support to create an outside space for stroke patients and families. The Board discussed the successful Forget Me Not scheme and for a similar approach to be taken, linking with National and Regional initiatives to create a show garden which could be

	donated back to the Trust. The Board thanked colleagues for sharing the story recognising the improvements, shared learning and collaborative working that had been promptly put in place.
BM/19/11/103	**Welcome, Apologies & Declarations of Interest** The Chair opened the meeting and welcomed colleagues. Apologies noted above. Previously agreed standing declarations were noted. No other declarations in relation to the agenda were noted.
BM/19/11/104	**Minutes of the meeting held 25 September 2019** Pg 3, delete Healthcare Assistants (HCAs) before the penultimate sentence. Pg 4, 2nd para delete This ? increasing support in ED, replace with ..and support is being increased in ED. Pg 13, MC to read MP, date of next meeting to read 27 November 2019. With these amendments, the minutes of 25 September 2019 were agreed as an accurate record.
BM/19/11/105	**Actions and Matters Arising. Action log and rolling actions were noted.** BM/18/07/57 Junior doctor update deferred to 29.1.2020.
BM/19/11/106	**Chief Executive's report** The CEO referred to his first written CEO report highlighting matters to the Board that would not ordinarily be addressed through the agenda. SC highlighted the staff recognition awards in the Trust and staff recognition at the Warrington Guardian Inspiration Awards. The Trust is one of 70 Trusts earmarked to receive new cancer screening equipment such as CT and MRI. This will support our place as a Rapid Diagnostic Centre, as well as assist with the non-elective pathway. Referring to innovation and improvement, a successful 2nd Trust Patient Safety Summit had taken place on 26.11.2019, demonstrating the robust processes being embedded to share learning from incidents and patient safety matters across the whole trust. SC had also attended the NIHR Applied Research Collaboration for the North West Coast on 20.11.2019 which is a key resource that can support the Trust in its Quality Improvement, Innovation and Research agenda. Summary of NHS Providers Board papers noted. NHSE/I Assurance meeting positive feedback acknowledging actions that had been taken by WHH both operationally and financially. SC and SMcG referred to the Shrewsbury and Telford investigation and it is quite right that this Trust will review findings of that report against systems in place at WHH. In relation to HSMR and SHMI October position, SC explained the Trust is within the expected range within 95% confidence intervals, reassuring the Board that qualitative assessments are in place to review unexpected deaths and care through Structured Judgement Reviews (SJRs) and the Mortality Review Group. KSJ informed the Board in relation to One to One Midwifery that an independent review is planned and ToR being considered May/June, an anticipated 3-6 months. In relation to query raised by AW of any current issues, KSJ assured the Board that a strong rigorous internal process was followed when contacting women regarding their chosen care

	pathway, any issues reported to Commissioners immediately and that all options that would have been provided by One to One were provided by WHH. In addition, IJ explained a limited response to his letter had been received from the Chair of Wirral CCG. AMcG added that the outcome of the administrators review will be reported to Trust Board when completed. KSJ assured the Committee that robust internal maternity governance and mechanisms are in place including internal and external reviews explaining incidents are SIs are reviewed by an external organisation, Perinatal Mortality Review Team, a deep dive had been undertaken and reported to Quality Assurance Committee (QAC) as appropriate, ie still birth review. MB also provided assurance of robust maternity systems in place through her Maternity Safety Champion role walk rounds and discussions and reporting through PSCE and QAC • **One to One External Review ToR to be shared at March Board by KSJ**
BM/19/11/107	**Chairman's Report** The Chair had attended the staff Thank You Awards and Warrington Guardian Inspiration Awards recognising WHH staff and the hospital's role in Halton and Warrington. Council of Governors had received an update on the Warrington Recovery Assessment Gateway demonstrating collaborative working from Acute, MH and Community Providers. A number of Consultants had been appointed following recent Consultant recruitment panels. The Chair congratulated newly elected and re-elected Governors following the conclusion of the recent Governor elections.
BM/19/11/108 *(a)*	**IPR Dashboard** <u>Monthly Nurse Staffing Report August + September 2019 for noting</u>: Error noted in Appendix 2 of both reports which should read August and September respectively. KSJ reported good progress with retention of staff, exceeding NHSI trajectory and was pleased to report that the Nursing and HR Teams had won a National Best Career Planning and Development Offer award and were highly commended in the 'Best Use of Data Diagnostic to Inform Retention Initiatives' award. <u>September 2019</u> – KSJ highlighted cost of additional beds and staffing to support operational escalation in the GPAU, additional B3 beds and Discharge Lounge is £1,130,433.60. <u>Quality measures</u>: SC asked KSJ to provide an update on variances relating to (a) open incidences ahead of winter (b) never events (c) role of eMPA in medication safety and how this will support the Trust in driving improvement in this area. (a) KSJ reported an increase in incidents and decrease in the number being signed off, due to CBU capacity to support closing down of incidences. Meeting had taken place with CBUs and plans are in place for a reduction by next month and reassurance given that this is being monitored on a weekly basis. (b) KSJ explained there had been 3 never events January/August and October. The October incident related to a wrong site interscalene block being performed using ultrasound on a patient scheduled for surgery and had been discussed at September Board. Immediate actions were implemented following review and the investigation is underway. The Governance processes will be followed to understand what happed and to put in place the necessary new procedures. Duty of Candour was carried out, and support provided to patient who will go through normal follow-up procedure. Findings of the investigation will

	be reported to Quality Assurance Committee when complete. (c) KSJ explained ePMA roll-out is being positively received by nurses and medical teams on the pilot wards and the ward safety metric will benefit patient safety, especially prescribing and wider medication optimisation to reduce safety incidents, all monitored through PSCE and QAC. In relation to query raised by SMcG if savings and quality improvements are anticipated SC explained that system-wide savings will be realised, especially in the community, the Trust and pharmacies as all prescription information will be available through connectivity of primary care, acute and pharmacy systems. In response to query raised by MB relating to VTE indicator, KSJ explained completion of VTEs had been discussed at the last PSCE and a group established, led by Acting Deputy MD and Dr EH to support and embed process to completion documentation.
(b)	Quality Assurance Committee Chairs Key Issues Report (5.11.2019) – MB highlighted, findings of Urology Deep Dive to be reported at January QAC; SI Audit Report - further audit in 3-4 months to audit uploading of evidence to Datix to support improvement in closing off actions with report to January QAC; IPR continues to be scrutinised including those indicators moving in the right direction, Falls, Pressure Ulcers and medication safety. Reassurance that learning mechanisms are in place relating to a number of matters highlighted at previous QAC evidenced at the Safety Summit. JC added that Urology has been added to the Corporate Risk Register. In relation to HSMR and SHMI October position, SC explained the Trust is within the expected range of 95%, reassuring the Board that qualitative assessments are in place to review all deaths and care through Structured Judgement Reviews (SJRs) and the Mortality Review Group. Access and Performance measures – SC asked CE for update on variances relating to (a) 4 hr month position and mitigations to address performance and (b) winter resilience plans. CE reported the Trust had achieved 80.04% in October against trajectory of 80%, the position at 26.11.2019 76.28% meaning achievement of the trajectory in November is at risk; December and Q4 target remains at 80%, creating opportunity to supersede performance in 18/19. CE explained activity correlates with super stranded activity peaking at 145 in September, mitigations through the MADE event in October reduced this to 118. Plans in place to reduce further in December and January with focus on those wards with a concentration of super stranded patients through daily reviews with MDT teams to achieve trajectory of 95. Additional system support offered through Home Reablement Service and Frailty Hub. At 24.11.2019 the Trust was 49th out of 123 for Type 1 activity and 57th out of 123 for all types of activity. (b) CE summarised plans in place to prepare for Winter including use of K25 to protect GPAU for assessment capacity and the Combined Assessment Unit (CAU) from 9.12.2019; NHSEI support for additional capacity on B3 (10 beds) which will also support capacity and throughput. Decision to Admit (DTA) process has significantly improved waiting times in the ED. In terms of A&E attendance CE explained a growth of 3.18%, on the Warrington site with largest growth within the 0-18 years old age range. It is thought this could be linked to national delay in release of childhood flu vaccination and increase in sickness levels in schools. This had been discussed at the multi-agency A&E Delivery Board. In response to query raised by MB relating to management of Paediatric pressures, CE explained some changes to the ED model, pathways being refreshed and additional Senior Nurse and APN support in AED. People measures: MC was asked to provide an update on plans to (a) reduce sickness

	absence, (b) reduce agency spend (c) improve PDR compliance. MC explained the Trust is using NHSE/I Health & WellBeing framework and had undertaken a gap analysis to identify immediate actions to improve attendance. Two main areas for absence are mental health related absence and MSK related absence. Four workstreams to be established, pilot to commence in January 2020 including Healthy Lifestyles + improved Mental Health provision. This will include Tier 1-4 MH provision, Tier 1 will be web-based self-help support Tier 2, telephone support, Tier 3 Face to Face Counselling, provided externally through Employee Assistance Programme which will be implemented in December 2019. Tier 4, support Tiers 1-3 provided in-house including Line Manager Awareness Training, Resilience training, Group Counselling and MH First Aid. Focus on MSK-related absence and process to 'fast-track' for Physiotherapy support early in absence period. In addition a pilot within Estates +Facilities to 'Wrap around' support staff when they return to work or avoiding absence initially. Pilot outcomes and interventions to reduce absence will be monitored through Operational People Committee and reported to Strategic People Committee. (b) in relation to agency spend MC was pleased to report agreement from C&M CEOs to implement the C&M Agency Rate Card from 1.12.2019. Hard work of Associate Director of Procurement was acknowledged in achieving this. Additional costs related to escalated capacity will be reported to FSC in December, costs are recorded on a daily basis with weekly reports to Executives for enhanced monitoring. (c) Operational People Committee piloting streamlined appraisal process following feedback that the current system was onerous. Pilot to be launched January 2020 reducing paperwork with focus on conversation. Changes to be reflected in amended policy to ensure a clear process for Agenda For Change staff who are on pay progression scales. MC reassured the Board that CBU compliance is reported and monitored at the Trust Operational Board.
(c)	<u>Strategic People Committee Chairs Key Issues (20.11.2019):</u> AW highlighted, November 2019 launch of Clinical Excellence Awards 2018 to conclude December 2019; deep dive into compliance of local induction for medical staff with oversight by Acting Deputy MD. AW had undertaken a departmental visit to Occupational Health (20.11.2019), positive feedback relating to MH&WB framework discussed earlier, some issues relating to condition of referrals received. On target to improve last year's completion Staff survey (51%), current position reported at 51% with 2 days remaining. <u>Finance + Sustainability Measures:</u> AMcG was asked to provide an update (a) on plans to achieve break even Control Total and (b) changes to Capital programme. AMcG explained Trust on plan to end of October, with some risk remaining. High agency spend in month of £1m offset by over-achievement of CIP of £1m. Unidentified and high risk CIP remains going into Q4. Work continuing through FRG to identify further CIP. Implementation of Rate Card will support agency spend, particularly during winter. Executive Team continue to review all non-pay spend daily, additional controls agreed relating to non-clinical vacancies being shared collectively with Bridgewater and Commissioners to support system-side resilience and agreement for a shared PMO arrangement for future collaborative working. Mitigated forecast £2.4m off plan, variance from plan will mean PSF and FRF circa £11m is at risk and may result in request for additional working capital loan. AMcG reported that the loans due to expire this year had been extended to 2020/21. Discussion took place relating to funding of winter capacity, B3 and K25 costs circa £.6m. AMcG explained the Trust had been asked to review its LT Plan to identify if the £7.3m gap could be closed further, resubmission is 28.11.2019.

	• **The Board noted, reviewed and discussed the report.** • **The Board approved the change to the 2019-20 Capital Programme.**
(d)	Finance + Sustainability Committee (FSC) Chairs Key Issues, (20.11.2019). As Chair of FSC, asked the Board to note continued compliance and improvement with all access targets with the exception of AED.
(e)	Audit Committee (AC) Chairs Key Issues 21.11.2019) As Chair of AC, IJ provided a verbal update reporting the Committee had discussed and reviewed Management and MIAA Follow-Up reports and some delays to sign off recommendations within timescales. A significant improvement reported in closure of management actions. 5 MIAA reviews received, 2 Limited Assurance, (1) Discharge Summaries Review identified inadequate and timely completion of documentation, action plan in place to complete March 2020. (2) IT Service Continuity and Resilience Review to be paused to consideration action plan. Progress report requested for February 2020 Audit Committee. Report to be circulated with January 2020 papers. The Chairman referred to a number of items on the agenda which had previously been discussed at Assurance Sub Committees, proposing moving these to the end of future Board agendas for noting to allow focussed discussions on the IPR elements, quality, people, performance and sustainability. • **The Board reviewed and discussed the report.** • **Key Issues report to be circulated to enable assurance ratings indicating level of assurance provided at Sub Committees to be included in future reports.**
BM/19/11/109	**Learning From Experience Q2 Report 2019/2020** **The Board noted and reviewed the report**
BM/19/11/110	**Director Infection Prevention + Control (DIPC) Q2 Report** KSJ highlighted 11 Cdiff cases reported, current position 31, all of which are being investigated as part of RCA which will be reported to the QAC. - EColi above trajectory, reflected in the NW reporting the highest incidence and prevalence and C&M Community highest in NW. The Trust is working with community colleagues to support reduction. - QAC had discussed findings of the latest Infection Control audits and increase in low compliance attributed to Environment which the previous 4 audits had achieved compliance. Deep dive identified low compliance primarily relates to kit, not estate issues and some orders not been processed. KSJ has asked for a review of outstanding estate jobs and some of the non-stock requisitions which are being reviewed by Executives. • **The Board reviewed, discussed and reviewed the report.**
BM/19/11/111	**Care Quality Commission (CQC) Action Plan** KSJ outlined the CQC Action Plan and highlighted the key elements: - There are 61 actions across 35 recommendations in the CQC action plan - The Urgent and Emergency Care Improvement Plan (U+EC IP) progressing, 26 actions have been completed to date, leaving 4 remaining which are expected to be completed by end of December 2019. - A Moving to Outstanding framework is in development to be shared with Executives and Board January/February 2020 for approval. - Confirmation of dates awaited from CQC to attend Trust Board and Quality Assurance

	Committees over the next 1-2 years. - Current compliance of the CQC action plan was highlighted by core services. - U+EC IP action plan, 26 actions completed, others on track for completion by end of December. - 4 regulatory breaches identified will remain until the next ED inspection in 2021, however the Trust will notify CQC when these are closed down internally, anticipated by end of January 2020. - CE reassured the Board that preparedness plans are in place and being progressed through the U&EC Improvement Committee prior to the next focussed CQC inspection, anticipated January/February 2020. • **The Board discussed and reviewed the CQC action plan progress and update** • **The Board discussed and reviewed the Urgent and Emergency Care action plan progress**
BM/19/11/112	**Mortality Review Q2 Report (Learning From Deaths)** SC advised the Trust is to be visited by the Regional Medical Examiner on 3.12.2019 demonstrating a further enhancement relating to existing mortality review processes. • **The Board reviewed the report noting continued improvement in processes to review deaths in the Trust.**
BM/19/11/113	**Quarterly Progress on Carter Report Recommendations+ Use of Resources Assessment (UoRA)** AMcG highlighted the recent National Benchmarking Report for Corporate Services which highlighted a number of areas where costs are below the national median, however the Trust benchmarks higher when compared against turnover. This highlights the issue of corporate services costs and organisational size. Corporate Leads are reviewing their costs to identify any warranted variation, data issues and areas for improvement, including turnover which will be incorporated in the UoR workplan. • **The Board reviewed the report and progress being made.**
BM/19/11/114	**GMC Revalidation Annual Report** SC introduced the report which providing assurance to the Board of processes in place relating to re-validation. • **The Board noted the report which had been supported at the SPC on 20.11.2019.**
BM/19/11/115	**Guardian of Safe Working Q1 and Q2 Reports** • **The Board reviewed and noted the reports.**
BM/19/11/116	**Engagement Dashboard – 6 month report** PMcL highlighted key elements for the Board to note: - Increase in website enquiries, circa 2-3k per year; - Collaborative work with Alder Hey to launch virtual 'Chatbox' to the website which will improve patient experience and free up resource to provide support in other areas. - Significant improvement in ratings on NHS Choices. - FOI requests – increased requests related to Brexit and impact on employment of EU nationals highlighted which will be reflected in the next Dashboard. • **The Board reviewed and noted the report. Future report to include average response rate to NHS Choices outside of C&M.**

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BM/19/11/117	**Freedom to Speak Update following FTSU Month** KSJ provided an update to the Board following September national FTSU month. The increased visibility and visits had resulted in a possible 14 new FTSU Champions. • **The Board noted the progress of Freedom To Speak Up and recorded thanks to the FTSU Guardian for her continued work to raise FTSU across the Trust.** • **Report to be circulated as part of the CEO staff briefing.**
BM/19/11/118	**Flu Vaccinations Update** MC referred to the self-assessment checklist and compliance in all areas with the exception of (B3) Flu Vaccination programme and access to vaccination on induction programmes. This was due to knock on effect of delay in delivery of vaccinations however plans progressing to achieve 80% uptake required.
BM/19/11/119	**Strategic Risk Register and Board Assurance Framework (BAF)** JC provided an update on Risks since the last Board meeting. • No new risks were proposed for addition to the BAF; no proposed amendments to the ratings of any risks currently on the BAF; no proposed amendments to risk descriptions and no risks proposed for de-escalation from the BAF; The Board noted the updates to existing risks. • **The Board reviewed and noted the BAF and Strategic Risk Register.**
	Matters for Approval
BM/19/11/120	**Charities Commission Checklist** • **The Board noted the Assurance provided within the report.**
BM/19/05/57	**Any Other Business**
	Next meeting to be held: Wednesday 29 January 2020

Signed …… Date …….

Chairman ……..

Warrington and Halton Teaching Hospitals NHS Foundation Trust

BOARD OF DIRECTORS ACTION LOG

AGENDA REFERENCE:	BM/20/01/05	SUBJECT:	TRUST BOARD ACTION LOG	DATE OF MEETING	29 January 2020

1. ACTIONS ON AGENDA

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
BM/19/11/116	27.11.2019	Engagement Dashboard	The Board reviewed and noted the report. Future report to include average response rate to NHS Choices outside of C&M.	**Director Community Engagement + Fundraising**	**25.11.2020**		PMcL to provide verbal update January 2020	

2.ROLLING TRACKER OF OUTSTANDING ACTIONS

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
BM/19/11/108	27.11.2019	One to One	ToR, findings of external review to Board when completed.	**Chief Nurse**	**25.03.2020**			
BM/18/07/57		Junior Doctor/Trainee Engagement update Trello)	6 mth update presentation.	**Acting Executive Medical Director**	**Date TBC**		14.01.2019. Deferred to March 27.03.2019. Referred to future BTO 29.05.2019. Update to September Board to include results from GMC survey results. 06.09.2019. Deferred to November Board 18.11.2019. Deferred to January Board 13.01.2020 Date TBC	

3. ACTIONS COMPLETED AND CLOSED SINCE LAST MEETING

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
BM/19/11	27.11.2019	Key Issues Reports	Share draft key issues template	**Company Secretary**	**29.01.2020**	**10.01.2010**	Template circulated to Executives 10.01.2020	

RAG Key

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

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/20/01/05**			
SUBJECT:	**Chief Executive's Briefing**			
DATE OF MEETING:	29th January 2020			
AUTHOR(S):	Simon Constable, Chief Executive			
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Chief Executive			
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will…Always put our patients first through high quality, safe care and an excellent patient experience. ✓ SO2 We will…Be the best place to work with a diverse, engaged workforce that is fit for the future. ✓ SO3 We will...Work in partnership to design and provide high quality, financially sustainable services. ✓			
LINK TO BAF RISK:	All			
EXECUTIVE SUMMARY *(KEY ISSUES):*	This report provides the Trust Board with an overview of matters on a range of strategic and operational issues, some of which are not covered elsewhere on the agenda for this meeting.			
PURPOSE: *(please select as appropriate)*	Information ✓	Approval	To note	Decision
RECOMMENDATION:	The Board is asked to note the content of this report.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None			

SUBJECT	Chief Executive's Briefing	AGENDA REF:	BM/20/01/XX

1) BACKGROUND/CONTEXT

This report provides the Trust Board with an overview of matters on a range of strategic and operational issues, some of which are not covered elsewhere on the agenda for this meeting.

2) KEY ELEMENTS

2.1 Briefings shared with the Board since the last meeting

- Developing Genomics in the North West
- October 2019 Healthcare Evaluation Data Trust Mortality Report
- Cheshire & Merseyside Health & Care Partnership Chair's Communication
- Briefing on the Queen's Speech December 2019
- Letter to partners in relation to winter pressures
- Thank you letter to Urgent & Emergency Care staff

2.2 Key issues

2.2.1 Introduction

My report will highlight some key issues at the time of writing that may or may not be covered in other standing items or the cycle of business.

2.2.2 Visit by Secretary of State and Briefings of Prospective Parliamentary Candidates

The Chairman and I were delighted to host a visit by the Secretary of State for Health and Social Care, Rt Hon Matt Hancock MP, on 5th December 2019. We were able to brief him on the assessment capacity issues within our Emergency Department, showcase our successful roll out of Electronic Prescribing and Medicines Administration (EPMA) as well as discuss developing the strategic case for a new hospital.

The Chairman and I also hosted two briefing sessions for prospective parliamentary candidates for our four local constituencies on 27th November 2019 and 2nd December 2019 ahead of the General Election and in accordance with NHS Pre-election Period guidance. I delivered an overview presentation about our Trust, performance and key issues (such as improving access times in A&E, system financial recovery, our continuous improvement in quality and how we intend to invest, wisely, in our estate). We also provided a brief tour of our Emergency Department and two of our acute wards to demonstrate some of the challenges within our current buildings as well as what we have done to make things as good as possible (for example, the redevelopment of our Acute Cardiac Care Unit on A3).

2.2.3 New Warrington Hospital

I was pleased to attend a meeting convened by Professor Steven Broomhead, Chief Executive, Warrington Borough Council to discuss how we can further progress the case for a new hospital for Warrington. Andy Carter MP (Warrington South) and Charlotte Nichols MP (Warrington North) met with Councillor Russ Bowden, Leader of Warrington Borough Council and Councillor Rebecca Knowles, Cabinet Member, Statutory Health and Adult Social Care, to develop our shared approach. All agreed that the current facilities for an expanding town with an increasingly senior population were not fit for purpose despite the dedicated efforts of staff and other health and social care professionals.

We agreed that we would progress the case for a new, future-proofed and technologically-driven hospital that reflects the wider health needs of both Warrington and Halton populations. This would be made possible via a single estates strategy enabling the provision of a comprehensive and seamless range of acute and community clinical services alongside support services to maximise well-being and prevention, clear links to wider social care support and an opportunity for the establishment of a university-led medical school. While the size and scope of the new hospital will be clinically driven, and nothing has been decided yet, it was agreed that a Town Centre site would be most desirable to support easy patient access. Both MPs and the Council agreed to work together co-operatively in order for the new hospital to become a national priority for investment.

It is important for us to link developments in Warrington to those planned improvements in Halton as part of a single estates strategy. The two are complementary proposals.

2.2.4 Trust Mortality Rates

Under the leadership of Dr Phil Cantrell, Consultant Radiologist and the Lead Clinician for Mortality, the work of the Trust Mortality Review Group continues to make progress in understanding our mortality data both quantitatively and qualitatively to drive improvements. This work triangulates with independent feedback we get from our monthly Healthcare Evaluation Data reports which have shown marked improvements in recent months (although data reporting periods are always by necessity “in arrears”). HSMR has a green (“as expected”) rating for the period September 2018 to August 2019). Similarly, SHMI has a green (“as expected”) rating for the period August 2018 to July 2019. Continued improvements in data quality, ostensibly clinical documentation and then the resultant clinical coding, gives greater confidence so that the Structured Judgement Reviews can concentrate on learning and driving improvements in care.

Developing and implementing the Medical Examiner role at WHH by April 2020 as part of the national roll-out is the next phase in this improvement work.

2.2.5 Organisational Change

Since Project Springboard and the launch of our Clinical Business Unit operational structure in April 2016 we have seen a number of organisational developments and improvements as we need to evolve and adapt in the wider operating environment. On 1st January 2020 we launched a merged Clinical Business Unit of Surgical Specialties, comprising Musculoskeletal Care and Specialist Surgery as well as the development of the Clinical Support Services Unit, comprising Diagnostics, Outpatients and Therapies.

2.2.6 2020 – The Year of The Nurse & Midwife

2020 is Florence Nightingale's bicentennial year, designated by the World Health Organisation as the first ever global Year of the Nurse and Midwife. Nurses and midwives make up the largest numbers of the NHS workforce, as highly skilled, multi-faceted professionals from a host of backgrounds. 2020 is a time to reflect upon these skills, the commitment and expert clinical care they bring, and the impact they make on the lives of so many. It is also an opportunity to say thank you to the professions, to showcase their diverse talents and expertise, and to promote nursing and midwifery as careers with a great deal to offer. The NHS is planning a series of activities to celebrate and WHH will participate fully in this programme. This will include the Florence Nightingale 200th birthday celebrations in May. WHH will have an event calendar to support both the national and more local events.

2.2.7 Joint Executive Team Meetings with Bridgewater Community Healthcare NHSFT

We continue to have fortnightly meetings with our executive colleagues at BCHFT in addition to other system meetings. We are working on developing a shared agenda for a programme of work that covers clinical/operational/quality delivery and improvement, system financial recovery as well as the wider integration agenda so welcomed by all of our partners.

2.2.8 Winter Pressures

Earlier this month, I was very fortunate to be in the position of being able to thank staff for their individual and collective contribution to the achievement of the 95% 4 hour emergency access standard on Saturday 11th and Sunday 12th January 2020. This key NHS constitutional standard is a key quality standard that is easily measurable and yet a surrogate for so many domains of care quality, including patient safety, clinical effectiveness and patient experience.

This is historically one of the most difficult times of year, especially when I reflect upon previous years when we have been in a very different situation. It is of course as multifactorial as when things are not going quite so well, and the weather has, for instance, been relatively kind to us thus far. However, it is it is testament to the hard work of many (including system partners who I have also been able to thank) and how much importance we have given to improvement over the last few months, including the actions around so called 'super-stranded' long length-of-stay patients to help patient flow. Our 'new' Combined Assessment Unit only opened 24/7 on 6th January 2020 to deliver the assessment capacity we need to make good clinical decisions about the right patients in the right place at the right time.

It is still the very early days of winter and the marked improvement has not, unfortunately, been sustained to that level; we are certainly not celebrating. However, our resilience is much improved and I do consider it important to recognise the things that have had a positive impact so that we can do more.

Clearly this is very much a team approach but I would like to take this opportunity to specifically thank my colleagues, Kimberley Salmon-Jamieson (Chief Nurse), Chris Evans (Chief Operating Officer) and Dr Alex Crowe (Acting Medical Director), for their continued, responsive and very visible executive leadership throughout. I know that staff under pressure really do appreciate this level of support.

2.2.9 Development of Non-NHS Income Activity

For the avoidance of doubt this Trust does not, nor has it ever, charged NHS patients for NHS treatment - neither have we ever intended to do so. Hence, I am able to confirm that following discussions over the summer and culminating in a report to the Board's Part 2 session in September 2019 (item PBM/19/09/59) we have formally removed the fee-paying *My Choice* offer to remove any possibility of misunderstanding by patients or other interested parties in this regard. No patients were ever treated under the *My Choice* scheme in any case.

NHS organisations are permitted to carry out and receive income via private patient work provided it does not impact upon NHS time or patient care. Private patient income is recognised as a legitimate income stream to support a Trust's sustainability. Like almost all other NHS acute Trusts, WHH carries out a very small amount of chargeable patient activity, including private and overseas patients. This is established and well within the limits described in the Health and Social Care Act 2012 which states that Foundation Trusts' private patient income cannot exceed the amount of income received from their primary focus of NHS health care.

The Trust carried out a benchmarking exercise in the summer of last year looking at trusts in Cheshire and Merseyside and the surrounding area. The outcome of the exercise highlighted that the compared to other trusts, WHH generates the least income from private patients. While there is potential to develop our private patient activity within certain specialties, it should be noted that this activity will be clearly identified as fee-paying private activity, ie non-NHS.

2.2.10 NHS England Responsible Officer Compliance

Further to the Trust Board receiving the GMC Revalidation Annnual Report in November 2019, the statement of compliance is included as Appendix 1 for noting by the Board.

2.2.11 Notification of Change of Status Update

The CQC have provided the Trust with a new Certificate of Registration (attached as Appendix 2) to reflect the change in registration relating to the name of the Trust.

2.2.12 Volunteer Celebration Event

The Chairman, myself and Kimberley Salmon-Jamieson, Chief Nurse, were delighted to host our first Volunteer Celebration Event at the Village Hotel in Warrington on 10th December 2019. This was a great way to officially recognise and celebrate the diverse work done by our volunteers and we hope it will be the first of many.

2.2.13 Employee Recognition

Team of the Month (October 2019): Audiology

Audiology work closely with paediatric hearing aid staff (teaching of the deaf) . When a child's hearing aid is identified as being faulty by their teacher these staff members meet the team - usually in the carpark during the school day - to deliver the hearing aid without any detriment to the child's listening and learning environments. Audiology Ambulance patients appointments are always accommodated for regardless of arrival time and the team purchase lunch for the patients if there is any delay in transport to take them home. A staff member is always on hand sit with them and reassure them while they wait.

The team has also established a service at HMP Risley to ensure inmates have access to audiology services without the need of a prison service providing escort for hospital appointments.

Employee of the Month (October 2019): Leah Ward

Leah was tasked with the *Thank You Award* nomination videos working around staff members' shifts and re-filming when they have requested or thought of something else they would like to add to their nomination, often at short notice. Leah has excelled by only just starting her course to learn film so her skills are self-taught. Leah also made a leaving video for Mel Pickup going out to interview staff to pull together a lovely send off for Mel. Leah joined the team four years ago as an apprentice and has flourished; she has also taken Ruby on work experience under her wing showing her film and editing skills.

Team of the Month (November 2019): Combined Assessment Unit

The CAU is a new unit comprising GPAU and SAU, combining assessment capacity in one facility – surgical and medical assessment areas. The team have embraced this change wholeheartedly following a successful test of change in September 2019 and have done so at short notice and despite the fact that the area has frequently been an escalation area for inpatients. The staff have worked together for an outstanding service. It has been commented upon that regardless of the fast paced turnaround of patients within the area, patients were never hurried or felt like they were being rushed. The team are very flexible and adapt to changing circumstances frequently.

Employee of the Month (November 2019): yet to be announced.

December 2019 and January 2020 awards have also yet to be announced.

This month I also launch my own Chief Executive's Award, in addition to the existing awards and nomination process for the above. In my future CEO briefings I look forward to being able to report on these as well.

3) MEETINGS ATTENDED/ATTENDING

The following is a summary of key external stakeholder meetings I have attended since the last Trust Board Meeting. It is not intended to be an exhaustive list.

November/December 2019

- Visit by Secretary of State for Health and Social Care, Rt Hon Matt Hancock MP
- Meetings with Prospective Parliamentary Candidates for Warrington, Halton and Weaver Vale
- Royal College of Physicians and Innovation Agency Research and Innovation in the NHS Event
- Mersey North West Leadership Society
- Warrington and Halton Palliative and End of Life Care Clinical Summit
- NHS Leadership Meeting, London
- Halton Provider Alliance

January 2020

- Meeting with Steve Broomhead, Chief Executive, and Russ Bowden, Leader, Warrington Borough Council, Andy Carter MP and Charlotte Nichols MP regarding New Warrington Hospital
- Gary Skentelbury, Director, Warrington Chamber of Commerce
- Official Reception with Commodore Phillip Waterhouse, HMS Eaglet, Liverpool
- Inaugural meeting – C&M Spinal Services Provider Board
- Interview with Sara Dumbell, BBC Radio Manchester re: Warrington New Hospital
- Warrington & Halton and Bridgewater System Finance Meeting witH NHSE/I
- Warrington Health and Wellbeing Board
- Warrington Health Scrutiny Committee
- Warrington Provider Alliance
- Halton Provider Alliance

4) RECOMMENDATIONS

The Board is asked to note the content of this report.

A Framework of Quality Assurance for Responsible Officers and Revalidation

Statement of Compliance Warrington & Halton Hospitals NHS Foundation Trust

NHS England and NHS Improvement

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex D – Annual Board Report and Statement of Compliance.

Publishing approval number: **000515**

Version number: 3.0

First published: 4 April 2014

Updated: February 2019

Prepared by: Lynda Norton, Claire Brown, Maurice Conlon

This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact Lynda Norton on England.revalidation-pmo@nhs.net.

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and annexes A – G. Included in the seven annexes is the Annual Organisational Audit (annex C), Board Report (annex D) and Statement of Compliance (annex E), which although are listed separately, are linked together through the annual audit process. To ensure the FQA continues to support future progress in organisations and provides the required level of assurance both within designated bodies and to the higher-level responsible officer, a review of the main document and its underpinning annexes has been undertaken with the priority redesign of the three annexes below:

- **Annual Organisational Audit (AOA):**
  The AOA has been simplified, with the removal of most non-numerical items. The intention is for the AOA to be the exercise that captures relevant numerical data necessary for regional and national assurance. The numerical data on appraisal rates is included as before, with minor simplification in response to feedback from designated bodies.

  Board Report Template:
  The Board Report template now includes the qualitative questions previously contained in the AOA. There were set out as simple Yes/No responses in the AOA but in the revised Board Report template they are presented to support the designated body in reviewing their progress in these areas over time.
  Whereas the previous version of the Board Report template addressed the designated body's compliance with the responsible officer regulations, the revised version now contains items to help designated bodies assess their effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance[1]. This publication describes a four-point checklist for organisations in respect of good medical governance, signed up to by the national UK systems regulators including the Care Quality Commission (CQC). Some of these points are already addressed by the existing questions in the Board Report template but with the aim of ensuring the checklist is fully covered, additional questions have been included. The intention is to help designated bodies meet the requirements of the system regulator as well as those of the professional regulator. In this way the two regulatory processes become complementary, with the practical benefit of avoiding duplication of recording.

  The over-riding intention is to create a Board Report template that guides organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

  a) to help the designated body in its pursuit of quality improvement,
  b) provide the necessary assurance to the higher-level responsible officer, and

[1] Effective clinical governance for the medical profession: a handbook for organisations employing, contracting or overseeing the practice of doctors GMC (2018) [https://www.gmc-uk.org/-/media/documents/governance-handbook-2018_pdf-76395284.pdf

c) act as evidence for CQC inspections.

- **Statement of Compliance:**
  The Statement Compliance (in Section 8) has been combined with the Board Report for efficiency and simplicity.

Designated Body Annual Board Report
Section 1 – General:

The Board / Executive Management Team – [*delete as applicable*] of Warrington & Halton NHS Foundation Trust can confirm that:

1. The Annual Organisational Audit (AOA) for this year has been submitted.

   Date of AOA submission: 6th June 2019

2. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

   Yes - Professor Simon Constable, Executive Medical Director & Deputy Chief Executive

3. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

   Yes

4. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

   Yes – the list is monitored and maintained on a regular basis to ensure it is an accurate and up to date reflection.

5. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

   Policies are reviewed on an annual basis and updated as when required.

6. A peer review has been undertaken of this organisation's appraisal and revalidation processes.

   No

7. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

   Yes

Section 2 – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

The Trust uses an electronic appraisal system which is MAG compliant. An Independent Sector Checklist is required as part of the appraisal documentation to cover any work undertaken outside the trust. Copies of claims, concerns and SI's are uploaded onto the system and discussed during the appraisal process.

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Doctors who fail to comply with their appraisal requirements without mitigating circumstances being known and agreed are subject to the Trust Non Engagement Policy. If the policy is exhausted they are reported to the GMC by way of a REV6.

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Yes. The policy is reviewed annually.

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

There are 67 trained appraisers with an average allocation of 4 each.

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

An Appraiser training course was held in March 2019. Appraiser Forums are held twice yearly where the Appraisal and Revalidation Team provide information and updates for appraisers and appraiser feedback data is provided. At the forum Appraisers also have the opportunity to raise any issues or ask for guidance. All appraisals are quality assured by the Appraisal Lead prior to final sign-off being given. As part of the process, the Appraiser must provide a comprehensive Appraisal Summary of the discussions and reflections which have taken place with the Appraisee in each domain. The appraisal is returned for

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/
[2] Doctors with a prescribed connection to the designated body on the date of reporting.

amendments if the information provided is either too brief or below the standard required.

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Doctors who are becoming due for revalidation are identified from the list of those for whom this Trust is the Designated Body via GMC Connect. Supporting evidence is collated for each Doctor and presented at the next Revalidation Decision Making Panel. This consists of the Responsible Officer, Deputy RO, Governance Lead, Revalidation Lead and Non-Executive Director. Doctors are considered for revalidation in time for any shortfalls to be addressed if possible. All recommendations have been submitted to the GMC either ahead of time on the actual submission date.

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

The Revalidation Lead contacts the doctor approximately 3 months prior to their revalidation becoming due to inform them that evidence to support a decision is being gathered. The doctor is made aware of any deficiencies by e-mail, asked to provide additional information or documentation required and informed that they cannot be given a positive recommendation for revalidation if they do not meet the criteria and that this would require a deferral being requested. Once a revalidation decision has been made, this is submitted to the GMC via GMC Connect. Each doctor is e-mailed to inform them of the decision. Those who did not receive a positive recommendation are given details of what remains outstanding and what they need to do. If the shortfall in what is required is likely to be achieved before the submission deadline, for example, the 360 MSF report isn't yet available then the decision would be held back internally and reviewed again by the Responsible Officer nearer the submission deadline. Non-engagers are normally dealt with via the appraisal policy rather than through the revalidation process.

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Yes

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

The trust uses an electronic, web-based appraisal system (CRMS), which includes a depository for doctors to store any supporting information as it is accrued for ease of access during the appraisal process. In addition a suite of reports is produced and uploaded by the trust onto each doctor's appraisal documentation prior to their annual appraisal becoming due. The reports are mapped to the GMC Domains as below.

Service	Report Type	Link to GMC FRAMEWORK Link to GMC SI TYPE *at least once within each 5 yr. cycle*
Medical Staffing	➢ CRMS - Job Plan, Sickness, Annual Leave	**General Information**
Medical Education (CPD)	➢ Delivery of Local Teaching & Grand Round Attendance Report ➢ Evaluation Reports ➢ Medical Education Excellence Awards	Domain 1,2,3 SI Type - 1,2,6
Audit (CPD)	➢ Clinical Audit Data Activity and Attendance Report	Domain 1,2 SI Type - 1,2
Complaints	➢ Detailed Complaints Reports	Domain 1,2 SI Type – 6
Claims	➢ Detailed Claims Report - **Outcomes**	Domain 3 SI Type - 2,3,6
360◦ Clinical	➢ e-system generated reports to the Appraiser ***Colleague and Patient Feedback***	Domain 3 SI Type - 4,5,6
Research & Development (CPD)	➢ R&D Activity Report ***to include funding and achievement***	Domain 1,2 SI Type - 1,2
Learning & Development (CPD)	➢ Statutory & Mandatory Training Activity Report ➢ ***(Inc. e-learning)***	Domain 1,2 SY Type 1,2

Lorenzo PAS System	➢ Clinical Activity – **Clinical Outcomes**	Domain 1,2 SI Type – 1,2,3
Risk Management Clinical Governance	➢ Significant Events/SUI's/Incidents - **Outcomes**	Domain 1,2 SI Type – 1,2,3,6

3. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

The Trust has procedural documents/Policies which such as "Maintaining High Professional Standards Procedures for Medical and Dental Staff" which were reviewed and ratified in March 2019. The Trust also has a Remediation Policy for Medical and Dental Staff and documents actions required when concerns arise. The Trust also has a monthly Triangulation Group meeting chaired by the Responsible Officer which oversees all concerns, ranging from late appraisals, MHPS investigations as well as from formal GMC fitness-to-practice issues, triangulating with the suite of governance data.

4. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

The Trust has procedural documents/Policies such as "Maintaining High Professional Standards Procedures for Medical and Dental Staff" which were reviewed and ratified in March 2019. The Trust also has a Remediation Policy for Medical and Dental Staff and documents actions required when concerns arise.

5. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors[3].

The Trust has a policy based around Maintaining High Professional Standards. A Remediation Policy is also in place.

6. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other

[4]This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

places, and b) doctors connected elsewhere but who also work in our organisation[4].

The Trust has developed an 'Independent Sector Checklist' and every doctor who undertakes additional work outside the Trust must ensure a checklist is completed by an authorised person from each additional workplace and attached to their appraisal record. MPIT Forms are also utilised as and when required.

7. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: **The Board are required to note the delivery of medical appraisals and GMC Revalidation to support the Medical Workforce at WHH and to review the data provided for assurance**.

Comments: **For Information and Assurance to Board**

Action for next year: **The Board are required to note the delivery of medical appraisals and GMC Revalidation to support the Medical Workforce at WHH and to review the data provided for assurance.**

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

There are systems in place to ensure the appropriate pre-employment background checks are in place.

Section 6 – Summary of comments, and overall conclusion

Please use the Comments Box to detail the following:

- **General review of last year's actions – The Trust has again maintained a very high compliance rate and this is a reflection of the processes and systems that are in place to monitor both the annual Medical Appraisal and the GMC Revalidation for the medical workforce.**
- **Actions still outstanding – NONE**
- **Current Issues – NONE**
- **New Actions:**

  1. Ensure all Locum/Temporary/Short-Term Doctors are provided with EXIT Reports are in line with the Strengthened Medical Appraisal Policy

[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

and that this Action is recorded or all locum and short-term contracts. This will also ensure their practice is reported for every contractual movement whilst employed within the health service/health care setting.

2. Ensure Remediation "maintaining high professional standards" MHPS - Processes are factored and robustly coordinated to ensure a doctor can be appropriately supported (e.g. further training and resources (financial and otherwise) provided and recognised accordingly.

2. Continuation of current practice for Reporting and Monitoring Systems for WHH

4. Annual Review of the following Policies and SOP's:

Overall conclusion:

We ask the Board to accept the report (noting it will be shared, along with the annual audit, with the higher level responsible officer) and to consider any needs/resources.

The Board should also be requested to approve the 'Statement of Compliance' confirming that the organisation, as a Designated Body, is in compliance with the regulations. This is also submitted annually to the higher level responsible officer.

Section 7 – Statement of Compliance:

The Board /executive management team – of Professor Simon Constable has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: Warrington & Halton Hospitals NHS Foundation Trust

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _ _

Certificate of Registration

This is to certify the following service provider has been registered by the Care Quality Commission under the Health and Social Care Act 2008

Certificate number: CRT1-7926781781
Certificate date: 26/11/2019
Provider ID: RWW

Section 1 **Service Provider details**

Name of service provider: Warrington and Halton Teaching Hospitals NHS Foundation Trust

Address of service provider: Warrington Hospital
Lovely Lane
Warrington
Cheshire
WA5 1QG

Date of Registration: 01/04/2010

Signed

Ian Trenholm
Chief Executive

You can email CQC at: enquiries@cqc.org.uk
You can contact CQC on telephone number: 03000 616161
You can write to CQC at: CQC National Correspondence, Citygate, Gallowgate, Newcastle upon Tyne, NE1 4PA

Section 2

Warrington and Halton Teaching Hospitals NHS Foundation Trust is registered in respect of
Regulated Activity: **Assessment or medical treatment for persons detained under the Mental Health Act 1983**

For Regulated Activity **Assessment or medical treatment for persons detained under the Mental Health Act 1983** the Nominated Individual (where applicable) is:
Kimberley Salmon-Jamieson

Conditions of registration that apply to:
Warrington and Halton Teaching Hospitals NHS Foundation Trust for **Assessment or medical treatment for persons detained under the Mental Health Act 1983**

1. This Regulated Activity may only be carried on at or from the following locations:

Location Name and address	Halton General Hospital Hospital Way Runcorn Cheshire WA7 2DA
Location ID	RWWHG
Additional conditions that apply at this location	

Location Name and address	Warrington Hospital Lovely Lane Warrington Cheshire WA5 1QG
Location ID	RWWWH
Additional conditions that apply at this location	

Warrington and Halton Teaching Hospitals NHS Foundation Trust is registered in respect of
Regulated Activity: **Diagnostic and screening procedures**

For Regulated Activity **Diagnostic and screening procedures** the Nominated Individual (where applicable) is:
Kimberley Salmon-Jamieson

Conditions of registration that apply to:
Warrington and Halton Teaching Hospitals NHS Foundation Trust for **Diagnostic and screening procedures**

1. This Regulated Activity may only be carried on at or from the following locations:

Location Name and address	Bath Street Health and Wellbeing Centre Legh Street Warrington Cheshire WA1 1UG
Location ID	RWWX1
Additional conditions that apply at this location	

Location Name and address	Halton General Hospital Hospital Way Runcorn Cheshire WA7 2DA
Location ID	RWWHG
Additional conditions that apply at this location	

Location Name and address	Warrington Hospital Lovely Lane Warrington Cheshire WA5 1QG
Location ID	RWWWH
Additional conditions that apply at this location	

Warrington and Halton Teaching Hospitals NHS Foundation Trust is registered in respect of
Regulated Activity: **Family planning**

For Regulated Activity **Family planning** the Nominated Individual (where applicable) is:
Kimberley Salmon-Jamieson

Conditions of registration that apply to:
Warrington and Halton Teaching Hospitals NHS Foundation Trust for **Family planning**

1. This Regulated Activity may only be carried on at or from the following locations:

Location Name and address	Halton General Hospital Hospital Way Runcorn Cheshire WA7 2DA
Location ID	RWWHG
Additional conditions that apply at this location	

Location Name and address	Warrington Hospital Lovely Lane Warrington Cheshire WA5 1QG
Location ID	RWWWH
Additional conditions that apply at this location	

Warrington and Halton Teaching Hospitals NHS Foundation Trust is registered in respect of
Regulated Activity: **Maternity and midwifery services**

For Regulated Activity **Maternity and midwifery services** the Nominated Individual (where applicable) is:
Kimberley Salmon-Jamieson

Conditions of registration that apply to:
Warrington and Halton Teaching Hospitals NHS Foundation Trust for **Maternity and midwifery services**

1. This Regulated Activity may only be carried on at or from the following locations:

Location Name and address	Halton General Hospital Hospital Way Runcorn Cheshire WA7 2DA
Location ID	RWWHG
Additional conditions that apply at this location	

Location Name and address	Warrington Hospital Lovely Lane Warrington Cheshire WA5 1QG
Location ID	RWWWH
Additional conditions that apply at this location	

Warrington and Halton Teaching Hospitals NHS Foundation Trust is registered in respect of
Regulated Activity: **Surgical procedures**

For Regulated Activity **Surgical procedures** the Nominated Individual (where applicable) is: **Kimberley Salmon-Jamieson**

Conditions of registration that apply to:
Warrington and Halton Teaching Hospitals NHS Foundation Trust for **Surgical procedures**

1. This Regulated Activity may only be carried on at or from the following locations:

Location Name and address	Bath Street Health and Wellbeing Centre Legh Street Warrington Cheshire WA1 1UG
Location ID	RWWX1
Additional conditions that apply at this location	

Location Name and address	Halton General Hospital Hospital Way Runcorn Cheshire WA7 2DA
Location ID	RWWHG
Additional conditions that apply at this location	

Location Name and address	Warrington Hospital Lovely Lane Warrington Cheshire WA5 1QG
Location ID	RWWWH
Additional conditions that apply at this location	

Warrington and Halton Teaching Hospitals NHS Foundation Trust is registered in respect of
Regulated Activity: **Termination of pregnancies**

For Regulated Activity **Termination of pregnancies** the Nominated Individual (where applicable) is:
Kimberley Salmon-Jamieson

Conditions of registration that apply to:
Warrington and Halton Teaching Hospitals NHS Foundation Trust for **Termination of pregnancies**

1. This Regulated Activity may only be carried on at or from the following locations:

Location Name and address	Halton General Hospital Hospital Way Runcorn Cheshire WA7 2DA
Location ID	RWWHG
Additional conditions that apply at this location	

Location Name and address	Warrington Hospital Lovely Lane Warrington Cheshire WA5 1QG
Location ID	RWWWH
Additional conditions that apply at this location	

Warrington and Halton Teaching Hospitals NHS Foundation Trust is registered in respect of
Regulated Activity: **Treatment of disease, disorder or injury**

For Regulated Activity **Treatment of disease, disorder or injury** the Nominated Individual (where applicable) is:
Kimberley Salmon-Jamieson

Conditions of registration that apply to:
Warrington and Halton Teaching Hospitals NHS Foundation Trust for **Treatment of disease, disorder or injury**

1. This Regulated Activity may only be carried on at or from the following locations:

Location Name and address	Bath Street Health and Wellbeing Centre Legh Street Warrington Cheshire WA1 1UG
Location ID	RWWX1
Additional conditions that apply at this location	

Location Name and address	Halton General Hospital Hospital Way Runcorn Cheshire WA7 2DA
Location ID	RWWHG
Additional conditions that apply at this location	

Location Name and address	Warrington Hospital Lovely Lane Warrington Cheshire WA5 1QG
Location ID	RWWWH
Additional conditions that apply at this location	

End of certificate

Summary of board papers – statutory bodies

NHS England and NHS Improvement - 28 November 2019

For more detail on any of the items outlined in this summary, please find the full agenda and papers available online.

Chief executive's report

- Simon Stevens notified the board that UCAS has reported an increase of 6% in applications to medicine courses, and a 6.3% increase in acceptance to nursing programmes.
- He gave an update to the board on the independent review into The Shrewsbury and Telford Hospital NHS Trust, led by Donna Ockenden. Professor Stephen Powis, national medical director at NHS England and NHS Improvement (NHSE/I), noted that updated terms of reference for the review have been published and are now available online. He also confirmed that NHSE/I will be increasing resources available to review the additional cases that have come forward.

Financial performance report

- The month 6 financial position across the NHS against plan is a year to date revenue overspend of £129.6m, a variance of 0.2% against plan.
- The provider sector is forecast to the finish year on plan, with a deficit of £320m. It is also forecast to deliver savings of £3.1bn by the end of the year. Mental health trusts are off plan by around £43m.
- The NHS has spent £1.5bn on capital, compared to £1.2bn at this point last year.

Operational performance report

- Urgent and emergency care: The board notes that NHSE/I aim to embed same day emergency care (SDEC) provision in every acute hospital with a Type 1 A&E department. NHSE/I note that 90% of providers are on track to have SDEC available for at least 12 hours a day, 7 days a week by the end of 2019.
- Referral to treatment: The total waiting list in September 2019 was 4.4 million, which has increased by 9,000 from August 2019.
- Primary care and system transformation: NHSE/I expect all STPs to have completed the System Diagnostic by December (which is a self-assessment against the attributes described in the ICS maturity matrix). So far, 85% of systems have submitted self-assessments.
- Mental health: 377,866 children and young people accessed mental health services in 2018/19. Data for the first quarter of 2019/20 show 86% of children and young people accessed treatment for eating disorders within four weeks.
- Learning disability and/ or autism: Between October 2018 and October 2019, 2,986 learning from deaths review (LeDeR) notifications were raised. NHSE/I have allocated £2.4m to support CCGs to increase capacity to complete LeDeR reviews and implement subsequent learning.

Care Quality Commission - 20 November 2019

For more detail on any of the items outlined in this summary, please find the full agenda and papers available online.

Executive office update

- Representatives from the Care Quality Commission (CQC) spoke about its State of Care 2018/19 publication at a parliamentary event in the House of Lords.
- The CQC updated parliamentarians on the progress of the CQC review of restraint, prolonged seclusion and segregation (RSS).
- Ted Baker updated the board on the CQC report into care in closed environments, following David Noble's inspections into Whorlton Hall. The guidance emphasised the human rights approach to care, and the CQC suggest considering the impact of commissioning of out of area placements on how services are inspected and regulated.
- On 5 November the Secretary of State for Health and Care announced his commitment to delivering the CQC's recommendation to review everyone identified as being in segregation in its interim RSS report.

Publications

- The Joint Committee on Human Rights has published its report, The detention of young people with learning disabilities and/or autism. The report makes a number of recommendations to the CQC, including:
  - Unannounced inspections, including weekends and evenings and the use of covert surveillance where appropriate
  - Changes in legislation to enable CQC to react more swiftly where concerns have been raised
  - A review of the system which currently allows a service to be rated 'Good' overall, even when individual aspects (such as safety) may have a lower rating
- The results from the CQC's Community Mental Health Survey will be published soon.

Whistleblowing and enforcement report

- CQC summarised the whistleblowing concerns data it received in 2018/19.
- The report notes that in 2018/19, the CQC received 8,906 whistleblowing concerns, an increase of 9% from 2017/18. Of the 8,906 whistleblowing enquiries, just over half were used to support future inspections, 2% triggered responsive inspections and close to 5% brought inspections forward.
- The team leading the programme of work transforming how the CQC handle, respond and provide feedback are working on ways to improve. This will include developing a new coding system that will lead to a significant reduction in the use of the 'to be considered at next inspection' term.

Change and people update

- The paper presented to the board reported on key CQC achievements over the last quarter, including the 'Quality Improvement programme', designed to build an organisation wide culture of learning and improvement, and 'improving regulation today', which focusses specifically on driving targeted regulatory interventions within the CQC's existing strategy.

Health Education England board meeting: 19 November 2019

For more detail on any of the items outlined in this summary, please find the full agenda and papers available online.

Chief executive update

- No board paper available

Reviewing 2019/20 performance

- HEE presented a paper to the board reporting on its financial position as of 30 September 2019.
  - Programme budgets are £2.1m overspent, and admin budgets are £0.1m overspent.
- HEE presented a paper to the board summarising its latest performance figures, and its position against key metrics.
  - Of the 54 high priority deliverables, three have been delivered, 45 are on track for delivery and six have been indicated to have potential challenges to delivery.
  - HEE note that by 2020, there will be a significant gap in demand for learning disability nurses and the available workforce. This is due to insufficient recruitment, increased attrition and increased demand within the private independent and voluntary sector.

Quality of Education and Training

- David Farrelly, Regional Director for Midlands and East, and Professor Wendy Reid, Director of Education and Quality, presented an update to the board on developing HEE's quality approach.
- In light of HEE's restructure to seven regions, each with a regional postgraduate dean, HEE's quality governance has been refreshed and the deans will have oversight of quality across learning environments.
- The results from last year's national pilot of the National Education and Training Survey (NETS) were also presented. HEE aim to develop the NETS to become a multi-professional source of insight and intelligence, which will support ICSs in their workforce planning, and aid their leverage of place-based funding for education and training.

Health careers

- The board was presented a paper on the Health Careers programme, highlighting its main areas of activity, setting out future development and longer term proposals.
- The paper outlined the health careers strategy and showed the importance of interventions to attract people into the NHS workforce, including young people, those looking to change career and people returning to work.

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/20/01/07**	
SUBJECT:	**Integrated Performance Report Dashboard**	
DATE OF MEETING:	29th January 2020	
AUTHOR(S):	Marie Garnett – Head of Contracts and Performance	
EXECUTIVE DIRECTOR SPONSOR:	Alex Crowe, Acting Medical Director Kimberley Salmon-Jamieson, Chief Nurse & Director of Infection Prevention & Control Michelle Cloney – Director of Human Resources & Organisational Development Andrea McGee - Director of Finance & Commercial Development Chris Evans - Chief Operating Officer	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future. SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.	x x x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	#115 Failure to provide adequate staffing levels in some specialities and wards. #134 (a) Failure to sustain financial viability. #134 (b) Failure to deliver the financial position and a surplus #224 Failure to meet the emergency access standard.	
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The Trust has 63 IPR indicators which have been RAG rated in December as follows: **Red: 20 (same as November)** **Amber: 11 (from 10 in November)** **Green: 32 (from 33 in November)** **Non RAG Rated: 0 (same as November)** Quality areas highlighted for improvement are Friends and Family Test for ED, Healthcare Acquired Infections for MRSA, Mixed Sex Accommodation Breaches, Incidents and Medication Safety. It should be noted that whilst the Friends and Family Test for ED has not met the Trust internal standard, the recommendation rate is comparable to other organisations across the Cheshire and Mersey footprint and an ED action plan is being monitored via the ED Improvement Committee.	

	The Mixed Sex Accommodation breaches are patients who are awaiting step down from the Intensive Care unit. Where appropriate, patients are cohorted within the unit to minimise the impact, however it is noted that patient feedback is consistently positive and environmental changes to create additional side rooms are being progressed. Open Incidents are monitored with progress tracked weekly via the Trust Meeting of Harm and though Trust Operational Board. Whilst there has been an increase noted, specifically within Integrated Medicine, Womens and Childrens and Urgent and Emergency Care, there is a proactive focus to ensure timely closure. The Governance team continues to support the CBUs by meeting weekly with the triumvirate. The implementation of ePMA and 7 day on ward pharmacy service was completed in December 2019. This will support an increase in pharmacy ward staffing levels leading to improvements in medicine reconciliation performance and prescribing, therefore improving patient safety. The remaining quality indicators are Green/Amber and are on track as a result of work plans that are monitored and aligned to each quality indicator to ensure continual improvement supported where necessary by Trust QI collaborative programmes. The Trust deficit for the period ending 31 December 2019 is £3.2m, which is £0.3m better than plan. The actual control total (excluding Provider Sustainability, Financial Recovery and Marginal Rate Emergency Tariff funding) is £15.1m deficit which is in line with plan. The Trust has received formal notification of the extension of working capital loans which were due to expire in 2019/20. These loans have been extended into 2020/21.

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

RECOMMENDATION:	The Trust Board is asked to: **1.** Note the contents of this report. **2.** Note the changes and approve the proposed changes to the 2019/20 capital programme.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.	

REPORT TO BOARD OF DIRECTORS

SUBJECT	Integrated Performance Report Dashboard	**AGENDA REF:**	BM/20/01/07

1. BACKGROUND/CONTEXT

The RAG rating for all 63 indicators from November 2018 to December 2019 is set out in **Appendix 1**. The Integrated Performance Dashboard (**Appendix 2**) has been produced to provide the Board with assurance in relation to the delivery of all KPIs across the following areas:

- Quality
- Access and Performance
- Workforce
- Finance Sustainability

2. KEY ELEMENTS

In month, there has been a movement in the RAG ratings outlined in **Table 1**:

Table 1: RAG Rating Movement

	November	December
Red	20	20
Amber	10	11
Green	33	32
Other	0	0
Total:	63	63

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

The dashboard has been refreshed to show improvement actions in addition to narrative. In order to incorporate this information, the descriptions of the indicators has been moved from the dashboard to **Appendix 3**.

Statistical Process Control (SPC) charts and narrative have been added to the IPR dashboard, **Appendix 4** contains further information on these charts.

Quality

Quality KPIs

There are 6 indicators rated Red in December, the same number as November.

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

- Incidents – there were 76 open incidents over 40 days old at the end of December, increased from 66 at the end of November against a target of 0.

- Healthcare Acquired Infections (MRSA) - there were 2 MRSA cases reported in August 2019, therefore this indicator will be Red for the remainder of the year. There were no MRSA cases reported in month.
- VTE – the Trust achieved an average of 90.59% in Q3 against a target of 95%.
- Medication Safety – 41.00% of patients had medicines reconciliation within 24 hours in December, increased from 39.00% in November against a target of 80.00%.
- Friends & Family Test (ED and UCC) – the Trust achieved 78.00% in December, an increase from November's position of 77.00%, against a target of 87.00%.
- Mixed Sex Accommodation Breaches (MSA) – there were 8 Mixed Sex Accommodation Breaches reported in December (all within critical care), decreased from 10 in November, against a target of 0. There is a zero tolerance threshold for this indicator.

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

- Continuity of Carer – the Trust achieved 28.50% in December, a decrease from 39.00% in November against a Trust target of 30.00%.

Access and Performance

Access and Performance KPIs

There are 6 Access and Performance indicators rated Red in December, the same number as November.

The 5 indicators which were Red in November and remain Red in December are as follows:

- A&E Waiting Times 4 hour national target – the Trust achieved 75.98% excluding walk ins in December, decreased from November's position of 77.79%, against a target of 95.00%.
- A&E Trajectory – the Trust did not meet the trajectory of 80.00% in December 2019.
- Ambulance Handovers 30>60 minutes – there were 209 patients who experienced a delayed handover in December, increased from 142 in November against a target of 0.
- Ambulance Handover at 60 minutes or more – there were 61 patients who experienced a delayed handover in December, increased from 41 in November against a target of 0.
- Discharge Summaries % sent within 24 hours – the Trust achieved 84.11% in December, decreased from 87.96% in November against a target of 95.00%.

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

- Cancer 62 days screening – the Trust achieved 66.67% for November's validated position, a decrease from October's validated position of 91.67% against a target of 90.00%.

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

- Super Stranded Patients – there were 92 super stranded patients at the end of December, decreased from 125 at the end of November against a trajectory of 95.

PEOPLE

Workforce KPIs

There are 4 indicators rated Red in December, the same number as November.

The 4 indicators which were Red in November and remain Red in December are as follows:

- Sickness Absence – the Trust's sickness absence rate was 6.19% in December, increased from 5.95% in November against a target of less than 4.20%.
- Bank/Agency Reliance – the Trust reliance was 11.40% in December, decreased from 12.13% in November against a target of less than 9%.
- Monthly Pay Spend – was £16.1m in December against a budget of £15.9m.
- Agency Shifts Compliant with the Cap – 37.73% of shifts were compliant with the Cap in December, a slight increase from 37.66% in November, against a target of over 49%.

SUSTAINABILITY

Finance and Sustainability KPIs

There are 4 indicators rated Red in December, the same number as November.

The 4 indicators which were Red in November and remain Red in December are as follows:

- Capital Programme – the actual spend is £5.4m (55%) which is £4.4m below the planned spend of £9.8m. This is due to an under spend against the Kendrick Wing Fire Scheme, Estates and Medical Equipment schemes.
- Better Payment Practice Code (BPPC) – the challenging cash position results in a year to date performance of 40% which is below the national standard of 95%.
- Agency Spending – the actual spend to date is £7.8m which is £0.6m (8%) above the £7.2m ceiling.
- CIP Recurrent Savings – the forecast recurrent savings are £3.1m (41%) which is £4.4m below the £7.5m target. This presents a risk of £1.3m to the 2020/21 financial plan which estimated recurrent delivery of £4.4m.

The Income, Activity Summary and Use of Resources Rating Statement as presented to the Finance and Sustainability Committee is attached in **Appendix 5**.

The Trust has signed up to a break even control total. The Trust is currently achieving plan however the current mitigated forecast is £2.9m variance from plan. Key risks are CIP delivery, remaining cost pressures within diagnostics and medical staffing, agency usage and

winter capacity costs. The Trust is working with system partners on a system recovery plan and has been reporting progress to NHSE/I. Should the plan not be delivered, the PSF and FRF of c£6.0m (for Q4) is at risk, as achievement is based upon delivery of the plan each quarter. An adverse variance from plan may mean the Trust would need to request a loan. Further mitigations are therefore required.

The Trust has received formal notification of the extension of working capital loans which were due to expire in 2019/20. These loans have been extended into 2020/21.

Capital Programme

On 15 October 2019, NHSI/E notified all Trusts that additional national funding was available to replace imaging equipment that was 10 years old (or older) on 31 March 2019. The funding is available to replace any CT scanner, MRI scanner and mammography equipment. The Trust has secured funding for 2 Breast Symptomatic machines at a cost of £0.6m. In addition, the Trust has secured a CT scanner at a cost of £0.9m (excluding turnkey costs). The Trust has appealed through a process with NHSE/I as there is a shortfall in funding received for the CT scanner of £0.5m.

The Diagnostics funding of c£1.0m increases the 2019/20 capital programme to £14.6m.

The funding set aside in the 2019/20 capital programme for the CT scanner was £1.0m, once the funding shortfall of £0.4m and the turnkey costs of £0.07m have been covered, there is £0.6m available to support additional schemes.

The proposed changes and emergency approvals to the capital programme in month are summarised in Table 2.

Table 2: Proposed changes (including schemes approved as an emergency) to the 2019/20 capital programme.

Scheme	Value £000
Additional Funding Required	
Additional costs of theatre equipment for ASCA accreditation (1)	59
Ward B3 Nurse Call system (1)	60
Substation C Roof Leak (1)	16
Intensive Care Unit CCTV (1)	6
Ward C21/22 Medical Gas Alarm Panel (1)	8
Croft Wing Doors (1)	8
IFRS 16 Software (1)	9
CT Scanner – Turnkey (1)	68
CT Scanner - Electrical Works (1)	10
Breast Symptomatic Machines (2)	535
Audiology Software	35
Increase in contingency (balance from CT scanner less items above)	224

Sub total	**1,038**
Funded by	
Public Dividend Capital Funding	1,038
Sub total	**1,038**
Total	**0**

(1) Emergency approval by the Director of Finance & Commercial Development.
(2) Funded by Public Dividend Capital.

The remaining contingency available to support the Trust in Quarter 4 is £0.4m. The latest forecast position is a underspend of £0.8m.

To date the planned spend is £9.8m and the actual spend is £5.4m. This is a £4.4m under spend that is due to a combination of under spend across all areas but mainly the Kendrick Wing Fire scheme.

There are further proposed changes to the capital programme as the Trust may receive external support for the shortfall in funding of the CT scanner scheme and the opening of an additional 18 beds across the Trust resulting from the closure of Ward K25.

- CT scanner - NHSI/E will consider an increase in funding to partially or fully cover the funding shortfall. It is assumed that additional funding of at least £0.3m will be received which will increase the funding to £0.7m, which is the average funding allocated to Trusts for a CT scanner.
- 18 additional beds - a bid to cover the capital and revenue costs of opening these beds has been submitted to NHSI/E. The capital costs associated with opening these beds is £0.2m.

This £0.5m increase in funding and the forecast underspend of circa £0.8m results in additional resources available of c£1.3m. It is proposed that if the additional funding is secured the schemes in Table 3 are approved:

Table 3: Further potential changes to the 19/20 capital programme.

Scheme	**Value £000**
Emergency Schemes approved post 1st January 2020	
Bladder Scanner	9
Ultrasound Machine	50
Sub total	**59**
Schemes that will need to be completed	
Decommissioning of Ward K25 (1)	180
Opening of an additional 18 beds across the Trust	203
Patient Stretchers (Ophthalmology)	20
Reception Desk (Ophthalmology)	10
Sub total	**413**
Proposed schemes	
ESX Physical servers (2)	240
VDI Resilience – Disaster Recovery (2)	210
Sub total	**450**
Total	**922**

(1) The claim submitted to insurers for the Kendrick Wing Fire includes the decommissioning costs of Ward K25.
(2) These are schemes that are currently included in the proposed 2020/21 capital programme and are considered critical for business continuity purposes. If these schemes can be completed in 2019/20, the funding will be available to support other schemes in 2020/21.

The proposal outlined in Table 3 would leave a contingency of £0.4m.

Should the additional £0.5m funding not be provided, the business critical schemes would remain on the 2020/21 capital programme.

The Board is requested to note the changes and approve the proposed changes to the 2019/20 capital programme.

An updated capital programme is attached in **Appendix 6**.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

The KPI's that are underperforming are managed in line with the Trust's Performance Assurance Framework.

4. ASSURANCE COMMITTEE

The following committees provide assurance to the Trust Board:

- Finance and Sustainability Committee
- Audit Committee
- Quality & Assurance Committee
- Trust Operational Board
- Strategic People Committee
- KPI Sub-Committee

5. RECOMMENDATIONS

The Trust Board is asked to:

1. Note the contents of this report.
2. Note the changes and approve the proposed changes to the 2019/20 capital programme.

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Appendix 1 – KPI RAG Rating January 2019 – December 2019

	KPI	Performance Improvement Direction	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sept 19	Oct 19	Nov 19	Dec 19
	QUALITY													
1	Incidents	↓ (Incidents over 40 days old)	↓	↓	↓	↑	↑	↑	↑	↑	↓	↑	↑	↑
2	CAS Alerts	↓ (Alerts not actioned in time - 0)	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
3	Duty of Candour	↓ (In month compliance)	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
4	Adult Safety Thermometer	↑ (In month compliance)	↓	↓	↑	↔	↑	↓	↑	↓	↑	↓	↑	↑
5	Children Safety Thermometer	↑ (In month compliance)	↓	↑	↔	↓	↑	↔	↔	↔	↓	↑	↔	↔
6	Maternity Safety Thermometer	↑ (In month compliance)	↓	↑	↓	↓	↑	↓	↑	↓	↑	↓	↑	↓
7	Healthcare Acquired Infections - MSRA	↓ (MRSA cases in month)	↓	↔	↔	↔	↔	↔	↔	↑	↔	↔	↔	↔
8	Healthcare Acquired Infections – Cdiff	↓ (Cdiff cases in month)	↑	↓	↑	↔	↓	↑	↔	↑	↓	↑	↓	↓
9	Healthcare Acquired Infections – Gram Neg	↓ (Gram Neg cases in month)	↑	↓	↓	↑	↑	↓	↓	↓	↑	↓	↑	↓
10	VTE Assessment		↑	↓	↑	↓	↓	↓	↑	↑	↓	↑	↑	↓
11	Total Inpatient Falls & Harm Levels	↓ (No. of inpatient falls in month)	↓	↓	↑	↓	↓	↓	↓	↑	↑	↓	↑	↑
12	Pressure Ulcers	↓ (No. of pressure ulcers in month)	↑	↓	↑	↑	↓	↑	↔	↓	↑	↑	↑	↓
13	Medication Safety	↓ (Medicines reconciliation within 24 hours)					↓	↑	↑	↑	↔	↑	↑	↑
14	Staffing – Average Fill Rate	↑ (% staffing fill rates in month)	↑	↓	↓	↑	↑	↑	↓	↓	↑	↑	↓	↓
15	Staffing – Care Hours Per Patient Day						↔	↓	↔	↓	↑	↑	↑	↑
16	Mortality ratio - HSMR	(Based on Ratio)	↓	↑	↓	↓	↑	↓	↑	↓	↔	↓	↑	↑
17	Mortality ratio - SHMI	(Based on Ratio)	↑	↓	↑	↓	↑	↔	↑	↔	↔	↓	↓	↑
18	NICE Compliance	↑ (compliance in month)	↓	↑	↑	↓	↑	↓	↑	↑	↓	↑	↓	↓
19	Complaints													
20	Friends & Family – Inpatients & Day cases	↑ (% recommending the Trust)	↓	↑	↔	↓	↑	↔	↓	↑	↑	↓	↑	↔
21	Friends & Family – ED and UCC	↑ (% recommending the Trust)	↓	↑	↑	↑	↑	↓	↔	↑	↓	↔	↓	↑
22	Mixed Sex Accommodation Breaches	↓ (Number of breaches)	↑	↓	↓		↓	↑	↓	↑	↓	↑	↑	↓
23	Continuity of Carer	↑						↓	↑	↑	↓	↑	↑	↓
24	CQC Insight Indicator Composite Score	↑ (Trust Score)	↓	↔	↔	↔	↔	↔	↔	↔	↑	↔	↔	↔

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 1 – KPI RAG Rating January 2019 – December 2019

	ACCESS & PERFORMANCE													
25	Diagnostic Waiting Times 6 Weeks	↑ (% Monthly Performance)	↑	↑	↔	↔	↓	↑	↑	↑	↓	↑	↑	↓
26	RTT - Open Pathways	↑ (% Monthly Performance)	↑	↓	↓	↓	↑	↓	↑	↓	↑	↑	↑	↓
27	RTT – Number Of Patients Waiting 52+ Weeks	↔ (Number of breaches – 0)	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
28	A&E Waiting Times – National Target	↑ (% Monthly Performance)	↓	↑	↑	↓	↑	↑	↑	↑	↓	↓	↓	↓
29	A&E Waiting Times – STP Trajectory	↑ (% Trajectory Performance)	↓	↑	↑	↓	↑	↑	↑	↑	↓	↓	↓	↓
30	A&E Waiting Times – Over 12 Hours	↓				↔	↔	↔	↔	↔	↔	↔	↔	↔
31	Cancer 14 Days*	↑ (% Monthly Performance)	↓	↓	↑	↓	↓	↑	↓	↑				
32	Breast Symptoms 14 Days*	↑ (% Monthly Performance)	↑	↑	↓	↓	↑	↑	↓	↓				
33	Cancer 31 Days First Treatment*	↑ (% Monthly Performance)	↔	↔	↔	↓	↑	↓	↑	↑	↑	↓	↑	↑
34	Cancer 31 Days Subsequent Surgery*	↑ (% Monthly Performance)	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
35	Cancer 31 Days Subsequent Drug*	↑ (% Monthly Performance)	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
36	Cancer 62 Days Urgent*	↑ (% Monthly Performance)	↓	↑	↓	↔	↑	↓	↓	↓	↓	↑	↑	↑
37	Cancer 62 Days Screening*	↑ (% Monthly Performance)	↑	↓	↑	↓	↑	↑	↓	↑	↓	↑	↓	↓
38	Ambulance Handovers 30 to <60 minutes	↓ (Number of patients)	↓	↓	↓	↑	↓	↑	↑	↓	↓	↑	↑	↑
39	Ambulance Handovers at 60 minutes or more	↓ (Number of patients)	↓	↓	↓	↓	↓	↑	↓	↓	↑	↓	↑	↑
40	Discharge Summaries - % sent within 24hrs	↓ (% Monthly Performance)	↑	↑	↓	↑	↓	↑	↑	↓	↓	↑	↓	↓
41	Discharge Summaries – Number NOT sent within 7 days	↔ (Number of patients)	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
42	Cancelled Operations on the day for a non-clinical reasons	↓ (Number of Cancellations)				↔	↓	↓	↑	↓	↑	↓	↓	↓
43	Cancelled Operations– Not offered a date for readmission within 28 days	↓ (Number of Cancellations – not rebooked))	↑	↓	↔	↑	↔	↔	↑	↓	↓	↔	↔	↔
44	Urgent Operations – Cancelled for a 2nd time	↓				↔	↔	↔	↔	↔	↔	↔	↔	↔
45	Super Stranded Patients	↓ (Number of patients)	↓	↑	↑	↓	↔	↓	↑	↑	↑	↓	↑	↓

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Appendix 1 – KPI RAG Rating January 2019 – December 2019

	KPI		Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sept 19	Oct 19	Nov 19	Dec 19
	WORKFORCE													
46	Sickness Absence	↓ (% Monthly Performance)	↑	↓	↓	↓	↓	↑	↑	↓	↓	↑	↑	↑
47	Return to Work	↑ (% Monthly Performance)	↓	↓	↓	↓	↓	↓	↑	↓	↓	↓	↓	↓
48	Recruitment	↓ (Average Number of Days)	↑	↓	↓	↓	↓	↓	↑	↑	↓	↔	↓	↑
49	Vacancy Rates	↓ (% vacancy Rate)				↓	↓	↓	↑	↓	↓	↓	↓	↓
50	Retention	↑ (% staff retention)				↑	↓	↑	↑	↑	↑	↑	↑	↓
51	Turnover	↓ (% staff turnover)	↓	↑	↓	↑	↑	↑	↑	↓	↓	↑	↓	↑
52	Bank & Agency Reliance	↓ (% reliance on bank/agency)				↓	↑	↑	↓	↑	↓	↓	↓	↓
53	Agency Shifts Compliant with the Cap	↑ (% compliant agency shifts)				↑	↓	↓	↓	↑	↓	↓	↓	↑
54	Monthly Pay Spend (Contracted & Non-Contracted)	↓ (% of budget spent)	↓	↓	↑	↓	↓	↓	↑	↓	↓	↑	↓	↓
55	Core/Mandatory Training	↑ (% Monthly Performance)	↓	↓	↓	↑	↑	↓	↑	↓	↓	↑	↑	↓
56	PDR	↑ (% Monthly Performance)	↑	↓	↑	↓	↓	↑	↓	↓	↑	↑	↑	↓
	FINANCE													
57	Financial Position	↑ (Cumulative against plan)	↓	↑	↑	↑	↓	↓	↓	↓	↓	↓	↓	↑
58	Cash Balance	↑ (Balance against plan)	↔	↔	↔	↔	↑	↑	↑	↓	↓	↓	↑	↑
59	Capital Programme	↑ (Performance against plan)	↓	↓	↓	↑	↓	↑	↓	↓	↓	↓	↓	↓
60	Better Payment Practice Code	↑ (Monthly actual against plan)	↑	↓	↓	↑	↑	↓	↓	↑	↑	↑	↓	↑
61	Use of Resources Rating	↑ (Rating against plan)	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
62	Agency Spending	↓ (Monthly planned vs actual)	↓	↑	↑	↑	↓	↔	↑	↓	↓	↑	↓	↓
63	Cost Improvement Programme – Performance to date	↑ (Monthly vs target)	↓	↓	↔	↔	↑	↑	↑	↑	↑	↑	↓	↓
64	Cost Improvement Programme – Plans in Progress (In Year)	↑ (Monthly vs plan)	↓	↓	↔	↔	↔	↔	↑	↑	↑	↑	↑	↑
65	Cost Improvement Programme – Plans in Progress (Recurrent)	↑ (Forecast)				↑	↑	↑	↑	↓	↓	↓	↓	↓

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

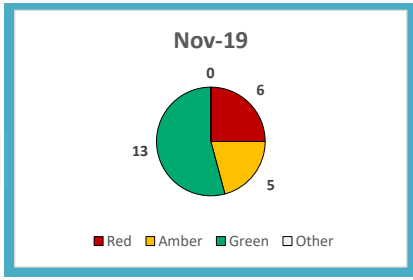
Warrington and Halton Teaching Hospitals NHS Foundation Trust

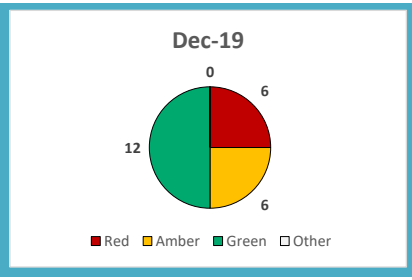
Integrated Dashboard - December 2019

Appendix 2

Key Points/Actions

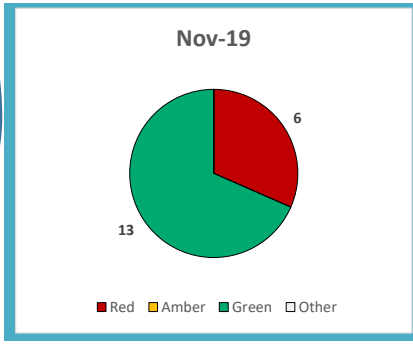
Quality Improvement

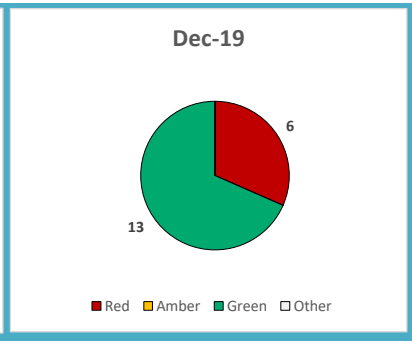




There are 405 open incidents that required review and sign off. Compliance in month in relation to Duty of Candour remains 100%. All thresholds in the 3 categories of the Safety Thermometer have been achieved. The Trust is above trajectory for MRSA having 2 YTD against a target of 0 and is performing within targets for; CDI 36 against a target of 44 in year; E-Coli 39 against a target of 47 in year. The Trust has had a total of 52 category 2 & 3 pressure ulcers YTD. There were 8 mixed sex accommodation breaches in December.

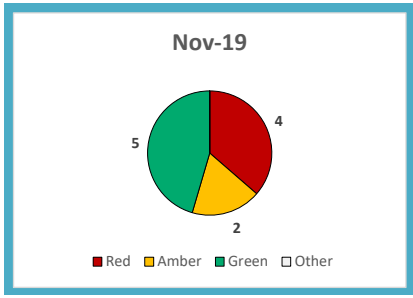
Access & Performance

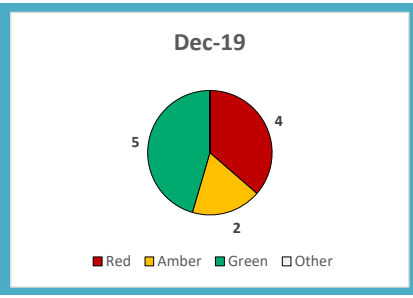




In December 2019, 13 out of the 19 indicators were RAG rated as Green. The Trust has continued to achieve the RTT and the 6 week diagnostic standards in month. The Trust did not meet the 4 hour A&E standard or the improvement trajectory in month which reflects the regional and national position. The number of ambulance handover delays remains challenging with an increase in month due to the high demand in A&E. Cancer 62 day screening was not met in month, this was in relation to one breach due to a late referral from another Trust. All other cancer standards were met (based on the November 2019 position). Discharge summaries sent within 24 hours continues to be challenging, and work continues to improve this position. The number of cancelled operations remains low at 0.24% with no cancellations not rebooked within 28 days and no urgent operations cancelled for a 2nd time. The number of super stranded patients has reduced to 92 as at the end of December.

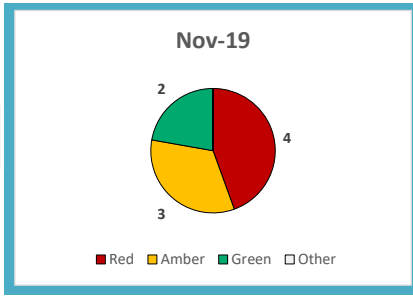
Workforce

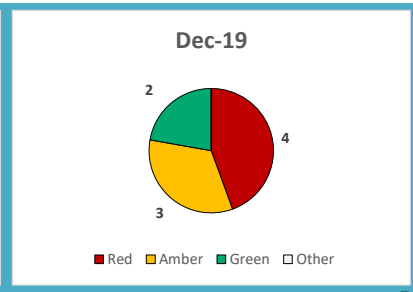




Trust sickness absence in month was 6.19%, several programmes are underway to address this. Return to work compliance was 76.12%; timeliness of completion is being addressed. Recruitment timeframes over the 12 month rolling period are on average 63 days. Turnover at 10.99% and Retention at 88.53% remain positive. Vacancy rates remain below target (positive) at 8.84%. Bank and Agency reliance has reduced, however is still above target at 11.40%. Core Skills Training compliance continues to be positive at 88.67%. PDR compliance is below the target in month at 74.57%. Agency shift compliance pay cap is at 37.73%. Pay spend was £0.25m above budget at £16.1m.

Finance





In month, the Trust recorded a deficit of £0.8m which results in a year to date deficit to £3.2m which is £0.3m better than plan. The year to date control total (excluding Provider Sustainability, Financial Recovery and Marginal Rate Emergency tariff funding) is a £15.1m deficit which is in line with plan. Year to date income is £4.9m above plan, expenditure is £4.7m above plan and non operating expenses are £0.1m better than plan. Capital spend is £5.4m which is £4.4m below the planned capital spend of £9.8m. Annual saving schemes identified are £6.9m which is £0.6m below the £7.5m annual target and to date savings achieved are £4.8m which is £1.6m above the planned savings. However the recurrent CIP is £3.1m which is below the estimate in the 2020/21 plan by £1.3m. Due to the historic and current operating position the cash balance remains challenging and at month end the cash balance is £3.4m which is £2.2m better than plan. The year to date performance against the Better Payment Practice Code is 40% which is lower than the 95% target. The Trust has recorded a Use of Resources Rating of 3.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:

Single Oversight Framework

Care Quality Commission

Trust Strategy

Quality Improvement - Trust Position

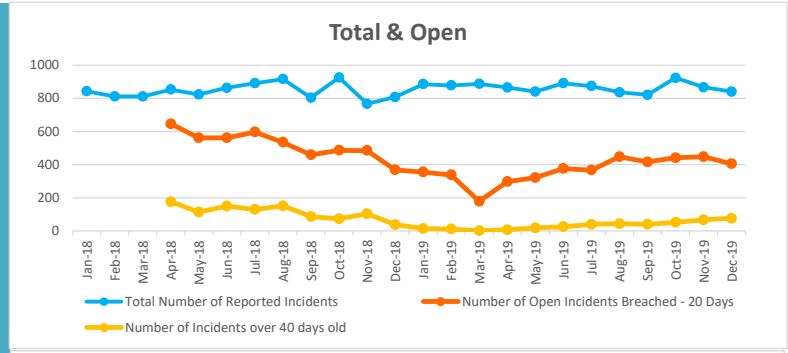
Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?

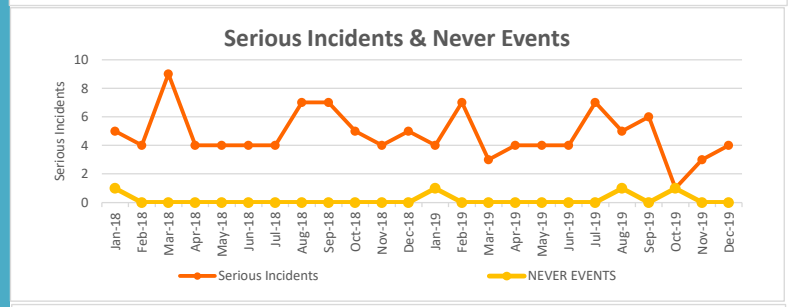
Patient Safety

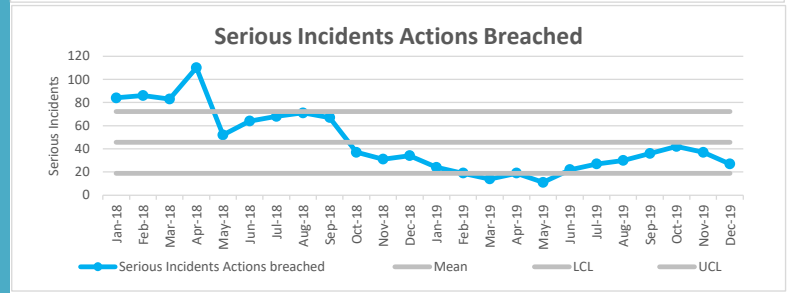
Incidents

Red: Open incidents outside 40 day timeframe
Amber: Open incidents between 20 - 40 days old.
Green: Open incident within timeframe of 20 days.

There were 76 incidents over 40 days old open in December 2019.
There were 4 Serious Incidents and 0 Never Events Reported in December 2019.







There were 4 Serious Incidents reported in December 2019. Whilst the Trust has seen marked improvement over the past 12 months, actions and incidents continue to be a focus to ensure that they are reviewed and completed in a timely manner. This improvement has been driven by scrutiny at Patient Safety & Clinical Effectiveness Sub Committee, Trust Operational Board and the weekly Meeting of Harm.

The Trust 'Reporting to Improve' campaign continues with over 200 managers now trained on the use of Datix for incident reviewing. Training and support will continue as required.

Concise RCA investigations are now reviewed and signed off at the Weekly Executive Meeting of Harm in line with the approach for Serious Incident Investigations.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

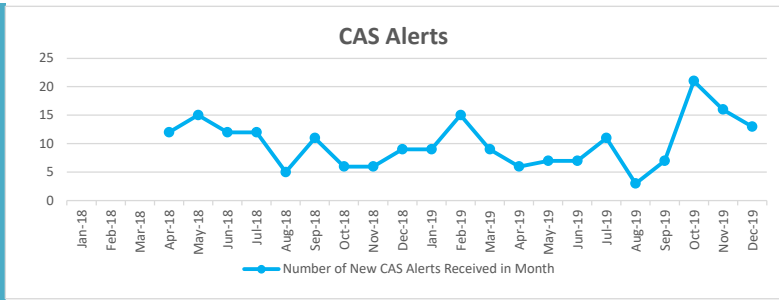
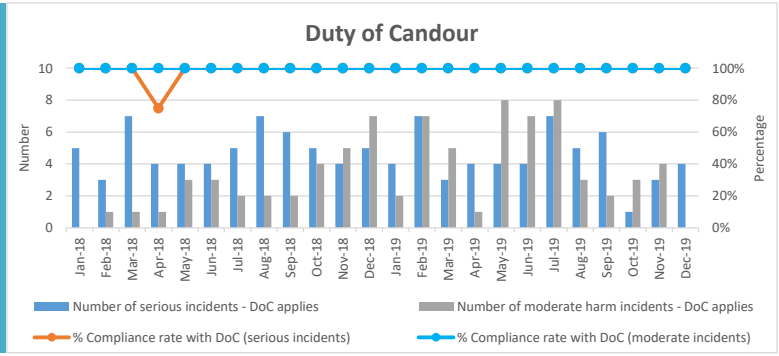
Key:

Single Oversight Framework

Care Quality Commission

Trust Strategy

Quality Improvement - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
CAS Alerts - Green - All relevant CAS Alerts actioned within timescales Red - Applicable CAS Alert not actioned within the timescale.	CQC There were 13 new CAS Alerts received in month. There were no CAS alert actions which breached the timescale in month.		The Trust received 13 CAS alerts in month with no breaches.	There is ongoing monitoring and oversight at the Health and Safety and Patient Safety and Effectiveness Sub Committees in relation to CAS alerts.
Duty of Candour Red: <100% Green: 100%	CQC The Trust achieved 100% for Duty of Candour in month.		Compliance with Duty of Candour remains in line with Trust policy and continues to be supported through monitoring via the Datix system with oversight by the clinical governance department in relation to all correspondence/contact. National Trajectory: The Trust is performing in line with the national trajectory of being 100% compliant.	There is weekly scrutiny and monitoring in place with the Deputy Director of Governance and Quality.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:

Single Oversight Framework

Care Quality Commission

Trust Strategy

Quality Improvement - Trust Position

Childrens Safety Thermometer

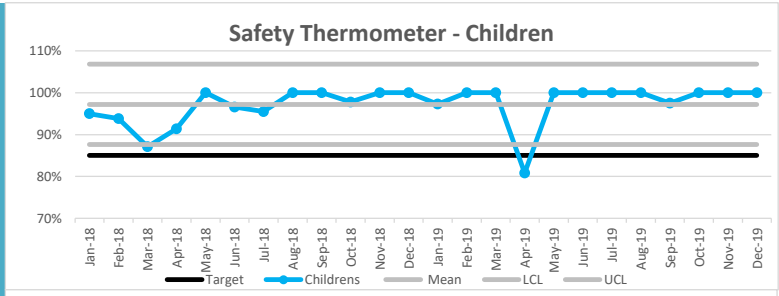
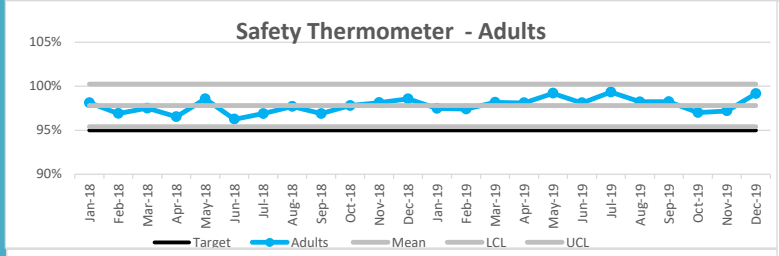
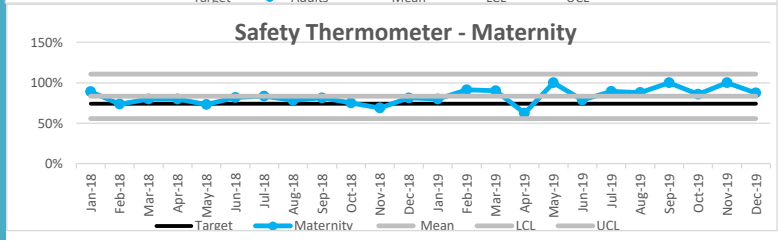
Red: Less than 80%
Amber: 81% to 84%
Green: 85% or more

Adult Safety Thermometer

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

Maternity Safety Thermometer

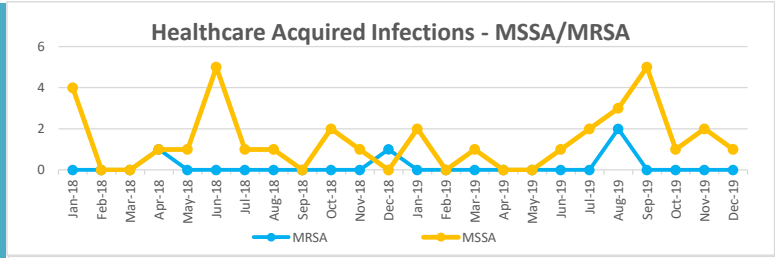
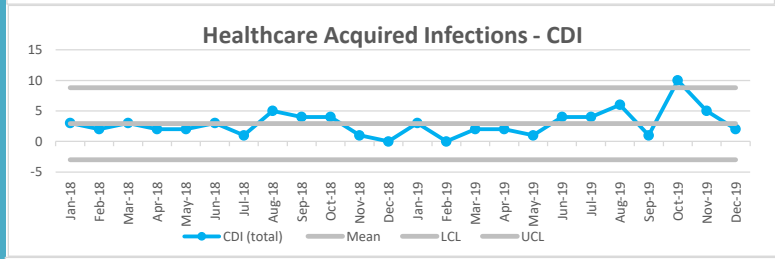
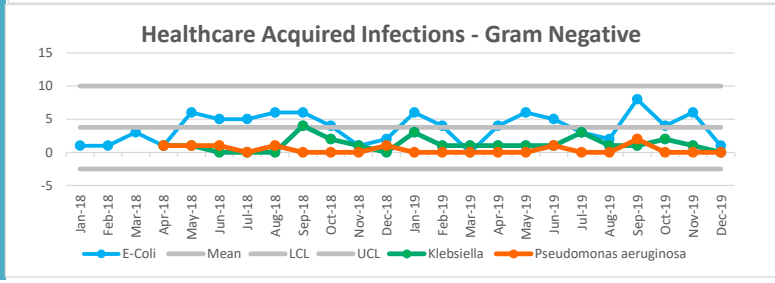
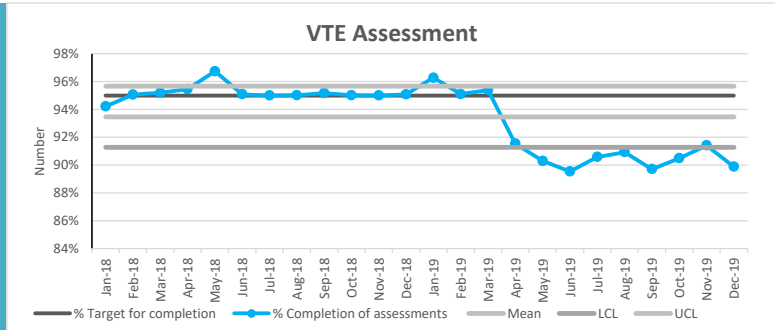
Red: Less than 70%
Amber: 70% to 73%
Green: 74% or more

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
The Trust achieved the following results for Safety Thermometer in month; **Adult - 99.17%** **Children's – 100%** **Maternity – 87.5%** **SPC - These indicators are within common cause (expected) variation.**	  	**All areas of the Safety Thermometer are above the threshold.** **Adult - 99.17% (95% threshold)** **Children's – 100% (85% threshold)** **Maternity – 87.5% (74% threshold)** **National Trajectory: All areas of the safety thermometer are performing above the national trajectories.** **Adult - 4.17% above threshold** **Children's – 15% above threshold** **Maternity – 13.5% above threshold**	**There is ongoing monitoring and oversight at the Health and Safety and Patient Safety and Effectiveness Sub Committees.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Quality Improvement - Trust Position

Key:
Single Oversight Framework (SOF)
Care Quality Commission (CQC)
Trust Strategy (S)

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Healthcare Acquired Infections **MRSA** **Red: 1 or more** **Green: 0** **Healthcare Acquired Infections** **C-Difficile** **Red: 44+ per annum** **Green: Less than 44 per annum** **Healthcare Acquired Infections - Gram Negative** **E-Coli** **Red: 47+ per annum** **Green: Less than 47 per annum**	CQC SOF S **April - December 2019** **Zero tolerance to avoidable MRSA bacteraemia cases - 2 cases YTD/1 avoidable.** **15 MSSA bacteraemia cases YTD** **36 C. difficile cases include community onset/healthcare associated and hospital onset cases YTD** **39 E. coli bacteraemia cases reported YTD.** **11 Klebsiella bacteraemia cases YTD.** **3 P. aeruginosa bacteraemia cases YTD.** **No targets set for MSSA; Klebsiella, P. aeruginosa bacteraemia cases.**	  	**National Trajectory: The Trust is above trajectory for MRSA having 2 cases YTD against a target of 0. The Trust is performing within target for other areas, CDI 36 against a target of 44 in year; E-Coli 39 against a target of 47 in year. There are no targets set for MSSA; Klebsiella, P. aeruginosa bacteraemia cases.**	**Focus areas include urinary catheter care and ANTT training; patient hand hygiene and hydration. Education on the UTI pathway is underway, this is linked to the CQUIN which is reviewing antimicrobial resistance in lower UTIs. The Trust has joined an AQuA collaborative for GNBSI reduction and wards A4, A8, B14 and HICU have been selected for phase 1 of the QI collaborative.**
VTE Assessment **Red: <95%** **Green: 95% or above based on previous months' figures due to timescales for validation of data**	SOF S **The Trust achieved 90.59% for VTE assessments on average in Q3 2019.**		**The Trust achieved 90.59% for VTE assessments on average in Q3 2019. National Trajectory: The Trust is 4.41% below the 95% target for VTE. From October to March 2020, the Trust has aligned the VTE audit process with the GIRFT framework for further oversight on quality.**	**Focussed work with clinical teams to improve compliance with the VTE electronic risk assessment processes in operation. Escalation supported by the Deputy Medical Director is now in place to ensure ongoing actions are completed.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

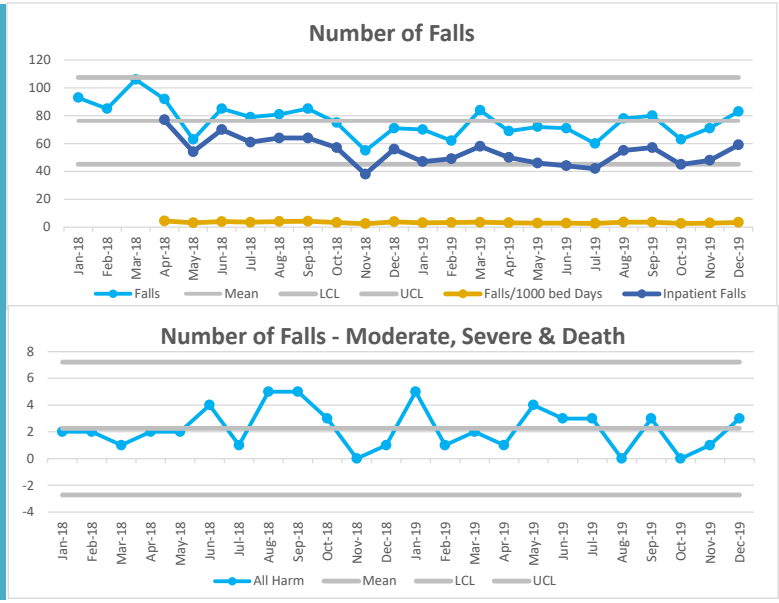
Key:

Single Oversight Framework SOF

Care Quality Commission CQC

Trust Strategy S

Quality Improvement - Trust Position

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Total number of Inpatient Falls & harm levels **Red: <10% decrease from 18/19** **Amber: 10-19% decrease from 18/19** **Green 20% or more decrease from 18/19**		**There were a total of 83 falls in the month; of which 59 were inpatient falls. SPC - Falls are within common cause (expected) variation.**	**There were a total of 83 falls in the month; of which 59 were inpatient falls. Of the remaining 24 falls in the month; 5 were staff falls, 16 occurred in other clinical and community settings, and 3 were visitor falls** **Internal Variance Plan: A reduction of 24.15% is noted for inpatient falls as of December 2019 compared with the same reporting period in 2018/19.**	**A Quality Improvement collaborative project continues with clinical areas of focus and nominated leads identified. There is a CQUIN relating to Falls which is underway. Innovation walk arounds are underway with progress reported through the Trust Falls Steering Group which is overseen by the Patient Safety and Clinical Effectiveness Sub Committee.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:

Single Oversight Framework

Care Quality Commission

Trust Strategy

Quality Improvement - Trust Position

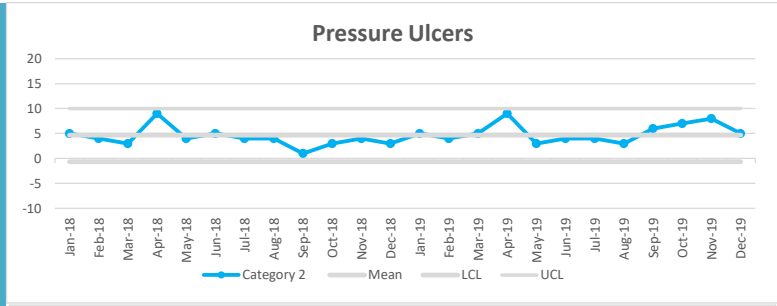
Trust Performance

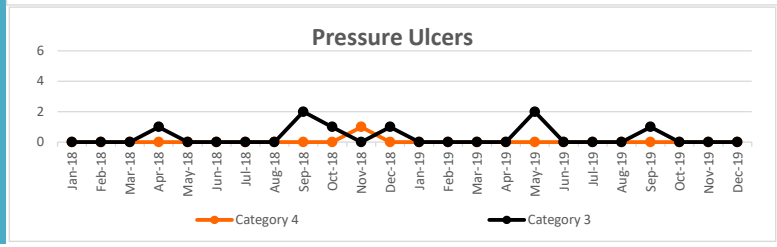
Pressure Ulcers
Based on 57 in 2018/19
Red: 4% reduction or below
Amber: 5%-9% reduction
Green: 10% reduction or above.

Trend

CQC

There were 0 hospital acquired Category 4 pressure ulcers, 0 Category 3 pressure ulcers and 5 Category 2 pressure ulcers reported in month.
SPC - Pressure ulcers are within common cause (expected) variation.





What are the reasons for the variation and what is the impact?

There is evidence of variation in accuracy of risk assessments and ongoing monitoring in change of patients condition.
Internal Variance Plan: The Trust has had a total on 52 category 2 & 3 pressure ulcers YTD.

How are we going to improve the position (Short & Long Term)?

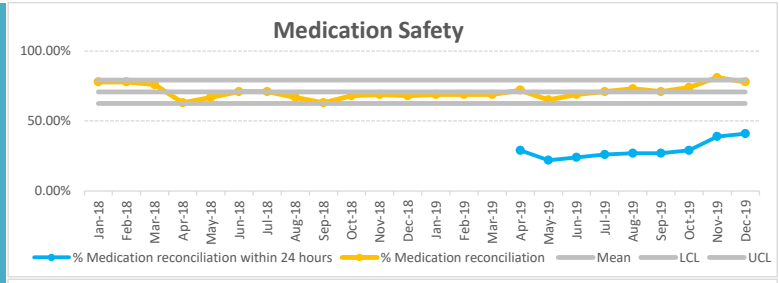
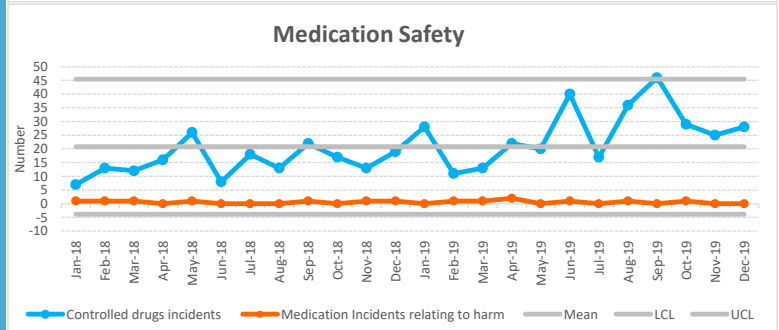
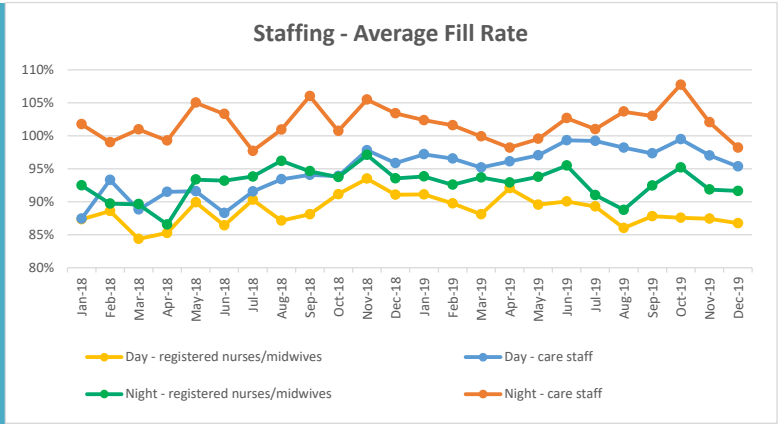
The Quality Improvement collaborative work is ongoing with good progress being made in areas of innovation. Tests of change have commenced and innovation walk arounds are underway, updates are reported through the Trust Tissue Viability Steering Group which is overseen by the Patient Safety and Effectiveness Sub Committee.

There have been instances where there has been a delay in obtaining or upgrading pressure relieving mattresses. Pressure ulcer prevention face to face training continues with additional training in the clinical areas where necessary.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:
Single Oversight Framework
Care Quality Commission
Trust Strategy

Quality Improvement - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Medication Safety Reconciliation within 24 hours Red: below 60% Amber: 60% - 79% Green: 80% or above	Medication Reconciliation within 24hrs was 41% in December 2019. There were 0 incidents of harm relating to medication safety in month.	 	Medicines Reconciliation has increased to 41%. Internal Variance Plan: The Trust is below the 80% target (set by the Trust), achieving 41% in month.	A Saturday on ward pharmacist and technician service was introduced on 07/12/2019. There has been modest improvement in Medicines Reconciliation due to: 1. Increase in dispensary activity and the need to return staff to the dispensary in the late afternoon. A review of dispensary staffing needs is underway. 2. The impact of the Christmas & New Year bank holidays, estimated to have impacted reconciliation by 1%. 3. ePMA: Time pressures on Pharmacy staff who are continuing to support prescribers with ePMA. The Pharmacy team is working with IM&T to optimise use of the system. 4. Service to ED on Mondays and Fridays launched on 06/01/2020. It is anticipated by April 2020, the Trust will achieve 55% medicines reconciliation within 24 hours.
Staffing - Average Fill Rate Red: 0-79% Amber: 80-89% Green: 90-100%	In month the average staffing fill rates were: Day (Nurses/Mwife) 86.74% Day (Care Staff) 95.36% Night (Nurses/Mwife) 91.65% Night (Care Staff) 98.19%		The Trust is achieving over 95% for Care Staff, both Day and Night. Nurses and Midwives for Day and Night is consistently over 85%. National Trajectory: The Trust is above trajectory for all areas except Staffing fill rates for Day (Nurses / Midwives) which was 3.26% below trajectory. Any individual ward that falls below 90% provides mitigation to ensure it is safe and that high quality care is consistently delivered in those areas.	The Trust continues to make progress in the Trust wide Recruitment and Retention Strategy which will improve the positon further.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:

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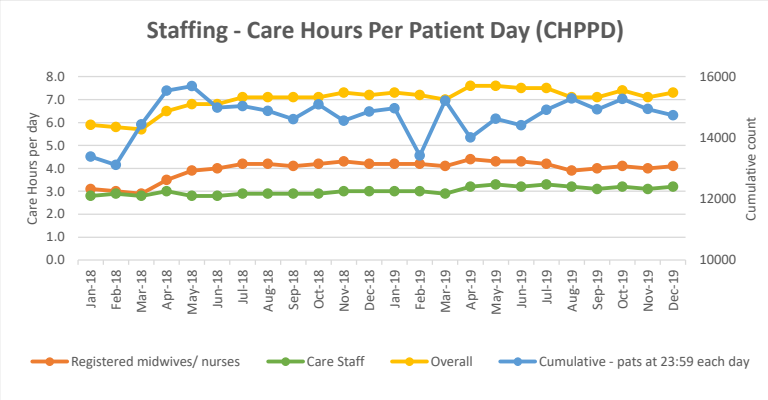
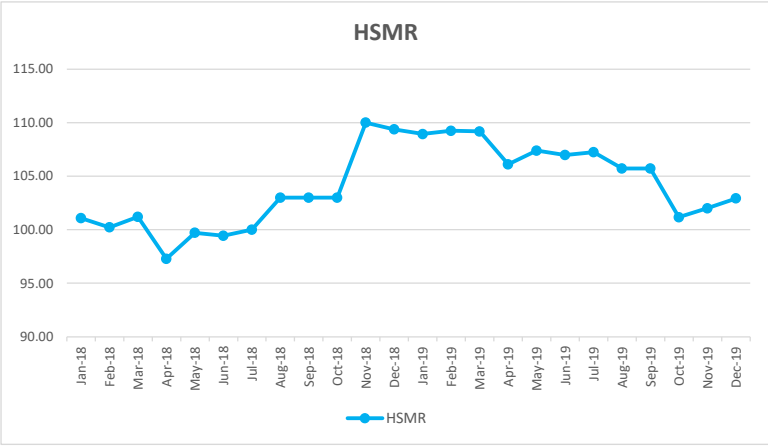
Staffing - Care Hours Per Patient Day (CHPPD) Red: Below 6.0 Amber: 6.0 - 7.8 Green: 7.9 or More	In month, the average CHPPD were: Nurse/Midwife: 4.1 hours Care Staff: 3.2 hours Overall: 7.3 hours		The overall Trust CHPPD has increased by 0.2 to 7.3. National Trajectory: The Trust is 0.6 behind the national target of 7.9 for CHPPD. This continues to be monitored monthly by the Senior Nursing Team.	Ward staffing levels continue to be systematically reviewed, which includes Planned vs Actual staffing levels. These are reported monthly as part of the Unify submission and any ward that falls below 90% provides mitigation to ensure safe, high quality care is consistently being delivered in those areas.
Mortality ratio - HSMR Red: Greater than expected Green: As or under expected	The HSMR ratio in month was 102.92		The most recent HSMR/SHMI ratios are within the expected range. Work continues at Mortality Review Group to undertake deep dives and the continuation of Structured Judgement Reviews. National Trajectory: The Trust is within the expected range for HSMR and is currently at 102.92.	The Ward Round Accreditation will review the quality of documentation which impacts on these results. Focussed reviews have been completed where the Trust is an outlier. Work in relation to improving coding, working diagnosis and finished consultant episodes, all of which impact on the mortality data, are underway.

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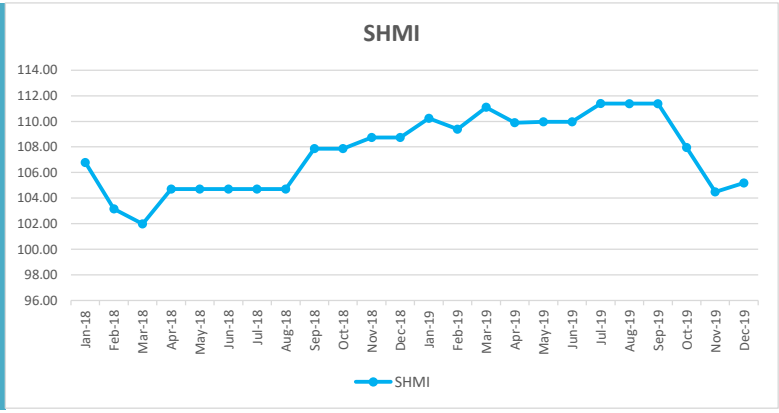
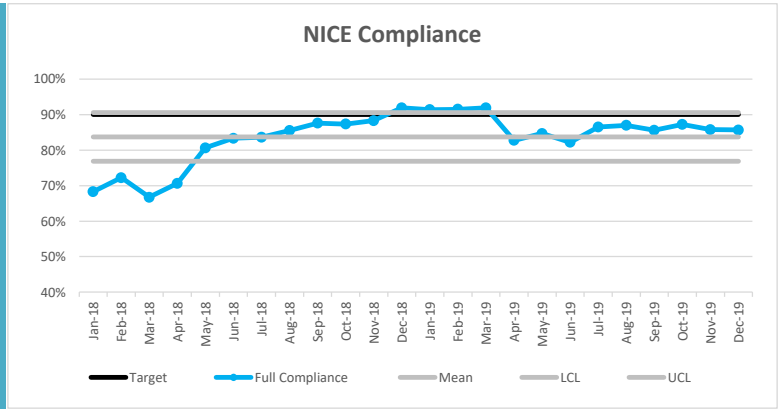
Mortality ratio - SHMI **Red: Greater than expected** **Green: As or under expected**	SOF CQC **The SHMI ratio in month was 105.18.**		**The most recent HSMR/SHMI ratios are within the expected range. Work continues at Mortality Review Group to undertake deep dives and the continuation of Structured Judgement Reviews.** **National Trajectory: The Trust is within the expected range for HSMR and is currently at 105.18.**	**The Ward Round Accreditation will review the quality of documentation which impacts on these results.** **Focussed reviews have been completed where the Trust is a outlier. Work in relation to improving coding, working diagnosis and finished consultant episodes, all of which impact on the mortality data, are underway.**
NICE Compliance **Red: Below 75%** **Amber: 75% to 89%** **Green: 90% or Above**	SOF **NICE Compliance was 85.69% in month.** **SPC - there is evidence of special cause variation.**		**The overall Trust compliance level is 85.69%, the Trust is implementing an action plan to reach the agreed target of 90%.** **Internal Variance Plan:** **The Trust is below the 90% target however we are on track to achieve this target by April 2020 through targeted work with the CBUs.**	**The Trust is currently risk assessing all partial compliance NICE Guidance to ensure that any risks are elevated to the risk register with robust action plans in place to ensure compliance. This is reported to Patient Safety and Effectiveness Sub Committee.**

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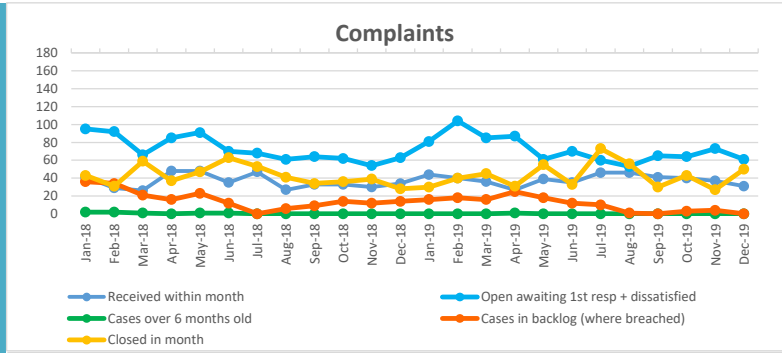
Quality Improvement - Trust Position

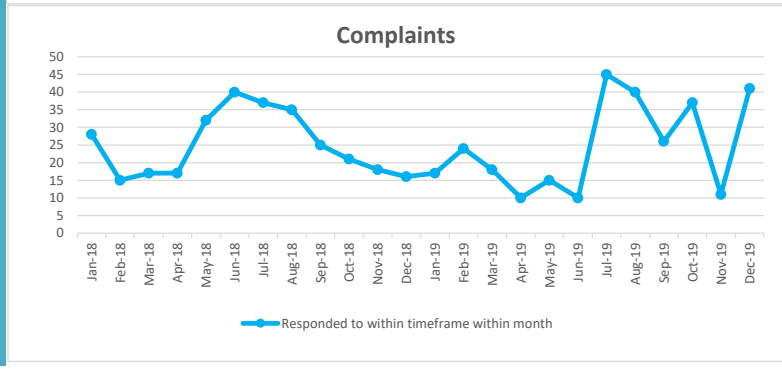
Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?

Patient Experience

Complaints
Red: Complaints over 6 months old/69% or less responded to within the timeframe
Amber: No complaints over 6 months old, 70% - 89% responded to within the timeframe
Green: No backlog, 90% responded to within the timeframe.

The Trust has continued to implement the Quality Account target of 90% complaints responded to within agreed timescales. In December 2019 there were 0 complaints in backlog.





Timeliness of complaints improved during December to 80% compared to 41% in November which is an increase of 39%. The aim remains to reach 90% by April 2019.
Internal Variance Plan:
The Trust is below the 90% target however we are on track to achieve this target by April 2020 through targeted work with the CBUs.

There were no breached complaints and the Complaints team continue to work closely with CBUs in order plan each case and deliver a sustained improvement. Performance is monitored via the Chief Nurse and the Deputy Director of Governance at the weekly Meeting of Harm.

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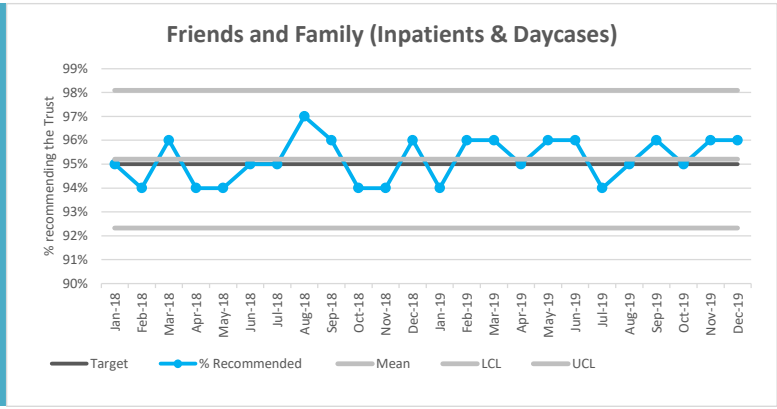
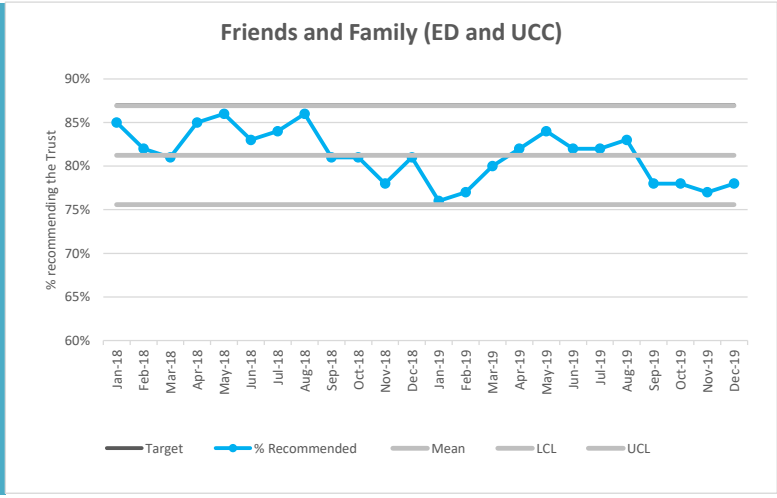
Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Friends and Family (Inpatients & Day cases) **Red: Less than 95%** **Green: 95% or more**		**The Trust has met the target set of 95% recommendation rate at 96%. The response rate was 27%.** **National Trajectory:** **The Trust is achieving the national trajectory.**	**CBUs provide a high level briefing paper to Patient Experience Subcommittee monthly since August 2019 and FFT feedback response and recommendation rates continue to be monitored and through Quality Metric reports.**
The Trust achieved 96% in month. **SPC - FFT Inpatients is within common cause (expected) variation.**			
Friends and Family (ED and UCC) **Red: Less than 87%** **Green: 87% or more**		**The Trust achieved 78% recommendation rate against a target of 87% which is an improvement of 1%. The ED ACU recommendation rate continues to increase to 72.03% and this will continue to be monitored. Internal Variance plan: The Trust is below the target of 87%. The response rate was 17.0%, which is within the expected range.**	**The Information team completed the review of the location of the UEC departments on Envoy system, to ensure accuracy of data. Alternative methods of gathering feedback within UEC will be explored, such as online via IPad to increase the chance of real time or near real time feedback. This will be part of a wider review of the FFT process which is due for a refresh and relaunch April 1st 2020**
The Trust achieved 78% in month. **SPC - FFT ED & UCC is within common cause (expected) variation.**			

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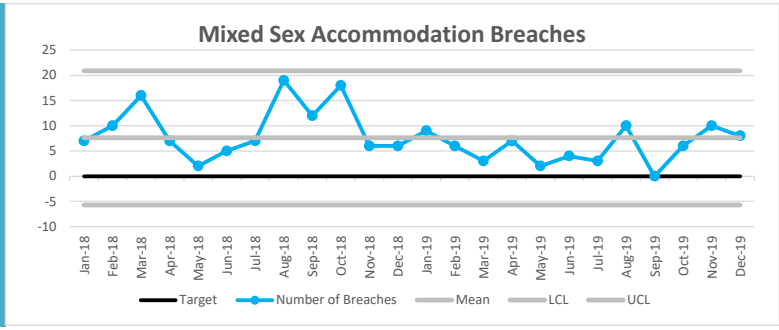
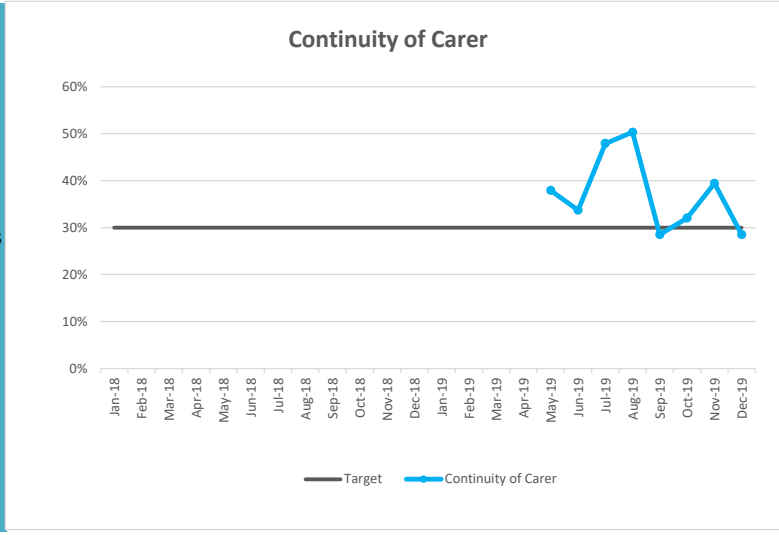
	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Mixed Sex Accommodation Breaches Red: 1 or more Green: Zero	There were 8 mixed sex accommodation breaches reported in month. SPC - Mixed Sex Accommodation Breaches are within common cause (expected) variation.		There were 8 MSA breaches in December. National Trajectory: The Trust is above the national target of 0 by 8. In comparison to the 100 beaches in 2018/19 there have been 50 in 2019/20 YTD.	All breaches are in the Intensive Care Unit. Patients are cohorted to minimise breaches and step down is expedited as soon as is practicable. Patient experience continues to be rated highly.
Continuity of Carer Green: 30% or Above Amber: 20% - 29% Red: below 20%	The target percentage for women being booked onto a continuity of carer pathway in 2019 is at least 20% (National). The target by March 2020 is over 35% (National), and from March 2021, the target is over 51% (National). The Trust achieved 28.5% in December 2019.		The percentage of women booked onto a continuity of carer pathway in December was 28.5%. This is above current national target (20%) but will need to be over 35% to reach the target set for March 2020. Internal Variance Plan: The Trust is surpassing the current national target of 20% (for 2019/20) and is on trajectory to meet the 35% by March 2020.	All community midwives have received updated training and are aware to ensure they document on Lorenzo that women are on a continuity of carer pathway. The matron for community and community midwives managers are currently working with the IM&T team to resolve the IT issues.

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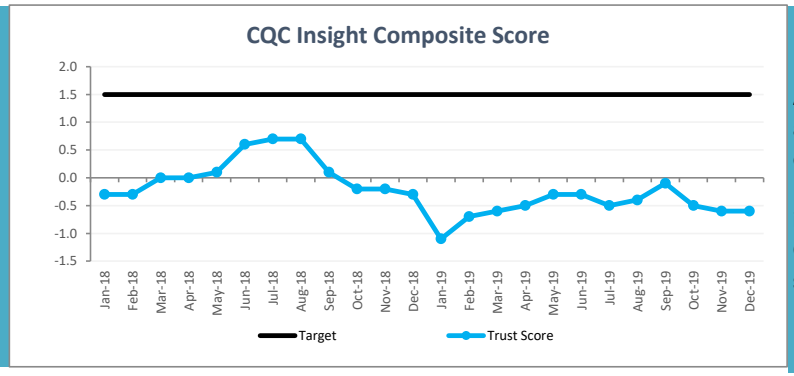
CQC

CQC Insight Composite Score

Red (inadequate): <-3
Amber (req improvement): >-2.9 - 1.5
Green (good/outstanding): >1.5

The Trust CQC Insight Composite Score is -0.6.



Areas where the Trust has improved are in; Patient-led assessment of environment for dementia care, Proportion of reported patient safety incidents that are harmful, Safety Culture, Staff Engagement, Digital scores and Inpatient response rate.

The Moving to Outstanding Steering Group has been established to track and oversee the Trust response to the CQC inspection report and the Moving to Outstanding Framework within the organisation.

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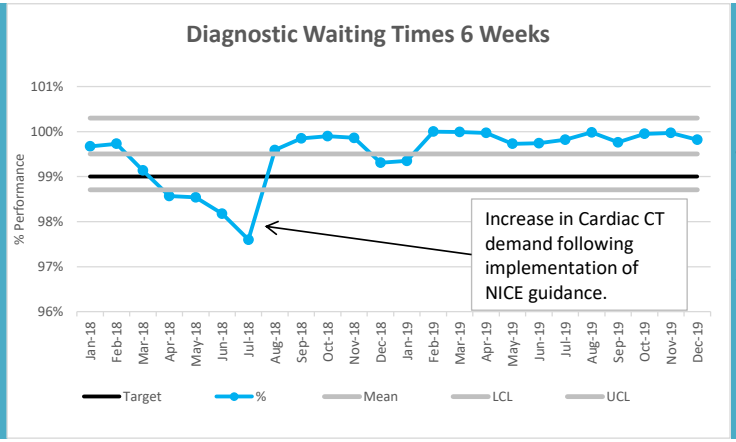
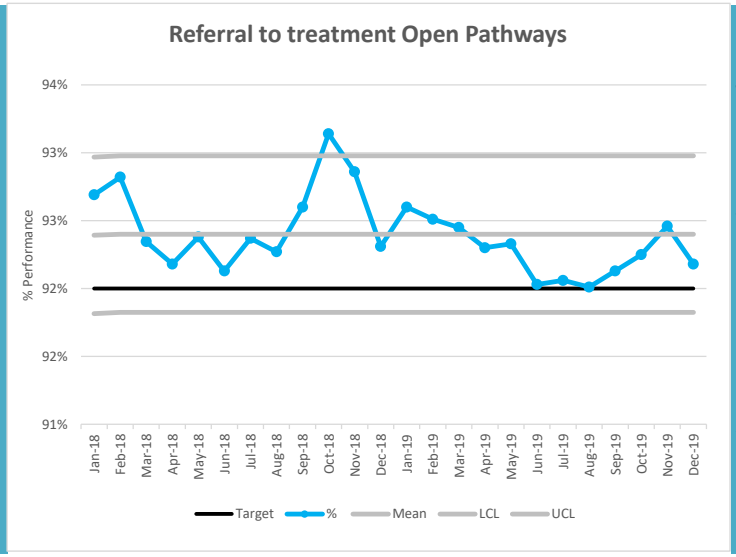
	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Diagnostic Waiting Times 6 Weeks Red: Less than 99% Green: 99% or above	SOF CQC The Trust achieved 99.82% in month. SPC - There has previously been evidence of special cause variation for Diagnostic Waiting Times however this has stabilised.		The Trust achieved the diagnostic target with 99.82% in December 2019. This indicator is being monitored on a daily basis with appropriate actions being taken to sustain this standard.	Maintain compliance against the diagnostic waiting times standard.
Referral to treatment Open Pathways Red: Less than 92% Green: 92% or above RTT - Number of patients waiting 52+ weeks Green = 0, otherwise Red	SOF CQC The Trust achieved 92.18% in month. SPC - RTT pathways are within common cause (expected) variation. The Trust has consistently achieved this standard.		The Trust continues to achieve the 18 week Referral to Treatment target in a very challenging operating environment, achieving 92.18% in December 2019 against a target of 92%. Trajectories have been developed for 2019/20 to maintain compliance with the standard for all specialities. The Surgical Specialties team have a recovery plan for T&O and ENT paediatrics, both areas aim to achieve compliance before the end of the financial year. These are being monitored weekly by Performance Review Group (PRG).	The Trust has consistently delivered the RTT standard over the last 47 consecutive months and has not incurred any end of month 52 week wait breaches. December 2019 saw a decrease in the waiting list size from previous months and has not recorded any further increase in referrals noted in October. The RTT standard along with the Trust waiting list size is being monitored on a daily basis via the new RTT dashboard to ensure actions instigated are achieving as expected.

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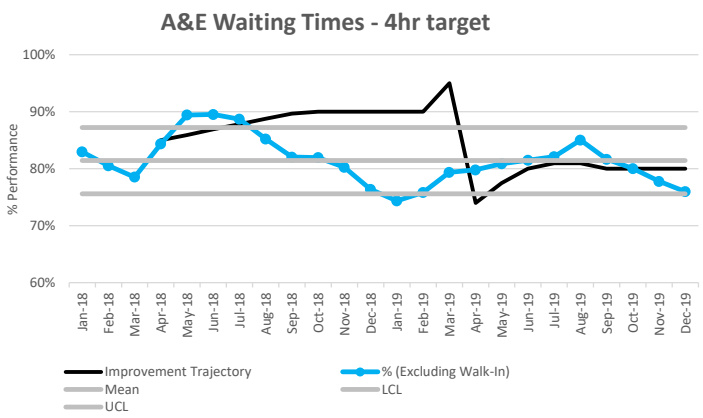
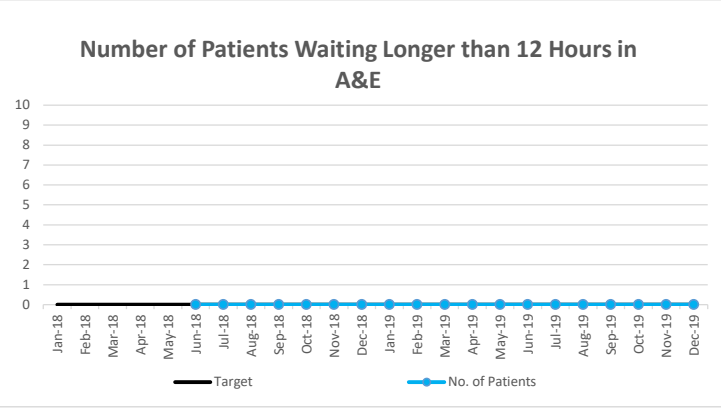
	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Four Hour Standard - National Target Red: Less than 95% Green: 95% or Four Hour Standard Waiting Times - STP Trajectory Red: Less than trajectory	SOF CQC The Trust achieved 75.98% excluding walk ins in month. SPC - There is special cause variation present in the Four Hour A&E standard.		Performance deteriorated in December 2019 with the performance excluding Widnes Walk-In activity not meeting the agreed trajectory of 80.00%, achieving 75.98%. The performance was comparable to December 2018 despite seeing over 800 more patients in the same period this year. This has been supported by new ways of working implemented during the year; ED Ambulatory and the Combined Assessment Unit.	The new 24 hour (CAU) was launched in December and when functioning, has supported improvements in performance however, on occasions one side of the CAU was utilised to bed patients at times of increased pressure in the system. In order to release some pressure on the assessment areas and keep these functioning, K25 continues to be used as an escalation area along with the increase of beds on B3.
The number of patients who has experienced a wait in A&E longer than 12 hours from the decision to admit. Green = 0 Red = > 0	SOF There were 0 patients waiting longer than 12 hours in A&E in month.		The Trust has achieved the standard in not having any patients wait longer than 12 hours from the decision to admit in December 2019. This has been consistently achieved over time.	Maintain compliance against the 12 hour standard from decision to admit.

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Cancer 14 Days Red: Less than 93% Green: 93% or above	This indicator has temporarily been removed from the Trust IPR due to the pilot for the 28 day faster cancer diagnosis standard.			
Breast Symptoms 14 Days Red: Less than 93% Green: 93% or above	This indicator has temporarily been removed from the Trust IPR due to the pilot for the 28 day faster cancer diagnosis standard.			

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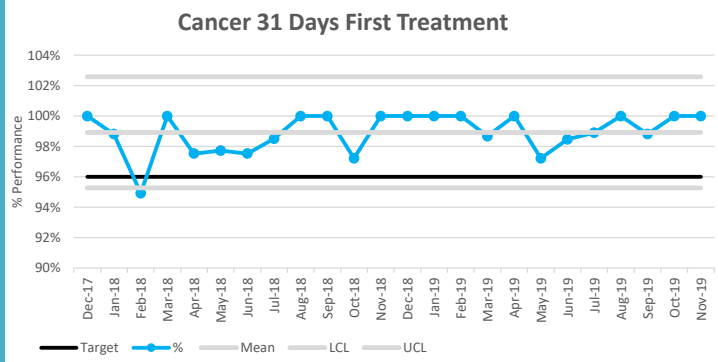
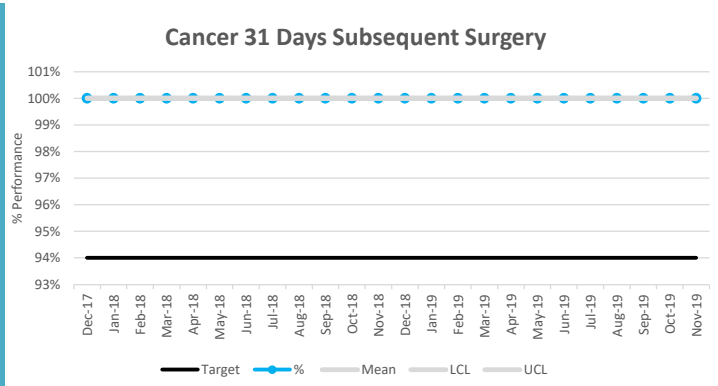
Cancer 31 Days First Treatment Red: Less than 96% Green: 96% or above	SOF CQC **The Trust achieved 100% in November 2019.** **SPC - Cancer 31 days is within common cause (expected) variation.**		**The Trust achieved 100% in November 2019.**	**Maintain compliance against the 31 day first treatment standard.**
Cancer 31 Days Subsequent Surgery Red: Less than 94% Green: 94% or above	SOF CQC **The Trust achieved 100% in November 2019.** **SPC - Cancer 31 days surgery is within common cause (expected) variation. The Trust has consistently achieved this standard.**		**The Trust achieved 100% in November 2019.**	**Maintain compliance against the 31 day subsequent treatment (surgery) standard.**

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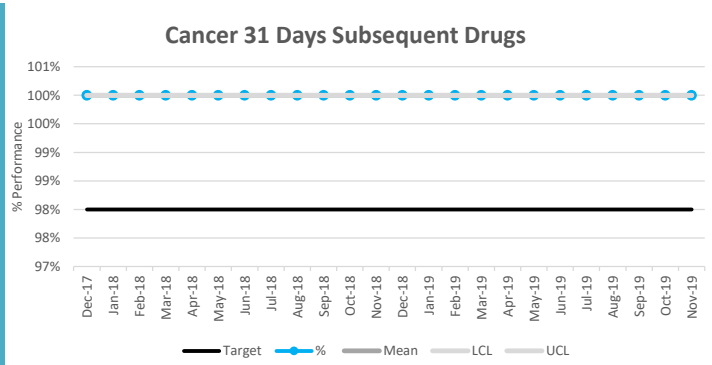
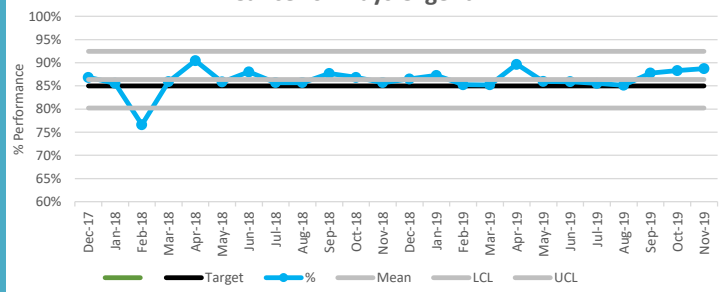
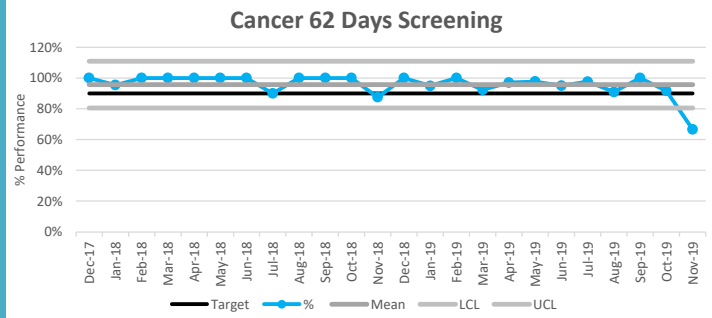
Cancer 31 Days Subsequent Drug Red: Less than 98% Green: 98% or above	SOF CQC **The Trust achieved 100% in November 2019.** **SPC - Cancer 31 days drugs is within common cause (expected) variation. The Trust has consistently achieved this standard.**		**The Trust achieved 100% in November 2019.**	**Maintain compliance against the 31 day subsequent treatment (drug) standard.**
Cancer 62 Days Urgent Red: Less than 85% Green: 85% or above	SOF CQC **The Trust achieved 88.73% in November 2019.** **SPC - Cancer 62 days urgent is within common cause (expected) variation.**		**The Trust achieved 88.73% in November 2019.**	**Maintain active monitoring of all pathways to maintain compliance against the 62 day standard.** **Positively, this standard has consistently achieved which has only been possible through full engagement with the CBU Teams and supportive leadership via the Cancer Team.**
Cancer 62 Days Screening Red: Less than 90% Green: 90% or above	SOF CQC **The Trust achieved 66.67% in November 2019.** **SPC - Cancer 62 days Screening are within common cause (expected) variation.**		**The 62 day screening standard was not achieved in November 2019. There were 3 patients on this pathway in month with 1 breach due to a late referral from another Trust (LUHFT) where further investigations were required.**	**The Trust has achieved this standard consistently over the past 12 month, early indications from December's data suggest the Trust has met this standard.**

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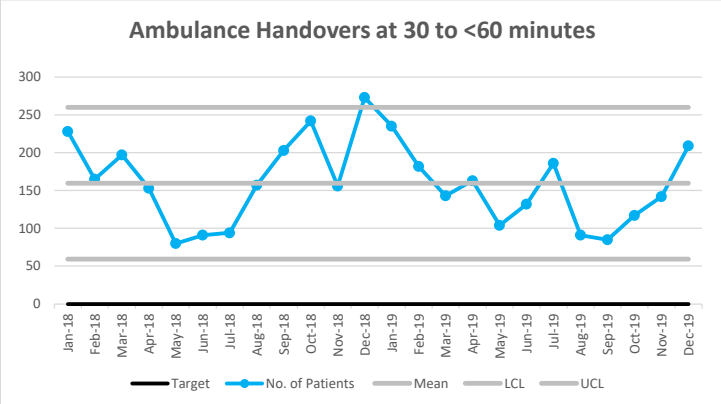
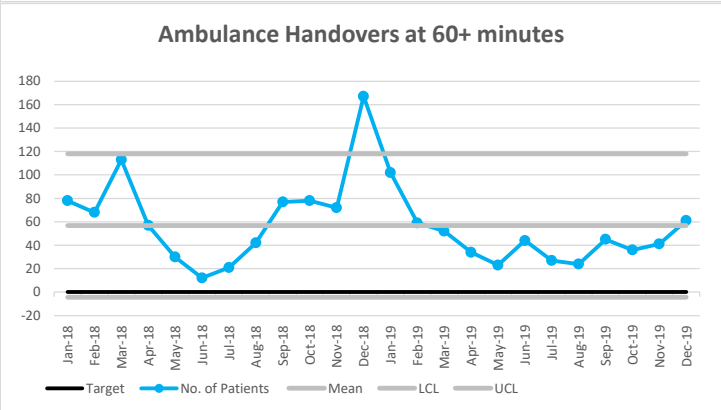
Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Ambulance Handovers 30 to <60 minutes Red: More than 0 Green: 0 There were 209 patients waiting between 30 and 60 minutes for handover in month. SPC - There has previously been special cause variation present for Ambulance Handover Times however this has stabilised.		Ambulances handovers in December 2019 has shown that 49.5% were handed over in December 2019 between 0 to 15 mins which is a slight deterioration from November and impacts on the Trust's performance for 30-60 minutes and 60 minutes +. There has been an increase in patients handed over between 30-60 minutes; and a slight decrease in performance against the 60+ minute standards.	Regionally, the Trust has performed well compared to peers for over 60+ minute delays and continues to participate within the regional collaborative aimed at reducing delays during the winter period.
Ambulance Handovers at 60 minutes or more Red: More than 0 Green: 0 There were 61 patients waiting over 60 minutes for handover in month. SPC - There has previously been special cause variation present for Ambulance Handover Times however this has stabilised.			

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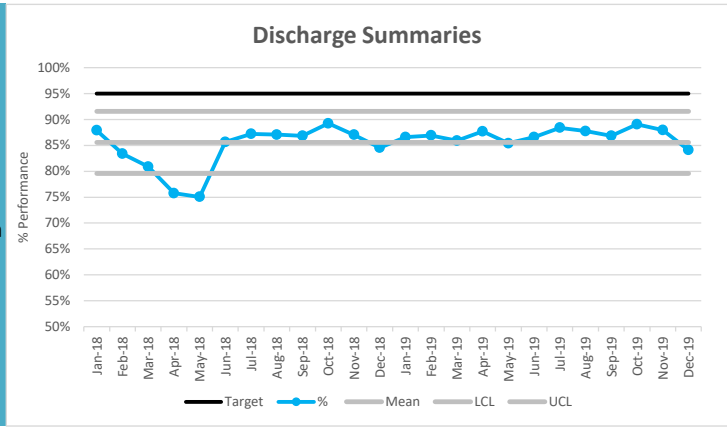
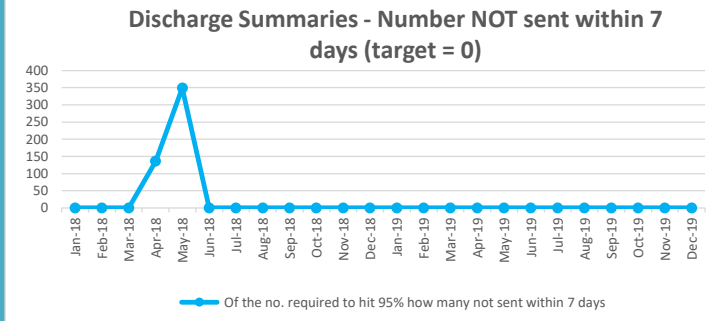
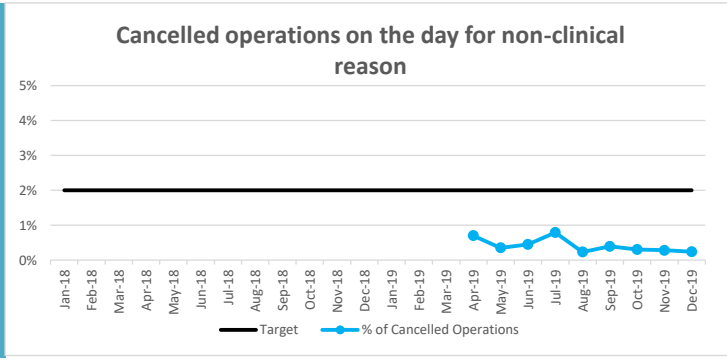
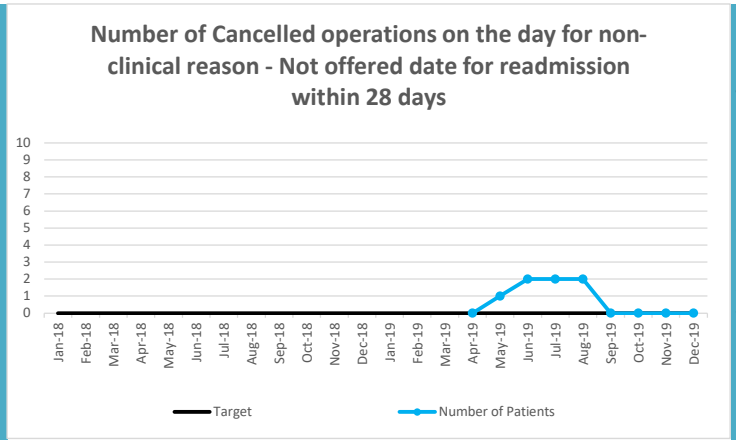
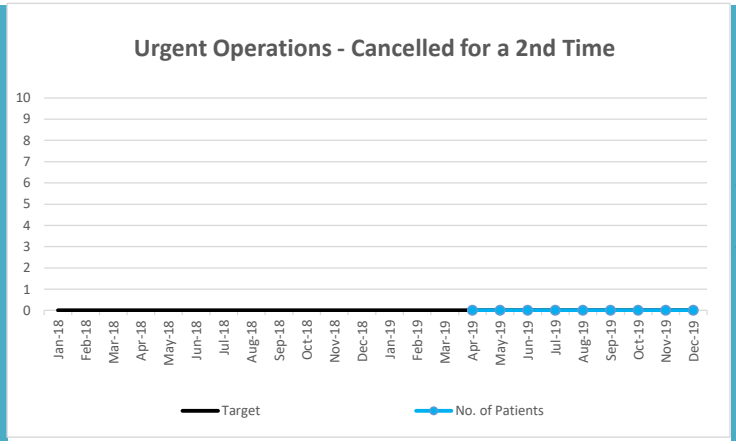
	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Discharge Summaries - % sent within 24hrs Red: Less than 95% Green: 95% or above	The Trust achieved 84.11% in month. SPC - There has previously been special cause variation in Discharge Summaries however this has stabilised.		The Trust continues to monitor compliance across all CBUs. This is monitored via the weekly PRG and monthly KPI meetings. A Standard Operating Procedure has been in place however, this is being reviewed in conjunction with the medical teams to ensure effective processes are embedded.	This standard remains challenging for the Trust with performance remaining static in recent months. Although a Standard Operating Procedure has been in place, a review has been requested via the monthly KPI forum in conjunction with the medical team to improve current processes and drive improvement.
Discharge Summaries - Number NOT sent within 7 days Red: Above 0 Green: 0	There were 0 discharge summaries not sent within 7 days required to meet the 95% threshold.		The Trust achieved compliance against the 7 day discharge summary standard in December 2019.	The Trust KPI group will continue to monitor at CBU level to maintain performance against this standard.
Cancelled Operations on the day for a non-clinical reason Red: > 2% Green: < 2%	CQC 0.24% operations were cancelled on the day for non clinical reasons in month.		The Trust cancelled 0.24% of operations on the day for non-clinical reasons. Benchmarking would suggest that although the Trust continues to maintain a zero tolerance to cancellations, a rate of less than 2% compares favourably.	A dedicated sub-group of the Theatre Productivity Group to focus on reducing cancellations on the day remains in place focusing on the escalation process, reporting and validation.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

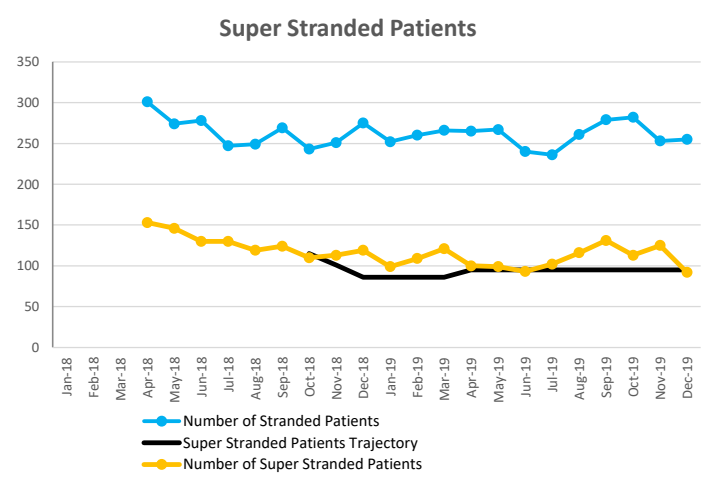
Key:
Single Oversight Framework
Care Quality Commission

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Cancelled Operations on the day for a non-clinical reason - Not offered a date for readmission within 28 days of the cancellation Red: Above zero	There were 0 cancelled operations on the day for non clinical reasons in month, where the patient was not booked in within 28 days.		There were no breaches of the 28 day standard in December 2019 or for Q3 and the number of cancellations on the day has reduced overall for Q3. The task and finish group focusing on the escalation process, reporting and validation remains in place. An enhanced escalation process is embedded to ensure cases are fully reviewed before cancellation is approved.	Maintain compliance against the 28 day readmission standard. Monitored via weekly PRG and monthly KPI meetings.
Urgent Operations - Cancelled for a 2nd Time Green = 0 Red = > 0	There were 0 urgent operations cancelled for a second time in month. The Trust has consistently achieved this standard.		This is an additional standard to enhance monitoring of cancelled operations. The Trust continues to maintain this standard.	Maintain the standard that no urgent operation is cancelled for a second time.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:
Single Oversight Framework
Care Quality Commission

Access & Performance - Trust Position

	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Super Stranded Patients Green: Meeting Trajectory Red: Missing Trajectory	There were 255 stranded and 92 super stranded patients at the end of the December 2019.		The number of stranded and super stranded patients has reduced in December 2019, due to the "where best next" campaign to ensure patients were home or in the right place prior to the festive period.	Whilst the position is slightly below trajectory at the beginning of January 2020, sustaining and building on the improvement is essential; the learning from the event in October is being embedded into the Trusts Long Length of Stay sustainability plan and includes more regular length of stay visits by consistent teams supporting the ward based board rounds. Based on the successful MADE events, the "Where Best Next" event will continue in January to support patients to create bed capacity and flow during our most challenging part of the year.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

Key:
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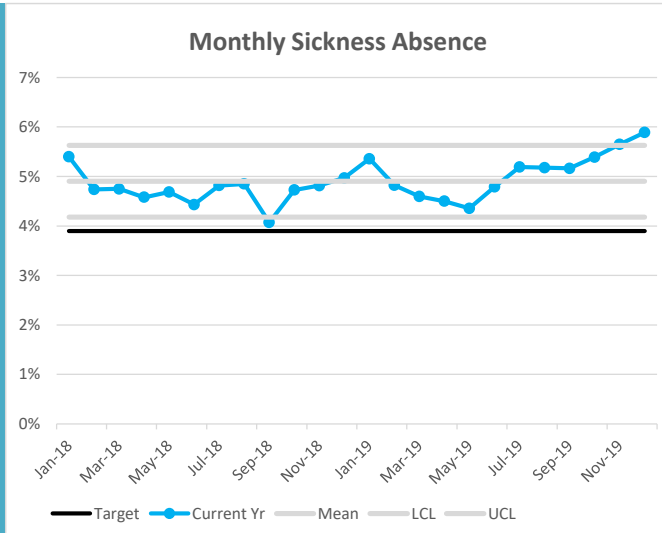
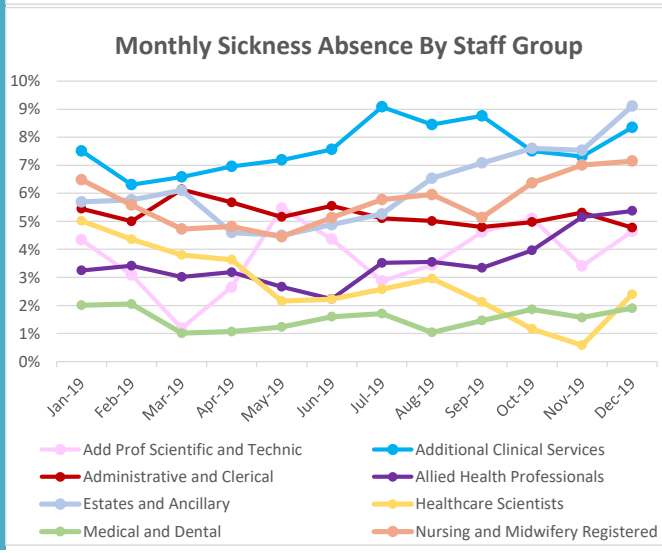
Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?

Sickness Absence

Red: Above 4.5%
Amber: 4.2% to 4.5%
Green: Below 4.2%

The Trust's sickness absence was 6.19% in month. There is evidence of special cause variation for sickness absence.





Sickness absence has increased in month. This is in line with seasonal trends however absence rates are higher than the same period last year.

The regional HR Network has noted an increase in sickness absence across the NHS workforce in the Cheshire and Mersey region.

The most commonly occurring reasons for sickness absence are mental health related illness and musculoskeletal illness/injury.

There is a significant amount of long term sickness absence across the workforce, which is impacting the position.

The CBUs/Departments with the highest sickness absence rates are:
- **Musculoskeletal Care (10.4%)**
- **Estates and Facilities (9.58%)**
- **Urgent and Emergency Care (7.33%)**
- **Women's and Children's Health (7.26%)**
- **Integrated Medicine and Community (6.29%)**

The staff groups with the highest levels of sickness absence are:
- **Estates and Ancillary (9.11%)**
- **Additional Clinical Services (8.35%)**
- **Nursing and Midwifery (7.15%)**

Work streams / actions in place and on-going:
- **The Employee Assistance Programme implemented from 01.12.2019 – 24/7 access to telephone counselling and rapid access to face to face counselling;**
- **Supported Early Return pilot in Facilities Teams;**
- **Mental Health First Aiders;**
- **Mental Health Awareness Training for line managers implemented in January 2020;**
- **Action planning for high absence staff groups, by staff group leads, via Health and Wellbeing Steering Group;**
- **Additional Assistant HR Advisor resource appointed to work on long term sickness only within HR Team (within budget);**
- **Weekly Deputy Director of HR and OD overview of management of long term sickness absence cases;**
- **Menopause support group;**
- **Standard and bespoke Resilience Training;**
- **Essential Managers Training on managing attendance;**
- **On-going support and guidance for line managers via HR Team.**

Work streams / actions in development:
- **Implementation of Schwartz Rounds;**
- **Attendance Management Policy Review;**
- **Distribution of hard copy resilience packs (for hard to reach staff groups);**
- **Later Life Transitions course – supporting our aging workforce;**
- **Population Health modelling;**
- **'Monday Brews' – weekly group catch up for staff on long term sick, facilitated by Staff Counsellor;**
- **Menopause Training Sessions for line managers – supporting our aging workforce.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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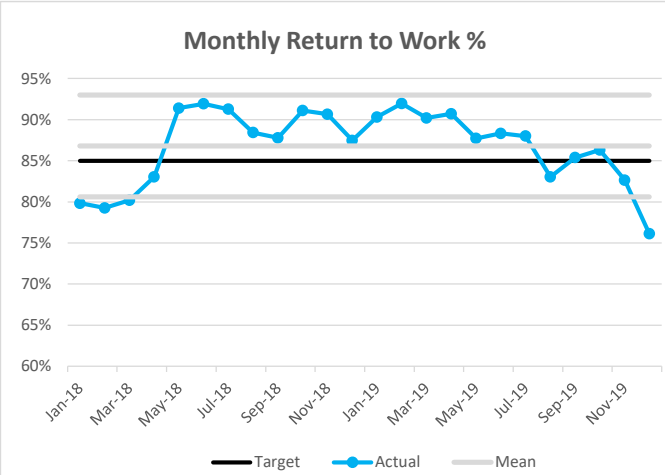
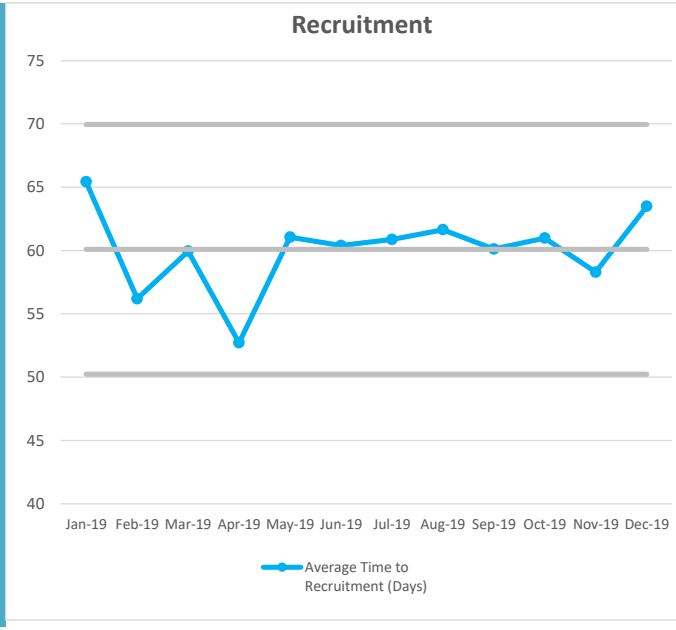
	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Return to Work Red: Below 75% Amber: 75% to 85% Green: Above 85%	The Trust's return to work compliance was 76.12% in month. SPC - There is evidence of special cause variation for Return to Work compliance.		The late and retrospective recording of return to work interviews impacts on the monthly reporting position. Local spot checks have confirmed that return to work interviews are being completed but not recorded in a timely manner.	A review of essential manager training has been completed and changes have been implemented - this includes information about the importance of timeliness of policy application. The revised training also includes a session on 'Difficult Conversations' to help managers feel confident in completing RTWIs and to get the best out of the interviews. There is 1:1 Coaching by the HR Business Partner team with line managers on an ongoing basis.
Recruitment Red: 76 days or above Amber: 66 to 76 days Green: 65 days or below	The average number of working days to recruit is 63, based on the last 12 months average. SPC - Recruitment time is within common cause (expected) variation.		Time to hire has remained below the 65 day requirement.	Improving recruitment processes and reducing time to hire – a task and finish group has been set up to review our current processes and to identify and suggest improvements. The group is currently working with both recruiting managers and new employees to understand their perceptions of the current process. The group is also reviewing the diversity and inclusivity of our recruitment processes. This piece of work is being undertaken in partnership with Bridgewater Community Healthcare NHS Foundation Trust. Feedback collected from new employees in general praise the seamless process, with the overwhelming request to offer a flexible approach to collecting information. In the longer term, we plan to work with IM&T colleagues to improve the on-boarding system for our new candidates - moving it online.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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Key:
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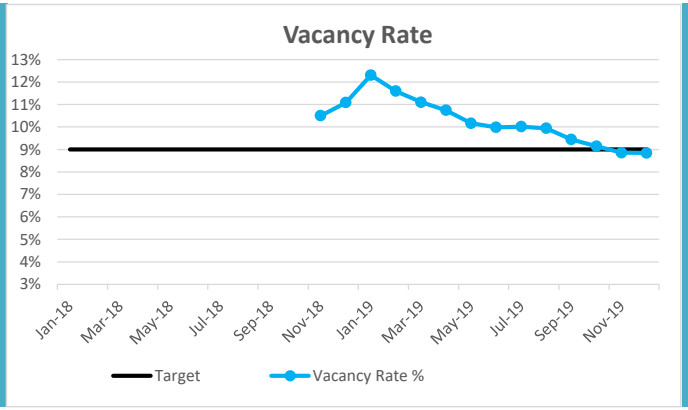
Vacancy Rates

Red: 11% or Above
Amber: 11% to 9%
Green: 9% or Below

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
UoR **Trust vacancy rate was 8.84% in month.** **SPC - there is evidence of special cause variation for Vacancy Rates.**		**The continued reduction in vacancy rate is linked to improved retention/turnover and overall improvements in average time to hire.**	**The Trust's Recruitment and Retention Group continues to focus on opportunities to increase attraction and recruitment through work streams such as the development of the 'Work at WHH' website, improved recruitment open days, career clinics and international recruitment.**

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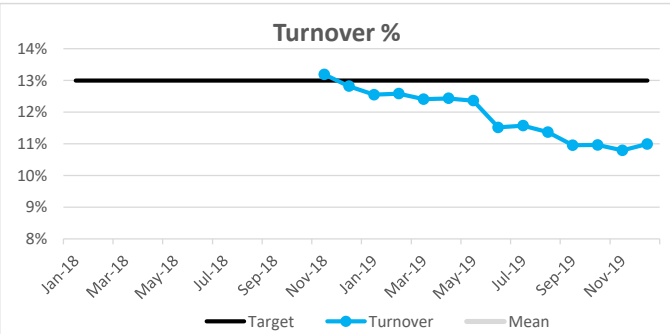
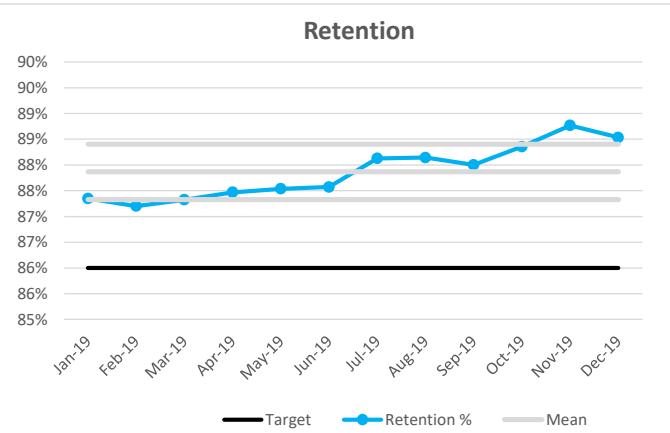
	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Turnover Red: Above 15% Amber: 13% to 15% Green: Below 13%	**Trust turnover was 10.99% in month.** **SPC - There is evidence of special cause variation for Turnover.**		**Turnover has remained below target (positive). This is linked to improved employee engagement (as evidenced by the 2018 Staff Survey results and LIA pulse check survey results) and to the work commenced as part of the NHSI Retention Programme.**	**The programme of work to implement the NHSI nursing retention programme and roll out to other staff groups includes:** **• Improve our workforce's ability to achieve a better work life balance through promoting what we offer and reviewing our processes/policies.** **• Support our staff to explore and pursue career progression within the Trust. The Careers cafés have been set up throughout the year promoting development and career opportunities.** **• The promotion of the Recognising and Valuing Experience (RAVE) role/initiative.** **• Develop and empower our Line Manager's to retain their staff through developing our expertise – a recent Ward Manager Retention Master class provided opportunity for discussion and the sharing of good retention practice in the workplace.** **• Develop a R&R Champion role, so they are able to support our Managers in both Recruitment and Retention practices.** **• Retaining our experienced staff is vital to support this, we are currently reviewing the Trust's retire and return policy.** **• Improving our retire and return options/promotion through the Pre-Retirement courses.**
Retention Red: Below 80% Amber: 80% to 85% Green: Above 86%	**Trust Retention was 88.53% in month.** **SPC - There is evidence of special cause variation for Retention.**		**Retention remains above target (positive) and has increased in month. This is linked to improved employee engagement (as evidenced by the 2018 Staff Survey results and LIA pulse check survey results) and to the work begun as part of the NHSI Retention Programme.**	

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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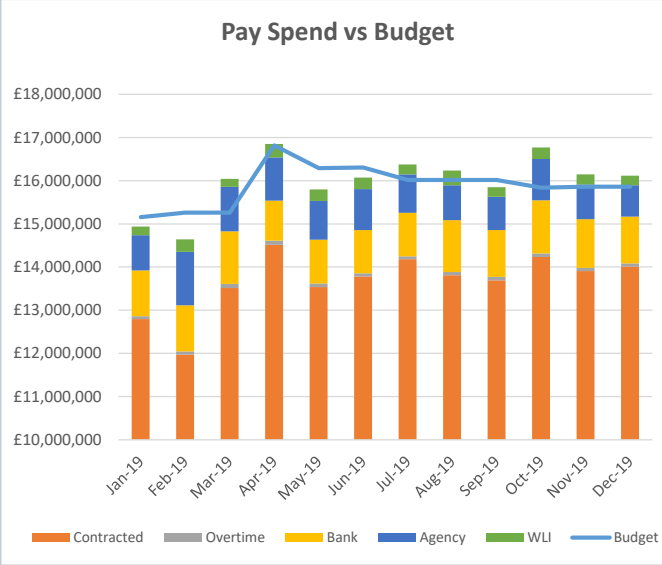
	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Pay Red: Greater than Budget Green: Less than Budget	**Trust pay was £0.25m above budget in month.**		**Pay spend in December 2019 was £16.1M against a budget of £15.9M.**	**Additional controls and challenge around pay spend have been identified to support a reduction in premium pay:** **• Monthly deep dives into Nursing Agency, supported by NHS Professionals;** **• Enhanced ECF process for non-clinical vacancies;** **• Expanded ECF process for some temporary staffing pay spend;** **• Implementation of Cheshire and Mersey Rate Cards;** **• Introduction of Patchwork Medical Bank system;** **• Review and action of pay elements within NHSI/E Grip and Control Checklist.**

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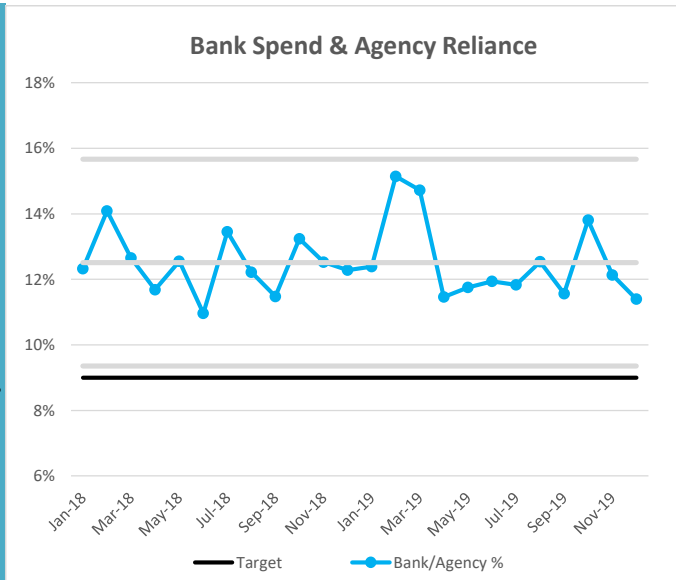
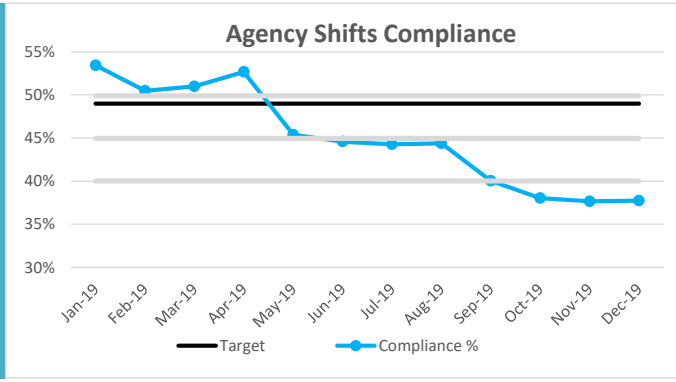
	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Bank and Agency Reliance Red: 11% or Above Amber: 11% to 9% Green: 9% or Below	UoR **Bank and Agency Reliance reduced to 11.40% in month.** **SPC - Bank/Agency reliance is within common cause (expected) variation.**		• The most commonly recorded reason for temporary staffing usage is vacancy. • Both bank and agency spend has reduced in month. • Agency spend was £0.1m lower than the same period in 2018/19. • Monthly agency spend for Medical and Dental staff has been lower than the same period in 2018/19. • Both bank and agency spend reduced in the Nursing and Midwifery staff group, despite increases in vacancies and sickness absence for this group.	• The Bank and Agency team have refined the agency booking processes, currently being managed through a centralised team. Since the central team went live, cost avoidance over and above that set out in the initial business case has been achieved. This is achieve via the on-going negotiated rates, recruitment onto the bank, removing the requirement for an agency workers and a lower administration fee for using +US agency engagement system. • Actions outlined above relating to nursing attraction, recruitment and retention will positively impact this indicator, as substantive posts are filled. • In order to reduce agency spend through increased bank fill rate, Patchwork system will be implemented in February 2020.
Agency Shifts Compliant with the Cap Red: below 49% Green: above 49%	UoR **37.73% of shifts were compliant with the NHSI Price Cap.** **SPC - There is evidence of special cause variation within Agency Shift Compliance.**		The majority of shifts that are not compliant with the NHSI Price Cap relate to Medical and Dental agency bookings.	• The central bank and agency team continue to negotiate rates down towards the NHSI Price Cap compliance. • Increasing medical bank usage will support improving the compliance. • The Trust is part of the Cheshire and Mersey Collaborative group, which has implemented a new rate card from 1 December 2019.

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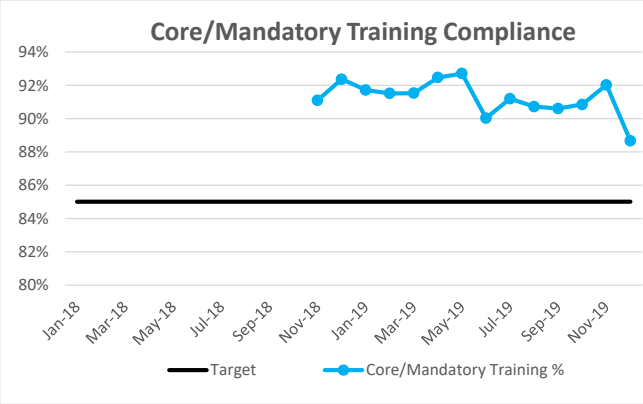
	Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Core/Mandatory Training Red: Below 70% Amber: 70% to 85% Green: Above 85%	CQC **Core/Mandatory training compliance was 88.67% in month.**		**Mandatory Training compliance has remained above target (positive) since June 2018. The Trust approach to Mandatory Training has been reviewed and expectations clarified. Compliance with Mandatory Training has now become 'business as usual' for staff and managers.**	**Compliance with Mandatory Training is closely monitored at CBU/Department and topic level via Educational Governance Committee and by Subject Matter Experts.**

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Key:
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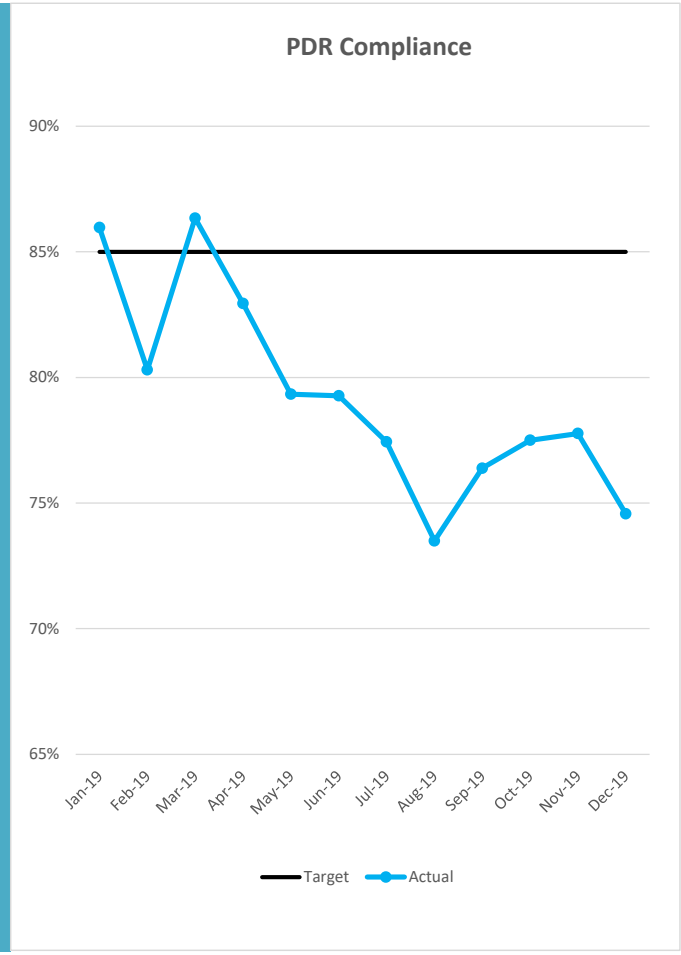
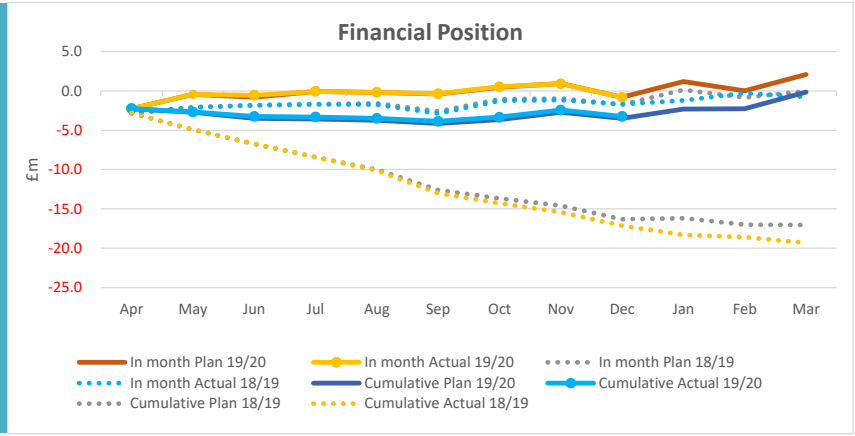
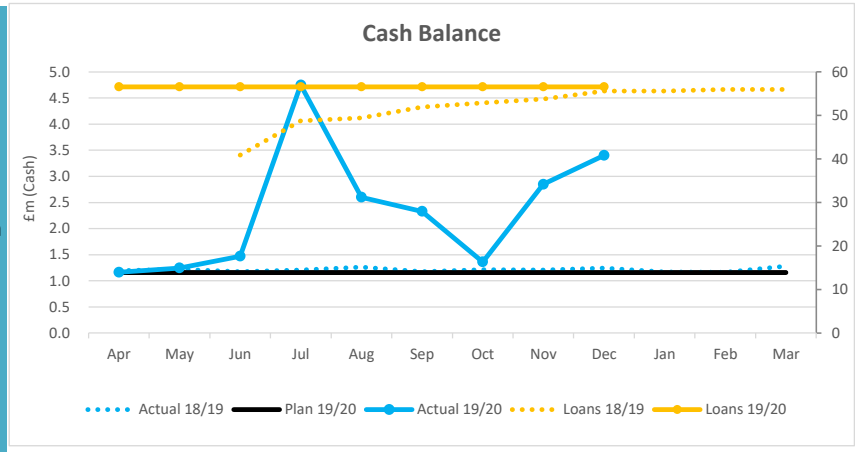
Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
PDR Red: Below 70% Amber: 70% to 85% Green: Above 85%		PDR compliance has reduced in month. The following CBUs/Departments are below target: • Digestive Diseases (73%) • Medical Care (80%) • Urgent and Emergency Care (73%) • Women's and Children's Health (75%) • Integrated Medicine and Community (71%) • Clinical Support Services (75%) • Surgical Specialties (77%) • Estates and Facilities (69%) • IT (55%) • Nursing and Governance (65%) *Teams with 10 members or fewer have been removed. Whilst there has been some improvement with PDR compliance since August 2019, the trend data would indicate that PDR completion is not embedded as 'business as usual' across the trust. The peaks in PDR compliance have been as a result of an organisational focus on compliance. This has not been sustained for any substantial period of time following the organisational focus.	• Monthly compliance reports issued to managers, including a list of all staff showing individual compliance and expiry date, to support planning. • Compliance reported monthly to CBU/Departmental meetings, • Compliance monitored bi-monthly through the Trust Operational Board, Operational People Committee and Moving to Outstanding group; • Compliance will be monitored bi-monthly via the Education Governance Committee. The Lowest performing CBUs/Departments are offered further support from the L&D Manager via a bi-monthly email highlighting areas of concern for their CBU. • The HR Team continues to offer additional support to any managers around how to approach PDR discussions. • With the intention of supporting improvements in the quality of PDRs undertaken across the organisation, PDR paperwork is currently being reviewed. The launch of the new PDR is due in Q4 2019/20. • Pay progression will be live for all members of staff from 1 April 2021, linking progression to PDR compliance.
PDR compliance was 74.57% in month.			

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Finance & Sustainability - Trust Position

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

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Financial Position Red: Deficit Position Amber: Actual on or better than planned but still in deficit Green: Surplus Position			
UoR SOF S **The actual deficit in the month is £0.8m which increases the year to date deficit to £3.2m.**		**The cumulative deficit of £3.2m is £0.3m better than plan. The monthly control total (excluding Provider Sustainability, Financial Recovery and Marginal Rate Emergency Tariff funding) is a £15.1m deficit which is in line with plan.**	**The Trust continues to work with commissioners and providers across the local healthcare system to develop a recovery plan. The Trust continues to drive improvements by working closely with CBUs and Corporate Divisions to manage financial performance.**
Cash Balance Red: Less than 90% or below minimum cash balance per NHSI Amber: Between 90% and 100% of planned cash balance Green: On or better than plan			
UoR SOF **The current cash balance is £3.4m (equates to circa 5 days operational cash).**		**The current cash balance of £3.4m is £2.2m better than plan.**	**To support all CBUs and Corporate Divisions to improve the operating position which will result in improved cash position. Cash is monitored on a daily basis and an annual cash plan is supported by a rolling 13 week plan. All debtors are actively pursued to support liquidity.**

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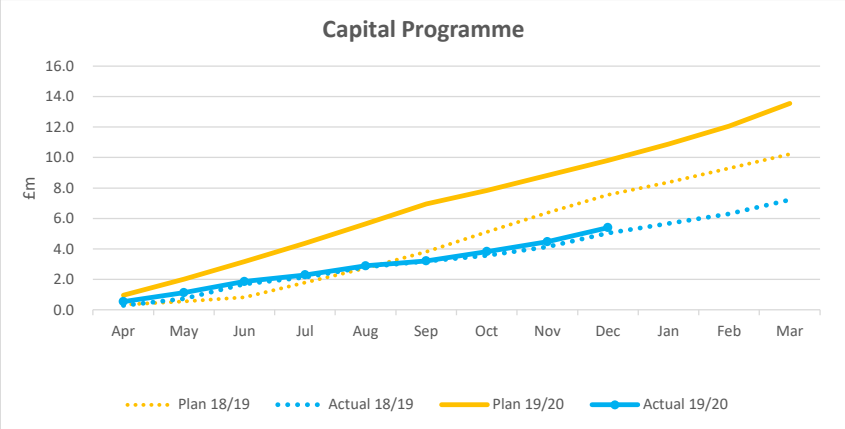
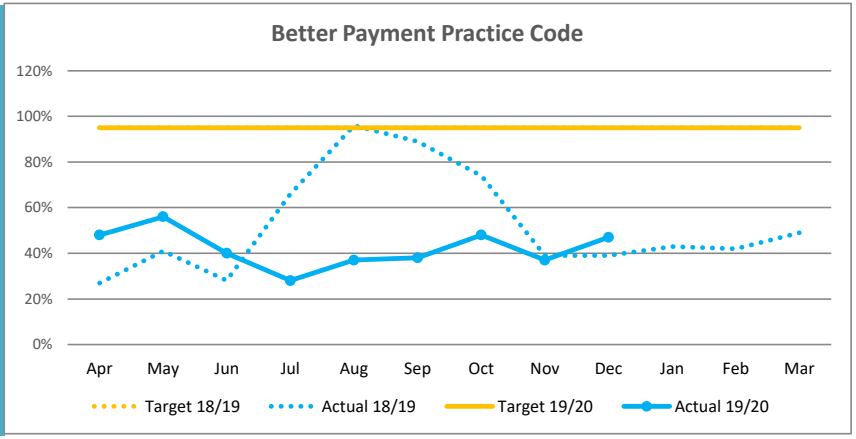
Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Capital Programme Red: Off plan <80% - >110% Amber: Off plan 80-90% or 101 - 110% Green: On plan 90%-100%	UoR SOF **The actual capital spend £0.9m in month which increases the year to date spend to £5.4m.**		**The cumulative capital spend of £5.4m is £4.4m below the planned capital spend of £9.8m (mainly due to limited spend on the Kendrick Wing Fire).**	**To monitor, report and manage capital planning and spend through the Capital Planning Group to ensure the most effective use of the limited capital resource.**
Better Payment Practice Code Red: Cumulative performance below 85% Amber: Cumulative performance between 85% and 95% Green: Cumulative performance 95% or better	UoR SOF **In month, the Trust has paid 40% of suppliers within 30 days which increases the year to date performance to 40%.**		**The cumulative performance of 40% which is below the national standard of 95%, this is due to the low cash balance and the need to manage cash very closely.**	**The operating position results in a challenging cash position which makes it difficult to pay all invoices within the recommended target. Invoices are paid as promptly as possible to avoid additional interest charges.**

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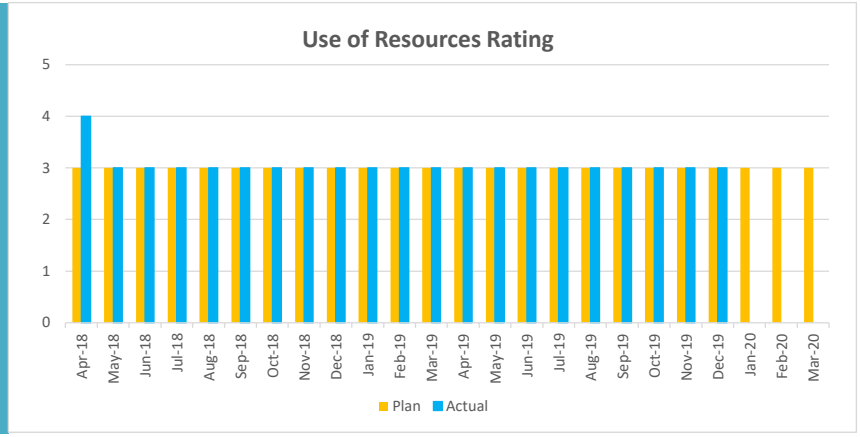
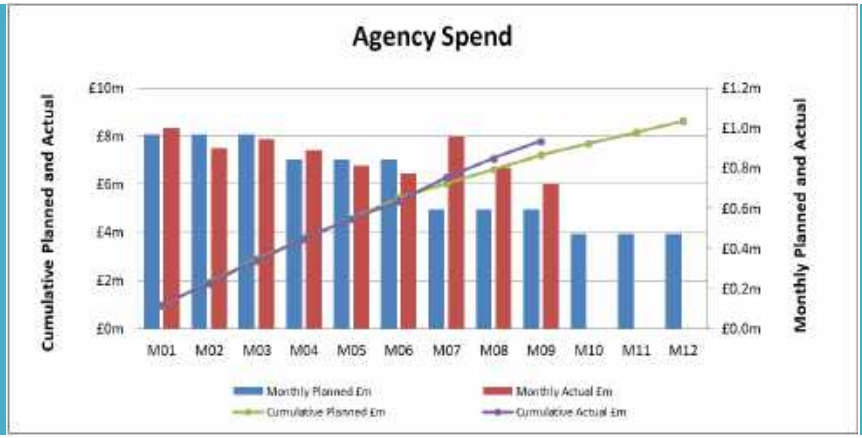
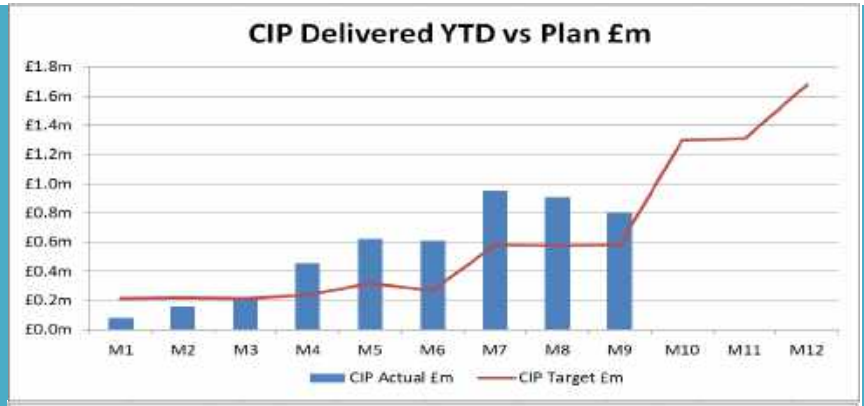
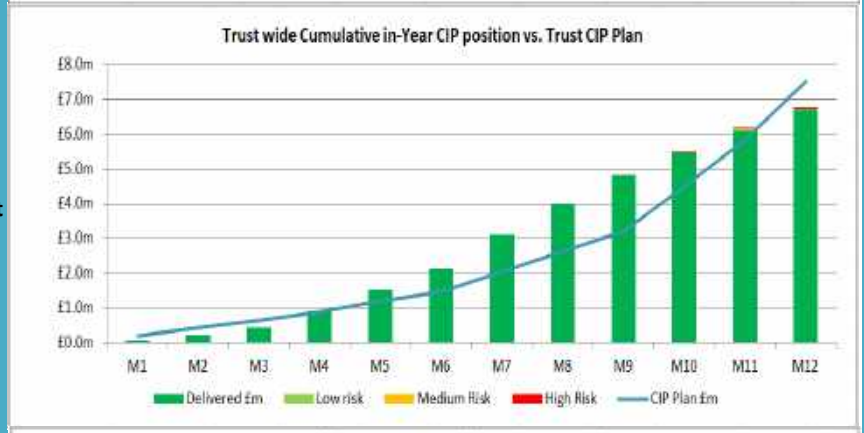
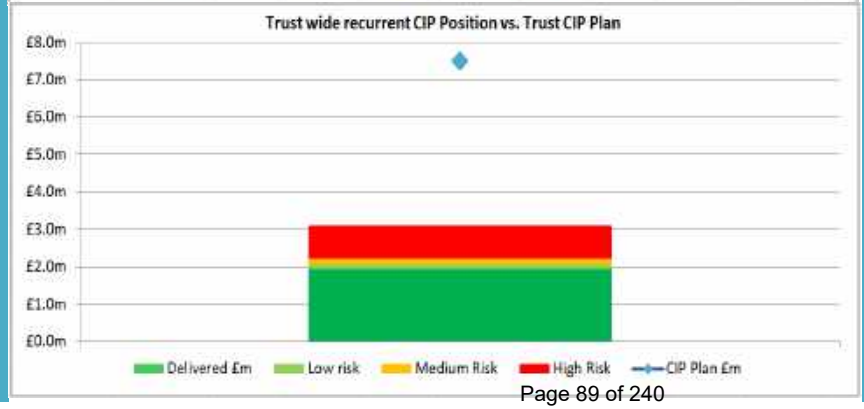
Trust Strategy

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Use of Resources Rating Red: Use of Resource Rating 4 Amber: Use of Resource Rating 3 Green: Use of Resource Rating 1 and 2	UoR SOF **The current Use of Resources Rating is 3 (Liquidity and I&E margin are 4, Capital Servicing Capacity is 3, Agency Ceiling is 2 and Distance from Financial Plan is 1).**		**The current Use of Resources Rating of 3 which is the planned rating.**	**To monitor, report and manage financial performance to improve all Use of Resources metrics and achieve the planned rating of 3.**
Agency Spending Red: More than 105% of ceiling Amber: Over 100% but below 105% of ceiling Green: Equal to or less than agency ceiling.	UoR SOF **The actual agency spend in the month is £0.7m which increases the year to date spend to £7.8m.**		**The cumulative spend of £7.8m is £0.6m above the cumulative agency ceiling of £7.2m.**	**To monitor and report the use and spend on agency and use VAT efficient models to reduce costs. The Trust is part of a Cheshire & Mersey collaborative that has established a standard rate card across all staff groups and specialties to reduce rates and is enhancing processes and controls to ensure appropriate and best use of agency staff.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Finance & Sustainability - Trust Position

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

Trust Performance	Trend	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
Cost Improvement Programme - In year performance to date Red: 0-70% Plan delivered YTD Amber: 70-90% Plan delivered YTD Green: >90% Plan delivered YTD		The monthly savings are £0.8m which increases the year to date savings to £4.8m.	The cumulative savings of £4.8m are £1.6m above the £3.2m target.
Cost Improvement Programme - Plans in Progress - In Year Red: Forecast is less than 50% of annual target Amber: Forecast is between 50% and 90% of the annual target Green: Forecast is more than 90% of the annual target		Best case In-year forecast for CIP is £6.9m (92% of target).	Best case In-Year forecast for CIP is £6.9m which is £0.6m below the £7.5m target.	To support all CBUs and Corporate Divisions with schemes utilising all tools and benchmarking information available such as Model Hospital, GIRFT, NHSI support. CIP progress is reviewed on a weekly and monthly basis. Where possible, the Trust seeks to accelerate schemes and is reviewing additional areas to support further cost reductions.
Cost Improvement Programme - Plans in Progress - Recurrent Red: Forecast is less than 50% of annual target Amber: Forecast is between 50% and 90% of the annual target Green: Forecast is more than 90% of the annual target		Best case Recurrent forecast for CIP is £3.1m (41% of target).	Best case Recurrent forecast for CIP is £3.1m which is £4.4m below the £7.5m target. This presents a risk of £1.3m to the 2020/21 financial plan which estimated recurrent delivery of £4.4m.	

Appendix 3 – Trust IPR Indicator Overview

Indicator	Detail
Quality	
Incidents	Number of Serious Incidents and actions breached. Number of open incidents is the total number of incidents that we have awaiting review. As part of the 2018 - 2021 Trust Quality Strategy, the Trust has pledged to Increase Incident Reporting to ensure that we don't miss opportunities to learn from our mistakes and make changes to protect patients from harm.
CAS Alerts	The Central Alerting System (CAS) is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and others, including independent providers of health and social care. Timescales are individual dependent upon the specific CAS alerts.
Duty of Candour	Every healthcare professional must be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress. Duty of Candour is where we contact the patient or their family to advise of the incident; this has to be done within 10 working days. Duty of Candour must be completed within 10 working days.
Adult, Children's and Maternity Safety Thermometer	Measures % of adult patients who received "harm free care" defined by the absence of pressure ulcers, falls, catheter-acquired UTI's and VTE (Safety Thermometer). Children's and Maternity data has been requested. Measures % of child patients who have received an appropriate PEWS (paediatric early warning score), IV observation, pain management, pressure ulcer moisture lesion. Measures % of maternity patients who received "harm free care" in relation to defined by proportion of women that had a maternal infection, 3rd/4th perineal trauma, that had a PPH of more than 1000mls, who were left alone at a time that worried them, term babies born with an Apgar of less than 7 at 5 minutes, mother and baby separation and women that had concerns about safety during labour and birth not taken seriously.
Healthcare Aquired Infections (MRSA, CDIFF and Gram Negative)	Methicillin-resistant Staphylococcus aureus (MRSA) is a bacterium responsible for several difficult-to-treat infections in humans. Those that are sensitive to methicillin are termed methicillin susceptible Staphylococcus aureus (MSSA). Clostridium difficile, also known as C. difficile or C. diff, is a bacterium that can infect the bowel. Escherichia coli (E-Coli) bacteraemia which is one of the largest gram negative bloodstream infections. MRSA - National objective is zero tolerance of avoidable MRSA bacteraemia. If breached a £10,000 penalty in respect of each incidence in the relevant month. MSSA - Has no National objective set by public health. Clostridium Difficule (c-diff) due to lapses in care; agreed threshold is <=27 cases per year. E-Coli, Klebsiella, Pseudomonas aeruginosa - A national objective has been set to reduce gram negative bloodstream infections (GNBSI) by 50% by March 2021.
Total Falls & Harm Levels	Total number of falls per month and their relevant harm levels (Inc Staff Falls).
Pressure Ulcers	Pressure ulcers, also known as pressure sores, bedsores and decubitus ulcers, are localised damage to the skin and/or underlying tissue that usually occur over a bony prominence as a result of pressure, or pressure in combination with shear and/or friction.

Medication Safety	Overview of the current position in relation to medication, to include; medication reconciliation, controlled drugs incidents and medication incidents relating to harm.
Staffing Average Fill Levels	Percentage of planned verses actual for registered and non-registered staff by day and night. Target of >90%. The data produced excludes CCU, ITU and Paediatrics.
Care Hours Per Patient Day (CHPPD)	Staffing Care Hours Per Patient Per Day (CHPPD). The data produced excludes CCU, ITU and Paediatrics.
HSMR Mortality Ratio	Hospital Standardised Mortality Ratio (HSMR 12 month rolling). The HSMR is a ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in-hospital deaths (multiplied by 100) for 56 specific Clinical Classification System (CCS) groups.
SHMI Mortality Ratio	Summary Hospital-level Mortality Indicator (SHMI 12 month rolling). SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.
NICE Compliance	The National Institute for Health and Clinical Excellence (NICE) is part of the NHS and is the independent organisation responsible for providing national guidance on treatments and care for people using the NHS in England and Wales and is recognised as being a world leader in setting standards for high quality healthcare and are the most prolific producer of clinical guidelines in the world.
Complaints	Overall review of the current complaints position, including; Number of complaints received, number of dissatisfied complaints, total number of open complaints, total number of cases over 6 months old, total number of cases in backlog where they have breached timeframes, number of cases referred to the Parliamentary and Health Service Ombudsman and the number of complaints responded to within timeframe.
Friends and Family Test (Inpatient & Day Cases)	Percentage of Inpatients and day case patients recommending the Trust. Patients are asked - How likely are you to recommend our ward to friends and family if they needed similar care or treatment?
Friends and Family (ED and UCC)	Percentage of AED (Accident and Emergency Department) patients recommending the Trust: Patients are asked - How likely are you to recommend our AED to friends and family if they needed similar care or treatment?
CQC Insight Composite Score	The CQC Insight report measures a range of performance metrics and gives an overall score based on the Trust's performance against these indicators. This is the CQC Insight Composite Score.
Continuity of Carer	Better Births, the report of the National Maternity Review, set out a clear recommendation that the NHS should roll out continuity of carer, to ensure safer care based on a relationship of mutual trust and respect between women and their midwives. This relationship between care giver and receiver has been proven to lead to better outcomes and safety for the woman and baby, as well as offering a more positive and personal experience.
Access & Performance	
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.
RTT Open Pathways and 52 week waits	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.
Four hour A&E Target and 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.
A&E Waiting Times Over 12 Hours (Decision to Admit to Admission)	The number of patients who has experienced a wait in A&E longer than 12 hours.
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.
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.
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.
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.
Ambulance Handovers 30 – 60 minutes	Number of ambulance handovers that took 30 to <60 minutes (based on the data record on the HAS system).
Ambulance Handovers – more than 60 minutes	Number of ambulance handovers that took 60 minutes or more (based on the data record on the HAS system).
Discharge Summaries – Sent within 24 hours	The Trust is required to issue and send electronically a fully contractually complaint Discharge Summary within 24 hrs of the patients discharge. This metric relates to Inpatient Discharges only.
Discharge Summaries – Not sent within 7 days	If the Trust does not send 95% of discharge summaries within 24hrs, the Trust is then required to send the difference between

	the actual performance and the 95% required standard within 7 days of the patients discharge.
Cancelled operations on the day for non-clinical reasons	% of operations cancelled on the day or after admission for non-clinical reasons.
Cancelled operations on the day for non-clinical reasons, not rebooked in within 28 days	All service users who have their operation cancelled on the day or after admission for a non-clinical reason, should be offered a binding date for readmission within 28 days.
Urgent Operations – Cancelled for a 2nd Time	Number of urgent operations which have been cancelled for a 2nd time.
Super Stranded Patients	Stranded Patients are patients with a length of stay of 7 days or more. Super Stranded patients are patients with a length of stay of 21 days or more. The number relates to the number of inpatients on the last day of the month.
Workforce	
Sickness Absence	Comparing the monthly sickness absence % with the Trust Target (4.2%) previous year, and peer average.
Return to Work	A review of the completed monthly return to work interviews.
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.
Vacancy Rates	% of Trust vacancies against whole time equivalent.
Retention	Staff retention rate % over the last 12 months.
Turnover	A review of the turnover percentage over the last 12 months.
Bank & Agency Reliance	Trust reliance on bank/agency staff against the peer average.
Agency Shifts Compliant with the Price Cap	% of agency shifts compliant with the Trust cap against peer average.
Pay Spend – Contracted and Non-Contracted	A review of Contracted and Non-Contacted pay against budget.
Core/Mandatory Training	A summary of the Core/Mandatory Training Compliance, this includes: Conflict Resolution, Equality & Diversity, Fire Safety, Health & Safety, Infection Prevention & Control, Information Governance, Moving & Handling, PREVENT, Resuscitation and Safeguarding.
Performance & Development Review (PDR)	A summary of the PDR compliance rate.
Finance	
Financial Position	Operating surplus or deficit compared to plan.
Cash Balance	Cash balance at month end compared to plan (excluding cash relating to the hosting of the Sustainability and Transformation Partnership).
Capital Programme	Capital expenditure compared to plan (The capital plan has been increased to £10.2m as a result of additional funding from the Department of Health, Health Education England for equipment and building enhancements).
Better Payment Practice Code	Payment of non NHS trade invoices within 30 days of invoice date compared to target.
Use of Resources Rating	Use of Resources Rating compared to plan.
Agency Spending	Agency spend compared to agency ceiling.
Cost Improvement Programme – In Year Performance	Cost savings schemes deliver Year to Date (YTD) compared to plan.

Cost Improvement Programme – Plans in Progress (In Year)	Cost savings schemes in-year compared to plan.
Cost Improvement Programme – Plans in Progress (Recurrent)	Cost savings schemes recurrent compared to plan.

Appendix 4 - Statistical Process Control

What is SPC?

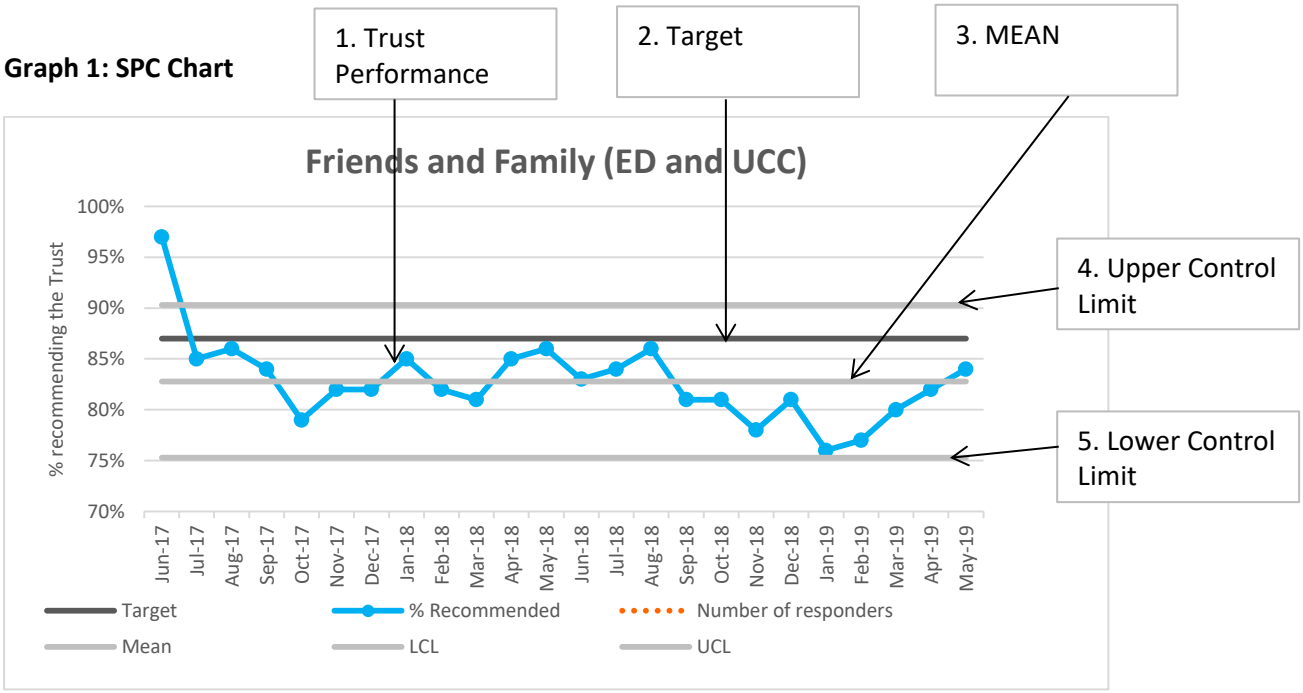
Statistical Process Control (SPC) is method used to measure changes in data/processes over time and is designed to move away from month to month data comparisons. SPC charts help to overcome the limitations of RAG ratings, through using statistics to identify patterns and anomalies, distinguishing changes and both common cause (normal) and special cause (unexpected) variation.

SPC Charts

In addition to the process/metric being measured, SPC charts on the IPR have 3 additional lines.

- Mean – is the average of all the data points on the graph. This is used a basis for determining statistically significant trend or pattern.
- Upper Control Limit – the upper limit that any data point should statistically reach within expected variation. If any one datapoint breaches this line, this is what is known as special cause variation.
- Lower Control Limit – the lower limit than any data point should statistically reach within expected variation. If any one datapoint breaches this line, this is what is known as special cause variation.

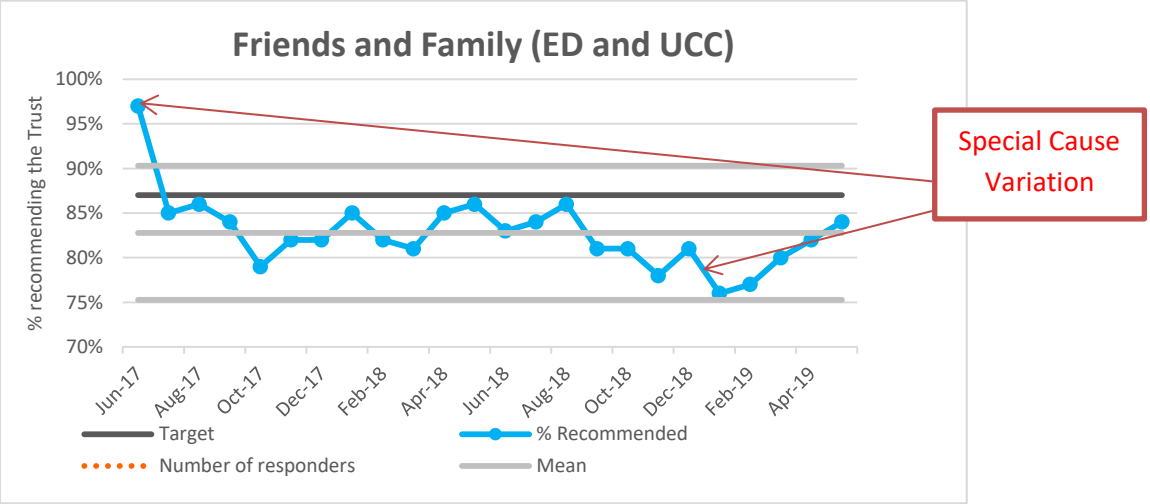
Graph 1: SPC Chart



Interpreting a SPC Chart

There are 3 main rules to interpreting a SPC chart, if one of these rules is broken, there special cause variation present and this means the process is not in control and requires investigation. Please note that breaching the rules does not necessarily mean the process needs to be changed immediately, but it does need to be investigated to understand the reasons for the variation.

1. All data points should be within the upper and lower control limits.
2. No more than 6 consecutive data points are above or below the mean line.
3. There are more than 5 consecutive points either increasing or decreasing.



In the example above, there are two instances of special cause variation; in June 2017 the data point was outside of the upper control limit. Between September 2018 and April 2019, the data points all fall below the mean line.

For high targets (e.g. above 90%) if the upper control limit is below the target, it's unlikely the Trust will achieve the target using the current process.

For low targets (e.g. below 10%) if the lower control total is above the target, it's unlikely the Trust will achieve the target using the current process.

For the purposes of the Trust IPR, the RAG ratings (Red, Amber, Green) will be maintained to understand the Trusts current performance against the outlined targets. SPC should be considered side by side with the RAG rating as it's possible for a process to be within control but not meeting the target.

Income Statement, Activity Summary and Use of Resources Ratings as at 31st December 2019

Income Statement	Month			Year to date		
	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Operating Income						
NHS Clinical Income						
Elective Spells	2,376	2,381	5	24,773	23,057	-1,716
Elective Excess Bed Days	14	1	-13	124	136	12
Non Elective Spells	5,167	5,907	740	48,288	52,515	4,227
Non Elective Bed Days	163	-34	-197	1,483	1,425	-58
Non Elective Excess Bed Days	257	38	-219	2,312	1,029	-1,283
Outpatient Attendances	2,678	2,833	155	27,579	28,007	428
Accident & Emergency Attendances	1,356	1,396	41	12,472	12,590	118
Other Activity	5,208	5,369	161	48,830	48,185	-645
Sub total	**17,219**	**17,891**	**672**	**165,860**	**166,944**	**1,084**
Non NHS Clinical Income						
Private Patients	21	20	-1	197	105	-92
Non NHS Overseas Patients	6	12	6	54	93	39
Other non protected	85	114	29	769	740	-29
Sub total	**112**	**146**	**34**	**1,020**	**938**	**-82**
Other Operating Income						
Training & Education	609	669	60	5,482	5,633	150
Donations and Grants	0	0	0	0	40	40
Provider Sustainability Fund (PSF)	487	487	0	3,165	3,392	227
Financial Recovery Fund (FRF)	1,202	1,202	0	7,809	7,809	0
Marginal Rate Emergency Tariff (MRET)	81	81	0	729	729	0
Miscellaneous Income	1,168	1,615	447	10,438	13,960	3,522
Sub total	**3,547**	**4,054**	**507**	**27,623**	**31,562**	**3,939**
Total Operating Income	**20,878**	**22,091**	**1,213**	**194,503**	**199,443**	**4,940**
Operating Expenses						
Employee Benefit Expenses	-15,864	-16,119	-255	-145,032	-146,219	-1,188
Drugs	-1,230	-1,359	-129	-11,118	-11,918	-800
Clinical Supplies and Services	-1,620	-1,894	-274	-14,756	-16,292	-1,536
Non Clinical Supplies	-2,150	-2,714	-564	-19,787	-21,117	-1,331
Depreciation and Amortisation	-595	-591	4	-5,341	-5,207	134
Total Operating Expenses	**-21,459**	**-22,676**	**-1,218**	**-196,033**	**-200,754**	**-4,720**
Operating Surplus / (Deficit)	**-581**	**-585**	**-4**	**-1,530**	**-1,311**	**220**
Non Operating Income and Expenses						
Interest Income	3	11	8	27	73	46
Interest Expenses	-73	-73	0	-665	-669	-4
PDC Dividends	-148	-148	0	-1,328	-1,328	0
Total Non Operating Income and Expenses	**-218**	**-210**	**8**	**-1,966**	**-1,924**	**42**
Surplus / (Deficit)	**-799**	**-795**	**3**	**-3,496**	**-3,235**	**261**
Adjustments to Financial Performance						
Less Donations & Grants Income	0	0	0	0	-40	-40
Add Depreciation on Donated & Granted Assets	14	16	2	122	146	24
Total Adjustments to Financial Performance	**14**	**16**	**2**	**122**	**106**	**-16**
Performance against Control Total inc PSF, FRF & MRET	**-785**	**-779**	**6**	**-3,374**	**-3,129**	**245**
Less PSF, FRF & MRET Funding	-1,770	-1,770	0	-11,703	-11,930	-227
Performance against Control Total exc PSF, FRF & MRET	**-2,555**	**-2,549**	**6**	**-15,077**	**-15,059**	**19**

Activity Summary	Planned	Actual	Variance	Planned	Actual	Variance
Elective Spells	2,638	2,575	-63	26,752	26,018	-734
Elective Excess Bed Days	-407	-510	-103	0	0	0
Non Elective Spells	2,894	2,458	-436	27,237	30,016	2,779
Non Elective Bed Days	463	-97	-560	4,211	4,046	-165
Non Elective Excess Bed Days	-7,883	-3,777	4,106	0	0	0
Outpatient Attendances	22,714	23,798	1,084	233,965	235,401	1,436
Accident & Emergency Attendances	9,826	9,497	-329	90,361	86,902	-3,459

Use of Resources Ratings	Planned Metric	Actual Metric	Variance Metric	Planned Metric	Actual Metric	Variance Metric
Metrics						
Capital Servicing Capacity (Times)				1.88	1.40	-0.47
Liquidity Ratio (Days)				-47.0	-45.2	1.9
I&E Margin - Metric (%)				-1.73%	-1.69%	0.05%
I&E Margin - Distance from financial plan (%)				0.00%	0.05%	0.05%
Agency Ceiling (%)				0.00%	8.10%	8.10%
Ratings						
Capital Servicing Capacity (Times)				2	3	1
Liquidity Ratio (Days)				4	4	0
I&E Margin - Metric (%)				4	4	0
I&E Margin - Distance from financial plan (%)				1	1	0
Agency Ceiling (%)				1	2	1
Use of Resources Rating				**3**	**3**	**0**

Appendix 6

Capital Programme as at 31st December 2019

Scheme Name	Approved Programme	Externally Funded	Budget Adjustments M01-M08	Proposed Budget Adjustments M09	Total Revised Budget
	£000	£000	£000	£000	£000
ESTATES					
Estates - Schemes b/f 18/19					
Emergency Fire Exit Staircases (Kendrick & Appleton)	41		(41)		0
Water Safety Compliance	3		(3)		0
Halton Endoscopy Essential power supply to rooms 1 & 2	20		(20)		0
Air Conditioning / Cooling Systems upgrade. Phase 1 - Survey	12		(12)		0
Automatic sliding / entrance doors across all sites	20				20
Estates Minor Works	12				12
Dishwasher x 5	1		(1)		0
CCU Relocation to Ward A3	8				8
Substation B Air Circuit Breakers	404		(356)		48
Electrical Infrastructure Upgrade	42				42
North Lodge Fire Compartmentation	150				150
Appleton Wing Fire Doors	100		(100)		0
Thelwall House Emergency Escape Lighting	4				4
Cheshire House Fire Doors	23		(3)		20
Discharge Lounge/Bereavement Office	17				17
Essential Power Installation - Halton Pharmacy	6				6
N20 Exposure	100				100
Catering EHO Works	9		(9)		0
CQC (Environmental Improvements)	923		(449)		474
CQC Prep Room Doors	24				24
CQC (Enviromental Improvements) - A4 Bathroom	24				24
CQC (Enviromental Improvements) - A8 Bathroom	24				24
Halton Outpatients Refurbishment	69		(69)		0
CQC (MLU)	600		268		868
Emergency Generator Repairs - Halton	7				7
Butterfly Suite	19				19
ITU UPS Replacement	7				7
Door Lock (FAU)	5				5
Estates Schemes b/f 18/19 Total	**2,674**	**0**	(795)	0	**1,879**
Estates - Mandated Schemes 19/20					
Replacement Lift - Phase 1 Halton	250		(70)		180
Staffing Costs for Capital Team on Capital Schemes	177		6		183
Halton 30 Minute Fire Compartmentation	150				150
Appleton Wing 60 Minute Fire Doors	100		(100)		0
Warrington & Halton Gas Meter Replacement	100		(100)		0
North Lodge Basement - Fire Compmt Part 2/2	100				100
Fixed Installation Wiring & Testing & Repairs	150				150
6 Facet Survey	60		(20)		40
North Lodge & Catering Emergency Lighting	50				50
Water Safety Compliance	50				50
Replacement of External Fire Escapes to Kendrick & Appleton	40				40
Asbestos Management Survey Reinspection and works	30				30
Pharmacy Fire Doors	30		(30)		0
Halton Residential Blocks 2 & 3 Fire Doors	25		(25)		0
Daresbury Plant Room - Alternative Fire Escape	20				20
Estates Dept Fire Doors	20		(20)		0
Cheshire House Emergency Lighting	20		(20)		0
Thelwall House - Improvements to Fire Alarm system	20		(20)		0
Estates Dept Fire Compartmentation of Risk Areas	10				10
Estates - Mandated Total	**1,402**	**0**	**(399)**	**0**	**1,003**
Estates - Trust Funded Schemes 19/20					
Appleton Wing - replace 5 No LV Changeover Switches	40		(40)		0
Backlog - High Voltage Annual Requirements & Maintenance	60		(20)		40
Backlog - Patient Environment Improvements	100		(65)		35
Induction of Labour Ward (CQC)	78		(78)		0
CT Scanner Electrical Substation	1,365		(468)		897
CT Scanner Estates Works			468		468
CT Scanner Turnkey Works				68	68
CT Scanner Electical Works (Connection Box)				10	10
Chillers - Day case Theatre & MRI			65		65
Contact Centre Relocation (OPD)			24		24
Paediatric Outpatients			20		20
Ward Bathroom Falls Prevention			80		80
Conversion of 6 Accommodation Rooms			20		20
Front Entrance			80		80
CCTV - ITU				6	6
Croft Wing Doors				8	8
Medical Gas Alarm Panel				8	8
Substation C Roof				16	16
Ward B3 Nurse Call				60	60
Estates - Trust Funded 19/20 Total	**1,643**	**0**	**86**	**176**	**1,905**
Estates Total	**5,719**	**0**	**(1,108)**	**176**	**4,787**
INFORMATION TECHNOLOGY					

Information Technology b/f from 18/19					
Technology & Devices Refresh and Developments	141				**141**
IPPMA / ePrescribing / EPMA	0				**0**
Security (Stonesoft Firewall Renewal)	2				**2**
VDI Roll Out	117				**117**
Meditech Restoration	5				**5**
Deontics Care Pathway	8				**8**
Falsified Medicines Directive	83				**83**
BI Interactive Screens	11				**11**
Information Technology b/f from 18/19 Total	**367**	**0**	**0**	**0**	**367**
Information Technology Trust Funded 19/20					
EPMA	319		65		**384**
EPMA - Eprescribing/Drugs Trolleys	229				**229**
ICE Upgrade			31		**31**
Devices Refresh Phase 1			188		**188**
Molis Infection Control Module			32		**32**
Cardiology Systems Upgrade			92		**92**
H & W Workspace Computer Migration			13		**13**
Lease 4000				9	**9**
Audiology Auditbase Software				35	**35**
Information Technology Trust Funded 19/20 Total	**548**	**0**	**421**	**44**	**1,013**
Information Technology Total	**915**	**0**	**421**	**44**	**1,380**
MEDICAL EQUIPMENT					
Medical Equipment - Schemes b/f 18/19					
Oral Surgery Dental Chair x 1	1		(1)		**0**
Bladder Scanner (FAU)	8		(8)		**0**
Ultrasound Rheumatology	29				**29**
Stress Test System	31				**31**
Medical Equipment Schemes b/f 18/19 Total	**69**	**0**	**(9)**	**0**	**60**
Medical Equipment Trust Funded 19/20					
Ultrasound Machines	150				**150**
Ultrasound Transducer No1			7		**7**
Curvilinear Transducer			6		**6**
Paediatric MRI Scanning			13		**13**
Osmometer			11		**11**
Ultrasound Transducer - No 2 - Interventional Radiology			7		**7**
CT Scanner Machine (Part 1 Trust Funded Exc Estates Work & Turnkey)		390	1,000	(512)	**878**
Cell Washer			7		**7**
Intra-Aortic Balloon Pump			49		**49**
Mortuary Equipment			73		**73**
Anaesthetic Machines & Monitors Inc Networking	260		324	59	**643**
Recovery Monitors Wa, Ha & CMTC	390				**390**
Anaesthetic Ultrasound for Vascular	70				**70**
Patient Transfer Ventilators	55				**55**
Laparoscopic Video Imagery Systems	160				**160**
Facial Nerve Monitor	0		18		**18**
NIV Machines	47				**47**
Bladder Scanners - Urology	0		18		**18**
Replacement Patient Monitoring System in ED	300		81		**381**
Foetal CTG Monitor Labour Ward	39				**39**
Screening Quality Assurance Service - Cold Coagulation & Monitors	0		41		**41**
AER machines (4 W 2 H)	700				**700**
Medical Equipment Trust Funded 19/20 Total	**2,171**	**390**	**1,655**	**(453)**	**3,763**
Medical Equipment Total	**2,240**	**390**	**1,646**	**(453)**	**3,823**
Total Trust Funded Capital	**8,874**	**390**	**959**	**(233)**	**9,990**
CONTINGENCY					
Prior Year Adjustments (VAT Rebates)					**0**
General Contingency	972		(959)	346	**359**
Contingency Total	**972**	**0**	**(959)**	**346**	**359**
Externally Funded					
CANTREAT Modifications	84		**(72)**		**12**
Outdoor Play Area Phase 1 (CF)	5		36		**41**
Cancer Trans Prog - MDT Equipment (PDC)	7		(7)		**0**
EPR Developments WA Digital Maturity (PDC)	81				**81**
Training Simulator Equipment (HEE)	10				**10**
Tomosynthesis (Boot Out Breast Cancer)	10				**10**
Parents Bathroom - Childrens Ward (CF)			8		**8**
Bladder Scanner - FAU (LOF)			9		**9**
Breast Symptomatic Schemes (PDC Funded)		648		(113)	**535**
Externally Funded Total	**197**	**648**	**(26)**	**(113)**	**706**
Kendrick Wing Fire					
Kendrick Wing Fire	3,500				**3,500**
Kendrick Wing Fire Total	**3,500**	**0**	**0**	**0**	**3,500**
Grand Total	**13,543**	**1,038**	**(26)**	**0**	**14,555**

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/20/01/07**			
SUBJECT:	**Safe Staffing Assurance Report – October 2019**			
DATE OF MEETING:	29 January 2020			
AUTHOR(S):	Rachael Browning, Assistant Chief Nurse, Clinical Effectiveness			
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse			
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience.			
	SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future.			
	SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.			
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	#115 Failure to provide adequate staffing levels in some specialities and wards.			
EXECUTIVE SUMMARY *(KEY ISSUES):*	In October 2019 ward staffing data continued to be systematically reviewed to ensure we safely staff our wards and provide mitigation and action when a ward falls below 90% of planned staffing levels. In the month of October 2019 it was noted that 13 of the 23 wards were below the 90% target during the day, which was the same as September 2019. In order to ensure safe staffing levels, mitigation and responsive plans continue to be put in place to ensure that the safe delivery of patient care is discussed at every bed meeting and escalated as appropriate. It is a recommendation of the National Quality Board (NQB 2018) that the Board of Directors receives a monthly Safe Staffing report, which includes the measure of Care Hours Per Patient Day (CHPPD) and 'planned' versus 'actual' staffing levels, highlighting areas where average fill rates fall below 90%, along with mitigation to ensure safe, high quality care is consistently delivered for those areas. CHPPD has increased to 7.4 in October, which is an increase 7.1 reported in September giving and overall year to date figure of 7.4. The report demonstrates the progress that continues to be made across the organisation in Nursing and Midwifery staffing levels as the number of wards reporting staffing levels below the 90% and CHPPD levels remaining consistent.			
PURPOSE: *(please select)*	Information *	Approval	To note *	Decision
RECOMMENDATION:	Trust Board asked to note the contents of this report as discussed and received at the Strategic People Committee			
PREVIOUSLY CONSIDERED BY:	**Committee**	Strategic People Committee		
	Agenda Ref.	SPC/20/01/XXX		
	Date of meeting			
	Summary of Outcome			
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED:	None			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Safe Staffing Assurance Report – October 2019	AGENDA REF:	BM/20/01/07

1. BACKGROUND/CONTEXT

Safe Staffing Assurance Report – October 2019

The purpose of this report is to provide transparency with regard to the nursing and midwifery ward staffing levels during October 2019. The Trust has a duty to ensure nursing and midwifery staffing levels are sufficient to maintain safety and provide quality care. It forms part of the expectation set out in the National Quality Board (NQB) guidance published in 2016 and in their recommendations in 2018, that Boards take full responsibility for the quality of care provided to patients, and, as a key determinant of quality, take full responsibility for nursing, midwifery and care staffing capacity and capability. This paper provides assurance that any shortfalls on each shift are reviewed and addressed, with actions to ensure safe staffing levels are provided and reviewed at the daily staffing meeting. It is well documented that nurse staffing levels make a difference to patient outcomes (mortality and adverse events, including levels of harm), patient experience, and quality of care and the efficiency of care delivery.

2. KEY ELEMENTS

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

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

Care Hours Per patient Day

Warrington and Halton Hospitals NHS Trust currently collects and reports CHPPD data on a monthly basis. CHPPD is the total time spent on direct patient care based on the number of occupied beds at midnight. The October 2019 Trust wide staffing data was analysed and cross-referenced, with ward level data for validation by the Deputy Chief Nurse, Lead Nurses, and the Associate Chief Nurse (Clinical Effectiveness).

Chart 1 illustrates the monthly data and in October 2019 and increase in CHPPD was seen at 7.4, in comparison to the previous months. The Trust overall year to date position is 7.4. This is in comparison to the peer median of 7.8 and the national median figure of 8.1 hours over the same period and represents an improvement from 2018 / 19 where we ended the year with an overall rate of 7.0.

This will continue to be monitored via the Trust monthly Safer Staffing Report.

Chart 1 – CHPPDD 2019

Financial year	Month	Cumulative count over the month of patients at 23:59 each day	CHPPD - Registered	CHPPD - Care Staff	CHPPD All
2019/20	April	14008	4.4	3.2	7.6
	May	14623	4.3	3.3	7.6
	June	14410	4.3	3.2	7.5
	July	14917	4.2	3.3	7.5
	August	15282	3.9	3.2	7.1
	September	14927	4.0	3.1	7.1
	October	15271	4.1	3.2	7.4
2019/20 Total		103438	4.2	3.2	7.4

Key Messages

Currently we have 98 registered nurse vacancies at WHH, which requires reliance on temporary staffing to ensure safe staffing levels on the ward. Although there are areas above the 90% fill rate in month, it is acknowledged that the percentage of registered nurses/midwives on 13 of the 23 wards is below target during the day.

In order to ensure safe staffing levels, mitigation and responsive plans continue to be put in place to ensure that the safe delivery of patient care is discussed at every bed meeting and escalated as appropriate. Shift fill rates continue to improve month on month.

Maternity (ward C23) although showing below the 90% target on the ward (77.1%), use their responsive staffing plans in the unit to move staff to support if acuity requires additional staffing.

Recruitment and retention remains a priority for the senior nursing team. Further recruitment events are planned for both registered nurses and health care assistants. This will include a rolling adverts on NHS jobs, attendance at university / college open days and nurse recruitment open days taking place in January, May and October 2020.

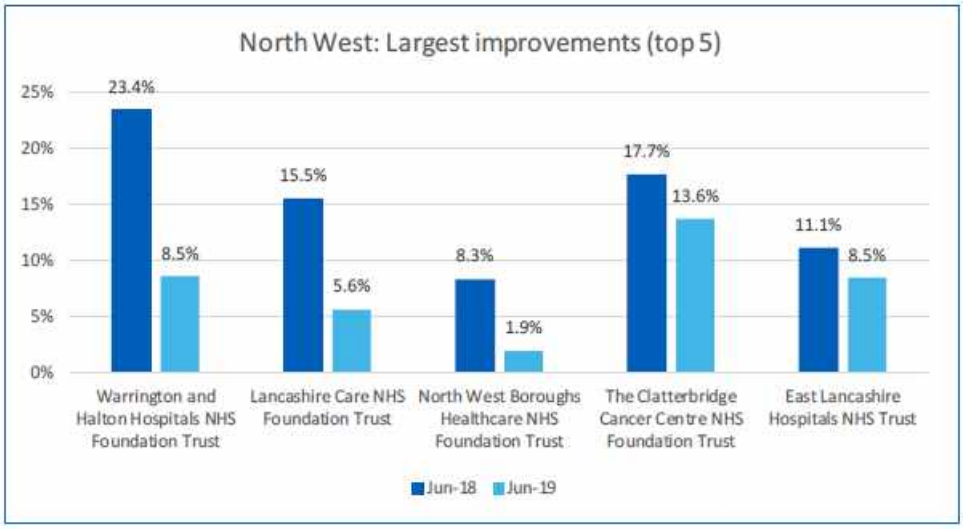
The Trust are part of cohort 4 of the NHSI Retention workforce collaborative, which has enabled access to best practice and exemplar practice from other organisations as well as identifying our retention priorities and plan for 2019.

Initial assessment of the data, in conjunction with staff engagement, has indicated a requirement to focus on the following areas

- Work life balance
- Continued professional development
- Recognising and Valuing Experience (RAVE)
- Developing and empowering line managers

The aim of the collaborative is to reduce the turnover of our Nursing and Midwifery workforce by 1.5% over the next 12 months. Good progress has been made under these work streams, it is pleasing to note in October 2019 nursing and midwifery turnover is at 12.03%, making an overall reduction of 2.96% at month 11 of the NHSI programme.

NHS England and NHS Improvement have recently submitted a presentation to the Joint Directors of Nursing and CCG Chief Nurses detailing nurse vacancy data. It is pleasing to note WHH were recognised in this presentation as one of the top 5 Trusts in the North West making the largest improvements to nursing vacancies, reducing our overall vacancies from 23.4% to 8.5%.



Escalation Beds and Costs

Additional bed capacity has been utilised to support the operational pressures in the Trust in October 2019. The General Practitioner Assessment Unit (GPAU, 16 beds) on occasion, has been used as an inpatient overnight facility. The senior nursing team monitor the additional beds and associated staffing costs for these areas (based on NHSP rates). The table below provides a summary of the areas with associated weekly, monthly and annual costs;

Area	Weekly cost	Monthly	Annual
Discharge Lounge	£529	£2116	£25,392
GPAU (7nights)	£5720	£22,880	£274,560
Ward B3	£17,301.70	£69,206.80	£830,481.60
Total	**£23,550.70**	**£94,202.80**	**£1,130,433.60**

Staffing levels are reviewed daily to determine the additional staffing required ensuring patient safety as part of the daily operational staffing plans.

Patient Harm by Ward

In October 2019 we have reported 8 category 2 pressure ulcers on wards A4, A5, A9, B12, B14 (x2) and C21 (x2). There have been no patient falls with moderate or major harm in October 2019.

Infection Incidents

In October 2019 we haven't reported any cases of MRSA bacteraemia, or infection outbreaks.

Warrington and Halton

Appendix 1	MONTHLY SAFE STAFFING REPORT –October 2019

Monthly Safe Staffing Report – October 2019

		Day	Day	Day	Day	Day	Day	Night	Night	Night	Night	Night	Night		CHPPD				
CBU	Ward	Planned RN hours	Actual RN hours	Planned HCA hours	Actual HCA hours	% RN fill rate	% HCA fill rate	Planned RN hours	Actual RN hours	Planned HCA hours	Actual HCA hours	% RN fill rate	% HCA fill rate	Cumulative count over the month of patients at 23:59 each day	RN	HCA	RNA	AHP	Overall
		= above 100%		= above 90%			= above 80%			= below 80%									
DD	SAU	930	922.5	697.5	667.5	99.2%	95.7%	0	0	0	0	-	-						
DD	Ward A5	1633	1334	1391.5	1316.8	81.7%	94.6%	1069.5	1069.5	1069.5	1069.5	100%	100%	992	2.4	2.4	0.0	0.2	5.0
DD	Ward A6	1633	1316.5	1391.5	1316.8	80.6%	94.5%	1069.5	1046.5	1069.5	1069.5	97.8%	100%	992	2.4	2.4	0.0	0.0	4.9
DD	Ward B4	701.5	701.5	517.5	517.5	100%	100%	241.5	241.5	264.5	264.5	100%	100%	0	-	-	-	-	-
DD	Ward A4	1633	1344	1391.5	1391.5	81.7%	100%	1069.5	1023.5	1069.5	1069.5	95.7%	100%	992	2.4	2.5	0.2	0.0	5.0
MSK	Ward CMTC	1150	1130	828	797	98.3%	96.3%	713	701.5	644	621	98.4%	96.4%	355	5.2	4.0	0.3	0.0	9.5
MSK	Ward A9	1782.5	1459	1449	1418	81.9%	97.9%	1069.5	1069.5	1426	1426	100%	100%	989	2.6	2.9	0.1	0.0	5.6
W&C	Ward B11	3012.5	2984.5	940	922.5	99.1%	98.1%	1649.2	1638.4	322.4	322.4	99.3%	100%	458	10.1	2.7	0.6	0.0	13.8
W&C	NNU	1782.5	1694.4	356.5	241.5	95.1%	67.7%	1782.5	1610	356.5	276	90.3%	77.4%	297	11.1	1.7	0.0	0.0	12.9
W&C	Ward C20	966	897	644	736	92.9%	114.3%	644	735	0	345	114.3%	-	444	3.7	2.4	0.4	0.0	6.5
W&C	Ward C23	1426	1099	713	713	77.1%	100%	770.5	770.5	713	701.5	100%	98.4%	383	4.9	3.7	0.0	0.0	8.6
W&C	Birth Suite	2495.5	2306.1	355.5	304.5	92.4%	85.4%	2495.5	2079.5	356.5	322	83.3%	90.3%	246	17.8	2.5	0.0	0.0	20.3
UEC	Ward A1	2325	2037.5	2325	2875	87.5%	123.7%	1527.5	1623.6	970	1116	99.8%	115.1%	1147	3.2	3.5	0.0	0.0	6.7
UEC	Ward A2	1426	1115.5	1782.5	1662.5	78.2%	93.3%	1069.5	1069.5	1069.5	1138.5	100%	106.5%	868	2.5	3.2	0.0	0.0	5.7
IM&C	Ward C21	1357	1014.5	1664	1442.5	74.8%	86.7%	839.5	839.5	839.5	1196	100%	142.5%	821	2.3	3.2	0.0	0.0	5.5
IM&C	Ward A8	1782.5	1426	1426	1610	80%	112.9%	1426	1380	1069.5	1161.5	96.8%	108.6%	1054	2.7	2.6	0.0	0.1	5.4
IM&C	Ward B12	1069.5	986	2495.5	2385.8	92.2%	95.6%	713	713	1782.5	1781	100%	99.9%	651	2.6	6.4	0.0	0.1	9.1
IM&C	Ward B14	1426	1096.5	1426	1601.5	76.9%	112.3%	713	713	713	1265	100%	177.4%	744	2.4	3.9	0.0	0.0	6.3
IM&C	Ward B18	1426	1171.3	1805.5	1400	82.1%	77.5%	1069.5	965.9	1449	1391.5	90.3%	96%	744	2.9	3.8	0.0	0.0	6.6
IM&C	Ward B19	1069.5	1058	1426	1621.5	98.9%	113.7%	713	713	1069.5	1259	100%	117.7%	744	2.4	3.9	0.0	0.0	6.3
MC	Ward A7	1782.5	1477.5	1426	1434	82.9%	100.6%	1426	1403	1069.5	1092.5	98.4%	102.2%	1023	2.8	2.5	0.0	0.0	5.3
MC	ACCU	2495.5	2368.5	1069.5	1069.5	94.9%	100%	1782.5	1702	1068.5	1127	95.5%	105.4%	791	5.1	2.8	0.1	0.0	8.0
MC	ICU	4991	4358.5	1069.5	994.8	87.3%	93%	4991	4450.5	1069.5	954.5	89.2%	89.2%	536	16.4	3.6	0.0	0.0	20.1

Appendix 2

October 2019 - Mitigating Actions

The Unify Safe Staffing return guidance states that all wards with inpatient beds need to be included, with the exception of;

- Day care wards
- CDU/other clinical assessment units
- Additional capacity wards (B3)

Ward B1 at Halton is a CCG Ward and therefore is not part of the Trusts Unify return

	DAY		NIGHT		MITIGATING ACTIONS
	Average fill rate - registered nurses/midwives (%)	Average fill rate – Health Care support staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - Health Care support staff (%)	
SAU	99.2%	95.7%	-	-	**Vacancy:** - Band 6 1.0 wte (Vacancy on hold due to merge with GPAU to form CAU) **Sickness rate** 13.22% **Action taken:** - Attendance management policy followed.
Ward A5	81.7%	94.6%	100%	100%	**Vacancy:** Band 6 2.59 wte Band 5 2.35 wte **Sickness rate:** 5.67% **Action taken:** Daily review by the matron to review staffing levels and acuity, staff moved from other areas to support. Attendance management policy followed, monthly meeting with HR and welfare meetings arranged. Ongoing recruitment plans in place
Ward A6	80.6%	94.5%	97.8%	100%	**Vacancy:** - Band 6 1.36 wte Band 5 6.33 wte **Sickness rate** – 6.98% **Action taken:** Daily review by the matron to review staffing levels and acuity, staff moved from other areas to support. Attendance management policy followed, monthly meeting with HR and welfare meetings arranged. Targeted recruitment plan in place
Ward B4	100%	100%	100%	100%	**Vacancy**: no vacancies **Sickness rate** –12.75% **Action taken:** Daily staffing review against acuity and activity. Sickness absence being managed in line with the Trust policy.
Ward A4	81.7%	100%	95.7%	100%	**Vacancy:** - Band 6 3.36wte, Band 5 2.0 wte, band 2 2.0wte **Sickness rate** – 2.79% **Action taken:** Staffing and activity reviewed daily. Recruitment programme in place. Attendance management policy followed, Sickness absence being managed in line with the Trust policy.
Ward CMTC	98.3%	96.3%	98.4%	96.4%	**Vacancy:** Band 5 3.0 wte band 2 1.0 **Sickness rate –** 9.96% **Action taken**: Recruitment plan in place Sickness absence being managed in line with the Trust policy.
Ward A9	81.9%	97.9%	100%	100%	**Vacancy:** Band 5 – 1.0 wte band 2 3.0wte **Sickness rate** – 2.98% **Action taken:** Staffing reviewed daily and support provided if necessary. Sickness absence being managed in line with the Trust policy.
Ward B11	99.1%	98.1%	99.3%	100%	**Vacancy:** Band 6 0.67wte **Sickness Rate:** 1.7% **Action taken:** - Staffing reviewed daily and support provided if necessary.
NNU	95.1%	67.7%	90.3%	77.4%	**Vacancy rate:** Band 7 0.15 wte, band 5 0.41

					Sickness Rate: 1.83% **Action taken:** Sickness is managed via the Trust policy. Staffing reviewed daily and support provided if necessary.
Ward C20	92.9%	114.3%	114.3%	-	**Vacancy: :** Band 5 2.0 wte, Band 2 0.89 wte **Sickness Rate:** 7.90% **Action taken:** Staffing reviewed daily by the matron and staff moved to support if required and additional shifts request via NHSP. Sickness is being managed in line with Trust policy.
Ward C23	77.1%	100%	100%	98.4%	**Vacancy:** fully established **Sickness rate** – 6% **Action taken:** Daily review of staffing and staffed moved from other areas depending on acuity and occupancy. Sickness policy followed and supported by HR
Delivery Suite	92.4%	85.4%	83.3%	90.3%	**Vacancy:** - Band 5 0.6wte Band 2 1.6 wte **Sickness rate** – 4.60% **Action taken:** Daily review of staffing and acuity, staff moved from other areas to support and additional staff access via NHSP. Sickness is being managed in line with Trust policy.
Ward A1	87.5%	123.7%	99.8%	115.1%	**Vacancy :** - 0.54 wte Band 6, Band 5 4.66wte and 2.51wte band 2 **Sickness Rate:** 4.51% **Action taken:** 7 band 5 nurses commenced in post in October 2019. Ongoing recruitment. Daily review of staffing and acuity, staff moved from other areas to support and additional staff access via NHSP.
Ward A2	78.2%	93.3%	100%	106.5%	**Vacancy:** Band 5 9.91wte **Sickness Rate:** 9.73% **Action taken:** Daily review of staffing and acuity, staff moved from other areas to support and additional staff access via NHSP. Band 5 recruitment plans in place. Sickness is being managed in line with Trust policy.
Ward C21	74.8%	86.7%	100%	142.5%	**Vacancy :-** Band 5 0.54 wte **Sickness Rate:** 21.35% **Action taken:** - Daily review of staffing and acuity, staff moved from other areas to support and additional staff access via NHSP. Sickness is being managed in line with Trust policy.
Ward A8	80%	112.9%	96.8%	108.6%	**Vacancy :** - Band 6 2.0 wte band 5 –3.0wte Band 2 2.35wte **Sickness Rate:** 11.9% **Action taken** 2.0 wte band 6 awaiting start dates. Recruitment plan in place. Ward support by the continued use of NHSP and agency to ensure safe staffing levels. Pharmacy Technician support morning and lunchtime supports nursing staff.
Ward B12	92.2%	95.6%	100%	99.9%	**Vacancy :** - Band 5 2.57wte Band 2 1.0 wte **Sickness Rate:** 7.59% **Action taken**: - Recruitment plan in place. Daily review by the matron to review staffing levels and acuity, staff moved from other areas to support.
Ward B14	76.9%	112.3%	100%	177.4%	**Vacancy :-** 3.37wte Band 5, 1.68wte band 2 **Sickness Rate:** 12.72% **Action taken:** - recruitment plan in place Staffing reviewed daily against acuity and activity. Sickness is being managed in line with Trust policy.
Ward B18	82.1%	77.5%	90.3%	96%	**Vacancy :** -Band 5 2.94 wte band 2 0.5wte **Sickness Rate:** 6.44% **Action taken:** - Recruitment ongoing, staffing reviewed on daily basis by matron and ward

					manager
Ward B19	98.9%	113.7%	100%	117.7%	**Vacancy :** -Band 5 1.21wte band 2 1.94 **Sickness Rate:** 1.55% **Action taken:** - Ward reviewed daily for acuity and staffing.
Ward A7	82.9%	100.6%	98.4%	102.2%	**Vacancy :** Band 5 4.92wte band 2 0.22wte **Sickness Rate:** 6.4% **Action taken:** - Staffing reviewed daily against acuity and activity. Recruitment plan in place
ACCU	94.9%	100%	95.5%	105.4%	**Vacancy :** band 2 0.68wte **Sickness Rate:** 9.2% **Action taken:** Staffing reviewed daily against acuity and activity, staff support accessed from other areas when required. Sickness is being managed in line with Trust policy
ICU	87.3%	93%	89.2%	89.2%	**Vacancy :** – 2.6wte band 5 2.76wte band 2 **Sickness rate** – 6.83% **Action taken:** - Sickness absence managed robustly in line with Trust Attendance Management Policy. Rota shortfall managed with temporary staffing, mainly own staff via NHSP. Recruitment plan in place
Total Fill Rate (%)	**87.6%**	**99.5%**	**95.2%**	**107.7%**	

3. ASSURANCE COMMITTEE

The monthly staffing report is received and discussed at the Strategic People Committee

4. RECOMMENDATIONS

Board asked to note the contents of this report as discussed and received at the Strategic People Committee

Kimberley Salmon-Jamieson
Chief Nurse and DIPC
December 2019

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/20/01/07**	
SUBJECT:	**Safe Staffing Assurance Report – November 2019**	
DATE OF MEETING:	29 January 2020	
AUTHOR(S):	Rachael Browning, Assistant Chief Nurse, Clinical Effectiveness	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future. SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.	 *
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	#115 Failure to provide adequate staffing levels in some specialities and wards.	
EXECUTIVE SUMMARY *(KEY ISSUES):*	In November 2019 ward staffing data continued to be systematically reviewed to ensure we safely staff our wards and provide mitigation and action when a ward falls below 90% of planned staffing levels. In the month of November 2019 it was noted that 13 of the 23 wards were below the 90% target during the day, which was the same as October 2019. In order to ensure safe staffing levels, mitigation and responsive plans continue to be put in place to ensure that the safe delivery of patient care is discussed at every bed meeting and escalated as appropriate. It is a recommendation of the National Quality Board (NQB 2018) that the Board of Directors receives a monthly Safe Staffing report, which includes the measure of Care Hours Per Patient Day (CHPPD) and 'planned' versus 'actual' staffing levels, highlighting areas where average fill rates fall below 90%, along with mitigation to ensure safe, high quality care is consistently delivered for those areas. CHPPD has decreased to 7.2 in November, in comparison to 7.4 reported in October giving an overall year to date figure of 7.4. The report demonstrates the progress that continues to be made across the organisation in Nursing and Midwifery staffing levels as the number of wards reporting staffing levels below the 90% and CHPPD levels remaining consistent.	
PURPOSE: *(please select as appropriate)*	Information * / Approval / To note * / Decision	
RECOMMENDATION:	Trust Board asked to note the contents of this report as discussed and received at the Strategic People Committee	
PREVIOUSLY CONSIDERED BY:	**Committee**	Strategic People Committee
	Agenda Ref.	SPC/20/01/12

	Date of meeting	22 January 2020
	Summary of Outcome	Supported
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

REPORT TO BOARD OF DIRECTORS

SUBJECT	Safe Staffing Assurance Report – November 2019	AGENDA REF:	BM/20/01/07

1. BACKGROUND/CONTEXT

Safe Staffing Assurance Report – November 2019

The purpose of this report is to provide transparency with regard to the nursing and midwifery ward staffing levels during November 2019. The Trust has a duty to ensure nursing and midwifery staffing levels are sufficient to maintain safety and provide quality care. It forms part of the expectation set out in the National Quality Board (NQB) guidance published in 2016 and in their recommendations in 2018, that Boards take full responsibility for the quality of care provided to patients, and, as a key determinant of quality, take full responsibility for nursing, midwifery and care staffing capacity and capability. This paper provides assurance that any shortfalls on each shift are reviewed and addressed, with actions to ensure safe staffing levels are provided and reviewed at the daily staffing meeting. It is well documented that nurse staffing levels make a difference to patient outcomes (mortality and adverse events, including levels of harm), patient experience, and quality of care and the efficiency of care delivery.

2. KEY ELEMENTS

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

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

Care Hours Per patient Day

Warrington and Halton Hospitals NHS Trust currently collects and reports CHPPD data on a monthly basis. CHPPD is the total time spent on direct patient care based on the number of occupied beds at midnight. The November 2019 Trust wide staffing data was analysed and cross-referenced, with ward level data for validation by the Deputy Chief Nurse, Lead Nurses, and the Associate Chief Nurse (Clinical Effectiveness).

Chart 1 illustrates the monthly data and in November 2019 a decrease in CHPPD was seen at 7.2, in comparison to the previous month of October which was 7.4. The Trust overall year to date position is 7.4. This is in comparison to the peer median of 7.8 and the national median figure of 8.1 hours over the same period and represents an improvement from 2018 / 19 where we ended the year with an overall rate of 7.0.

This will continue to be monitored via the Trust monthly Safer Staffing Report.

Chart 1 – CHPPDD 2019

Financial year	Month	Cumulative count over the month of patients at 23:59 each day	CHPPD - Registered	CHPPD - Care Staff	CHPPD All
2019/20	April	14008	4.4	3.2	7.6
	May	14623	4.3	3.3	7.6
	June	14410	4.3	3.2	7.5
	July	14917	4.2	3.3	7.5
	August	15282	3.9	3.2	7.1
	September	14927	4.0	3.1	7.1
	October	15271	4.1	3.2	7.4
	November	14940	4.0	3.1	7.2
2019/20 Total		118378	4.2	3.2	7.4

Key Messages

Currently we have 89 registered nurse vacancies (a reduction from 98 in Oct 19) at WHH, which requires reliance on temporary staffing to ensure safe staffing levels on the ward. Although there are areas above the 90% fill rate in month, it is acknowledged that the percentage of registered nurses/midwives on 13 of the 23 wards is below target during the day.

In order to ensure safe staffing levels, mitigation and responsive plans continue to be put in place to ensure that the safe delivery of patient care is discussed at every bed meeting and escalated as appropriate. Shift fill rates continue to improve month on month.

Maternity (ward C23) although showing slightly below the 90% target on the ward (89.9%), use their responsive staffing plans in the unit to move staff to support if acuity requires additional staffing.

Recruitment and retention remains a priority for the senior nursing team. Further recruitment events are planned for both registered nurses and health care assistants. This will include a rolling adverts on NHS jobs, attendance at university / college open days and nurse recruitment open days taking place in January, May and October 2020.

The Trust are part of cohort 4 of the NHSI Retention workforce collaborative, which has enabled access to best practice and exemplar practice from other organisations as well as identifying our retention priorities and plan for 2019.

Initial assessment of the data, in conjunction with staff engagement, has indicated a requirement to focus on the following areas

- Work life balance
- Continued professional development
- Recognising and Valuing Experience (RAVE)
- Developing and empowering line managers

The aim of the collaborative is to reduce the turnover of our Nursing and Midwifery workforce by 1.5% over the next 12 months. Good progress has been made under these work streams, it is pleasing to note in November 2019 nursing and midwifery turnover is at 12.55%, making an overall reduction of 2.44% at month 11 of the NHSI programme.

Escalation Beds and Costs

Additional bed capacity has been utilised to support the operational pressures in the Trust in November 2019. The General Practitioner Assessment Unit (GPAU, 16 beds) on occasion, has been used as an inpatient overnight facility. The senior nursing team monitor the additional beds and associated staffing costs for these areas (based on NHSP rates). The table below provides a summary of the areas with associated weekly, monthly and annual costs;

Escalation Beds Open

November 2019

Unfunded Beds	In Month				Year to Date			
Ward	No. Bed Days	Additional Costs £	Notional Bed Day Cost £	Total Cost £	No. Bed Days	Additional Costs £	Notional Bed Day Cost £	Total Cost £
GPAU	116	28,509	0	28,509	1075	264,204	0	264,204
C20 / GAU	75	16,176	0	16,176	420	90,583	0	90,583
A4	25	0	6,000	6,000	174	0	41,760	41,760
A5	18	0	4,320	4,320	44	0	10,560	10,560
AMU	13	0	3,120	3,120	32	0	7,680	7,680
C21	0	0	0	0	55	17,387	0	17,387
CDU	34	0	8,160	8,160	44	0	10,560	10,560
Totals	**281**	**44,685**	**21,600**	**66,285**	**1844**	**372,174**	**70,560**	**442,734**

Funded Beds	In Month				Year to Date			
Ward	No. Bed Days	Additional Costs £	Notional Bed Day Cost £	Total Cost £	No. Bed Days	Additional Costs £	Notional Bed Day Cost £	Total Cost £
B3	687	155,297	0	155,297	4759	1,075,780	0	1,075,780
K25	353	79,796	0	79,796	849	191,918	0	191,918
Totals	**1040**	**235,094**	**0**	**235,094**	**5608**	**1,267,697**	**0**	**1,267,697**

**NB B3 – funded by Halton Borough Council / Winter Funding*
K25 – funded by winter funding

Staffing levels are reviewed daily to determine the additional staffing required ensuring patient safety as part of the daily operational staffing plans.

Patient Harm by Ward

In November 2019 we have reported 8 category 2 pressure ulcers on wards A2, A9, B14, B18 (x2), C20, C21 and K25. There have been no patient falls with moderate or major harm in Novemeber 2019.

Infection Incidents

In November 2019 we haven't reported any cases of MRSA bacteraemia.

Appendix 1	MONTHLY SAFE STAFFING REPORT – November 2019																		
Monthly Safe Staffing Report – November 2019																			
		Day	Day	Day	Day	Day	Day	Night	Night	Night	Night	Night	Night		CHPPD				
CBU	Ward	Planned RN hours	Actual RN hours	Planned HCA hours	Actual HCA hours	% RN fill rate	% HCA fill rate	Planned RN hours	Actual RN hours	Planned HCA hours	Actual HCA hours	% RN fill rate	% HCA fill rate	Cumulative count over the month of patients at 23:59 each day	RN	HCA	RNA	AHP	Overall
		= above 100%		= above 90%			= above 80%			= below 80%									
DD	SAU	930	922.5	697.5	667.5	99.2%	95.7%	-	-	-	-	-	-	-	-	-	-	-	-
DD	Ward A5	1621.5	1322.5	1380	1276.5	81.6%	92.5%	1035	931.5	1035	1046.5	90%	101.1%	960	2.3	2.4	0.0	0.2	4.9
DD	Ward A6	1621.5	1178.8	1380	1293.5	72.7%	93.7%	1035	908.5	1035	1035	87.8%	100%	960	2.2	2.4	0.0	0.2	4.8
DD	Ward B4	701.5	671	616	616	95.7%	100%	241.5	241.5	0	0	100%	-	0	-	-	-	-	-
DD	Ward A4	1621.5	1357	1380	1368.5	83.7%	99.2%	1035	920	1035	1035	88.9%	100%	960	2.4	2.5	0.2	0.0	5.0
MSK	CMTC	1000.5	983.5	816.5	778.5	98.3%	95.3%	690	678.5	414	414	98.3%	100%	275	6.0	4.3	1.0	0.0	11.4
MSK	Ward A9	1725	1505.5	1633	1518	87.3%	93%	1161.5	1150	1380	1368.5	99%	99.2%	1018	2.6	2.8	0.1	0.0	5.6
W&C	Ward B11	2858.3	2823.3	870	870	98.8%	100%	1596	1596	312	312	100%	100%	399	11.1	3.0	0.0	0.0	14.2
W&C	NNU	1725	1604	345	276	93%	80%	1725	1403	345	289	81.3%	83.8%	289	10.4	2.0	0.0	0.0	12.4
W&C	Ward C20	966	880.5	644	506	91.1%	78.6%	678	678.5	0	0	100.1%	-	432	3.6	1.2	0.1	0.0	5.1
W&C	Ward C23	1426	1282	713	667	89.9%	93.5%	759	759	713	713	100%	100%	526	3.9	2.6	0.0	0.0	6.5
W&C	Birth Suite	2415	2283.5	345	306.5	94.6%	88.8%	2415	2079.5	345	345	86.1%	100%	246	17.7	2.6	0.0	0.0	20.4
UEC	Ward A1	2250	1737.5	2250	2625	77.2%	116.7%	1575	1560.1	938.7	938.7	99.1%	100%	1110	3.0	3.2	0.0	0.0	6.2
UEC	Ward A2	1380	1046.5	1725	1391.5	75.8%	80.7%	1035	1035	1035	1081	100%	104.4%	840	2.5	2.9	0.0	0.0	5.4
IM&C	Ward C21	1035	842	1035	1268.5	81.4%	122.6%	690	690	1035	958	100%	92.6%	720	2.1	3.1	0.0	0.2	5.5
IM&C	Ward A8	1725	1289	1380	1241	74.7%	89.9%	1380	1173	1035	1020.5	85%	98.6%	1020	2.4	2.2	0.0	0.1	4.8
IM&C	Ward B12	1035	892.5	2415	2146.5	86.2%	88.9%	690	690	1725	1690.5	100%	98%	630	2.5	6.1	0.0	0.2	8.9
IM&C	Ward B14	1380	1257.5	1380	1456.5	91.1%	105.5%	690	690	690	1174.5	100%	170.2%	720	2.7	3.7	0.0	0.0	6.4
IM&C	Ward B18	1380	1131	1725	1481	82%	85.9%	1035	851	1380	1311	82.2%	95%	720	2.8	3.9	0.0	0.0	6.6
IM&C	Ward B19	1035	1016.5	1380	1399.5	98.2%	101.4.%	690	701.5	1035	1023.5	101.7%	98.9%	720	2.4	3.4	0.0	0.0	5.8
MC	Ward A7	1725	1384.5	1380	1443	80.3%	104.6%	1380	1242	1035	1230.5	90%	118.9%	990	2.7	2.7	0.0	0.0	5.4
MC	ACCU	2495.5	2481.5	1069.5	1069.5	99.4%	100%	1782.5	1782.5	1069.5	1138.5	100%	106.5%	931	4.6	2.4	0.0	0.0	7.0
MC	ICU	4830	4122.8	1035	1075.3	85.4%	103.9%	4830	4094	1035	885	84.8%	85.5%	474	17.3	4.1	0.0	0.0	21.5

Appendix 2

November 2019 - Mitigating Actions

The Unify Safe Staffing return guidance states that all wards with inpatient beds need to be included, with the exception of;

- Day care wards
- CDU/other clinical assessment units
- Additional capacity wards (B3)

Ward B1 at Halton is a CCG Ward and therefore is not part of the Trusts Unify return

	DAY		NIGHT		MITIGATING ACTIONS
	Average fill rate - registered nurses/midwives (%)	Average fill rate – Health Care support staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - Health Care support staff (%)	
SAU	99.2%	95.7%	-	-	**Vacancy:** - Band 6 1.0 wte (Vacancy on hold due to merge with GPAU to form CAU) **Sickness rate** 13.22% **Action taken:** - Attendance management policy followed.
Ward A5	81.6%	92.5%	90%	101.1%	**Vacancy:** Band 6 2.59 wte Band 5 2.35 wte **Sickness rate:** 5.67% **Action taken:** Daily review by the matron to review staffing levels and acuity, staff moved from other areas to support. Attendance management policy followed, monthly meeting with HR and welfare meetings arranged. Ongoing recruitment plans in place
Ward A6	72.7%	93.7%	87.8%	100%	**Vacancy:** - Band 6 1.36 wte Band 5 6.33 wte **Sickness rate** – 6.98% **Action taken:** Daily review by the matron to review staffing levels and acuity, staff moved from other areas to support. Attendance management policy followed, monthly meeting with HR and welfare meetings arranged. Targeted recruitment plan in place
Ward B4	95.7%	100%	100%	-	**Vacancy**: no vacancies **Sickness rate** –12.75% **Action taken:** Daily staffing review against acuity and activity. Sickness absence being managed in line with the Trust policy.
Ward A4	83.7%	99.2%	88.9%	100%	**Vacancy:** - Band 6 3.36wte, Band 5 2.0 wte, band 2 2.0wte **Sickness rate** – 2.79% **Action taken:** Staffing and activity reviewed daily. Recruitment programme in place. Attendance management policy followed, Sickness absence being managed in line with the Trust policy.
Ward CMTC	98.3%	95.3%	98.3%	100%	**Vacancy:** Band 5 3.0 wte band 2 1.0 wte **Sickness rate –** 5.71% **Action taken**: Recruitment plan in place Sickness absence being managed in line with the Trust policy.
Ward A9	87.3%	93%	99%	99.2%	**Vacancy:** Band 5 – 3.0 wte band 2 3.06wte **Sickness rate** – 5.94% **Action taken:** Staffing reviewed daily and support provided if necessary. Sickness absence being managed in line with the Trust policy.

Ward B11	98.8%	100%	100%	100%	**Vacancy:** Band 6 0.67wte **Sickness Rate:** 1.84% **Action taken:** - Staffing reviewed daily and support provided if necessary.
NNU	93%	80%	81.3%	83.8%	**Vacancy rate:** band 5 0.47 wte **Sickness Rate:** 6.71% **Action taken:** Sickness is managed via the Trust policy. Staffing reviewed daily and support provided if necessary.
Ward C20	91.1%	78.6%	100.1%	-	**Vacancy: :** Band 5 2.0 wte **Sickness Rate:** 7.90% **Action taken:** Staffing reviewed daily by the matron and staff moved to support if required and additional shifts request via NHSP. Sickness is being managed in line with Trust policy.
Ward C23	89.9%	93.5%	100%	100%	**Vacancy:** fully established **Sickness rate** – 6.32% **Action taken:** Daily review of staffing and staffed moved from other areas depending on acuity and occupancy. Sickness policy followed and supported by HR
Delivery Suite	94.6%	88.8%	86.1%	100%	**Vacancy:** - fully established **Sickness rate** – 5.12% **Action taken:** Daily review of staffing and acuity, staff moved from other areas to support and additional staff access via NHSP. Sickness is being managed in line with Trust policy.
Ward A1	77.2%	116.7%	99.1%	100%	**Vacancy :** - 1.54 wte Band 6, Band 5 4.66wte, band 4 3.75wte and 1.51wte band 2 **Sickness Rate:** 5.29% **Action taken:** Ongoing recruitment. Daily review of staffing and acuity, staff moved from other areas to support and additional staff access via NHSP.
Ward A2	75.8%	80.7%	100%	104.4%	**Vacancy:** band 6 1.0wte, Band 5 2.5wte, band 4 1.0wte and band 2 1.0wte **Sickness Rate8.5**% **Action taken:** Daily review of staffing and acuity, staff moved from other areas to support and additional staff access via NHSP. Band 5 recruitment plans in place. Sickness is being managed in line with Trust policy.
Ward C21	81.4%	122.6%	100%	92.6%	**Vacancy :-** Band 5 0.56 wte, band 4 1.96wte **Sickness Rate:** 24.43% **Action taken:** - Daily review of staffing and acuity, staff moved from other areas to support and additional staff access via NHSP. Sickness is being managed in line with Trust policy.
Ward A8	74.7%	89.9%	85%	98.6%	**Vacancy :** - Band 6 1.0 wte band 5 –4.0wte Band 2 2.0wte **Sickness Rate:** 6.78% **Action taken 1**.0 wte band 6 awaiting start dates. Recruitment plan in place. Ward support by the continued use of NHSP and agency to ensure safe staffing levels. Pharmacy Technician support morning and lunchtime supports nursing staff.
Ward B12	86.2%	88.9%	100%	98%	**Vacancy :** - Band 5 3.57wte Band 2 3.25 wte **Sickness Rate:** 7.85% **Action taken**: - Recruitment plan in place. Daily review by the matron to review staffing levels and acuity, staff moved from other areas to support.

Ward B14	91.1%	105.5%	100%	170.2%	**Vacancy :-** 3.36wte Band 5, 1.68wte band 2 **Sickness Rate:** 15.44% **Action taken:** - recruitment plan in place Staffing reviewed daily against acuity and activity. Sickness is being managed in line with Trust policy.
Ward B18	82%	85.9%	82.2%	95%	**Vacancy :** -Band 5 2.98 wte band 2 0.89wte **Sickness Rate:** 6.82% **Action taken:** - Recruitment ongoing, staffing reviewed on daily basis by matron and ward manager
Ward B19	98.2%	101.4.%	101.7%	98.9%	**Vacancy :** -Band 5 1.21wte band 2 0.98wte **Sickness Rate:** 1.0% **Action taken:** - Ward reviewed daily for acuity and staffing.
Ward A7	80.3%	104.6%	90%	118.9%	**Vacancy :** Band 5 4.92wte band 2 0.22wte **Sickness Rate:** 11.53% **Action taken:** - Staffing reviewed daily against acuity and activity. Recruitment plan in place
ACCU	99.4%	100%	100%	106.5%	**Vacancy :** band 5 1.47wte **Sickness Rate:** 4.17 **Action taken:** Staffing reviewed daily against acuity and activity, staff support accessed from other areas when required. Sickness is being managed in line with Trust policy
ICU	85.4%	103.9%	84.8%	85.5%	**Vacancy :** – 3.0wte band 5 2.76wte band 2 **Sickness rate** – 4.86% **Action taken:** - Sickness absence managed robustly in line with Trust Attendance Management Policy. Rota shortfall managed with temporary staffing, mainly own staff via NHSP. Recruitment plan in place
Total Fill Rate (%)	**87.5%**	**96.9%**	**91.9%**	**102.1%**	

3. ASSURANCE COMMITTEE

The monthly staffing report is received and discussed at the Strategic People Committee

4. RECOMMENDATIONS

Board asked to note the contents of this report as discussed and received at the Strategic People Committee

Kimberley Salmon-Jamieson
Chief Nurse and DIPC
November 2019

BOARD OF DIRECTORS CHAIR'S KEY ISSUES REPORT

AGENDA REFERENCE:	BM 20/01/07 b	COMMITTEE OR GROUP:	Trust Board	DATE OF MEETING	29 January 2020

Date of Meeting	7 January 2020
Name of Meeting + Chair	Quality Assurance Committee, Chaired by Margaret Bamforth
Was the meeting quorate?	Yes

The Quality Assurance Committee met on 7th January 2020. The following matters were discussed:

- A Patient Story was received;
- Update provided of a deep dive in to Urology was received;
- The Committee received a High Level Briefing relating to Moving to Outstanding Action Plan;
- The Committee reviewed the Quality Dashboard and associated KPIs;
- An update was provided on Maternity Services and on the Maternity Safety Champions work;
- The Committee reviewed and considered Medicines Governance Report;
- The Committee reviewed and considered Review of Cardiology Governance Activity;
- The Committee reviewed and considered outcomes of Never Event Investigation;
- The Committee reviewed and received the Dementia Strategy Q2 report;
- The Strategic Risk Register, Board Assurance Framework and Corporate Risk Register were reviewed and considered;
- The Committee reviewed and received Access to Health Records Policy;
- The Committee reviewed and approved proposed amendments to Terms of Reference and 2020-21 Cycle of Business
- A HLB was received from the Patient Safety and Clinical Effectiveness Sub-Committee, the Urgent & Emergency Care Improvement Committee, the Safeguarding Sub-Committee, the Complaints Quality Assurance Group, the Patient Experience Sub-Committee, the Infection Control Sub-Committee, the End of Life Steering Group & Strategy and the Information Governance & Corporate Records Sub Committee.

Following consideration of the above, the Committee wishes to bring the following matters to the attention of the Board:

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/ mandate to receiving body	Follow up/ Review date
QAC/20 /01/05	Moving to Outstanding	The Committee noted the following in respect of the action plan following the recent CQC inspection: • 63 actions, 24 completed,; 9 part completed and further evidence requested; 18 actions on track for completion; 5 'Should Do' actions had amended agreed dates. To date 27 actions are compliant. 34 actions are outstanding; 20 due to be delivered by the end of December which includes 16 'Should Do' and 4 'However' actions. • UEC Improvement Committee and action plan closed down. The meeting will be replaced by a UEC Task & Finish Group, action plan monitored through the M2O Group with reporting to the QAC through the High Level Briefing report.	The Committee noted the update and received high assurance.	**QAC March 2020**
QAC/20 /01/03	Matters Arising - Outpatient Follow-up Backlog	• Improvements reported, the initial trajectory for completion had not been achieved. Contributing factors included, capacity challenges compounded by pension growth tax changes and subsequent impact on ability to undertake additional waiting list sessions. • A revised trajectory set to be on track by summer 2020. • All patients had been reviewed to ensure no associated harm and all patients reviewed through a continuum process. Virtual appointments and telephone consultations/reviews in a number of specialties taking place to avoid patients having to come into the hospital for follow-up appointments and to allow more efficient use of this resource.	The Committee noted the update	**PRG, PSCE and QAC**
QAC/20 /01/06	Urology	• Outcomes of Urology Deep Dive received and reviewed. • An action plan containing 15 actions against the recommendations of the report had been developed with the team; • In relation to the recommendation to create a Diagnostic unit, AMcG and CE to discuss outside of the meeting to ensure any funding requests are captured within the Capital Programme	The Committee noted the update and agreed that the action plan progress would be monitored at Patient Safety & Clinical Effectiveness Sub-Committee and Quality Assurance Committee.	**PSCE Jan & Feb 2020, QAC March 2020**

			Moderate assurance received	
QAC/20 /01/07	Quality Dashboard and Review and refresh of KPIs	The Committee received the Quality Dashboard which highlighted the following matters which are included in the IPR which will be received by the Trust Board at this meeting. Of particular note were the following matters: • 66 incidents over 40 days old open in November across 8 CBUs, targeted support for CBUs to ensure timeliness and quality of responses; • Medication safety - implementation of the 7 day service on track; medicines reconciliation – achieved 39% in month; • Friends and Family (A&E + UCC) – below internal target of 80% by 3%; action plan monitored through ED Improvement Committee • MSA – 10 breaches in November, environmental changes to create additional side rooms being progressed. • Complaints - below 90%, actions plan in place to achieve target by April 2020 through targeted work within CBUs and at Ward level. December position for timeliness of complaints reported at 80%, overall figure of 73%. • The current level of sickness absence Trust Wide was escalated to the Committee and the subsequent impact within Nursing.	The Committee received moderate assurance and the Board will review the full IPR as part of the meeting today	**Trust Board January 2020 and QAC March 2020**
QAC/20 /01/08	Maternity Safety Champion Report	• Maternity Improvement Committee to be established to support interim solution IT and Maternity Services to address current issues and explore proposals for a long term solution across the Trust and Community for Maternity data quality/recording	The Committee noted the update and agreed that a risk should be added to the Corporate Risk Register. Moderate assurance received	**Risk Review Group Feb 2020 & QAC March 2020**
QAC/20 /01/12	Spinal Services	• C&M Network are working with the Walton Centre which has been identified as Lead Provider of all future Spinal Services. • Option 3, Hub and Spoke model is the current preference. • Support for Provider and Commissioner discussions to continue to agree clear timescales and feasible options to enable a decision to be made as soon as possible. • C&M Spinal Network in infancy stages – need robust processes around appropriate patient flows; Clarification required on Non-Complex services and	The Committee discussed the quality aspects of the proposal noting that future discussions will be held in other forums ahead of final decision	**Trust Board Jan 2020**

		what these are; Risks to be fully considered when preferred option identified; Suitability of CMTC as future site for services to be reviewed		
QAC/20 /01/13	Dementia Strategy Q2	• Significant assurance provided relating to Dementia and Delirium assessments achieving above 90% for Part 1 and 2 and 100% for Part 3	The Committee noted the report and received significant assurance	**QAC March 2020**
QAC/20 /01/17	High Level Briefing - Patient Safety + Clinical Effectiveness Sub Committee	The Committee particularly noted the following matters: • DNACPR – changes to criteria for what is audited reviewed at December Resus Group, 35 sets of case notes audited, 91% compliance for completed documentation reported and compliance for documentation within notes reported at 85%. Findings of DNACPR baseline audit for period October 2019-March 2020 aligned to GIRFT, to be reported to March QAC. • Draft Consent Policy drafted, Training Needs Analysis relating to delegated Consent to be completed subject to Consent Policy approval. Update to be provided to February Audit Committee with milestones for 'Go Live'	The Committee received moderate assurance.	**February 2020 Audit Committee QAC March 2020**
QAC/20 /01/20	High Level Briefing Health + Safety Sub Committee	• Plans and pathways of communication being developed with local prisons to support arrival of patients for treatment. • Sharps compliance – slight improvement reported, continues to be addressed through informal ward rounds. Compliance to be re-audited	The Committee received moderate assurance.	**PSCE February 2020 + QAC March 2020**
QAC/20 /01/25	High Level Briefing U+E Care Committee	The Committee particularly noted the following matters: • 35 actions to address the 4 Regulatory Breaches; 9 actions transferred to Issues Log which will be monitored at CBU Governance and Operational meetings. M2O Group had agreed to close down the UEC Improvement Committee and action plan which will be replaced by a UEC Task & Finish Group. The action plan will be monitored through the M2O Group with reporting to the QAC.	The Committee received moderate assurance. Further updates to be presented at next meeting	**Moving to Outstanding, Jan & Feb 2020, QAC March 2020**

BOARD OF DIRECTORS CHAIR'S KEY ISSUES REPORT

AGENDA REFERENCE:	BM/20/01/07 c		TRUST BOARD OF DIRECTORS	DATE OF MEETING	29 January 2020

Date of Meeting	**22 January 2020**
Name of Meeting + Chair	**Strategic People Committee** **Anita Wainwright, Non-Executive Director**
Was the meeting quorate?	**Yes**

The Strategic People Committee met on 22 January 2020 and the following matters were discussed:

- The Committee received an update from the Director of HR and OD on regional and national workforce matters, and their implications for the Trust, including Digital Passports, Collaborative Working, NHS Pension, HR Priorities via Collaboration at Scare and Equality, Diversity and Inclusion.
- The Committee received a paper recommending additional workforce KPIs are added to the Integrated Performance Report, to enable Trust Board to have oversight of all key workforce indicators.
- The Committee received an overview and update of workforce related risks on the BAF and Corporate Risk Register.
- The Committee received a verbal update on the workforce implications of the Trust's Moving to Outstanding and Well Led meetings.
- The Committee received 2 policies for ratification and 1 for information.
- The Committee received an update on Employee Relations, including themes from partnership working, updates on high risk cases and progress against Improving People Practices recommendations.
- The Committee received the quarterly update from the Guardian of Safe Working for Q3.
- The Committee received the monthly Trust Board Staffing Report for October and November 2019.

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	RECEIVING BODY (eg Board or Committee)	Recommendation / Assurance/Decision/ mandate to receiving body	Follow up/ Review date
SPC/20/01/05	**Workforce KPIs**	The Committee received a recommendation to support the inclusion of the following workforce indicators on the	Trust Board	The Committee supported the	Trust Board January 2020

		IPR: • Agency Rate Card Compliance • % Use of Apprenticeship[Levy • % Workforce Carrying Out Apprenticeship Qualification • Role Specific Training		recommendation and the Board will review the full IPR as part of the meeting today	
SPC/20/01/06	**BAF and CRR – Workforce**	Risk 199 – Vacancies – vacancies across the Trust continue to reduce and a detailed work plan is in place via Recruitment and Retention Group Risk 1051 – Local Induction Temporary Medical Staff – compliance remains low, actions have been put in place at Corporate and CBU Level. Risk 200 – Sickness Absence – sickness absence increased in December 2019, drivers include long term sickness and mental ill-health. There was also discussion around the possible impact of annual leave restrictions in NWM staff. Trusts across the North West have also reported a significant increase. A number of work streams are in place to address this risk.	Trust Board	The Committee noted the update and received assurance. The Committee noted the update and received assurance. **The Committee were assured by the actions in place but would like to escalate sickness absence to Trust Board due to the level of absence in December 2019**	SPC March 2020 SPC March 2020 Trust Board January 2020 And SPC March 2020
SPC/20/01/08	**Policies and Procedures Report**	The Committee received a recommendation to ratify amendments to the Annual Leave Policy and the Policy on Time Off for Recognised Representatives and members of Trade Unions/Staff Organisations.	SPC	The Committee approved the recommendation and ratified the policies.	SPC June 2020
SPC/20/01/09	**Employee Relations Report**	Themes relating to partnership working include: • JNCC Priorities • Medical Study Leave • NHS Pensions • BMA Wellbeing Charter Within the reporting period there were 6 members of	SPC	The Committee noted the updates and received assurance. The Committee particularly noted the good practice in relation to Improving	SPC March 2020

		staff suspended, 2 members of staff on action short of suspension and 5 'other' high risk cases, including 3 employment tribunals. The action plan relating to the Improving People Practices Recommendations is on track to achieve all requirements within deadlines. Phase 2 will include evaluation of impact and scoping of opportunities to further increase inclusivity.		People Practices.	
SPC/20/01/10	**Guardian of Safe Working**	The 2016 Junior Doctor Contract is now well established. Issues regarding safe working hours, rota problems or patient safety issues are noted by Junior Doctors in the form of Exception Reporting. Trust rotas remain compliant and the Junior Doctors Forum continues to meet. As at the 6th Jan 2020, 92 Exception Reports had been received for Q3, The majority relate to doctors working in excess of their allocated hours, and reflect a busy acute workload generally. It is reassuring that only 12 reports related to missed educational opportunities, and there were no immediate safety concerns. Timeliness of sign off remains challenging. The Medical Director also updated the Committee that the outcome of the bid to NHSI relating to E-Rostering and E-Job Planning has not yet been received.	Trust Board	The Committee noted the update and the Board will review the full IPR as part of the meeting today	Trust Board January 2020

CHAIR'S KEY ISSUES REPORT

AGENDA REFERENCE:	BM/20/01/07 d	COMMITTEE OR GROUP:	Trust Board	DATE OF MEETING	29 January 2020

Date of Meeting	18 December 2019
Name of Meeting + Chair	Finance & Sustainability Committee - Terry Atherton
Was the meeting quorate?	Yes

REF	AGENDA ITEM	ISSUE	Recommendation / Assurance/ mandate to receiving body	Follow up/ Review date
FSC/19/12/162	Pay Assurance Dashboard Monthly Report	• Total pay in November £16.1m against a budget of £15.9m • Agency cap was breached in November with spend circa £0.8m. This is worrying as one of the Trust mitigations is to reduce agency. • The Trust is booking more staff cover than the established gaps some of this will relate to escalation areas. Temporary spend in month was £2.2m 12% of pay • The launch of standardised rate card across Cheshire and Mersey was expected to be delayed but this did commence at the start of December	The Committee reviewed, discussed and noted the report.	FSC Jan 2020
FSC/19/12/163	Risk Register	• No changes to risks in month 8, although it is anticipated that the BREXIT risks will change over the coming weeks. • Discussion for the Committee to look at the register in more detail in future meetings	The Committee reviewed, discussed and noted the report.	FSC Jan 2020
FSC/19/12/164	Corporate Performance	• November A&E performance is 77.81% missing trajectory of 80%. Regionally a leader and consistently middle or higher nationally.	The Committee noted the report.	FSC Jan 2020

		• Diagnostics, RTT and Cancer targets met for November • Cancer pilot – requested the Trust undertakes phase 2 to March 2020 • Super stranded 99 at present		
FSC/19/12/165	Monthly Finance report	• The monthly surplus is £0.9m which reduces the year to date deficit to £2.4m. • Elective activity is under recovering; year to date the activity is 774 spells and £1.7m below plan. In month, activity was 57 spells and £135k below plan. • Month 8 position included £0.4m "working together" support to achieve plan • Other issues discussed included B3, K25, CT scanner and Agency	The Committee reviewed, discussed and noted the report and the financial risks.	FSC Jan 2020
FSC/19/12/166	Cost Pressure	• Slight improvement in CIP bringing in year identified to £6.7m. • Noted reduction in recurrent CIP with spinal being the biggest impact • CIP delivery is above plan and expected to be until January 2020, main concern is the percentage of non-recurrent schemes which will impact on 2020/21 • Cost Pressures have been reassessed and the expected £3.0m is likely to increase to £3.9m and those which are not managed will impact on both 2019/20 and 2020/21	The Committee noted the report.	FSC Jan 2020
FSC/19/12/167	Committee Effectiveness	• The report was discussed and no key areas of concern raised	The Committee noted the report.	FSC Dec 2020
FSC/19/12/168	Key issues for escalation	• Note the impact of agency expenditure being above the ceiling on both the Trust finances and reputation. • Note the financial challenges facing the Trust including winter pressures, non-recurrent CIP and unfunded cost pressures • Note the shortfall of elective activity and Women's and Children's overspent position • Note the 4 hour performance and acknowledge achievement of all other standards		

BOARD OF DIRECTORS CHAIR'S KEY ISSUES REPORT

AGENDA REFERENCE:	BM/20/01/07 dii		TRUST BOARD OF DIRECTORS	DATE OF MEETING	29 January 2020

Date of Meeting	22 January 2020
Name of Meeting + Chair	Finance & Sustainability Committee – Terry Atherton
Was the meeting quorate?	Yes

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	RECEIVING BODY (eg Board or Committee)	Recommendation / Assurance/Decision/ mandate to receiving body	Follow up/ Review date
FSC/20/01/05	Pay Assurance Report	• Total pay In December £16.1m against a budget of £15.9m • Agency spend breached the ceiling but was the lowest monthly spend in the year to date • Agency spend was £0.135m lower than the same period in the previous year • Cheshire and Mersey rate card now live with a 60% compliance target in place	Committee	The Committee reviewed, discussed and noted the report.	FSC Feb 2020
FSC/20/01/06	BAF/Risk Register	• No changes to risks or amendment to titles in month 9 • Risk 701 in relation to step down from a no deal Brexit was discussed and agreed for closure • Risk 827 in relation to outstanding 'One to One' debt was discussed and agreed for closure • The Committee agreed for more detail to be	Committee	The Committee reviewed, discussed and noted the report.	FSC Feb 2020

		shared in future meetings as requested			
FSC/20/01/07	Corporate Performance Report	• December A&E performance is 79.45% missing the trajectory of 80%. Reasonable when compared to peers • Ambulance handovers favourable compared to peers • 'Home for Christmas' campaign proved effective, surpassing trajectory, with the lowest super stranded of 83 during the month, currently at 120 • RRT, Diagnostics, Cancer targets met in December	Committee	The Committee reviewed, discussed and noted the report.	FSC Feb 2020
FSC/20/01/08	Monthly Finance Report	• The monthly deficit of £0.8m is on plan, with a year to date deficit of £3.2m which is slightly better than plan • Compared to 2018/19 all activity is higher for the same period • The Trust is awaiting additional capital funds for diagnostic equipment, in light of this the capital programme has been amended and the Committee supported the change • Other issues discussed included agency, escalation beds and debt	Committee	The Committee reviewed, discussed and noted the report.	FSC Feb 2020
FSC/20/01/09	Combined Finance Position	• Governance arrangements for Combined Financial Position are being sought	Committee	The Committee noted the report.	FSC Feb 2020
FSC/20/01/10	Monthly Cost Pressure & CIP Report	• Cost pressures including mitigations stood at £3.0m. Further analysis has been carried out and this is now estimated to be £3.9m by year end • CIP delivery is £1.6m above plan year to date, there is a £0.6m gap as at March 20 with additional vacancy controls in place for non-clinical staff • Recurrent CIP is £3.1m at December with a £4.4m gap	Committee	The Committee reviewed, discussed and noted the report.	FSC Feb 2020
FSC/20/01/11	FRG Dashboard	• The dashboard was demonstrated and received	Committee	The Committee	N/A

		positively		discussed and noted the dashboard.	
FSC/20/01/12	Cheshire & Merseyside – 5 year strategy	• The Committee noted the report.	Committee	The Committee noted the report.	FSC Feb 2020
FSC/20/01/13	Capital Programme (process & timetable 2020/21)	• Unspent capital funds cannot carry forward into 2020/21. Two digital schemes have been brought forward. • The 2020/21 pre-approved schemes were listed followed by a breakdown of mandated, business critical, those requiring approval and non-mandatory items. • At present the capital allocation is £0.5m short for must do schemes. • Loan applications for specific schemes will be vital in securing further funds (such as the A&E plaza)	Committee	The Committee reviewed, discussed and noted the report. Request to be discussed further at the February Board Session	FSC Feb 2020
FSC/20/01/14	Key issues to the Board	• Note the impact of agency expenditure remaining above the ceiling • Note the setup of the Maternity Improvement Committee led by the Chief Operating Officer • Supported changes to the 2019/20 capital programme • Note the shortfall and continued challenge faced in identification and delivery of recurrent CIP • Note the unfunded cost pressures of £3.9m to be carried forward into 2020/21 • Note the importance of loan applications and the impact for capital funds	Committee		FSC Feb 2020

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/20/01/08**	
SUBJECT:	**M2O update**	
DATE OF MEETING:	**January 2020**	
AUTHOR(S):	John Goodenough, Deputy Chief Nurse / Layla Alani, Deputy Director of Governance	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future. SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.	X X X
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	#115 Failure to provide adequate staffing levels in some specialities and wards. #134 (a) Failure to sustain financial viability. #134 (b) Failure to deliver the financial position and a surplus #135 Failure to provide adequate and timely IMT system. #224 Failure to meet the emergency access standard. #125 Failure to maintain an old estate. #701 Failure to provide continuity of services caused by the planned EU Exit. #145 (a) Failure to deliver our strategic vision. #145 (b) Failure to fund two new hospitals. #143 Failure to deliver essential services, caused by Cyber Attack. #414 Failure to implement best practice information governance and information security. #241 Failure to retain medical trainee doctors.	
EXECUTIVE SUMMARY *(KEY ISSUES):*	In April/May 2019 the Trust underwent CQC inspection with the final report received in June 2019, rating the Trust as 'good'. Following review of the report an action plan has been developed highlighting key areas for further improvement and focus. There are 63 actions across 35 recommendations detailed within the CQC action plan. This includes: • The Urgent and Emergency Care Improvement Plan which has been completed identified some specific actions which have been transferred to the M20 meeting. Regulatory breaches will remain in place until the next CQC formal inspection. • The next quarterly CQC Provider Engagement Meeting is due to be held with Executives on 31st January 2020. Future dates for 2020 are now confirmed. The Trust CQC action plan following receipt of the CQC report	

	from the 2019 inspection is shown in **Appendix 1.**			
PURPOSE: ***(please select as appropriate)***	Information	Approval	To note √	Decision
RECOMMENDATION:	Assurance can be offered to the Board that the CQC action plan is on track with 57% of actions completed. The Moving to Outstanding framework will be discussed at the Board Away Day in February 2020.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.	QAC/20/01/05		
	Date of meeting	7 January 2020		
	Summary of Outcome	Quality Assurance Committee have noted 57% completion of the CQC action plan. This was approved by the Executive Directors and core service leads.		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

REPORT TO BOARD OF DIRECTORS

SUBJECT	CQC Update Report	AGENDA REF:	BM/20/01/08

1. BACKGROUND/CONTEXT

The Trust received the CQC Report in June 2019, following the inspection in April/May 2019.

An action plan has been developed in response to this report, which is outlined in Appendix 1. This action plan was approved by the Executive Directors and core service leads. This is monitored by the Moving to Outstanding Steering Group, which is chaired by the Chief Nurse.

In addition to the CQC action plan, a Moving to Outstanding Framework is under development. This will include a self-assessment of the Trust measured against the Key Lines of Enquiry (KLoE), outstanding characteristics and development of specific Core Service actions. This will provide focus to ensure progression towards the Trust achieving an 'outstanding' rating with a Moving to Outstanding Well Led Framework. This will be presented for consideration by the Executive team on 30th January 2020.

The next quarterly CQC Provider Engagement meeting is scheduled to be held at the Trust with the Chief Nurse, Chief Operating Officer, Medical Director and team on the 31st January 2020. The focus of this provider engagement meeting will be Urgent and Emergency Care as requested by the CQC.

2. KEY ELEMENTS

2.1 CQC action plan

The following are key summary points relating to the CQC action plan:

- There are 63 actions across 35 recommendations made by the CQC
- There are no 'Must Do' actions or regulatory breaches from the 2019 assessment
- There are 55 actions relating to 'Should Do' recommendations
- Current performance of the CQC action plan is as follows

Action Status by Type

	Report completed - Compliant	Report completed - further evidence requested	On Track	Amended date agreed	Report in progress	Action closed-merged with another	Grand Total
HOWEVER	5			1	1	1	8
SHOULD	28	4	8	10	1	4	55
Grand Total	**33**	**4**	**8**	**11**	**2**	**5**	**63**

This can be further shown broken down by Core Service as follows:

	HOWEVER	SHOULD	Grand Total
Surgery	**2**	**15**	**17**
Amended date agreed	1	2	3
On Track		3	3
Report completed - Compliant	1	3	4
Report completed - further evidence requested		4	4
Action closed-merged with another		3	3
Trustwide		**12**	**12**
Amended date agreed		5	5
On Track		1	1
Report completed - Compliant		6	6
Critical Care	**4**	**5**	**9**
Amended date agreed		1	1
Report in Progress	1		1
On Track		1	1
Report completed - Compliant	2	3	5
Action closed-merged with another	1		1
Maternity	**1**	**2**	**3**
Report completed - Compliant	1	2	3
Medical Care	**1**	**20**	**21**
Amended date agreed		1	1
Report in Progress		1	1
On Track		3	3
Report completed - Compliant	1	14	15
Action closed-merged with another		1	1
Outpatients		**1**	**1**
Amended date agreed		1	1
Grand Total	**8**	**55**	**63**

- There are 27 actions remaining:-
  - → 16 to be completed by end January 2020 (2 x 'However' and 14 x 'Should')
  - → 3 to be completed by end February 2020 (3 x 'Should')
  - → 8 to be completed by end March 2020 (8 x 'Should')

2.2 CQC Issues Log

50 issues are listed; 37 are rated green and 13 are rated amber. All issues rated amber were reviewed at M2O Meeting on the 16th January 2020 and updates provided verbally by the leads. The Chief Nurse has requested that these be progressed before the next M2O meeting on the 20th February 2020. These will be reviewed at a pre-meeting on 13th February 2020.

2.3 Urgent & Emergency Care Improvement action plan

The UEC action plan contained 35 actions to address 4 Regulatory Breaches identified by the CQC during the focused inspection on 18th February 2019.

- Regulation 12(2)(a)(b)(Patients whose clinical condition is at risk of deteriorating are rapidly identified and reviewed at suitable intervals)
- Regulation 12(2)(b) (Crowding in the emergency department is reduced so that patients do not have to wait on trolleys in corridors)
- Regulation 17(2)(a) (Information about the performance of the service is accurate and properly analysed and reviewed by the leadership team)
- Regulation 18(1) (There are sufficient numbers of suitably qualified, skilled and experienced doctors and nurses to meet the needs of patients in the Emergency Department)

Update reports with evidence for all actions have now been concluded and 9 actions have been transferred to an 'Issues Log' for further monitoring by the CBU via internal Governance and Operational meetings. The UEC work stream and action plan has now been formally closed at the Moving to Outstanding meeting on 19th December 2019 and will be overseen by the Trust Operational Board.

Intensive planning is underway for the impending Unannounced CQC ED Winter Visit:-

- A presentation has been delivered by the Chief Nurse and Chief Operating Officer to ED and other key members of staff, to ensure that staff know what to expect when the CQC arrive. A presentation is being delivered to ED medical staff on Thursday 23rd January 2020. This will continue to be presented throughout January 2020 to allow all staff to attend.
- A mock CQC winter visit is planned to take plac in ED the week commencing 20th January 2020, to assess the effectiveness of the arrangements that have been put in place. The outcomes of this visit will be shared with the operational teams with a verbal update to the Board of Directors.
- A standard operating procedure (SOP) has been developed for staff to ensure a robust mobilisation process is followed when the CQC arrive to ED unannounced.

2.4 Moving to Outstanding Work Streams

We have established Moving to Outstanding Work Streams in areas where we anticipate Core Service Visits. The work streams have developed action plans for Child Health Improvement, End of Life and Well Led. Terms of Reference have been approved and a High Level Briefing Paper was provided by each work stream and discussed at M2O. Each of the work streams has identified enablement projects to support moving the service from a rating of 'Good' to 'Outstanding'.

We have also established a Medicines Improvement Group, works towards improving the following areas which will be a key focus for CQC;

- Safe and Secure handling of medicines
- Medicines Reconciliation
- Omitted and delayed Medicines

- Controlled drugs

2.5 Well Led Work Stream

The CQC will assess Well-Led separately at the Trust-Wide level for Trusts approximately annually. Consequently, the Trust should be prepared for inspection from July 2020.

A Well-Led Steering Group has been established, attended by all the Executive Team, with each of the 8 Well-Led Key Lines of Enquiry (KLoEs) assigned to an Executive Lead. See appendix one for the KLOE header and Executive Lead.

An internal review of the requirements for each KLoE is currently underway to understand any gaps against the 'Outstanding' requirement. Furthermore, it is recommended that Trust's commission an external Well-Led review every three years. The previous externally commissioned Well-Led review took place in March 2017; therefore, we are currently in the process for tendering for another review. Additionally further areas of focus for Well Led across the Trust will be:

2.6 CQC Quarterly Engagement Meetings

Dates for 2020 have now been agreed as follows:

31st January – agreed focus on ED
16th April
16th July
3rd November

3. RECOMMENDATIONS

The Trust Board is asked to support:

- CQC action plan progress and update
- Urgent and Emergency Care closure of work stream and action plan

Kimberley Salmon-Jamieson
Chief Nurse

Reference	Core service	Domain	Areas for Review	Action	Type	Exec Lead	Lead Person	Target date for completion	Action Completion Status
CC01a	**Critical Care**	**Effective**	The trust should consider increasing the number of isolation rooms with negative and positive ventilation, in accordance with Department of Health guidelines. The unit only had two isolation rooms with negative and positive ventilation. This was below the recommended number in national guidance.	Ensure capital bid is developed and timeframe agreed Provide an option paper to enable decision on what can be done 19/20 or 20/21 to share with CQC with risk appraisal	SHOULD	Chris Evans	Mark Carmichael	29/02/20	**Amended date agreed**
CC01b	**Critical Care**	**Effective**	The trust should consider increasing the number of isolation rooms with negative and positive ventilation, in accordance with Department of Health guidelines. The unit only had two isolation rooms with negative and positive ventilation. This was below the recommended number in national guidance.	check with network and regulators what the specification is for regulation	SHOULD	Chris Evans	Mark Carmichael	31/08/19	**Report completed - Compliant**
CC02a	**Critical Care**	**Safe**	The trust should review the process for fridge checks so they are completed daily, in line with the trust's medicines management policy. Fridge checks were not always completed daily, in line with the medicines management policy. This had been an issue raised at the previous inspection.	implement a daily fridge check process to give assurance that the process is fully embedded in to practice	SHOULD	Alex Crowe	Sarah Brennan	31/08/19	**Report completed - Compliant**

CC02b	**Critical Care**	**Safe**	The trust should review the process for fridge checks so they are completed daily, in line with the trust's medicines management policy. Fridge checks were not always completed daily, in line with the medicines management policy. This had been an issue raised at the previous inspection.	audit of effectiveness of daily fridge checks in 6 months - Sarah Brennan	SHOULD	Alex Crowe	Sarah Brennan	29/02/20	**On Track**
CC03	**Critical Care**	**Responsive**	The trust should continue to review the number and occurrence of patients nursed in a recovery area while they await a critical care bed.	Audit in December 19 and present to January Patient Safety & Effectiveness Sub Committee	SHOULD	Chris Evans	Jerome McCann	31/01/20	**Report completed - Compliant**
CC04	**Critical Care**	**Responsive**	At the time of the inspection there was not a dedicated critical care pharmacist for the unit, although this was being addressed in the weeks following the inspection.	Ensure a dedicated pharmacist is allocated to the critical care unit	HOWEVER	Chris Evans	Natalie Crosby	04/12/19	**Report completed - Compliant**
CC05a	**Critical Care**	**Safe**	Not all prescriptions had review of stop dates documented; the indication for the antibiotic was not always recorded. A medicines reconciliation had been completed for most of the records reviewed.	standardise where information will be documented	HOWEVER	Alex Crowe	Jerome McCann	31/08/19	**Report completed - Compliant**
CC05aa	**Critical Care**	**Safe**	Not all prescriptions had review of stop dates documented; the indication for the antibiotic was not always recorded. A medicines reconciliation had been completed for most of the records reviewed.	standardise where information will be documented Audit of standardised document to be undertaken by Pharmacist end October and provided to M2O November meeting.	HOWEVER	Alex Crowe	Jerome McCann	24/12/19	**Action closed- merged with another**

CC05b	**Critical Care**	**Safe**	Not all prescriptions had review of stop dates documented; the indication for the antibiotic was not always recorded. A medicines reconciliation had been completed for most of the records reviewed.	standardise where information will be documented audit in 3 months for effectiveness - Jerome	HOWEVER	Alex Crowe	Jerome McCann	24/12/19	**No report provided**
M01	**Maternity**	**Safe**	The trust should ensure that all midwives complete adult safeguarding training level three. Midwifery staff compliance for adult safeguarding level three was below the trust target. Following implementation of updated guidance, compliance for midwives for safeguarding adults level three was 58% at time of inspection, although the service always had someone who was level three trained on each shift..	provide an assurance report to confirm that all band 7 staff are trained to adult safeguarding level 3 give assurance for training compliance going forward	SHOULD	Kimberley Salmon-Jamieson	Tracey Cooper	30/09/19	**Report completed - Compliant**
M02	**Maternity**	**Safe**	The trust should review the availability of nets in case of a pool evacuation. There were two birthing pools, however, only one net in the event of an emergency.	Give assurance that additional nets (1 net for each of the 2 pools) are available.	SHOULD	Kimberley Salmon-Jamieson	Tracey Cooper	31/08/19	**Report completed - Compliant**
M03	**Maternity**	**Responsive**	There was no information available in formats other than standard English. There was no information available in languages other than English or alternative formats such as easy read.	Present the Accessible Information Standards Programme Plan to M2O September 2019 meeting	HOWEVER	Pat McLaren	Gina Coldrick	30/09/19	**Report completed - Compliant**

MC01a	**Medical Care**	**Safe**	The trust should continue to monitor staffing levels and follow escalation plans to ensure levels of nursing and medical staff are sufficient to provide safe care and treatment. In medical care there were not always enough staff to meet planned staffing levels, although there were processes to review staff shortages and take action to keep people safe. The service did not always have enough staff with the right qualifications, skills, training and experience to meet planned staffing levels, although it had processes to review staff shortages and take action to keep people safe.	Reconfiguration of medicine ward management relating to medical staffing	SHOULD	Alex Crowe/ Kimberley Salmon-Jamieson	Fraser Gordon	24/12/19	**Report completed - Compliant**
MC01b	**Medical Care**	**Safe**	The trust should continue to monitor staffing levels and follow escalation plans to ensure levels of nursing and medical staff are sufficient to provide safe care and treatment. In medical care there were not always enough staff to meet planned staffing levels, although there were processes to review staff shortages and take action to keep people safe. The service did not always have enough staff with the right qualifications, skills, training and experience to meet planned staffing levels, although it had	Reconfiguration of management of outlying patients	SHOULD	Alex Crowe/ Kimberley Salmon-Jamieson	Fraser Gordon	31/12/19	**Report completed - Compliant**

			processes to review staff shortages and take action to keep people safe.						
MC01c	**Medical Care**	**Safe**	The trust should continue to monitor staffing levels and follow escalation plans to ensure levels of nursing and medical staff are sufficient to provide safe care and treatment. In medical care there were not always enough staff to meet planned staffing levels, although there were processes to review staff shortages and take action to keep people safe. The service did not always have enough staff with the right qualifications, skills, training and experience to meet planned staffing levels, although it had processes to review staff shortages and take action to keep people safe.	Implementation of electronic rostering	SHOULD	Alex Crowe/ Kimberley Salmon-Jamieson	May Moonan	31/03/20	**On Track**
MC01d	**Medical Care**	**Safe**	The trust should continue to monitor staffing levels and follow escalation plans to ensure levels of nursing and medical staff are sufficient to provide safe care and treatment. In medical care there were not always enough staff to meet planned staffing levels, although there were processes to review staff shortages and take action to keep people safe.	Review escalation processes for medical staff and develop a Standard Operating procedure	SHOULD	Alex Crowe/ Kimberley Salmon-Jamieson	Mark Forrest	24/12/19	**No report provided**

			The service did not always have enough staff with the right qualifications, skills, training and experience to meet planned staffing levels, although it had processes to review staff shortages and take action to keep people safe.						
MC01e	**Medical Care**	**Safe**	The trust should continue to monitor staffing levels and follow escalation plans to ensure levels of nursing and medical staff are sufficient to provide safe care and treatment. In medical care there were not always enough staff to meet planned staffing levels, although there were processes to review staff shortages and take action to keep people safe. The service did not always have enough staff with the right qualifications, skills, training and experience to meet planned staffing levels, although it had processes to review staff shortages and take action to keep people safe.	Review medical and nurse staffing and develop plans as appropriate	SHOULD	Alex Crowe/ Kimberley Salmon-Jamieson	Judith Burgess/ Sarah Coppell Mark Carmichael / Kate Brizell	30/09/19	**Report completed - Compliant**
MC01e(2)	**Medical Care**	**Safe**	The trust should continue to monitor staffing levels and follow escalation plans to ensure levels of nursing and medical staff are sufficient to provide safe care and treatment. In medical care there were not always enough staff to meet planned staffing levels, although there were	Review medical and nurse staffing and develop plans as appropriate	SHOULD	Alex Crowe/ Kimberley Salmon-Jamieson	Judith Burgess/ Sarah Coppell Mark Carmichael / Kate Brizell	30/09/19	**Report completed - Compliant**

			processes to review staff shortages and take action to keep people safe. The service did not always have enough staff with the right qualifications, skills, training and experience to meet planned staffing levels, although it had processes to review staff shortages and take action to keep people safe.						
MC01f	**Medical Care**	**Safe**	The trust should continue to monitor staffing levels and follow escalation plans to ensure levels of nursing and medical staff are sufficient to provide safe care and treatment. In medical care there were not always enough staff to meet planned staffing levels, although there were processes to review staff shortages and take action to keep people safe. The service did not always have enough staff with the right qualifications, skills, training and experience to meet planned staffing levels, although it had processes to review staff shortages and take action to keep people safe.	A7 tracheostomy competencies – ensure that all staff have achieved and there is a process of review in place	SHOULD	Alex Crowe/ Kimberley Salmon-Jamieson	Sarah Coppell	24/12/19	**Report completed - Compliant**
MC01g	**Medical Care**	**Safe**	The trust should continue to monitor staffing levels and follow escalation plans to ensure levels of nursing and medical staff are sufficient to provide safe care	Explore other wards re capacity to manage patients with tracheostomies in the Trust	SHOULD	Alex Crowe/ Kimberley Salmon-	Mark Carmichael / Kate Brizell	20/02/20	**Amended date agreed**

			and treatment. In medical care there were not always enough staff to meet planned staffing levels, although there were processes to review staff shortages and take action to keep people safe. The service did not always have enough staff with the right qualifications, skills, training and experience to meet planned staffing levels, although it had processes to review staff shortages and take action to keep people safe.			Jamieson			
MC01h	**Medical Care**	**Safe**	The trust should continue to monitor staffing levels and follow escalation plans to ensure levels of nursing and medical staff are sufficient to provide safe care and treatment. In medical care there were not always enough staff to meet planned staffing levels, although there were processes to review staff shortages and take action to keep people safe. The service did not always have enough staff with the right qualifications, skills, training and experience to meet planned staffing levels, although it had processes to review staff shortages and take action to keep people safe.	Develop and implement a speciality specific Competency training framework in medicine for nursing staff	SHOULD	Alex Crowe/ Kimberley Salmon-Jamieson	Judith Burgess/ Sarah Coppell	31/03/20	**On Track**

MC02a	**Medical Care**	**Safe**	The trust should continue to monitor audit performance to identify further potential improvements.	Ensure monthly reporting to Patient Safety & Effectiveness Sub Committee outlines remedial actions where performance needs to be improved and tracks the performance improvement.	SHOULD	Alex Crowe	Louisa Connolly	30/09/19	**Report completed - Compliant**
MC02b	**Medical Care**	**Safe**	The trust should continue to monitor audit performance to identify further potential improvements.	Ensure monitoring of clinical audit actions are tracked through specialty and CBU Governance processes.	SHOULD	Alex Crowe	Fraser Gordon/ Mark Forrest	24/12/19	**Report completed - Compliant**
MC02c	**Medical Care**	**Safe**	The hospital was below the England averages for audits for stroke and lung cancer. The trust had plans to improve performance. Audit results for patients following a stroke and for patients with lung cancer had been below England average. Improvement plans were identified and arrangements for transfer of hyper-acute stroke services to a neighbouring trust were imminent.	Provide assurance paper to Patient Safety & Effectiveness Sub Committee regarding remedial actions required in relation to stroke and lung cancer national audits	HOWEVER	Chris Evans	Jill Wright/ Mithun Murthy	31/10/19	**Report completed - Compliant**
MC03	**Medical Care**	**Safe**	The trust should continue to sustain improvement and practice in application of capacity assessment and application of Deprivation of Liberty Safeguards where required.	Ensure staff attend Safeguarding/DoLS Masterclasses being put in place	SHOULD	Kimberley Salmon-Jamieson	Judith Burgess/ Sarah Coppell	31/12/19	**Action closed- merged with another**

MC04a	**Medical Care**	**Responsive**	The trust should continue work to reduce delays in patient discharges where possible. In medical care, there were delays in discharge for patients. Delays in discharge were a frequent issue for patients, particularly in elderly care and dementia ward.	Co location of Health and Social Care Discharge Team - opening day 12/7/19	SHOULD	Chris Evans	Caroline Williams	12/07/19	**Report completed - Compliant**
MC04b	**Medical Care**	**Responsive**	The trust should continue work to reduce delays in patient discharges where possible. In medical care, there were delays in discharge for patients. Delays in discharge were a frequent issue for patients, particularly in elderly care and dementia ward.	Agree a trajectory for improvement in long length of stay with NHSE	SHOULD	Chris Evans	Caroline Williams	01/05/19	**Report completed - Compliant**
MC04c	**Medical Care**	**Responsive**	The trust should continue work to reduce delays in patient discharges where possible. In medical care, there were delays in discharge for patients. Delays in discharge were a frequent issue for patients, particularly in elderly care and dementia ward.	Development of discharge patient tracking list to further understand reasons for delays in discharge	SHOULD	Chris Evans	Caroline Williams	05/07/19	**Report completed - Compliant**

MC04d	**Medical Care**	**Responsive**	The trust should continue work to reduce delays in patient discharges where possible. In medical care, there were delays in discharge for patients. Delays in discharge were a frequent issue for patients, particularly in elderly care and dementia ward.	Work with system partners to review and agree actions from Venn Consultants system capacity and demand exercise undertaken in 2018	SHOULD	Chris Evans	Caroline Williams	01/08/19	**Report completed - Compliant**
MC04e	**Medical Care**	**Responsive**	The trust should continue work to reduce delays in patient discharges where possible. In medical care, there were delays in discharge for patients. Delays in discharge were a frequent issue for patients, particularly in elderly care and dementia ward.	Develop a plan to reconfigure Care of the Elderly workforce	SHOULD	Chris Evans	Caroline Williams	29/07/19	**Report completed - Compliant**
MC04f	**Medical Care**	**Responsive**	The trust should continue work to reduce delays in patient discharges where possible. In medical care, there were delays in discharge for patients. Delays in discharge were a frequent issue for patients, particularly in elderly care and dementia ward.	Continuation of ECIST long length of stay/safer collaborative - 3 out of 4 events completed, 4th event due September 2019	SHOULD	Chris Evans	May Moonan	30/09/19	**Report completed - Compliant**

MC04g	**Medical Care**	**Responsive**	The trust should continue work to reduce delays in patient discharges where possible. In medical care, there were delays in discharge for patients. Delays in discharge were a frequent issue for patients, particularly in elderly care and dementia ward.	Ward Round accreditation participation for medicine - Development of a ward round accreditation scheme to support reduction in delays in discharges • Paper presented to Executive Directors for approval - 15th August 2019 – complete • Wards participating in the Pilot are B19, B14, A6, AMU, A7, B10/11 (Medicine, Specialist Medicine, Surgery, Paediatrics and Rehabilitation) - agreed • Pilot dry run of Ward Round Accreditation Process to be undertaken 17th/18th September 2019 on Ward B19 to test agreed standards from the Rapid Improvement Event • Baseline questionnaire to be sent to every member of staff in WHH in respect of ward rounds to assess culture change in the organisation – date to be agreed following pilot of Ward B19 • Remaining wards participating in the pilot to undertake dry run – by end October 2019 • Schedule of roll out to all ther wards – by end May 2019	SHOULD	Simon Constable	Alex Crowe	31/12/19	**Report completed - Compliant**
MC04i	**Medical Care**	**Responsive**	The trust should continue work to reduce delays in patient discharges where possible. In medical care, there were delays in discharge for patients. Delays in discharge were a	Development of the Trust Frailty pathway	SHOULD	Chris Evans	Fraser Gordon	31/03/20	**On Track**

			frequent issue for patients, particularly in elderly care and dementia ward.						
OP01	**Outpatients**	**Safe**	The trust should review the training available for staff on updating patients' risk assessment records. Although staff assessed risks to patients, staff had not received specific training to be able to update the patient's risk record.	provide assurance to confirm that staff are trained to be able to update the patient's risk record and give assurance for training compliance going forward	SHOULD	Kimberley Salmon-Jamieson	Deb Hatton	07/02/20	**Amended date agreed**
S01	**Surgery**	**Safe**	The trust should consider needs such as safeguarding and deprivation of liberty are highlighted. Although records were clear, there was no system to quickly highlight issues such as whether there were any safeguarding concerns, or patients were subject to a deprivation of liberty.	Ensure the trust patient alerts policy is reviewed including alerts on Safeguarding and DoLS.	SHOULD	Kimberley Salmon-Jamieson	John Goodenough	31/01/20	**Amended date agreed**

S02a	**Surgery**	**Effective**	The trust should make sure that all care plans in paper records are filled in consistently. Care records were not always filled in consistently in the paper records, for example the cognitive impairment and dementia section in the fractured hip pathway. This was important as relevant information may be missed.	Weekly spot checks to be undertaken to ensure consistency of completed records and monthly audit of spot checks to give assurance that care plans in paper records are being completed correctly and consistently.	SHOULD	Kimberley Salmon-Jamieson	Cheryl Finney	31/10/19	**Action closed-merged with another**
S02b	**Surgery**	**Effective**	The trust should make sure that all care plans in paper records are filled in consistently. Care records were not always filled in consistently in the paper records, for example the cognitive impairment and dementia section in the fractured hip pathway. This was important as relevant information may be missed.	Audit to be conducted to give baseline and set further trajectories - will be added to the ward quality improvement metrics.	SHOULD	Kimberley Salmon-Jamieson	Cheryl Finney	31/01/20	**Report completed - further evidence requested**
S02c	**Surgery**	**Effective**	The trust should make sure that all care plans in paper records are filled in consistently. Care records were not always filled in consistently in the paper records, for example the cognitive impairment and dementia section in the fractured hip pathway. This was important as relevant	Ensure that an audit of hip fracture pathway is undertaken and present to the Patient Safety & Effectiveness Sub Committee	SHOULD	Alex Crowe	Rajiv Sanger	31/03/20	**On Track**

			information may be missed.						
S03	**Surgery**	**Safe**	The trust should review the monitoring of expiry dates of sepsis bags. We found that blood cultures stored in sepsis bags had expired, which was important for testing the presence of sepsis in a patient.	Ensure the process for monitoring of sepsis bag expiry is reviewed	SHOULD	Kimberley Salmon-Jamieson	Alison Kennah	24/12/19	**Report completed - Compliant**
S04a	**Surgery**	**Responsive**	The trust should ensure that mental capacity assessments and best interest decisions are recorded consistently in records. In surgery, we saw an example of mental capacity assessment not in line with current guidance and trust policy.	Ensure staff attend Safeguarding/DoLS Masterclasses being put in place	SHOULD	Kimberley Salmon-Jamieson	Cathy Johnson	31/12/19	**Action closed-merged with another**

S04b	**Surgery**	**Responsive**	The trust should ensure that mental capacity assessments and best interest decisions are recorded consistently in records. In surgery, we saw an example of mental capacity assessment not in line with current guidance and trust policy.	Ensure an audit of mental capacity/best interest is undertaken	SHOULD	Kimberley Salmon-Jamieson	Cathy Johnson	31/03/20	**On Track**
S05	**Surgery**	**Effective**	The trust should continue to look at ways to reduce the risk of readmission for elective admissions. From September 2018 to August 2019, all patients at Warrington Hospital had a higher than expected risk of readmission for elective admissions when compared to the England Average. Surgical leads have put measures in place to address this and have seen improvements in readmission rates.	clarity of governance arrangements and monitoring/scrutiny - clarify where readmissions are being recorded and monitored within the trust and put a process in place to understand the reasons for readmissions develop a SOP around performance monitoring and process of local specialty deep dive, and report to KPI meeting and escalation if we are an outlier for any specialty for readmissions	SHOULD	Chris Evans	Val Doyle	16/01/20	**Report completed - Compliant**
S06	**Surgery**	**Effective**	The trust should continue to look at ways to improve outcomes on the national hip fracture database. The service performed lower than other trusts in the national hip fracture database 2018. Surgical leads had recognised this and put an action plan in to place to address.	Ensure that the hip fracture action plan is received at Patient Safety & Effectiveness Sub Committee on a quarterly basis	SHOULD	Alex Crowe	Paul Scott	28/02/20	**Amended date agreed**

S07a	**Surgery**	**Safe**	The trust should ensure that controlled drugs are stored securely at all times in theatres. In surgery, we observed on instance of a controlled drug being left unattended in the operating theatres and found some consumables that were past their use by dates.	Controlled Drugs Immediate actions were taken at the time of the inspection. Pharmacy to conduct bi-monthly spot check audits and report to Theatre Manager - assurance to be given to Moving to Outstanding regarding this process	SHOULD	Alex Crowe	Mark Rigby	31/12/19	**Report completed - further evidence requested**
S07b	**Surgery**	**Safe**	The trust should ensure that controlled drugs are stored securely at all times in theatres. In surgery, we observed on instance of a controlled drug being left unattended in the operating theatres and found some consumables that were past their use by dates.	Consumables Weekly check list to be developed on each of the 3 trolleys to check expiry dates for replacement, managed by the Housekeeper, which ward manager oversees.	SHOULD	Kimberley Salmon-Jamieson	Cheryl Finney	24/12/19	**Report completed - Compliant**
S08	**Surgery**	**Safe**	The trust should review the levels of safeguarding training with reference to the intercollegiate documents on safeguarding.	Ensure a revised Training Needs Analysis is developed for Safeguarding training aligned to the intercollegiate document and that ESR is updated with these training requirements	SHOULD	Kimberley Salmon-Jamieson	John Goodenough	31/12/19	**Report completed - further evidence requested**
S09	**Surgery**	**Safe**	The trust should review the process for monitoring consumables so they remain in date and fit for use.	see action S07b - Day Case Ward- MERGE	SHOULD	Kimberley Salmon-Jamieson	Cheryl Finney		**Action closed- merged with another**
S10	**Surgery**	**Safe**	The trust should review the process for monitoring maintenance of patient trolleys. Some patient trolleys in Cheshire and Merseyside Treatment Centre also had not had annual	Ensure an audit is undertaken of the asset register and that all trolleys are included	SHOULD	Chris Evans	Cheryl Finney	31/03/20	**On Track**

			maintenance.						
S11	**Surgery**	**Safe**	The trust should continue the work around safer surgery and the pre-operative briefing and documentation. In surgery, some processes around the pre-operative briefing were not thorough, but work was in progress to improve this.	Revised process put in place from 1st June 2019. Ensure this process is audited across all theatres (observational audit) and reported to Patient Safety & Effectiveness Sub Committee	SHOULD	Alex Crowe	Mark Rigby	31/12/19	**Report completed - further evidence requested**
S12	**Surgery**	**Safe**	The hospital was below the England averages for audits for hip fractures. The trust had plans to improve performance.	Provide assurance paper to Patient Safety & Effectiveness Sub Committee regarding remedial actions required in relation to hip fracture national audits	HOWEVER	Alex Crowe	Paul Scott	28/02/20	**Amended date agreed**
S13	**Surgery**	**Safe**	Whilst staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005 and knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care; we saw an example of the application of such processes not in line with current guidance and trust policy.	Increased support via Masterclasses for staff in surgery	HOWEVER	Kimberley Salmon-Jamieson	Wendy Turner	31/12/19	**Report completed - Compliant**

TW01	**Trustwide**	**Well Led**	The trust should review the fit and proper persons processes so all the required information is retained for all directors.	Head of Corporate Affairs to give written assurance that there is a central electronic system held by the Trust for capturing all required information relating to fit and proper persons. The Head of Corporate Affairs will retain copies of all of this information within the Foundation Trust Office and updated as necessary.	SHOULD	Simon Constable	John Culshaw	12/09/19	**Report completed - Compliant**
TW02	**Trustwide**	**Well Led**	The trust should consider how it records the delivery plans for the enabling strategies.	Ensure a timetable is developed for key enabling strategy review in the Trust	SHOULD	Simon Constable	Lucy Gardner	30/09/19	**Report completed - Compliant**
TW03a	**Trustwide**	**Well Led**	The trust should review the progress of the implementation of strategies for patients living with dementia and with a learning disability and consider the implementation of a strategy for patients with mental health needs. The trust did not currently have strategies to support patients living with dementia, learning disabilities or mental health illness. Some of the enabling strategies lacked clear delivery plans.	Ensure there is a strategy and implementation plan for patients living with dementia	SHOULD	Kimberley Salmon-Jamieson	John Goodenough	31/03/20	**Amended date agreed**

TW03b	**Trustwide**	**Well Led**	The trust should review the progress of the implementation of strategies for patients living with dementia and with a learning disability and consider the implementation of a strategy for patients with mental health needs. The trust did not currently have strategies to support patients living with dementia, learning disabilities or mental health illness. Some of the enabling strategies lacked clear delivery plans.	Ensure there is a strategy and implementation plan for patients living with Learning Disabilities	SHOULD	Kimberley Salmon-Jamieson	John Goodenough	31/01/20	**Amended date agreed**
TW03c	**Trustwide**	**Well Led**	The trust should review the progress of the implementation of strategies for patients living with dementia and with a learning disability and consider the implementation of a strategy for patients with mental health needs. The trust did not currently have strategies to support patients living with dementia, learning disabilities or mental health illness. Some of the enabling strategies lacked clear delivery plans.	Ensure there is a strategy and implementation plan for patients living with Mental Health needs	SHOULD	Kimberley Salmon-Jamieson	John Goodenough	31/01/20	**Amended date agreed**
TW04	**Trustwide**	**Use of Resources**	The trust should continue to review the plans to achieve financial sustainability and the action required to deliver financial plan for 2019-20. The trust had not yet fully addressed the plans to break	Work collaboratively on the 2019/20 Recovery Plan with Bridgewater, Warrington CCG and Halton CCG, and present a High Level Recovery Plan to NHSI in August (6.8.19)	SHOULD	Andrea McGee	Jane Hurst	31/08/19	**Report completed - Compliant**

			even in 2019-20 which were predicated by the delivery of a cost improvement programme of £7.5million and the resolution of £5million of cost pressures.						
TW05	**Trustwide**	**Use of Resources**	The trust should review the information reported in the finance report to consider including remedial action on the financial position, risk-based forecasting and the level of recurrent cost improvement plans.	Provide robust forecast reporting, including risk and mitigation on financial position and in year and recurrent cost improvement programme to Finance & Sustainability Committee, including monthly CBU cost improvement and forecast updates at Financial Resources Group.	SHOULD	Andrea McGee	Jane Hurst	31/08/19	**Report completed - Compliant**
TW06	**Trustwide**	**Safe**	The trust should review the processes for identifying, reporting and investigation of missed doses for critical medicines across the trust. The service prescribed, gave, and stored medicines well. Although not all medicines prescribed had a signature or appropriate code to indicate if the medicines had been administered and some medicines were not available.	Ensure a review of missed doses and critical meds is undertaken and reported to Patient Safety & Effectiveness Sub Committee Review of Process – D Matthew Review of Datix missed doses – D Matthew Audit of missed doses and missed doses of critical meds – A Kennah	SHOULD	Alex Crowe	Diane Matthew	31/01/20	**Amended date agreed**

TW07	**Trustwide**	**Safe**	The trust should consider further development and investment in systems to improve medicines reconciliation rates across the trust. While medicines optimisation within the trust was well-led medicines reconciliation rates for the whole trust were currently at 33% of medicines reconciled within 24 hours; this is well below National Institute for Health and Care Excellence guidelines of 90% within 24 hours. The hospital was not following best practice for medicines reconciliation and in medical care and critical care medicines were not always properly recorded or available.	Ensure a plan is developed of how to meet the Trust trajectory to be 80% compliant with Medicines reconciliation within 24 hours by end March 2020 and present to Moving to Outstanding Steering Group	SHOULD	Alex Crowe	Diane Matthew	31/01/20	**Amended date agreed**
TW08	**Trustwide**	**Safe**	We saw examples where the trust did not properly record the best interest decisions or capacity assessments for patients who lacked capacity. The trust should review the root cause analysis form for serious incidents to consider how information about safeguarding, capacity, patient involvement is included. In Surgery, we saw two cases where mental capacity assessments and best interests decisions were not fully recorded in patient records.	Review the route cause analysis report templates to ensure safeguarding information is recorded appropriately	SHOULD	Kimberley Salmon-Jamieson	Layla Alani	30/09/19	**Report completed - Compliant**

TW09	**Trustwide**	**Safe**	The trust should review the process for senior clinician input into structured judgement reviews.	Undertake quarterly review of a random selection of SJRs across the board to assess the outcome reached by the reviewer (senior clinician), and give assurance to the Quality Assurance Committee that all issues are being identified following higher risk deaths. Commence October onwards with a review of the 2nd quarter reviews undertaken.	SHOULD	Alex Crowe	Phil Cantrell	31/10/19	**Report completed - Compliant**
TW10	**Trustwide**	**Safe**	Review of compliance with the current standards and level of risk for the organisation The professional guidance on the safe and secure handling of medicines is produced by the Royal Pharmaceutical Society and is NICE accredited. The updated guidance was issued in December 2018. The guidance advises that all medicines cupboards comply with British Standard 2881	Replacement of Medicines Storage cupboards that do not meet the British Standard requirements - Phase One	SHOULD	Alex Crowe	Diane Matthew	31/03/20	**On Track**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/20/01/09**			
SUBJECT:	**Progress on Lord Carter Report Recommendations & Use of Resource Assessment (UoRA)**			
DATE OF MEETING:	29th January 2020			
AUTHOR(S):	Marie Garnett, Head of Contracts & Performance			
EXECUTIVE DIRECTOR SPONSOR:	Andrea McGee, Director of Finance + Commercial Development			
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience.	x		
	SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future.	x		
	SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.	x		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	#115 Failure to provide adequate staffing levels in some specialities and wards. #134 (a) Failure to sustain financial viability. #134 (b) Failure to deliver the financial position and a surplus #135 Failure to provide adequate and timely IMT system. #125 Failure to maintain an old estate. #145 (a) Failure to deliver our strategic vision. #145 (b) Failure to fund two new hospitals. #241 Failure to retain medical trainee doctors.			
EXECUTIVE SUMMARY *(KEY ISSUES):*	The Trust continues to develop and improve its Use of Resources both internally and in collaboration with system wide partners.			
PURPOSE: *(please select as appropriate)*	Information	Approval	To note x	Decision
RECOMMENDATION:	The Board of Directors is requested to note the contents of the report.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: *(if relevant)*	Choose an item.			

REPORT TO BOARD OF DIRECTORS

SUBJECT	**Progress on Lord Carter Report Recommendations & Use of Resource Assessment (UoRA)**	**AGENDA REF:**	**BM/20/01/09**

1. BACKGROUND/CONTEXT

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

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

UoR

UoR data is from the Model Hospital and has been benchmarked against peer and national median groups. The RAG rating is based on the Trust's position against the national median on the model hospital. The peer median group is based on NHSI's peer finder tool.

2. KEY ELEMENTS

This paper presents the update for Quarter 2. Performance against each UoRA KLOE is set out in **Appendix 1**, the full detail for each KLOE indicator and progress against the Lord Carter recommendations can be found in **Appendix 2**. The majority of the Lord Carter recommendations are either complete or are on track.

The Trust continues to work with other organisations across the Cheshire & Mersey Network on Carter at Scale Collaboration opportunities across a number of corporate functions including; Procurement, Finance, Payroll, HR, Legal and IM&T.

The Trust continues to work strategically with Bridgewater Community Healthcare NHS Foundation Trust to look at opporuntites for collaboration, this includes the co-location of HR and Communications services and the delivery of some HR functions with opporuntites around procurement currently being explored.

Across the Cheshire & Mersyside network, a standardised agency rate card went live on 1st December 2019.

3. RECOMMENDATIONS

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

Andrea McGee
Director of Finance and Commercial Development
22nd January 2020

Appendix 1 – Benchmarking Performance against the National Median

KLOE Indicator	Quarter 1 18/19	Quarter 2 18/19	Quarter 3 18/19	Quarter 4 18/19	Quarter 1 19/20	Quarter 2 19/20	Quarter 3 19/20
KLOE 1 - Clinical							
Pre Procedure Elective Bed Days	Q4 2017/18	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q2 2019/20	Q2 2019/20
Pre Procedure Non Elective Bed Days	Q4 2017/18	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q2 2019/20	Q2 2019/20
Emergency Readmission (30 Days)	Q4 2017/18	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q2 2019/20	Q2 2019/20
Did Not Attend (DNA) Rate	Q4 2017/18	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q2 2019/20	Q2 2019/20
KLOE 2 - People							
Staff Retention Rate	March 2018	June 2018	September 2018	December 2018	December 2018	December 2018	December 2018
Sickness Absence Rate	February 2018	May 2018	August 2018	November 2018	November 2018	June 2019	October 2019
Pay Costs per Weighted Activity Unit	2016/17	2016/17	2017/18	2017/18	2017/18	2017/18	2017/18
Medical Costs per WAU	2016/17	2016/17	2017/18	2017/18	2017/18	2017/18	2017/18
Nurses Cost Per WAU	2016/17	2016/17	2017/18	2017/18	2017/18	2017/18	2017/18
AHP Cost per WAU (community adjusted)	2016/17	2016/17	2017/18	2017/18	2017/18	2017/18	2017/18
KLOE 3 – Clinical Support Services							
Top 10 Medicines - Percentage Delivery of Savings	March 2018	March 2018	March 2018	March 2018	March 2018	September 2019	November 2019
Pathology - Overall Costs Per Test	Q2 – 2017/18	Q4 2017/18	Q4 2017/18	Q2 2018/19	Q2 2018/19	Q4 2018/19	Q2 2019/20
KLOE 4 – Corporate Services							
Non Pay Costs per WAU	2016/17	2016/17	2017/18	2017/18	2017/18	2017/18	2017/18
Finance Costs per £100m Turnover	2016/17	2016/17	2017/18	2017/18	2017/18	2018/19	2018/19
Human Resource Costs per £100m Turnover	2016/17	2016/17	2017/18	2017/18	2017/18	2018/19	2018/19
Procurement Process Efficiency and Price Performance Score Clinics	Q4 2016/17	Q4 2016/17	Q4 2017/18	Q3 2018/19	Q3 2018/19	Q4 2018/19	Q4 2018/19
Estates Costs Per Square Meter	2016/17	2017/18	2017/18	2017/18	2017/18	2018/19	2018/19
KLOE 5 - Finance							
Capital Services Capacity*							
Liquidity (Days)*							
Income & Expenditure Margin*							
Agency Spend - Cap Value*							
Distance from Financial Plan*							

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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Key

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Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 3 2019/20

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

Lead Director: Director of Human Resources & Organisational Development

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Development and Approval of People Strategy and Dashboard	• The refreshed People Strategy was signed off by the Trust board in Q2 2018/19. Quarterly reports are presented to the Strategic People Committee.	• Ongoing monitoring and management of the dashboard.	Trust Board, TOB, Strategic People Committee	Complete
Restructure of HR Directorate	• The HR department restructure is complete and key posts in the Senior Management Team have been recruited to.		Trust Board, Strategic People Committee	Complete
HR Polices reviewed to ensure they are clear, simple and transparent	• The Human Resources & Organisational Development (HR&OD) Directorate has a policies and procedures group with management and staff side representation. All HR policies are taken through this group and then progressed to JNCC. • Policies reviewed and ratified to date include; the Disciplinary, Relationships at Work, Special Leave, Secondment, Annual Leave, Equality in Employment, Temporary Staffing and Professional Clinical Registration. • New Trust policies developed include; The recovery of employee overpayments and outstanding debt policy.	• The Trust is undertaking a programme to review, and where required, simplify HR policies. This is monitored by the Strategic People Committee. • In Q3, the Trust's commenced a review of the Attendance Management policy with staffside and this will continue throughout Q4. It is anticipated the new policy will be signed off during Q1 2020/21. • In Q4, the Trust will be reviewing the Associate Specialist job planning policy and will be developing a new Covering for Colleagues policy around the Medical Workforce.	Strategic People Committee	Ongoing Monitoring
"Fit to Care" Heath & Wellbeing Programme	• The Trust has a wide range of wellbeing approaches aimed at supporting staff back into work which has included; a Weight management clinic, Healthy Topics, Drop in sessions for healthy hearts and Wellbeing clinics. • The Trust launched its mental health first aid courses which aims to help managers spot the signs of mental health problems and signpost colleagues to support. • The rollout of the refreshed fit to care programme was completed during Q1 2019/20. The Trust is building on the previous approach of educational and information campaigns, to adopt an impact based approach e.g. Know Your Heart Age event in April 2019, where staff were offered a range of screening tests and access to a Consultant Cardiologist where appropriate. The new programme has now been introduced and will reviewed annually.	• Wellbeing initiatives will continue to be offered and monitored for effectiveness.	Strategic People Committee	Complete

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Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 3 2019/20

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Development of Workforce Streaming Programme across the North West	• The Trust has worked with colleagues across the North West to agree unified ways of working and to reduce bureaucracy. • Key actions included: o Implementation of factual references. o Streamlining of notice periods for new starters. o Agreed the honorary contract process and streamlining of mandatory training across the region. o Values based recruitment. • Region wide TUPE guidelines have been implemented. • The streamlining programme is now complete with benefits realisation signed off by Operational Peoples Committee in May 2019 and a summary provided to Strategic People Committee.		Operational People Committee	Complete
Staff Opinion Survey	• Themes from the staff survey were used to develop the refreshed People Strategy. • The Trust achieved a very positive response rate of 50.6% in 2018, a 4.6% improvement on the previous year. The Trust achieved average or above average score for 9/10 of the key themes as well as statistically significant improvements in safety culture and staff engagement. The CBU level results were shared for local implementation and the Trust level results was mapped to the delivery of key strategies such as the People Strategy and EDI Strategy. • A detailed analysis was undertaken around EDI by protected characteristics and was reviewed by the EDI sub-committee in Q2. • The 2019 SoS closed at the end of November, the Trust response rate was 53%, the average Acute Trust (for those using Quality Health) was 47%. The Trust had campaign in place throughout the survey period which included regular reporting across the workforce, a communications plan, incentives and a emphasis on ownership by local managers. This resulted in the best response rate for the Trust to date.	• CBUs and corporate departments have been asked to identify a local lead to commence operationalising results once received. The final national response rate and results will be published in March 2020.	Trust Board, TOB, Strategic People Committee	Rolling Programme

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 3 2019/20

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Reduction in the high rates of bullying and harassment with a sustained campaign led personally by each trust Chief Executive	• The Freedom to Speak Up Guardian has a network of champions to support staff to raise concerns. • The Trust performed in the upper quartile in the 2017 & 2018 staff surveys in relation to bullying and harassment in comparison with other Acute Trusts. • The Trust has reviewed the SoS results against other employee relations metrics around bullying and harassment and has analysed the areas where we are doing well to look how learning can be shared across other areas. This was focused specifically around; managers training, standards, policy implementation and reward. It was identified that the approach in leadership style within these areas was similar. This learning has been incorporated into the essential managers training. • Work was undertaken with the Trust's communications team to ensure staff know who to raise concerns with and how they would go about this. • An Equality, Diversity and Inclusion Strategy has been developed and implemented.	• The Trust has the culture and infrastructure to address bullying and harassment and this is supported by the latest staff survey results.	Strategic People Committee	Complete
Ensure Staff have regular performance reviews	• The number of staff with a valid PDR is 74.57% (December 2019) against a target of 85%. • The PDR process has been reviewed, with a particular focus on engaging staff and condensing timescales to avoid winter pressures. • The Trust has implemented the pay progression policy. As per the national policy, this is currently for new starters to the Trust only. • Part of the People Strategy focuses on improving the quality of appraisals. The Trust set up a task and finish group in July 2019 to initiate this review which included new documents/system, guidance and training. The appraisal system is integral to our talent management and succession planning framework.	• HR Business Partners will continue to work with the CBU managers to further improve PDR compliance. • A new appraisal tool has been drafted with engagement from staff across the workforce, the focus is on little paperwork, big conversation. This was piloted in November 2019 using a Plan Do Study Act (PDSA) test of change cycle. The pilot is now complete and the review of learning is underway. The final PDR tool will be rolled out during Q4.	Trust Board, TOB, Strategic People Committee	Ongoing Monitoring

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Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 3 2019/20

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Improving Sickness Absence	• Sickness absence was 6.19% in December 2019. • An audit was completed on compliance with the Trust's Attendance Management Policy and a number of recommendations were implemented. • Promotion and improvement of flu vaccination uptake takes place annually. • Mental Health "Train the Trainer" training is complete. • A new clinical supervision framework was rolled out which will help to address some of the stress/anxiety related absences. • An ongoing programme of Mental Health first aid training has been rolled out across the Trust. • The Trust has invested in a employee assistance programme which will enable the Occupational Health team to implement a four tier mental health provision, including the introduction of Schwartz rounds in Q3/4. This went live on 2nd December 2019 and staff now have access to 24/7 365 telephone counselling and rapid access to face to face counselling where appropriate. This has supported the in house Occupational Health team to focus on Tier 4 mental health provision including; structured support for mental health first aiders and the rolling out of mental health first aid for managers training.	• The HR&OD team have used the NHSE/I endorsed Health & Wellbeing Partnership framework to undertake a high level gap analysis in order to identify immediate actions to improve attendance. A number of initiatives are being piloted using a PDSA approach as advocated in the framework. A full impact evaluation will be undertaken in January 2020, which will feed into a Trust-wide employee engagement and wellbeing strategic plan including a detailed wellbeing diagnostic and health needs assessment of the workforce. It is the intention that the plan will be signed off by the end of Q4 with implementation ready to commence in April 2020.	Trust Board, TOB, Strategic People Committee	Ongoing Monitoring

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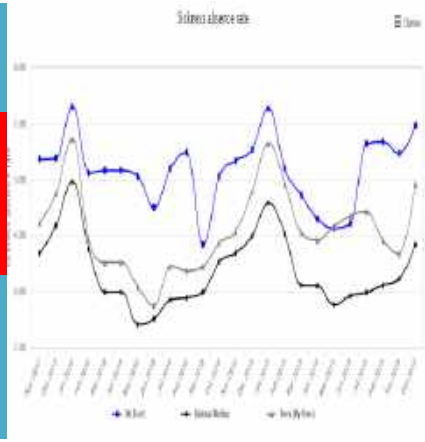
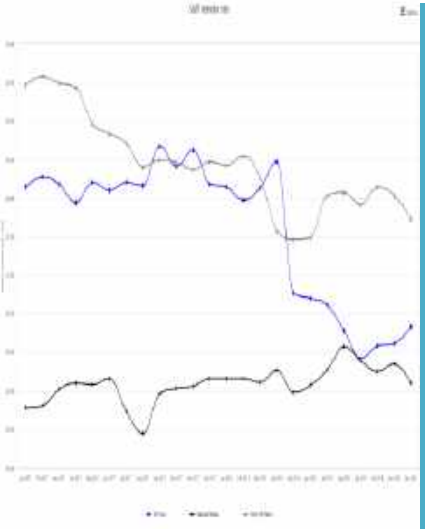
Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 3 2019/20

KLOE 2 - People

	Progress/Performance			Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Sickness Absence Rate	UoR Percentage of staff FTE sick days.	**National Median = 4.42%** **Peer Median = 4.96%** **1. Sunderland 1.49%** **2. Gateshead 4.14%** **3. Bournemouth 4.48%** **4. Chester 4.90%** **5. Southport 4.91%** **6. N Lincolnshire 5.01%** **7. Mid Cheshire 5.06%** **8. North Tees 5.28%** **9. STHK 5.32%** **10. WHH 5.48%** **11. Wirral 6.14%** **Current Quartile:** **4 (Worst)** **Best Quartile Target:** **3.89%** **Source: HSCIC - NHS Digital iView Stability Index** **Monitoring - Trust Board, TOB, SPC**	**October 2019**		The Trust is above the national and peer median for sickness absence in the latest reporting period. Significant strategic and operational work has been undertaken to improve the position.	• The HR&OD team have used the NHSE/I endorsed Health & Wellbeing Partnership framework to undertake a high level gap analysis in order to identify immediate actions to improve attendance. A number of initiatives are being piloted using a PDSA approach as advocated in the framework. A full impact evaluation will be undertaken in January 2020, which will feed into a Trust-wide employee engagement and wellbeing strategic plan including a detailed wellbeing diagnostic and health needs assessment of the workforce.	
Staff Retention Rate	UoR The percentage of staff that remained stable over 12 months period.	**National Median = 85.6%** **Peer Median = 87.7%** **1. N Lincolnshire 89.0%** **2. Wirral 89.0%** **3. Sunderland 88.6%** **4. STHK 88.4%** **5. Gateshead 87.8%** **7. Southport 87.7%** **8. Mid Cheshire 87.4%** **9. Bournemouth 86.5%** **10. North Tees 86.5%** **11. WHH 86.3%** **12. Chester 85.6%** **Current Quartile:** **3 (2nd Best)** **Best Quartile Target:** **87.50%** **Source: HSCIC - NHS Digital iView Stability Index** **Monitoring - SPC**	**December 2018**		As of November 2019, Retention is currently at the highest over the past 2 years at 88.77% and Turnover is at the lowest rate in 2 years at 10.79%, demonstrating the success of the programme of work implemented in line with the NHSI nursing retention programme.	• Improvement in our workforce's ability to achieve a better work life balance through promoting what we offer and reviewing our processes/policies. • Support our staff to explore and pursue career progression within the Trust. • The promotion of the Recognising and Valuing Experience (RAVE) role/initiative. • Develop an R&R Champion role, so they are able to support our managers in both Recruitment and Retention practices. • Improving our retire and return options/promotion through the Pre-Retirement courses.	

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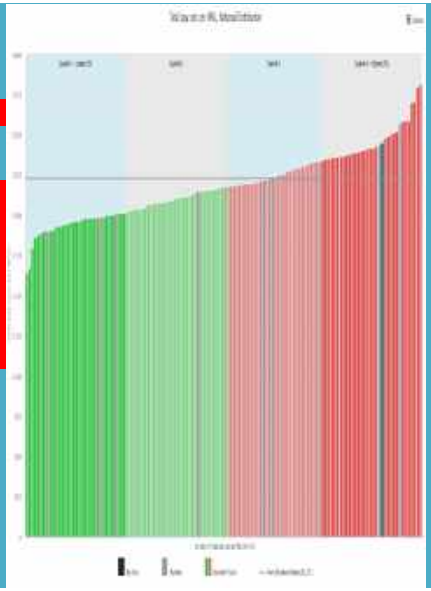
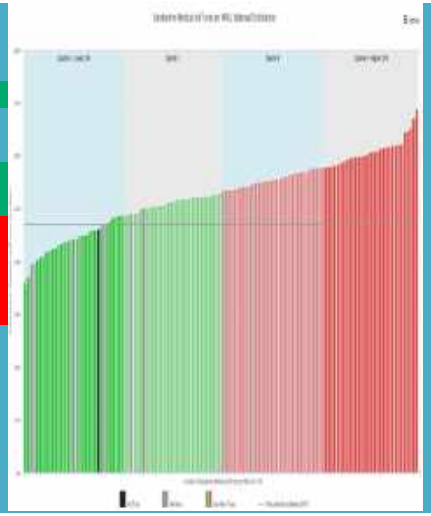
Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 3 2019/20

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Pay Costs per Weighted Activity Unit	UoR Cost per WAU is the headline productivity metric used within the Model Hospital. It shows the amount spent by a Trust to produce one Weighted Activity Unit (WAU) of clinical output. This metric shows the amount the trust spends on pay per WAU across all areas of NHS clinical activity. **National Median = £2180** **2017/18** **Peer Median = £2312** **1. Sunderland £1904** **2. STHK £1995** **3. Bournemouth £2010** **4. Gateshead £2151** **5. Wirral £2219** **6. North Tees £2242** **7. Chester £2336** **8. Mid Cheshire £2442** **9. WHH £2455** **10. N Lincolnshire £2482** **11. Southport £2577** **Current Quartile: 4 (Worse)** **Best Quartile Target: £2,014** **Source: Trust consolidated annual accounts and reference cost data.** **Monitoring - Trust Board, SPC (From March 2019), FSC, TOB.**	 Pay Costs per WAU exceeds the Peer and National Medians. The below shows the WAU Staff Costs per staff group and the percentage difference compared to our peers: **Staff Group / Trust / Peer %** **Medical £465 -4.5%** **Nursing £764 -6.2%** **AHP £188 19.1%** **Scientists £192 9.4%** **Corp Supp £413 -3.1%** **Agency £169 32.0%** **Non-Sub £183 8.2%** When removing AHP costs associated with external SLA, this impacts positively on the overall position.	Additional controls and challenge around pay spend have been identified, to support a reduction in premium pay: • Monthly deep dives into Nursing Agency, supported by NSH Professionals; • Enhanced ECF process for non-clinical vacancies; • Expanded ECF process for some temporary staffing pay spend; • Implementation of Cheshire and Mersey Rate Cards; • Implementation of consistent additional hours rates for Medical Staff; • Introduction of Patchwork Medical Bank system; • Review of all long term locums, led by the Chief Operating Officer ; • Review and action of pay elements within NHSI/E Grip and Control Checklist.	
Substantive Medical Costs per WAU	UoR Cost per WAU is the headline productivity metric used within the Model Hospital. It shows the amount spent by a trust to produce one Weighted Activity Unit (WAU) of clinical output. This metric shows the amount the trust spend on pay for medical staff per WAU across all areas of NHS clinical activity. **National Median = £533** **2017/18** **Peer Median = £471** **1. Gateshead £398** **2. Mid Cheshire £399** **3. Sunderland £442** **4. North Tees £444** **5. WHH £461** **6. Wirral £471** **7. Bournemouth £493** **8. Chester £502** **9. Southport £536** **10. N Lincolnshire £548** **Current Quartile: 1 (Best)** **Best Quartile Target: £488** **Source: ESR, Trust consolidated annual accounts and reference cost.** **Monitoring - SPC**	 The Trust is below the national and peer median (positive), however the large number of vacancies within this workforce will have contributed to this. As we seek to recruit to these vacant posts, we could see costs per WAU increase, however this may lead to the reduction in other areas such as agency.	The key actions relate to the Medical Establishment Review include: > Analyse the established medical model and the proposed effective establishment, within the context of RCP Safe Medical Staffing Guide. > Identify the gaps within the Medical Workforce based on the analysis, developing innovative solutions to fill the gaps. > Working with WWL to recruit Doctors Internationally.	

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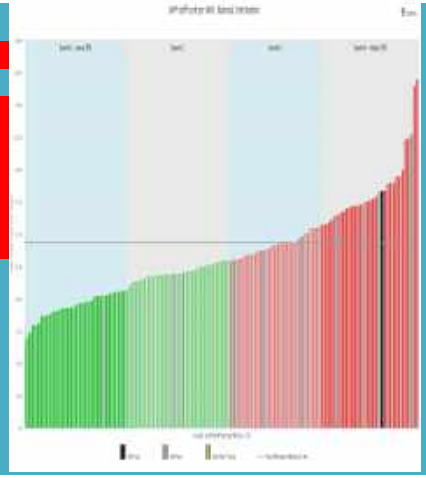
Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 3 2019/20

	Progress/Performance			Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Substantive Nursing Cost Per WAU	UoR Total pay costs for nursing staff, adjusted for the % of Trust expenditure reported in reference costs, the MFF, and the % of pay costs that are capitalised, divided by Cost Weighted Output in WAUs.	**National Median = £710** **Peer Median = £783** **1. Bournemouth £671** **2. Sunderland £694** **3. STHK £711** **4. Gateshead £750** **5. WHH £761** **6. Wirral £772** **7. Chester £778** **8. N Lincolnshire £789** **9. North Tees £801** **10. Southport £845** **11. Mid Cheshire £848** **Current Quartile:** **3 (2nd Worse)** **Best Quartile Target:** **£649** **Source: ESR, Trust consolidated annual accounts and reference cost.** **Monitoring - SPC**	**2017/18**		The Trust is below the peer median for Nursing Costs per WAU which is positive, however again the large number of vacancies will have contributed to this. The Trust seeks to reduce reliance on temporary staffing by offering alternative retention and recruitment solutions with the expansion of the nursing workforce, advanced practice and specialist interest roles.	The key actions are: > Working alongside the WHH Recruitment and Retention group, develop retention strategy and NHSI. > Continue the successful Staff Nurse recruitment open days. The Trust has been in contact with NHSI to look at conflicting data points, which has been escalated to national level within NHSI. The Trust has also been in contact with other Trusts who have the same data issue. The Trust has queried this indicator with NHSI as the data on the model hospital indicators does not triangulate with Trust data.	
Substantive AHP Cost per WAU	UoR Total pay costs for Allied Health Professionals, adjusted for the % of trust expenditure reported in Reference Costs, the MFF, and the % of pay costs that are capitalised, divided by Cost Weighted Output in WAUs.	**National Median = £130** **Peer Median = £141** **1. STHK £103** **2. Wirral £120** **3. Bournemouth £121** **4. Chester £131** **5. Sunderland £138** **6. Gateshead £149** **7. N Lincolnshire £166** **8. Southport £175** **9. Mid Cheshire £183** **10. WHH £184** **11. North Tees £228** **Current Quartile:** **4 (Worse)** **Best Quartile Target:** **£107** **Source: ESR, Trust consolidated annual accounts and reference cost.** **Monitoring - SPC**	**2017/18**		Across the therapy element of AHP, pay costs for community/other work has been included in the cost per WAU calculation on Model Hospital. This indicator includes costs for staffing who are outsourced via SLA to other Trusts. This activity is not included in the WAU, if these costs were removed, the revised estimated costs per WAU would be £123 which brings the Trust below the national median. • For example, we have Therapists working as 'first point of contact practitioners'. Rather than seeing a GP first, patients with musculoskeletal issues are triaged by a Therapist and either discharged, treated or referred to secondary care. Also Therapy staff within RARS form part of Halton integrated community teams and the activity sits with the borough council.		

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Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 3 2019/20

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
	Recommendation 2 - NHS Improvement should develop and implement measures for analysing staff deployment during 2016, including metrics such as Care Hours Per Patient Day (CHPPD) and consultant job planning analysis, so that the right teams are in the right place at the right time collaborating to deliver high quality, efficient patient care. **Lead Director(s):** Medical Director & Chief Nurse			
Care hours per patient day	• The Trust continues to systematically collect and submit Care Hours per Patient Day (CHPPD) data since the national changes in April 2016. • The data is included in the monthly safe staffing and assurance report presented by the Chief Nurse at the Trust Board as well as the Trust Board IPR. • Data is submitted monthly to NHSI via the Trust Information team.	• Care Hours are reviewed each month as part of the Integrated Performance Report (IPR). In 2018/19 this went from 6.2 to 7.6 CHPPD. As of December 2019, the Trust was at 7.3 CHPPD.	Trust Board	Ongoing Monitoring
Electronic roster and safe care module – six week rosters submitted to NHSI, process for improvement, cultural change and communications	• Implementation of Electronic Roster & Safe Care – all core wards are now live. • The corporate nursing team has taken over management of the e-roster team. • The E-Rostering team is co-located with the operational management team in a centralised location. • Capacity and demand meetings are held after the bed meetings and the staffing template updated in real time. • The interface between e-roster and NHS(P) is now in place and temporary staff must now be booked via e-roster. • Safe Care acuity is now embedded and the information is used for 6 monthly safe staffing review. • The Trust has shared its achievements with Safe Care and Health Roster products with 4 Trusts in the region and continues to be seen as an exemplar by Allocate for Nurse Rostering & SafeCare.	• Continue to support the Matron daily safe staffing meetings, allows for early identification of hotspots/issues. • Future rollouts for Outpatient Nursing, Administration Staff, Medical Staff and Corporate Function. • The Trust will be migrating to a cloud based solution for e-rostering in Q4.	Trust Board	Ongoing development and daily monitoring with Senior Nurse Oversight
Consultant job planning - improving analysis of consultant job plans and better collaboration within and between specialist teams	Information not available at time of writing this report.			

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Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 3 2019/20

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
	Recommendation 3 - Trusts should, through a Hospital Pharmacy Transformation Programme (HPTP), develop plans by April 2017 to ensure hospital pharmacies achieve their benchmarks such as increasing pharmacist prescribers, e-prescribing and administration, accurate cost, coding of medicines and consolidating stockholding by April 2020, in agreement with NHS Improvement and NHS England so that their pharmacists and clinical pharmacy technicians spend more time on patient facing medicines optimisation activities.			
	Lead Director(s): Medical Director & Chief Nurse			
Hospital Pharmacy Transformation Programme - developing HPTP plans at a local	• Developed and approved HPTP Plan, nominated Directors, Board sign off and submission of final plan to NHS Improvement. • The HPTP was completed in May 2017.	• Model hospital metrics are monitored at the Trust's Medicines Governance Committee.	Trust Board	Complete
Moving prescribing and administration from traditional drug cards to Electronic Prescribing and Medicines Administration systems (EPMA)	• The electronic prescribing and medicines administration (ePMA) business case and PID signed off by Trust Board and NHS Digital. • The ePMA rollout plan was signed off by the Digital Operational Group and the IM&T Committee. • The ePMA pilot commenced on CDU on 5th March 2018. Positive feedback from staff/system users was received. A 2nd ePMA pilot took place at Halton UCC – the pilot was a success and operation of the system has continued post pilot. • ePMA was successfully implemented on the surgical pathway on Ward B4 in December 2018 and within Ward and Theatre orthopaedic pathways at the CMTC in March 2019. • Planning for rollout across Warrington was completed with the lessons learned from Halton pilots incorporated. A desktop exercise was undertaken to determine implementation and early live support requirements. A number of issues were identified and resolved.	• The rollout of ePMA on the Warrington site was completed in December 2019 for all wards/services with the exception of Maternity, Paediatrics and ITU which will be completed during Q4. • Business cases are being developed to deliver parts 3 (dose range checking) and 4 (to develop interface with JAC Pharmacy to support closed loop prescribing).	Trust Board/IM&T Committee	Project expected completion – March 2020
Ensuing that coding of medicines are accurately recorded	• The Trust continues to work on improving data quality with workshops held to identify gaps, issues and areas for improvement with plans to address. • PHE SACT data has been reviewed, based on this, the Trust is achieving current data quality targets.	• The Trust continues to monitor and address any data quality issues around medicines. • Blueteq has been rolled out in all areas with the exception of Ophthalmology. Discussions are ongoing with the CSU and Cheshire and Mersey network in relation to further funding available for Trust's to implement Blueteq.	Medicines Governance Committee	Ongoing Work Programme

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Use of Resource Graph Key

Trust Position
National Median
Peer Median

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Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 3 2019/20

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
80% of Trusts' pharmacist resource utilised for direct medicines optimisation activities, medicines governance and safety remits	• The Trust is achieving the recommendation for pharmacists. • All Pharmacy technicians have now been upskilled to carry out medicines reconciliation with new starters being trained as they commence in post. • The ward medicines management technician role has been reviewed with the Associate Directors of Nursing. • Midwifes are screening for regular medication so that pharmacy resources can be focused on those specific patients, this has resulted in an increase in medicines reconciliation within the Women's & Children's CBU. • The Trust implemented weekend on ward pharmacy services in December 2019 and has increased dispensary hours. In addition there is now a pharmacist based in ED to complete medicine reconciliation before a patient is admitted which will have a positive impact on a number of areas.	• The ongoing training program continues to upskill pharmacy technicians on medicines optimisation and administration. • The Trust is providing training to new pharmacists for non-medical prescribing on a rolling programme.	Quality & Assurance Committee	Ongoing Monitoring
Reduce stockholding days from 20 to 15, deliveries to less than 5 per day and ensure 90% orders and invoices are sent and processed	• The Trust's current stockholding days are 18, which is below the national and peer median. • Average number of deliveries to the Trust per day is 14 which is below the national median. • 97% orders are carried out electronically.	• Reducing stockholding days or number of deliveries to the Trust per day any further would carry an unacceptable level of risk. The Trust continues to monitor performance against our peers.	Medicines Governance	Ongoing Monitoring

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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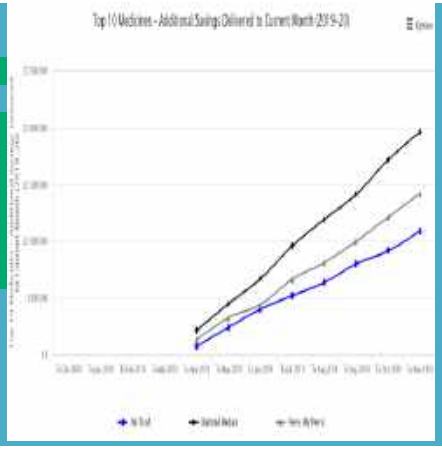
Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 3 2019/20

	Progress/Performance			Actions to Improve Position/Actions for Next Quarter	Assurance	Status
KLOE 3 - Clinical Support Services						
Top 10 Medicines - Percentage Delivery of Savings	This indicator identifies the year to date total % achievement toward the cumulative target saving opportunity.	**Benchmark = £847k** **Peer Median = £1.42m** **1. N Lincolnshire £2.3m** **2. Bournemouth £2m** **3. Gateshead £1.6m** **4. North Tees £1.5m** **5. Wirral £1.4m** **Current Quartile:** **Best Quartile Target:** **Source: Rx-Info Define© (processed by Model Hospital)** **Monitoring - Medicines Governance Committee**	**November 2019** **6. Chester £1.4m** **7. STHK £1.3m** **8. WHH £1.1m** **9. Mid Cheshire £1m** **10. Sunderland £851k** **11. Southport £756k** **N/A** **N/A**		As of November 2019, the Trust has achieved £1.1m savings which is positive and above the national benchmark.	The Trust continues to engage with the Top 10 savings schemes and will work with system partners to identify opportunities for further savings.	

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 3 2019/20

Recommendation 4 - Trusts should ensure their pathology and imaging departments achieve their benchmarks as agreed with NHS Improvement by April 2017, so that there is a consistent approach to the quality and cost of diagnostic services across the NHS. If benchmarks for pathology are unlikely to be achieved, trusts should have agreed plans for consolidation with, or outsourcing to, other providers by January 2017.

Lead Director(s): Chief Operating Officer & Director of Strategy

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Establishment of a shared pathology across the local economy	• NHSI has proposed 29 Pathology Networks across the country, with Cheshire & Merseyside being "North 4". An STP wide Pathology Board has been created with a Clinical Director and Pathology Manager from each of the Trusts in the region. • STP Cheshire & Mersey Pathology Board – the CEO of Aintree Hospital NHS Trust has been named Executive lead for the relaunched group. • A Transition Management Team has been established (Wirral, Chester, Aintree, Liverpool and Southport & Ormskirk). A project manager has been appointed by the STP. • Branch work stream meetings were established to look at equipment with a view to joint procurement opportunities and contract alignments. • Several drafts of the strategic outline case have been developed. The final case was approved by the Executive Oversight Group on 20th December 2018. • The project appointed a Clinical Director and Director of Operations during Q1 2019/20.	• NHSE/I have reviewed the options put forward around the future of pathology services across the Cheshire and Mersey Network. NHSE/I have asked Trusts to devise a local business case for working with the identified cohorts (the Trust will be working with St Helens and Knowsley Teaching Hospitals NHS Trust). This will commence in Q4. • As part of the benchmarking work undertaken by the network, Keele has identified a number of tests where the Trust is a outlier in terms of over and under testing. These results are being analysed and will be presented internally, followed by external discussions with the CCG to understand what the impact and potential benefits are during Q4.	Strategic Development and Delivery Committee	Project – expected completion 2021
Development of pathology service specification	• The original plan called for a new specification to be developed, however this has now been superseded by the STP wide pathology board.	N/A	N/A	N/A
Introduce the Pathology Quality Assurance Dashboard (PQAD) by July 2016	• A Pathology Quality Assurance Dashboard (PQAD) has been developed. • PQAD implemented from November 2016.	• Monthly data indicators continue to be submitted. • PQAD data is reviewed monthly at the KPI sub-committee. • The Trust continues to review quarterly and bi-annual indicators, however we understand that the indicators are under review and a new dashboard is under development. • A new POAQ has been developed and will commence implementation during Q4.	KPI Sub-Committee	Rolling Programme

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 3 2019/20

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

KLOE 3 - Clinical Support Services

Pathology - Cost Per Test

UoR

The cost per test is the average cost of undertaking one pathology test across all disciplines, taking into account all pay and non-pay cost items.

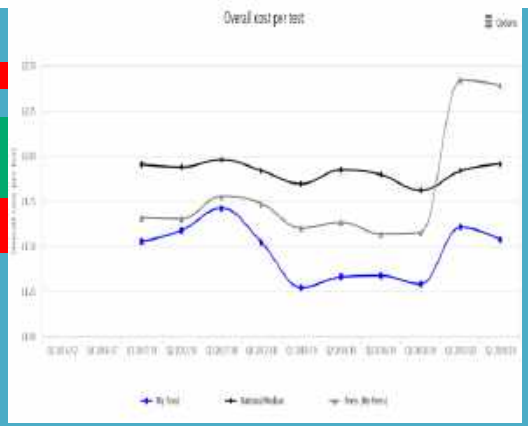
National Median = £1.96 **Q2 2019/20**
Peer Median = £2.39

1. Chester £1.38
2. WHH £1.54
3. Gateshead £1.94
4. Bournemouth £2.84
5. North Tees £5.58

Current Quartile: **1 (Best)**
Best Quartile Target: **£1.58**

Source: NHSI Q Pathology Data Collection 18/19

Monitoring - Pathology Business Meeting



The Trust benchmarks well against the peer and national medians and also against Trusts within our STP footprint. Overall the Trust's pathology service is efficient with the use of streamlined processes, technology and procurement opportunities.

The Trust is working with STP partners as part of the Lord Carter recommendations to look at how further efficiencies can be made across the footprint.
> The Trust will be working with STHK on a localised business case during Q4 to understand how pathology services will operate in the future.

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Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 3 2019/20

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
	Recommendation 5 - All trusts should report their procurement information monthly to NHS Improvement to create an NHS Purchasing Price Index commencing April 2016, collaborate with other trusts and NHS Supply Chain with immediate effect, and commit to the Department of Health's NHS Procurement Transformation Programme (PTP), so that there is an increase in transparency and a reduction of at least 10% in non-pay costs is delivered across the NHS by April 2018. **Lead Director(s):** Director of Finance & Commercial Development			
Provide data to NHSi for the NHS Spend Comparison Service (SCS)	• The procurement team continues to provide data to NHSI for the Spend Comparison Service tool on a monthly basis. • In August 2019, PPIB was replaced with the NHS Spend Comparison Service (SCS). • The Trust has reviewed the available suite of reports within SCS to understand how these can be most efficiently implemented. The Trust attended a SCS overview session on 9th December 2019. • The Trust is now submitting Accounts Payable data to the SCS.	• The Trust is carrying out analysis to look at data from the top quartile of performing Trusts who are paying lower prices using the SCS. A report has been run against the Top 500 products by price variance comparing our data, Cheshire & Mersey, NHSI Peer and Acute Trusts in Top 25% of the Procurement League Table based on price. This will be run every six months. This will serve two purposes; it will support the delivery of savings and support work required in line with model hospital requirements. The aim is to complete the review within 2 months. • Catalogue Benchmarking is to be undertaken annually. This will review how our catalogue prices benchmark against other Trusts. The aim is to complete the review within 3 months. • SCCL monthly tracking commenced on 01.04.2019 and is tracked on a monthly basis. This will review any increases/decreases in NHS SC prices and where prices have increased, enable an informed decision to be made on source of supply along with informed discussions with SCCL. • The Purchasing Team is to benchmark all non-stock requisitions.	Finance & Sustainability Committee	Rolling Programme
Developing PTP plans at a local level with each trust board nominating a director to work with their procurement lead to implement changes	• The Procurement Transformation Plan was submitted to NHSI. To support this, a procurement dashboard was established to measure Trust performance against the Carter metrics. The PTP was refreshed using the new NHSI format. • The Director of Finance & Commercial development is the responsible board member and will work with the Associate Director of Procurement to implemented changes around the PTP plan. • A review has been completed for all direct spend (i.e. that not with NHS SC) to determine which products can be transferred to NHS SC to further support the operating model. • All savings identified by Supply Chain Coordination Ltd (SCCL) will be incorporated in the Trust's 2019/20 CIP Plans. Based on 2018/19, 375 lines were transferred into the operating model representing a saving of £0.08m.	• The Trust continues to measure progress against the PTP. • The Trust continues to work with the network, SCCL account manager and the category towers to understand how savings can be achieved. • The Trust continues to develop working methodologies to streamline processes.	Finance & Sustainability Committee	Project Implementation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 3 2019/20

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Adoption plan for Scan4Safety	• The Trust's adoption plan for Scan4Safety (formally the Global Standard: GS1) and pan European Public Procurement Online (PEPPOL) standards was drafted, the procurement lead for the project is the Deputy Head of Procurement. • Scan4Safety was presented to a number of forums throughout the Trust. • A draft PID was developed. The Trust has made progress in a number of areas: • Been allocated our 10,000 GLN's by GS1 as a way to assign a GLN to all of the locations within the Trust. • Agreed in principle that the issue relating to GSRN will be dealt with by replacing all staff ID Badges with a badge which as well as a photograph, will contain a barcode linked to the member of staffs payroll number. • The inventory management systems offered by the main providers in this area have been evaluated. This area along with the associated hardware and software represents the biggest cost to the Trust, so care is required to ensure that the solution selected meets the requirements into the future. • It has been agreed that Trust's lead executive for Scan 4 Safety is the Chief Information Officer. A meeting will be arranged between the Chief Information Officer, the Director of Finance and Commercial Development and the Deputy Head of Procurement to agree an Executive handover and to ensure that Scan 4 Safety is incorporated in the Trust's Digital Strategy. • Cheshire & Merseyside Healthcare Partnership met with representatives from GS1 UK* on 19th December 2019 to discuss the possibility of implementing the Scan 4 Safety initiative across a wider footprint.	• Estimated costs have been obtained for a Trust inventory management system and visits to demonstrator sites are being set up. The Trust is positioning itself as leading the STP Scan4Safety on the Digital Collaboration @ Scale tracker. A briefing paper will be submitted to the Executive Team to consider next steps.	Trust Board, Trust Operational Board	Project Implementation
NHS Standards of Procurement - to achieve level 1 by October 2016, develop improvement plan to meet target by March 2017	• The Trust has achieved NHS Standards of Procurement Level 1 accreditation. • The Trust has successfully achieved Level 2 for the Procurement Skills Development Network (FSD) which was signed off in August 2019.	• The Trust will undertake a gap analysis during Q4 to understand what is required to achieve Level 3.	Finance & Sustainability Committee	Project Implementation

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Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 3 2019/20

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Benchmarking – Model Hospital Procurement	• The Trust is currently ranked 71/133 Trusts – placing the Trust in the 2nd upper quartile (2nd best). • A review has taken place for each of the model hospital procurement metrics which looks at how far the Trust is from reaching with upper quartile. • The procurement team has produced a strategy to look at the feasibility of the Trust reaching the upper quartile for each metric and actions needed to get there. • The procurement team has developed a tracker to review progress against the key metrics. • The main metrics are included on the Trust Procurement Dashboard.	• The Trust continues to work through actions to improve its position against the Model Hospital metrics as part of a rolling programme, the focus is on the new Spend Comparison Service.	Finance & Sustainability Committee	Ongoing
Key Procurement Metrics	• Target of 80% addressable spend transaction volume on catalogue - Trust currently is at 92% (Q3 2019/20). • Target of 90% addressable spend transaction volume with a purchase order - Trust currently at 98% (Q3 2019/20). • 90% addressable spend by value under contract - Trust currently at 77% (Q3 2019/20). • The procurement team produce monthly reports on all orders raised to ensure the contract register is up to date. The contract register is reviewed monthly by the Senior Contract Managers with oversight from procurement management meetings.	• Addressable Spend Transaction Volume Even though the target has been achieved, this continues to be monitored on a monthly basis. For suppliers where spend that is not transacted via a PO , these are placed on a 100% PO rule i.e. if they do not have an order number their invoice will be rejected.	Finance & Sustainability Committee	Ongoing Monitoring

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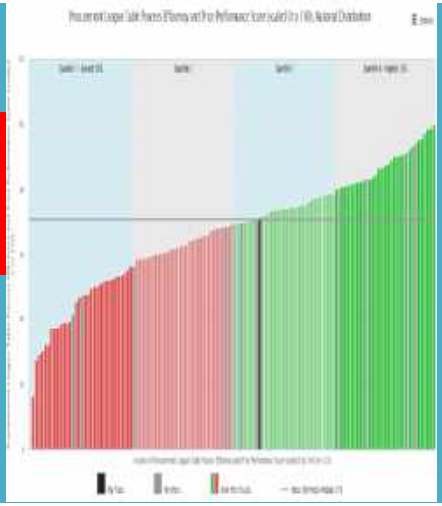
Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 3 2019/20

	Progress/Performance			Actions to Improve Position/Actions for Next Quarter	Assurance	Status
KLOE 4 - Corporate Services						
Procurement Process Efficiency and Price Performance Score Clinics	UoR This measure provides an overall view of how efficient and how effective an NHS Provider is in it's procurement process and price performance, respectively, when compared to other NHS providers.	**National Median = 69** **Peer Median = 71** **1. STHK 94** **2. Bournemouth 91** **3. Southport 83** **4. WHH 71** **5. N Lincolnshire 71** **6. Wirral 70** **7. Mid Cheshire 69** **8. North Tees 57** **9. Gateshead 47** **10. Sunderland 42** **Current Quartile:** **3 (2nd Best)** **Best Quartile Target:** **80** **Source: Purchase Price Index and Benchmark (PPIB) tool** **Monitoring: Senior Procurement Meeting**	**Q4 2018/19**		The Trust is performing better than the national median and is the same as the peer median. The latest procurement league table has the Trust at a weighted score of 71 which puts the Trust in the 3rd quartile (2nd Best). The Trust is ranked 58 which is better than both the peer and national medians. The Procurement Team has a strategy in place for improving performance which is reviewed on a monthly basis.	The Trust has undertaken a review of all procurement metrics and tracks this on a monthly basis. The Trust is carrying out analysis to look at data of the top quartile performing Trusts who are paying lower prices using the SCS. The Top 500 products are being reviewed to understand the reasons for the price variance and to see if this can be replicated by the Trust.	

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Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 3 2019/20

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
	Recommendation 6 - All trusts estates and facilities departments should operate at or above the benchmarks for the operational management of their estates and facilities functions by April 2017 (as set by NHS Improvement by April 2016); with all trusts (where appropriate) having a plan to operate with a maximum of 35% of nonclinical floor space and 2.5% of unoccupied or under-used space by April 2017 and delivering this benchmark by April 2020, so that estates and facilities resources are used in a cost effective manner. **Lead Director:** Chief Operating Officer			
Strategic estates strategy inc cost reduction based on benchmarks and in the longer term plan for investment/reconfiguration	• The Trust has an estates strategy in place to meet the overall Trust strategy. The strategy is phased 1, 2, and 3. Phase 1 is to explore immediate options for delivering savings by rationalising part of the estate. Phase 2 is to explore the potential for external and/or better utilised 'on site' accommodation for current service provision and phase 3 is to explore opportunities for wider STP collaborative initiatives. • Phase 1 is being delivered and monitored through Strategic Development and Delivery Committee. The strategy has been refreshed to reflect local clinical strategy and the STP estates strategy. • The Associate Director of Estates and Facilities has been nominated as co-chair for the One Halton estates enabler sub-group. • The estates and facilities strategy was approved during Q2.	• The Trust continues to explore internal and partnership collaboration opportunities for relocation of back office and clinical support functions with Bridgewater Community Healthcare NHS Foundation Trust using a joint executive estates working group to move forward this agenda. Analysis has been undertaken around current estates, heads, locations and space. Phase 1 and Phase 2 (Training HR and Communications) are complete. A plan for the relocation of the Bridgewater Executive Team has been shared with both Executive Teams with a view to commence implementation during Q4. • The Cheshire and Mersey Partnership is reviewing facilities management contracts across the patch and has identified four initial areas for collaboration opportunities, these include; Energy, Linen, Post and Decontamination, the Trust is fully engaged in all four work streams.	Estates and Facilities sub-Committee, TOB, Strategic Development and Delivery Committee	Ongoing management and monitoring of the plan
Investing in energy saving schemes such as LED lighting, combined heat and power units, and smart energy management systems	• The Trust has procured an energy infrastructure upgrade (CHP) which will save carbon, energy, money and future investment, upgrading their facilities using private sector capital repaid through guaranteed savings. • Estates have accessed funding from Carbon Energy Fund (CEF) replacing 4000 halogen bulbs with more cost effective LED. • The Trust has realised saving of £140k from the CHP contract which has been used for the departments CIP target.	• The Trust is progressing an internal replacement programme for emergency lighting, as and when the lighting needs to be replaced. • The Trust is seeking to recruit a Sustainability Manager in 2020/21.	Estates and Facilities Sub-Committee	Ongoing

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Estates and facilities costs embedded into trusts' patient costing and service line reporting systems.	• Estates and Facilities costs are incorporated into the PLICS system. Quarterly service line reports are provided to CBUs by the financial planning team. The costing teams use the estates system, MICAD, to export floor area and can allocate energy/facilities costs based on m2.		Estates and Facilities Sub-Committee	Complete
Model Hospital & Effectiveness of Estates	• The Trust continues to review the effectiveness of its estate and monitors cost efficiency metrics to ensure it provides value for money and take actions for any deviation from the benchmark values. • Results of the Trust PLACE assessment have been developed into an action plan which is monitored by the estates and facilities operational board and the Quality Assurance Committee.	• Model hospital data shows the Trust favourable when benchmarking against peer and national medians. The Trust's ERIC return was completed at the end of Q1, with new benchmarking data received in October 2019. The highlight report noted the Trust benchmarks poorly against backlog maintenance and critical infrastructure costs. This is managed going forward via the UoRA agenda.	Estates and Facilities Sub-Committee/TOB/ Quality Assurance Committee	Ongoing Monitoring
All Trusts (where appropriate) have a plan to operate with a maximum of 35% of 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	• Model hospital data reports the Trust utilises 38.7% of its estate for non-clinical use and has 2.3% of empty space. Whilst every effort to minimise the use of trust accommodation for non-clinical purposes has been made, it is difficult given the complexities of the numerous corporate functions and the estate footprint. • The current estate strategy addresses under-utilised space which has seen a reduction to under 2.5%.	• The Trust is working in collaboration with Bridgewater, it is possible that the non clinical area floor space will increase, however this can be considered warranted variation. The Trust is constantly reviewing available floor space to maximise opportunities. • An agile working pilot has taken place in several teams within the Finance Directorate; this has demonstrated a potential opportunity to reduce desk space by up to 20%. The pilot will be extended to the wider Finance Directorate in Q4.	Strategic Development and Delivery Committee	Ongoing Monitoring

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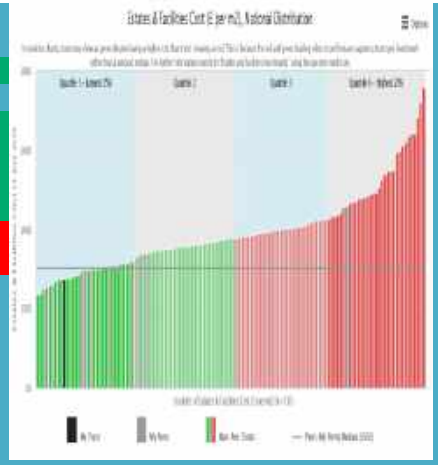
Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 3 2019/20

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
KLOE 4 - Corporate Services				
Estates & Facilities Costs (£ per m2)	UoR The total estates and facilities running costs is the total cost of running the estate in an NHS trust including, staff and overhead costs. In-house and out-sourced costs, including PFI costs, will be included. **National Median = £377** **2018/19** **Peer Median = £302** **1. Sunderland £253** **7. North Tees £305** **2. N Lincolnshire £263** **8. Chester £322** **3. WHH £275** **9. Gateshead £335** **4. Southport £296** **10. Bournemouth £342** **5. Wirral £297** **11. STHK £461** **6. Mid Cheshire £299** **Current Quartile:** **1 (Best)** **Best Quartile Target:** **£322** **Source: ERIC 2018-19 Total Estates and Facilities Running Costs Monitoring - Estates and Facilities Operational Group** 	The Trust benchmarks well against national and peer medians for hard facilities costs even with the challenges of maintaining an aging estate. We have invested year on year to reduce backlog maintenance, however without a significant increase in investment, the amount of backlog to bring the estate up to appropriate standards will always rise. This in turn has and will continue to have an adverse effect on overall estates and facilities costs.	Estates and facilities costs are continually monitored. Where efficiencies can be made, proposals/business cases are produced for consideration by the Trusts Executive Team.	

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	Recommendation 7 - All trusts corporate and administration functions should rationalise to ensure their costs do not exceed 7% of their income by April 2018 and 6% of their income by 2020 (or have plans in place for shared service consolidation with, or outsourcing to, other providers by January 2017), so that resources are used in a cost effective manner.			
	Lead Director(s): Director of HR & OD, Director of Finance & Commercial Development and Chief Information Officer			
Rationalisation of corporate and administration functions	• The Trust's corporate and administration functions current costs are 7.1% of income based on actual income as of Q3 2019/20. This includes Finance, HR, IM&T, Communications, Research, Transformational and Executive costs. • The Trust will collaborate with other organisations where appropriate to provide services in a more streamlined way maximizing opportunities to procure and work at scale, reduce waste and support the delivery of clinical services, facilitating change where required. • The NHSI operational productivity team visited the Trust in August 2018 to look at the whole of the model hospital and identify opportunities. • As a follow up to the NHSI productivity session, a specific corporate service session took place in October 2018 which will focus on IM&T, Finance and HR. • Corporate Services are utilising NHSI Corporate Service Productivity Programme to review opportunities around Chart of Accounts, Journal Policy, Budget Holder Support, Accounts Payable Automation, Sharing Ledger Costs, Policies and Procedures and Financial Reporting. The Trust is working with Mid-Cheshire Hospitals NHS Trust to review structures as part of a wider benchmarking exercise. • Improving the consistency of Benchmarking returns was discussed at the Collaboration @ Scale workshop. NHSi is to support work to assess returns and advise on amendments. • The IM&T SLT have reviewed the IM&T Model Hospital metrics and apportioned the costs so that they accurately reflect the work areas for pay and non-pay. Looking at the pure IT areas the department is within national levels however further work is underway to see where tangible improvements can be made.	• As part of the Use of Resources agenda, Corporate Leads are reviewing corporate costs to understand if further efficiencies can be made or where corporate costs can be explained as warranted variation. The Trust continues to work with Bridgewater to identify collaboration opportunities around corporate services and progress has been made in HR and Procurement. As part of the system wider recovery plan, the Trust will be looking to make c£2m of corporate savings over the next two years.	Strategic Development and Delivery Committee	Rolling Programme
Corporate CIP Targets	• All corporate divisions have been assigned costs savings targets in 2019/20. The targets and the progress to date in identifying schemes to meet the targets are summarised. The cost savings being delivered either reduce costs or increase income, thereby improving their respective percentage cost figures.	• Corporate CIP performance for 2019/20 as at M9 was £0.6m against a M9 target of £0.4m. The 2019/20 full year target is £1.2m. • Collaboration at Scale activity is seen as key to future gains and aims to identify future procurement opportunities.	Finance & Sustainability Committee	Rolling Programme

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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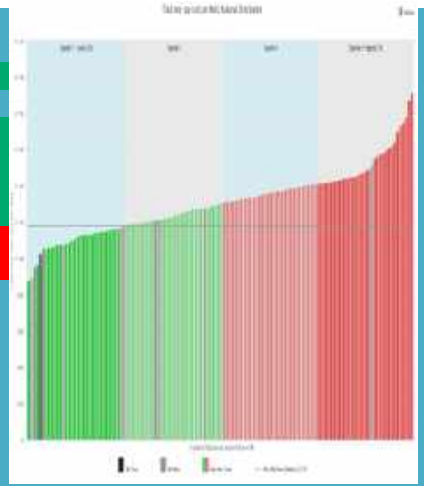
Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 3 2019/20

KLOE 4 - Corporate Services

	Progress/Performance			Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Non Pay Costs per WAU	UoR Cost per WAU is the headline productivity metric used within the Model Hospital. It shows the amount spent by a trust to produce one Weighted Activity Unit (WAU) of clinical output. This metric show the amount the trust spends on non-pay per WAU across all areas of NHS clinical activity.	**National Median = £1307** **Peer Median = £1200** **1. Chester £898** **2. Mid Cheshire £954** **3. WHH £1027** **4. Gateshead £1058** **5. Wirral £1078** **6. Southport £1172** **Current Quartile:** **Best Quartile Target:** **Source: HSCIC - NHS Digital iView Stability Index**	**2017/18** **7. N Lincolnshire £1187** **8. Bournemouth £1213** **9. STHK £1218** **10. North Tees £1280** **11. Sunderland £1518** **1 (Best)** **£1172**		The Trust is performing in the upper quartile (best) nationally. The Trust continues to review opportunities to reduce non-pay costs whilst maintaining quality.	All departments across the Trust are continuously looking at ways to reduce costs as part of day to day business as well as via CIP.	
Finance Costs per £100m Turnover	UoR Total finance cost divided by trust turnover multiplied by a £100m	**National Median = £653k** **Peer Median = £673k** **1. Bournemouth £560k** **2. Sunderland £572k** **3. STHK £649k** **4. Chester £656k** **5. Wirral £665k** **6. Mid Cheshire £682k** **Current Quartile:** **Best Quartile Target:** **Source: Trust consolidated annual accounts and NHSI improvement 18/19 data collection template.**	**2018/19** **7. North Tees £694k** **8. N Lincolnshire £701k** **9. Gateshead £745k** **10. WHH £839k** **11. Southport £1.1m** **4 (Worst)** **£541k**		The Trust is above the national and peer median when compared to costs per £100m income, however based on absolute costs, the Finance function is lower than the national and peer medians. There remains an issue with the way the SBS costs are treated and this has adversely affected the position, if these costs were removed, it would bring the Trust to below the national median.	The Trust is reviewing collaboration opportunities. As part of a system wide recovery plan, the Trust has plans to reduce corporate costs by £2m over the next 2 years.	

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 3 2019/20

	Progress/Performance			Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Human Resource Costs per £100m Turnover	UoR HR is made up of a number of sub compartments taken into consideration when considering total HR costs per £100m turnover.	**National Median = £911k** **Peer Median = £980k**	**2018/19**		The Trust is above the national median by £100 when compared to costs per £100m income based on the national benchmarking data for all Trusts.	The Trust is reviewing collaboration opportunities. As part of a system wide recovery plan, the Trust has plans to reduce corporate costs by £2m over the next 2 years.
		1. Sunderland £713k **2. Wirral £860k** **3. Gateshead £870k** **4. Bournemouth £872k** **5. STHK £958k** **6. Chester £1.00m**	**7. North Tees £1.01m** **8. WHH £1.1m** **9. Mid Cheshire £1.2m** **10. N Lincolnshire £1.3m** **11. Southport £1.7m**			
		Current Quartile: **Best Quartile Target:**	**3 (2nd Worse)** **£745k**			
		Source: Trust consolidated annual accounts and NHSI improvement 16/17 data collection template.				

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Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 3 2019/20

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Recommendation 8 - NHS Improvement and NHS England should establish joint clinical governance by April 2016 to set standards of best practice for all specialties, which will analyse and produce assessments of clinical variation, so that unwarranted variation is reduced, quality outcomes improve, the performance of specialist medical teams is assessed according to how well they meet the needs of patients and efficiency and productivity increase along the entire care pathway. **Lead Director(s):** Chief Operating Officer and Director of Strategy				
Variation in Theatres and Outpatients	• A new theatre scheduling process was launched and is designed to provide improved visibility and forward planning around utilising theatre and anaesthetic capacity. • Theatre listing meetings immediately follow '6-4-2' scheduling meetings and examine the patients on each individual list for the following week. • Theatre '6-4-2' scheduling meetings are now fully established. Theatre sessions are now 'locked down' at two weeks. • A list planning process was launched with the aim of formally introducing expected list timings into the discussion to ensure all scheduled lists are planned to run at or close to maximum operating time available. • Demand and Capacity work is complete and the model is now fully functional. Clinic templates for all specialties are being validated to ensure the accuracy of all outcomes. • The KPI Sub-Committee continue to monitor Theatre utilisation, Late starts and Cancellations. • A Theatre Transformation Board chaired by the CBU Manager for Digestive Diseases has been established. • The Transformation Team have developed a capacity and demand summary which CBU managers will monitor. • A programme of work around improving Theatre Utilisation and Late Starts has commenced. Full analysis and benchmarking with peers has been undertaken regarding late starts and improvements have been made. • The Theatre productivity group has been established with a sub-group focusing specifically on cancellations with a view to address the number of cancelled sessions. • The Trust has implemented new dashboards allowing live reporting of theatre productivity.	• Options and plans around the co-location of Breast Screening and Orthopaedics are being finalised, 3 tests of changes for Breast Surgery at CMTC have taken place and went positivity, a business case is going to be developed for the breast centre of excellence in early 2020. • An Outpatient Transformation scheme has been established and is a work stream on the Collaborative and Sustainability Group and includes T&O, Gastro and Ophthalmology. The scheme will entail the implementation of Straight to Test, Telephone and Virtual clinics. The CSM is changing to CSG in early 2020 involving partners from local authorities and Bridgewater Community NHS Foundation Trust.	Trust Operational Board	Ongoing

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Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 3 2019/20

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Emergency Care Improvement Programme	• An improvement programme for patient flow agreed a number of key work streams across mid Mersey following a system review, these work streams feed into the Mid-Mersey A&E delivery board. • The Trust has its own internal flow board which focuses on 9 key work streams to support improvements in flow. • Red 2 Green patient data is collected on all wards through daily board rounds and a process to share the data around patient delays with partner organisations is in place with partner organisations expected to respond with actions in place to reduce the delays. • Frailty work stream – the frailty assessment unit is operational. • The Emergency Care Improvement Programme visited the Trust. There was an NWAS challenge for all conveyances and a walk through of the urgent/emergency care system. Positive informal feedback was received. • As a result on the system wide capacity and demand review carried out by the Venn Group, the Trust has agreed with partners to approve capacity and flow in the short term. • ED Ambulatory Care opened January 2019. This has resulted in increased assessment throughput and a reduction in direct admissions from ED. • The Trust will continue to focus on Super Stranded Patients with system partners, the trajectory for 2019/20 is > 95 patients. • Ambulance Handovers over 30 and 60 minutes continues to reduce month on month. • The Trusts dedicated discharge lounge opened in March 2019. • The Integrated Care team is now co-located from June 2019. • A new ward round accreditation process is being developed. • CAU (Combined Assessment Unit) test of change took place in September 2019 bringing together GPAU and SAU, significant positive impact was demonstrated. • The Trust took part with NHSI in a SAFER/LLOS Collaboration which was completed in November 2019. • An Urgent & Emergency improvement committee is now in place with an action plan to support improvement and address breaches. All actions are complete with continual audits to be carried out. • The CAU (Combined Assessment Unit) business case was approved and went live in December 2019 with a full 24/7 rota in place by 5th January 2020.	• The Trust will continue to work with One Halton and Warrington Together to ensure proposals are developed consistently with an integrated approach. • A system wide winter plan has been developed and will be implemented throughout the winter period. • The Trust has hit its trajectory of no more than 95 patients with a LOS 21 days in December 2019 and will continue to work with system wide partners to maintain this standard.	A&E Delivery Board Flow Board	Ongoing

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 3 2019/20

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Specialty level reviews across local delivery system	• The Trust is participating in a series of specialty level reviews across the Local Delivery System (LDS). • Implementation of plans to reduce variation within pathways across the LDS. • Specialty reviews have now been held in urology, trauma & orthopaedics and ophthalmology. • A programme of workshops across priority specialties has been agreed, led by the LDS Director of Service Redesign. • A new clinical strategy was developed and launched. • Work to re-invigorate the DTOC process to include daily validation with weekly reviews and a weekly corporate flow meeting has been completed. • The Trust is working with Cheshire and Mersey Cancer Alliance to develop optimal pathways beginning with Colorectal, the Trust is supported by Aqua. A one stop shop has been launched. Colorectal Straight to Test has been implemented. • A new clinical model around the Stroke Pathway has been agreed, implementation took place in April 2019. • An Integrated Discharge Manager has been recruited who will manage both Health & Social Care Teams. • All 33 clinical services now have 3-5 year clinical strategies agreed and prioritised. The Clinical strategies seek to address variation and target improvement.	• GIRFT reviews continue to take place within a number of specialities across the Cheshire & Mersey footprint, with each speciality developing an action plan. • The Trust is working in collaboration with St Helens & Knowsley NHS Trust in the development of a Rapid Diagnostic Centre for Cancer, this is a virtual model to be operational for Q4 2020. • The Trust is working in collaboration with Bridgewater Community Healthcare NHS Foundation Trust to look at the integration of clinical pathways, this will continue into 2020.	Strategic Development and Delivery Committee	Ongoing

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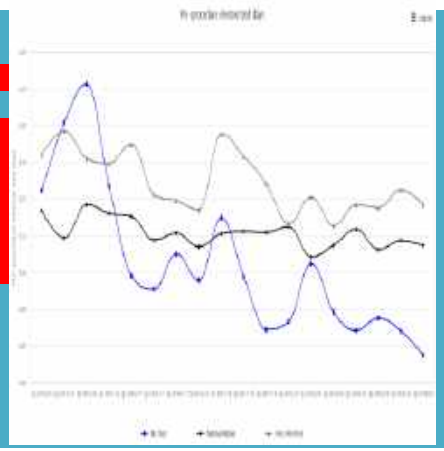
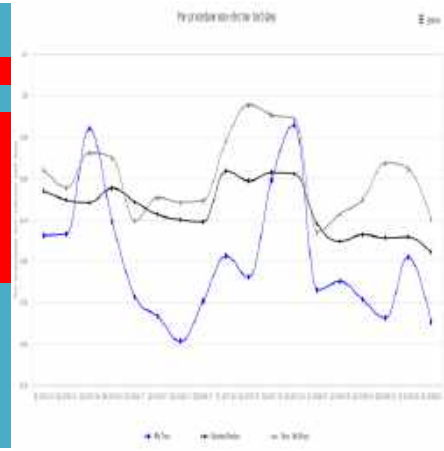
Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 3 2019/20

KLOE 1 - Clinical

	Progress/Performance			Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Pre Procedure Elective Bed Days	UoR The number of bed days between the elective admission date and the date that the procedure taken place.	**National Median = 0.12** **Peer Median = 0.15** **1. North Tees 0.01** **2. Mid Cheshire 0.02** **3. Bournemouth 0.03** **4. WHH 0.04** **5. STHK 0.13** **6. Chester 0.16** **7. Wirral 0.21** **8. N Lincolnshire 0.24** **9. Gateshead 0.39** **Current Quartile:** **1 (Best)** **Best Quartile Target:** **0.07 days** **Monitoring : KPI Sub-Committee** **Source: Hospital Episode Statistics**	**Q2 2019/20**		The Trust continually reviews opportunities to provide same day admission. The surgical transformation programme is supporting the reduction in theatre cancellations and improving productivity and efficiency.	Theatre productivity and efficiency remains a focus for the surgical theatre transformation in 2019/20. Performance against this metric is further monitored via the Theatre Performance Dashboard.	
Pre Procedure Non Elective Bed Days	UoR The number of bed days between an emergency admission date and the date the procedure taken place.	**National Median = 0.62** **Peer Median = 0.70** **1. Bournemouth 0.26** **2. WHH 0.45** **3. Wirral 0.47** **4. North Tees 0.54** **5. Chester 0.77** **6. Gateshead 0.87** **7. N Lincolnshire 1.01** **8. STHK 1.26** **Current Quartile:** **1 (Best)** **Best Quartile Target:** **0.49 days** **Monitoring: KPI Sub-Committee** **Source: Hospital Episode Statistics**	**Q2 2019/20**		The Trust continually reviews opportunities to improve efficiency around emergency and non elective procedures. The surgical transformation programme is supporting the reduction in theatre cancellations and improving productivity and efficiency.	Theatre productivity and efficiency remains a focus for the surgical theatre transformation in 2019/20. Performance against this metric is further monitored via the Theatre Performance Dashboard.	

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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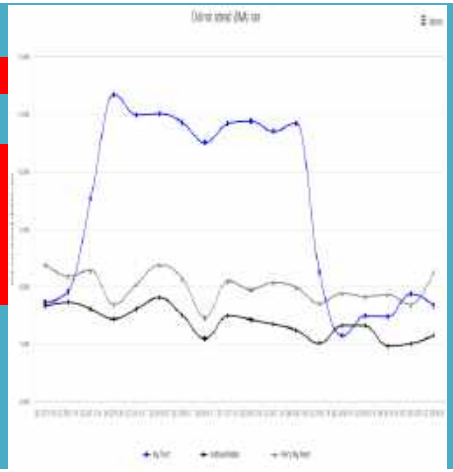
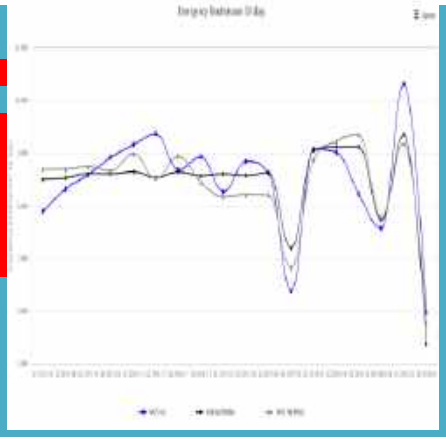
Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 3 2019/20

	Progress/Performance			Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Did Not Attend (DNA) Rate	UoR Rate of patients not attending their outpatient appointment.	**National Median = 7.14%** **Peer Median = 8.25%** **1. Chester 5.75%** **2. Mid-Cheshire 6.02%** **3. Southport 6.98%** **4. N Lincolnshire 7.25%** **5. WHH 7.68%** **6. Bournemouth 8.25%** **7. Gateshead 8.25%** **8. North Tees 8.30%** **9. STHK 9.18%** **10. Wirral 9.30%** **Current Quartile:** **3 (2nd Worst)** **Best Quartile Target:** **6.05%** **Monitoring: KPI Sub-Committee** **Source: Hospital Episode Statistics**	**Q2 2019/20**		The Trust reintroduced a text reminder service which has resulted in a significant improvement in the DNA rate. The Trust is slightly above the national median, however we perform better than our peers.	The Trust has continued to implement improvements in the interface with patients. Further improvements in the interface are being implemented via the Outpatient Steering group, which is intended to improve the position further.	
Emergency Readmission (30 Days)	UoR This indicator measures the percentage of admissions of people who returned to hospital as an emergency within 30 days of the last time they left hospital after a stay. Admissions for cancer and obstetrics are excluded as they may be part of the patient's care plan.	**National Median = 5.36%** **Peer Median = 5.78%** **1. N Lincolnshire 3.57%** **2. Chester 4.49%** **3. Wirral 5.06%** **4. Gateshead 5.72%** **5. Bournemouth 5.83%** **6. STHK 5.91%** **7. WHH 5.97%** **8. Mid Cheshire 6.07%** **9. North Tees 6.99** **Current Quartile:** **3 (2nd Worse)** **Best Quartile Target:** **4.75%** **Monitoring: KPI Sub-Committee** **Source: Hospital Episode Statistics**	**Q2 2019/20**		Every effort is made when discharging patients to ensure that the discharge is appropriate. Readmissions are reviewed by the clinical directors to review any inappropriate discharges and ensure lessons are learned.	The Trust will continue to review the improvement through the Trust clinical governance processes to ascertain if there is a need to review discharge procedures.	

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Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 3 2019/20

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
	Recommendation 9 - All trusts should have the key digital information systems in place, fully integrated and utilised by October 2018, and NHS Improvement should ensure this happens through the use of 'meaningful use' standards and incentives. **Lead Director:** Chief Information Officer			
Electronic Patient Record & Structured Clinical Notes	• The Trust implemented Lorenzo EPR in December 2015. • The Trust continues to optimise Lorenzo functionality to ensure that it meets with developing business and clinical needs. This project is monitored by the Digital Board. • The Trust continues to upgrade Lorenzo in line with the development roadmap. • The Trust has been selected as a Digital Exemplar for work relating to the use of the Electronic Patient Record. This project is making excellent progress. The team is pulling together conceptual designs to support future state for the selected pathways ' Head Trauma and Diabetes'. • Electronic Maternity Nursing Observations (MEWS) went live during Q4 2018/19. • The Trust was successful in their bid to HLSI (Health System Led Investment Programme) to support implementation of Inpatient nursing observations. • Lorenzo ePMA Phases 1 & 2 successfully deployed in December 2019.	• Lorenzo Digital Exemplar – Diabetes future state is making good progress. 'Day in Life' workshops are being held to run through principles of a digitised case note. Further workshops are planned for Q4. Head Trauma future state has been moved to the to end of Q4 to allow for ePMA go live. • Warrington Care Record - The Project Initiation Document for Phase 1 Integration to Share2Care has been drafted. A Programme Manager joined Trust in December 2019. The PID is being reviewed and stakeholders are being engaged to refine the plan. • Work continues with the GP viewer, which will give Trust clinicians access to Warrington GP records via Lorenzo. Go live has been delayed due to competing priorities and we are now anticipating implementation in Q4. • The GP Connect data sharing agreement remains in progress with 4 Halton GPs signed. DXC is working with NHS Digital to finalise the Supplier Conformance Assessment List, whilst testing of the live interface continues and key documents are completed. There is currently no test environment therefore, risk assessment of production testing is under development. The configuration is to be agreed with DXC as part of sign off process. • The HLSI (Health System Led Investment Programme) Funding Agreement has been submitted to NHSE for approval. Funding to deliver clinical decision support is expected in Q4 2019/20.	IM&T Sub-Committee/ Trust Board	Project Implementation – expected completion – Plan up to 2020 on track.
Electronic Document Management System	• A review of requirements now Lorenzo has been live for 3 years has been undertaken to ensure any investment required is for the right solution.	• The Trust Digital Strategy has been refreshed and is due to be published at the end of January 2020. • Estimated timescales are recognised in the Digital Strategy programme of work as "Ongoing EPR Forms Development".	IM&T Sub-Committee	Project Implementation – Initiation

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Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 3 2019/20

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
ePMA	• Electronic prescribing and medicines administration (ePMA) business case and PID signed off by Trust Board and NHS Digital – the outline business case was approved by the Trust board in October 2017, NHS Digital approved the business case in principle in November 2017. • The ePMA rollout plan was signed off by the Digital Operational Group and the IM&T Committee. • The ePMA pilot commenced on CDU on 5th March 2018. Positive feedback from staff/system users was received. 2nd ePMA pilot at Halton UCC – the pilot was a success and operation of the system has continued post pilot. • ePMA was successfully implemented on the surgical pathway on Ward B4 in December 2018 and within Ward and Theatre orthopaedic pathways at the CMTC in March 2019.	• ePMA Phases 1 & 2 deployment was successfully completed in early December 2019. Residual issues are now being resolved via Steering Group. • Business cases are being developed to deliver parts 3 (dose range checking) and 4 (to develop interface with JAC Pharmacy to support closed loop prescribing).	IM&T Sub-Committee	Project Implementation

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	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
	Recommendation 10 - DH, NHS England and NHS Improvement, working with local government representatives, to provide a strategy for trusts to ensure that patient care is focussed equally upon their recovery and how they can leave acute hospitals beds, or transfer to a suitable step down facility as soon as their clinical needs allow so they are cared for in the appropriate setting for themselves, their families and their carers. **Lead Director:** Not Applicable			
	Recommendation 11 - Trust boards to work with NHS Improvement and NHS England to identify where there are quality and efficiency opportunities for better collaboration and coordination of their clinical services across their local health economies, so that they can better meet the clinical needs of the local community. **Lead Director:** Not Applicable			
Collaborative working across the healthcare economy	• The Trust continues to work in collaboration with external providers and commissioners within the STP and LDS to seek to address clinical and financial constraints through service, productivity and rationalisation opportunities.			
	Recommendation 12 - NHS Improvement should develop the Model Hospital and the underlying metrics, to identify what good looks like, so that there is one source of data, benchmarks and good practice. **Lead Director:** Not Applicable			
Development of a Model Hospital	• NHS Improvement has now published the model hospital data and the Trust is focussing on the use of the information to drive forward clinical and corporate practices so that outputs and financial performances can be improved.	• A report that extracts all key metrics from the Model Hospital portal that enables our individual services to review and analyse has been produced. • The key metrics include Clinical Service Lines (Emergency, General Surgery, Urology and Paediatrics) Operational (Theatres, Procurement, Pathology, Estates) and People (Nursing, AHP, Medical, Workforce Analysis). https://model.nhs.uk	Ongoing Monitoring	

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

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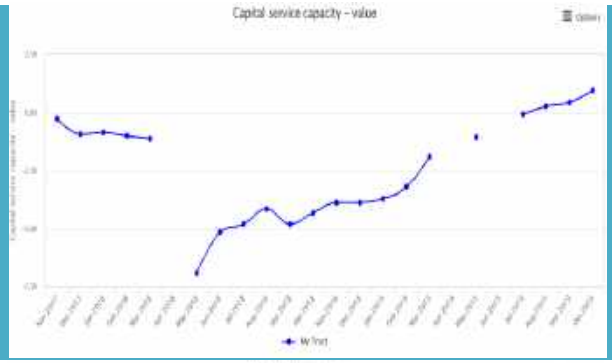
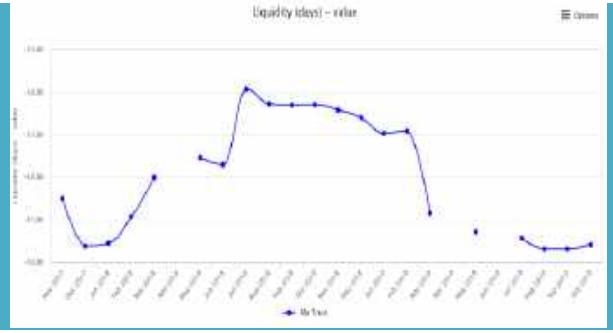
- Complete/Green on Model Hospital (against National median)
- On track for completion
- Progress off track - plans in place to get back on track/Amber on the Model Hospital
- Progress significantly off track/Red on Model Hospital
- Not started/Awaiting further information/New actions parameters to be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

Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 3 2019/20

KLOE 5 - Finance

	Progress/Performance		Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Capital Services Capacity	UoR The degree to which the provider's generated income covers its financial obligations	**WHH Model = 0.93 (October 2019)** **WHH Current = 1.40 (December 2019)** **Source: Provider returns** **Monitoring: FSC/Trust Board**		A score of 0.93 shows that the Trust is currently unable to cover its total operating expenses with the current working capital.	The Trust has worked with Warrington CCG, Halton CCG and Bridgewater Community Healthcare NHS Foundation Trust to develop 12 principles to support the delivery of the LTP. A work programme has been identified to support the future sustainability of services. This programme will be supported by a joint PMO overseen by the CEO oversight group.
Liquidity (Days)	UoR Days of operating costs held in cash or cash-equivalent forms, including wholly committed lines of credit available for drawdown.	**WHH Model = -47.93 days (October 2019)** **WHH Current = -45.2 (December 2019)** **Monitoring: FSC/Trust Board** **Source: Provider returns**		The Trust is in receipt of £11.7m YTD (full year plan of £17.9m) FRF/PSF for accepting a break even control total. Cash is monitored closely to support the operational requirements of the Trust.	The Trust is working to improve liquidity in a number of ways including the strengthening of treasury management, reduction in aged debt, management of the capital programme and access to working capital loans.
Income & Expenditure Margin	UoR The income and expenditure surplus or deficit, divided by total revenue.	**WHH Model = -2.27% (October 2019)** **WHH Current = -1.69% (December 2019)** **Monitoring: FSC/Trust Board** **Source: Provider returns**		The Trust I&E margin is a negative value due to the Trust's deficit position. The Trust is working towards a break even position within its 5 year plan.	The Trust has worked with Warrington CCG, Halton CCG and Bridgewater Community Healthcare NHS Foundation Trust to develop 12 principles to support the delivery of the LTP. A work programme has been identified to support the future sustainability of services. This programme will be supported by a joint PMO overseen by the CEO oversight group.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Use of Resource Graph Key

Trust Position
National Median
Peer Median

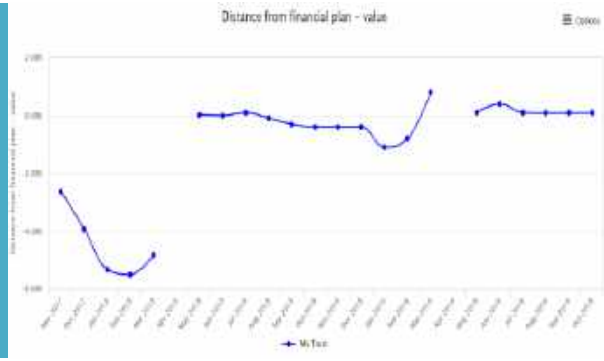
Key

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

Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 3 2019/20

	Progress/Performance		Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Distance from Financial Plan	UoR Year-to-date actual I&E margin in comparison to year-to-date plan I&E margin. I&E margin calculated on a control total basis. Measure is in percentage points.	**WHH Model = 0.09% (October 2019)** **WHH Current = -0.05% (December 2019)** **Monitoring: FSC/Trust Board** **Source: Provider returns**		There is a risk to the delivery of the plan.	The Trust is currently on plan and has achieved Q3. A number of mitigations have been identified. These plans are being overseen by the CEO oversight group.
Agency Spend - Cap Value	UoR The extent to which the trust is meeting the target for the amount spend on agency workers for the financial year.	**WHH Model = - 4.00% (October 2019)** **WHH Current = 8.1% (December 2019)** **Monitoring: FSC/Trust Board** **Source: Provider returns**		For the first half of the year, the Trust was below the agency ceiling, however in the second half of the year, despite numerous controls, the Trust has exceeded the ceiling.	A number of additional agency controls have been introduced as part of the mitigation plans to support the delivery of the control total including a standard agency rate card which is expected to support the reduction in agency costs.

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

WHH Digital Strategy 2020 – 2022

Digital Services

#WHHDigital

Welcome

We are excited to welcome you to our Digital Strategy. Our challenge is to provide Digital leadership within a fast moving healthcare technology environment as we look to directly contribute to our organisation aims and objectives on our journey to outstanding.

This document sets out our commitment to Warrington & Halton Teaching Hospitals NHS Foundation Trust (WHHFT) and our wider stakeholders to support the health and social care needs of our citizens in all aspects of their lives, irrespective of the services they rely upon.

The strategy is influenced by the NHS Long Term Plan, the 5 Year Forward View and the NHS vision for healthcare which clearly expect barrier free health & social care experiences through empowerment (ownership of one's own record and wellbeing), supporting care professionals and their practice, improving clinical efficiency and safety underpinned by modern technology.

Our paperless ambitions will focus upon optimisation of our Electronic Patient Records to support our staff, patients and carers in embracing digital solutions for complex yet seamless health & care services. We will continue to build upon the emerging national, regional and local solutions to realise our aim of outstanding services through our Quality, People and Sustainable objectives. Such initiatives include the MyGP app, now delivering real value to patients irrespective of their relationship with the health system.

Your data is our key asset when delivering outstanding services that allow our citizens to manage their health whilst also informing wider population health initiatives. Advanced clinical applications will demand a digitally skilled workforce to deliver responsive and high quality services reliant upon the digital care record. Security & confidentiality, accessibility & availability, accuracy, comprehensiveness and usability are all key facets of world class digitised care. It is our intention to develop ever more impactful and accessible decision support tools and insights for clinicians and patients in pursuit of the right information, advice, decision and support every time.

We are committed to supporting our workforce and our citizens to achieve outstanding care. Our rebranded "Digital Services" department states our intent.

Phill James, Chief Information Officer
Alex Crowe, Chief Clinical Information Officer

Why have we produced this strategy?

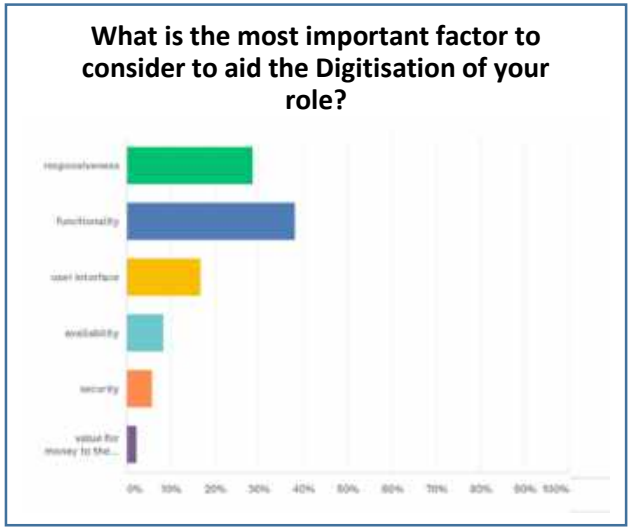
Delivering this strategy will support the Trust's work to be recognised as an outstanding provider.

The ambitions of the NHS Long Term Plan make clear references to the role of digital in enhancing out-of-hospital care, reducing A&E visits, enhancing self care opportunities and reducing outpatient appointments. This strategy defines the digitisation our patients, staff and wider stakeholders can expect from Warrington & Halton Teaching Hospitals to support these ambitions. A clear vision enables our existing and prospective employees to feel enthused by our ambitious digitisation plans whilst our patients will be confident we will deliver a high quality care experience.

Digital as a Clinical Tool

The Trust has invested in a range of technology schemes that centre upon the longitudinal Electronic Patient Record. The feedback from this experience cements the essential nature of our digital services on a par with our clinical tools. Delivering upon these needs in a cost effective manner requires clarity of vision to focus hearts and minds.

Consultation informs us of a desire to embrace a functional, responsive, well designed system experience of tailored workflows upon reliable infrastructure in pursuit of the perfect working day and the outstanding patient experience. A feeling that the system works for the user, not against the user.



We must now move towards flexible solutions built upon open data to deliver impactful outcomes. We will enable the Trust to compliment its EPR with appropriate specialist tools to provide one seamless experience without detriment to patient care, safety and clinical effectiveness.

Strong digital services will help tackle the challenge of scarce resources versus rising workload as we develop our Teaching Trust upon sustainable solutions to attract high calibre colleagues. A credible delivery plan will support these aspirations through a skilled digitally-ready workforce, robust governance and appropriate commercial acumen, protecting the Trust's interests whilst maintaining our reactiveness to the dynamic healthcare environment.

Forward

Key Statistics

Key Facts

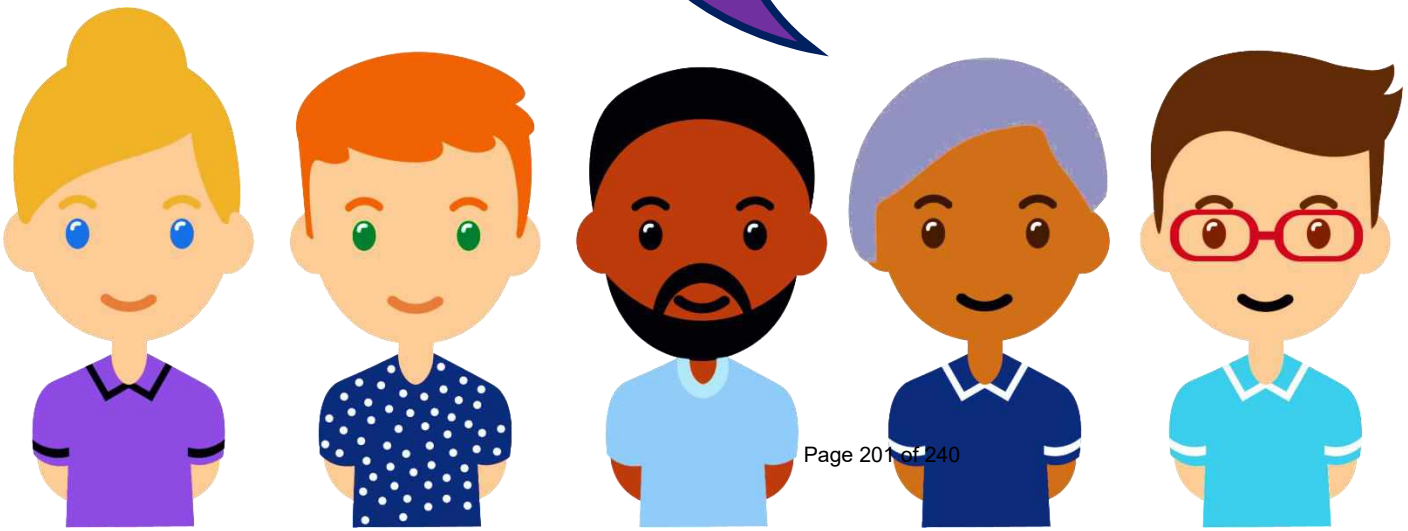
Warrington And Halton Teaching Hospitals NHS Foundation Trust has a high level of digitisation in place, as the following key facts demonstrate.

Recognising the Past

"Individual areas where the trust's productivity compared particularly well included robotic process automation in outpatients and a 'tap on tap off' system within the Emergency Departments."

"The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards."

"The trust used an electronic patient record and other systems to support a range of reports and dashboards from ward to trust level"



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The WHH Frame

The WHH Frame

Digitisation Will Support Our QPS objectives

Our digital services will enable clinical teams to successfully deliver their strategies and service transformation including service redesign and better shared communication.

Quality - Well executed digital services are a key care quality enabler, avoiding security risks and interpretation errors associated with paper processes and enhancing the information available in the right place, time and manner.

A strong marriage between our technology and users will lead to higher data entry compliance rates which in turn lead to greater accuracy. Higher levels of accuracy mean greater benefits of automation and reduced variation via planned Machine Learning, Artificial Intelligence and the Decision Support tools they inform. Our operational performance will benefit from digital support for integration of clinical services where safe handovers of care and utilisation of finite resources are optimised by ubiquitous records access, thus averting avoidable delays in care.

People - The accuracy and presentation of key information in real time is growing in influence. Robust and accurate information will reduce workload pressures on frontline and corporate personnel alike with less duplication, avoidance of unnecessary effort and further opportunities to automate repetitive tasks.

We anticipate outstanding digital services that contribute to a "learning organisation" will attract the highest quality workforce which in turn will contribute to the journey to a outstanding Teaching Trust with a reputation that attracts the commissioning of a greater range of clinical services. The Trust needs an attractive environment to support our valued workforce with the digital experience a contributor.

Sustainability – By directing investment to the areas of most need, use of resources is enhanced through eradication of costly mistakes and automation of low value tasks, supporting cost effective services delivered at scale.

As national investment in population health management continues to increase the sources of data available to healthcare professionals, digital services must assure the quality of contributing data. Only by deploying the most effective and seamless digital tools will the quality match the purpose and ensure the long term NHS commissioning decisions truly support greater self care and healthy lifestyle norms of patients.

Quality
We will… **Always put our patients first** through high quality, safe care and an excellent patient experience

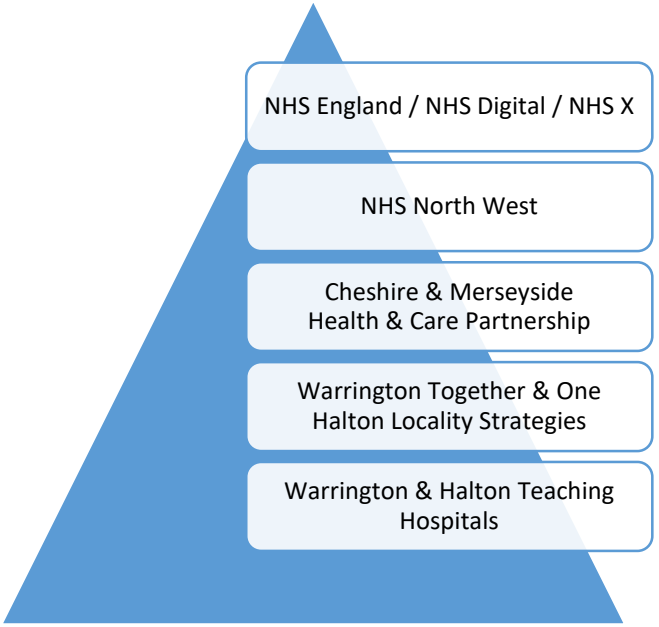
People
We will…
Be the best place to work with a diverse, engaged workforce that is fit for the future

Sustainability
We will… **Work in partnership**
To design and provide high Quality, financially sustainable services

Aims, Objectives & Landscape

Our digital aims and objectives are not unique yet our outstanding ambitions remain very personal. A range of digital transformations, from national to locality support, are being encouraged as the NHS aspires to a fully integrated system and we understand the value of working with peers to secure this necessary investment.

In late 2018 an NHS policy was issued to define “The future of healthcare: our vision for digital, data and technology in health and care”. We acknowledge the role these measures will play in removing technical barriers, taking the steering wheel from suppliers to purchasers such as ourselves. We will harness those policy aspects that progress our journey to outstanding services.



On our regional footprint our STP’s Cheshire & Merseyside Health & Care Partnership issued the Digit@LL strategy in 2018 to ensure all organisations collectively agreed a vision focused through six key themes (left). These themes have subsequently been cascaded as locality work streams. Our Warrington & Halton localities will continue to demonstrate their commitment to the Digit@LL strategy via their chosen solutions for locality care record sharing and personal health records, delivering upon the “connect” and “empower” themes.

An overarching Share2Care initiative is interconnecting the three North West shared record solutions (Cheshire & Merseyside, Lancashire & South Cumbria and Greater Manchester), further dissolving care boundaries and enabling geographically challenged providers such as the Ambulance Service to wholly partake in record sharing. These records will feed the Local Health Care Record Exemplar solution to inform STP and North West population health insights; a key facet of the NHS future plans.

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We continue to support the “innovate”, “enhance” and “secure” work streams in pursuit of safe and effective digital services.

Reflecting

Accepting the Present

"Adds a significant amount of time to the clinician"

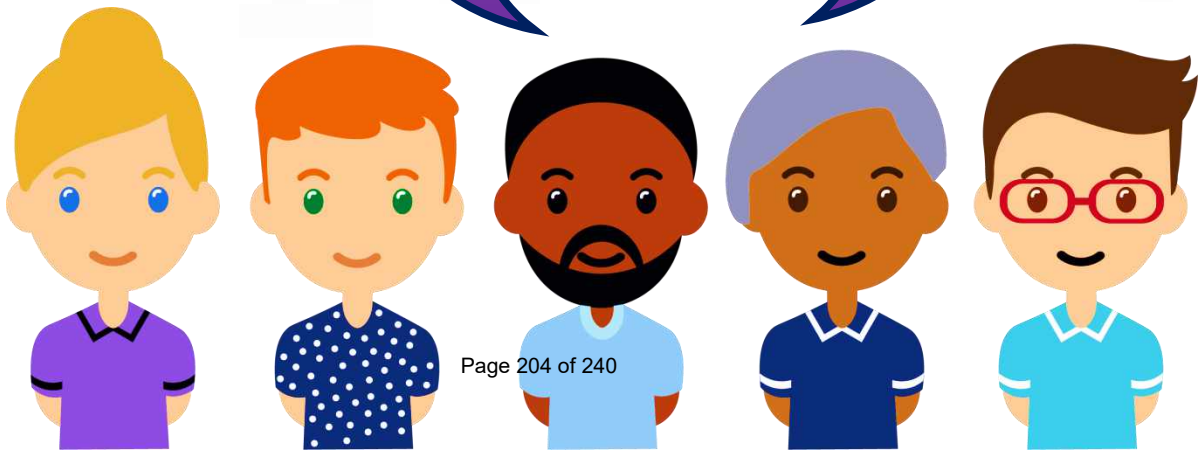
"Talk to clinicians more. Take advice on the functionality for clinicians on the front line…"

"I think this trust wastes forest loads of paper"

"the spinning circle of doom"

"easier to access, available any terminal."

"I agree with moving to paperless but not all systems/areas are ready for this and cannot be 100% paperless"

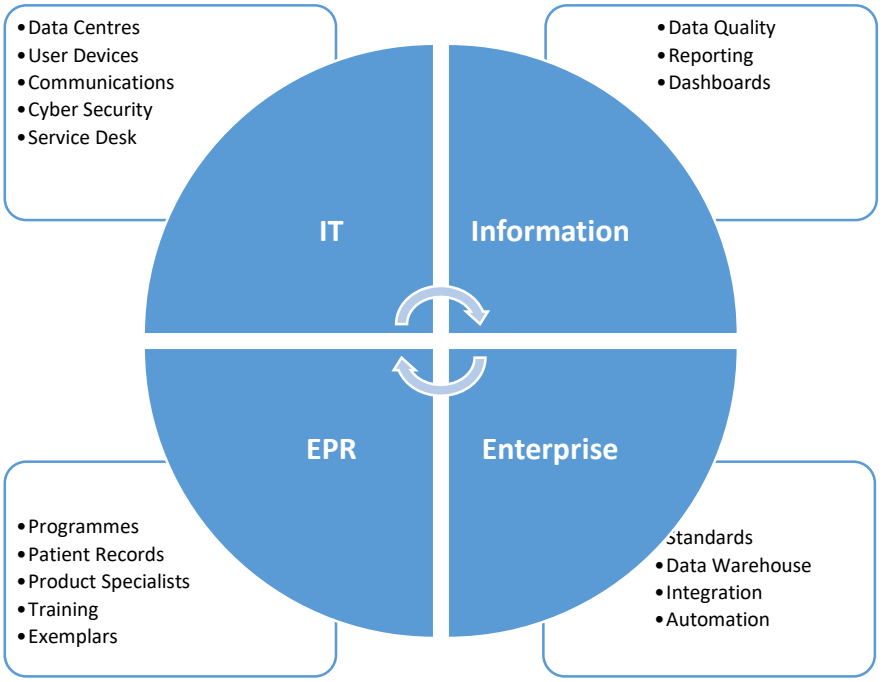


How Did We Get Here?

In 2016 we consulted with colleagues and published an IT Strategy "From PCs and Paper to Electronic Records" to progress the digital ambitions of the Trust. We have made good progress implementing what you said we should deliver with our digital expertise and resources organised as four complimentary teams.

We connected people; We introduced user devices, Patient Wifi and video services, digital telephony and infrastructure services.

We improved quality; We continue to progress structured forms, develop new datasets within our data warehouse, commission Business Intelligence services and improve communications to / from our GPs. We have successfully completed the first phase of our electronic prescribing project.



We optimised; we enhanced the Accident & Emergency experience with swift tap to logon/off, enhanced our ward e-whiteboards and introduced our first Robotic Process Automation.

We secured Electronic Patient Record (EPR) exemplar status and have progressed the optimised design of Diabetes and Head Trauma Pathways.

In 2018 we consulted once more, describing our ambitions to 2021 in the form of the tree. We changed the language to digital and looked to the exemplar scheme to drive our ambitions encompassing complimentary solutions and infrastructure. We have positioned our EPR to benefit from:

- Clinical Decision Support
- Voice recognition for outpatient clinics & wards
- Electronic patient observations and alerting
- Electronic prescribing
- Paperless (Electronic Documents).

A timeline of our subsequent EPR development journey is provided overleaf.

Reflecting

Reflecting

EPR Phase 1

- Patient Record
- Theatres
- Orders & Results
- WiFi
- Mobile Working
- Electronic Whiteboard
- Electronic Discharge
- Digital Dictation

EPR Optimisation

- Hospital @ Night Management
- Structured Clinical Data Capture
- Medical Take List
- Patient Text Reminder Service
- A&E Child Protection Service

Retaining Good

- Electronic Prescribing And Medicines Administration
- GP Medicines Reconciliation
- Primary Care Records Access
- End Of Life Records Access
- Live Dashboards
- Enhance Diagnostics Workflow
- Ward Accreditation
- Inpatient Clinical Data Capture eReferral Triage
- Patient Letter Enhancements

EPR Phase 2

- Outpatients Robotics Automation
- Nursing Risk Assessment Care Plans
- Referral to Treatment
- Care Pathways– Alcohol Smoking/Sepsis/Pre Operation Assessment/Acute Kidney Injury
- A&E Tap on/off

Transition Into Benefits Led BAU

- Record Exemplar Status (LDE)
- Community Electronic Prescription Service
- Patient Guest WiFi
- Maternity E-Whiteboard
- Patient Flow Red to Green
- Outpatients Clinic Room Management
- NHS Email
- Cyber Essentials
- Electronic Patient Letters to GPs

Business Intelligence

The Trust has recognised the need and role of accurate insights by supporting a case for enhancing our Informatics capabilities towards true Business Intelligence (BI) from the ground up. Our traditional approach to information with reporting islands allowed a range of challenges to emerge that prevented efficiency and timely insights and dashboards.

Investment in technology, skills and capacity has been made and the first fruits are now appearing.

The infrastructure to deliver truly corporate business intelligence has commenced and the Information Transformation road map deployed with a range of real time dashboards already successfully published.

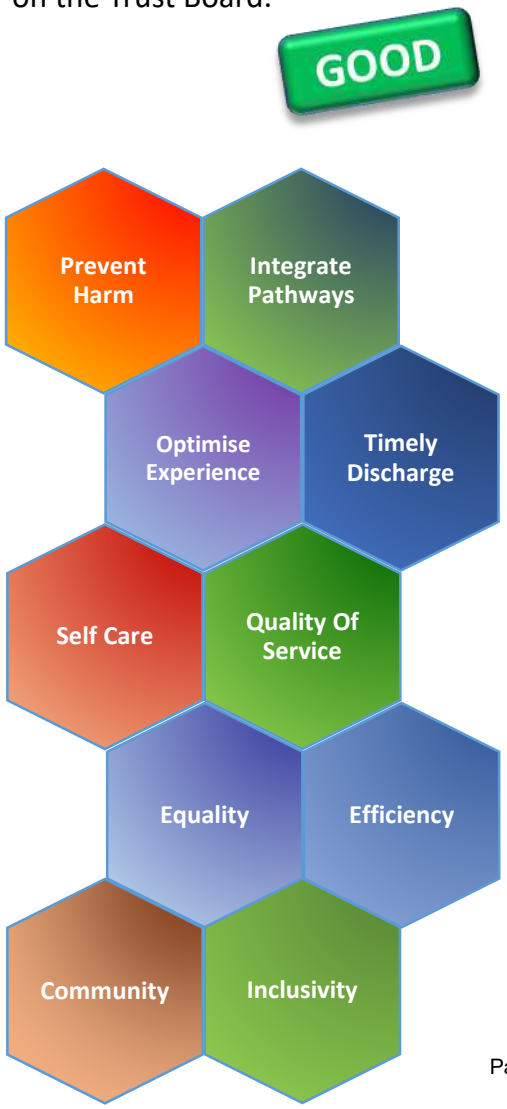
Ward to Board: Our programme for BI development continues with a plan for ubiquitous access to a BI portal to support actionable insights from ward to board. To democratise our data, we will open previously closed data capture and processing applications.

The Way To Outstanding

The Way To Outstanding

Strategic Alignment

In 2019 the Trust was successfully recognised as a “Good” organisation by CQC. This is a tremendous achievement that included recognition of our recent digital journey and reframed our ambition to outstanding. We must now set out our means to reach “Outstanding”. The Trust has published a range of strategies that, delivered in a complimentary manner, will realise the optimum patient benefits that pursue our vision. The profile of the digital strategy is raised by the strategic presence of the Chief Information Officer and Chief Clinical Information Officer on the Trust Board.



The benefits of outstanding digital will be judged on the effectiveness of the clinical and corporate services we underpin and the experience of colleagues and patients. We recognise the key words to the left as indicators of outstanding outcomes. Our services will be typified by:

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

Delivering this experience will rely upon the support of our people strategy to recruit and retain the right skills and expertise and improve practice with full Digital inclusivity. Digital will play a role in nurturing the characteristics of a learning organisation creating feedback loops to inform best practice. New ways of working will transform our Trust. Our delivery will dovetail into the Trust’s Quality Academy initiatives, supporting innovative tests of change to migrate new solutions swiftly into practice. Accreditation regimes to support Nursing/Midwifery and Clinical Strategies present us with opportunities to encourage new Digital behaviours.

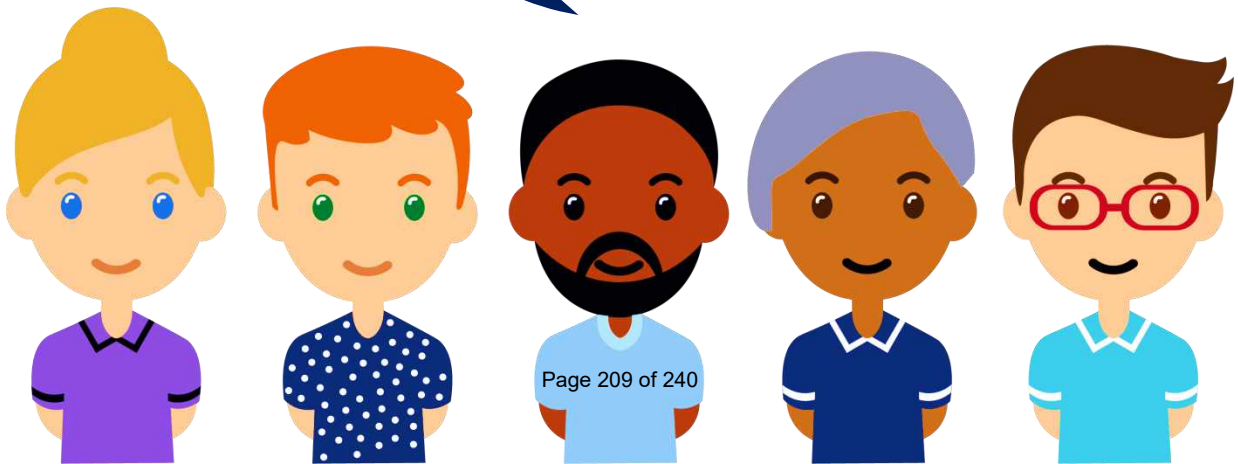
Reaching for the Future

"A system that works. A system that helps staff and doesn't hinder, a system that doesn't cause stress to the staff and delay in patient care."

"would welcome 100% paperless but current system does not have everything I need electronically."

"we need to move forward and we seem to be stuck. if we work together with good communication that would change."

"Making sure the system is appropriate for all users. Nurses, doctors, pharmacist, physios. Improves patient experience and safety"



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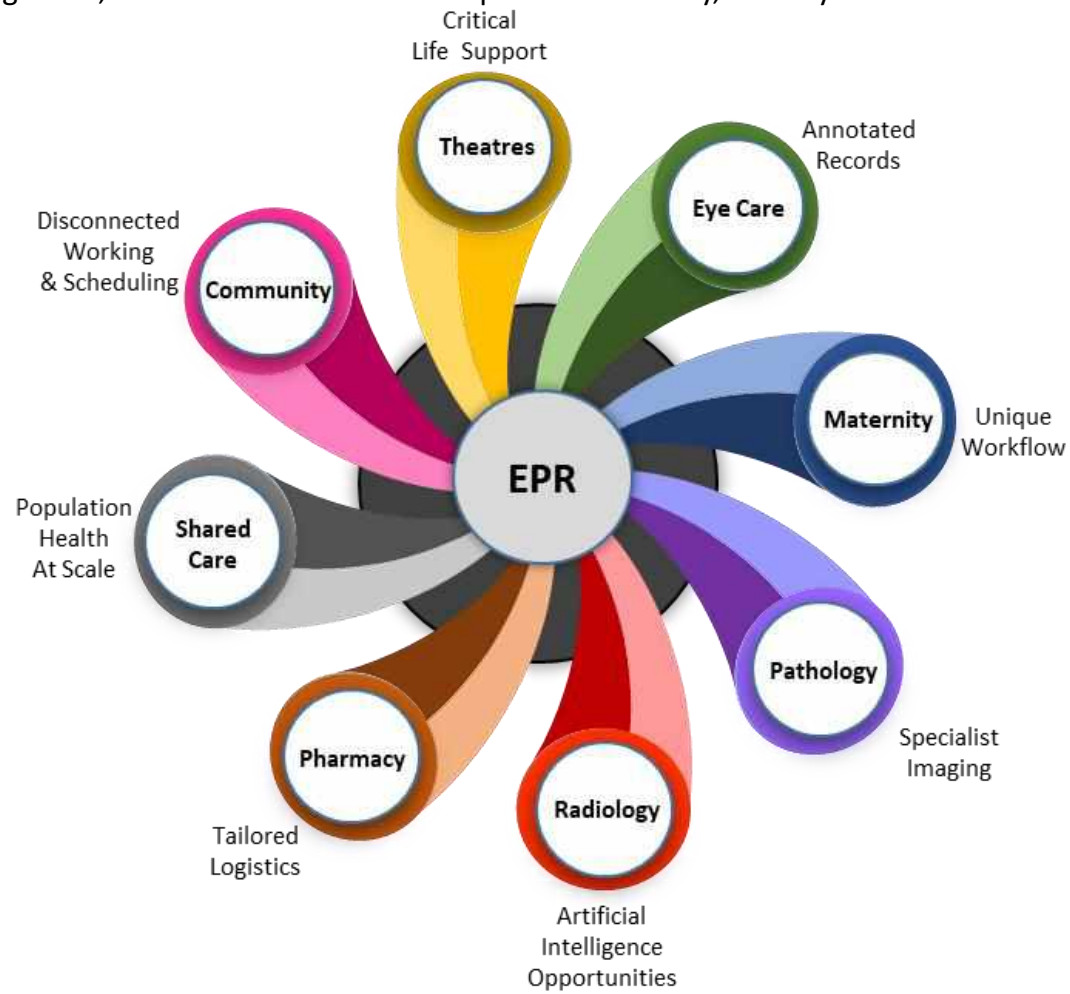
The Way To Outstanding

The Way To Outstanding

Assuring Clinical Flexibility & Agility

Acknowledging the need to assure basic performance and availability, our key Electronic Patient Record will remain our centrepiece to orchestrate our clinical digital services. We will strengthen our commercial position and resilience by allowing colleagues to influence the most appropriate workflow solutions within each care domain, centred around open data and rich integration, whilst we hold the tiller to protect efficiency, efficacy and thus value for money.

We will derive benefits from existing investments whilst introducing flexibility and agility. Innovations are often mentioned in harmony with Digital and true transformational change depends upon such measures. We will work with the Trust Quality Academy to assess opportunities, nurture their potential, assess their priority and realise their benefits whilst accepting that some will fail fast. We will be work with colleagues to further the influence of maturing technologies such as Robotic Process Automation, Voice Recognition and "Internet of Things".



The Trust has demonstrated its forward looking nature via its early adoption a board level Chief Information Officer whom also holds responsibilities across the two localities and accountability across the region. The time is right to extend the thinking to the entire pre-hospital, primary, acute, community, mental health and social care domains including self actuation of patient behaviours. Tightly coupled solutions through rich integration will deliver Digital in a seamless and resilient manner.

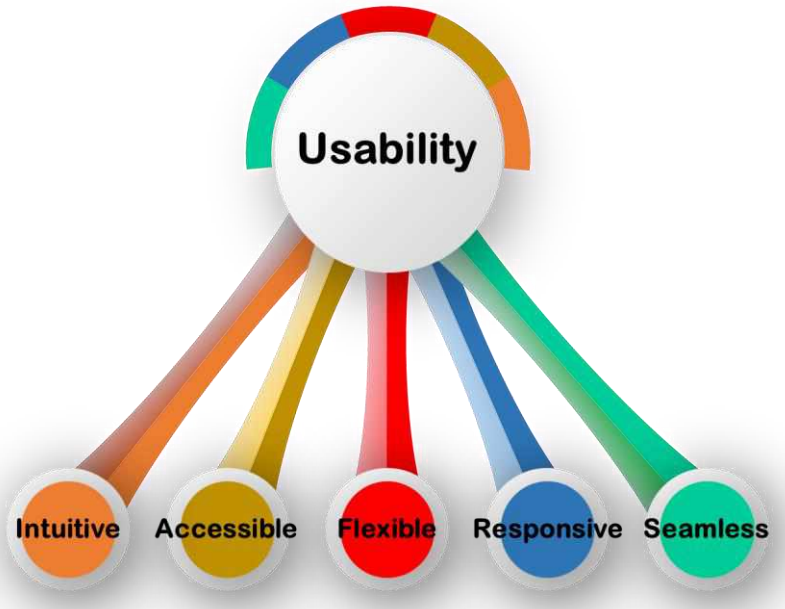
Moving To Outstanding – User Experiences

Our digital ambitions require strong foundations upon which to build. Consultation has gleaned our critical success factors with usability at the core. Whilst the Trust has achieved a strong level of digitisation the basics must be improved if the aspired transformation opportunities are to be successfully adopted.

We must meet this challenge whilst paying respect to national Digital Healthcare policy. Whilst our digital environment has introduced an impressive range of digital clinical services into a complex environment, we must review the most basic performance of our infrastructure and key applications that represent our foundations.

This will mean modernisation of our infrastructure and workforce to facilitate continuous optimisation without constraints and barriers.

Delivering upon this aim will require new workforce capacity and capability in areas such as Project Management, Product Application Development, Vendor Management and communications (publicity & consultation).



The NHS has adopted the international HIMSS framework to measure digital maturity. Raising our maturity is fundamental to demonstrating our digital credentials and wider credibility as a healthcare provider. We aim to move our capabilities from HIMSS EMRAM Stage 4 to Stage 7 over the coming 4 years by investing further in our EPR and its ecosystem to introduce capabilities such as management of blood products and human milk administration whilst further strengthening our business continuity and cyber security measures.

Our Electronic Patient Record (EPR) solution will benefit from NHS blueprints as part of the evolving Global Digital Exemplar regime; an expectation of the NHS Operating Framework. We will put in place a structure and team that will continually optimise our technology to make the organisation more safe and sustainable. This work will rely upon the skills and expertise of our CCIO structure, a key recommendation of the Watcher report. Our CCIO structure will be assessed to ensure its spread of expertise is adequate to fulfil its purpose.

The Way To Outstanding

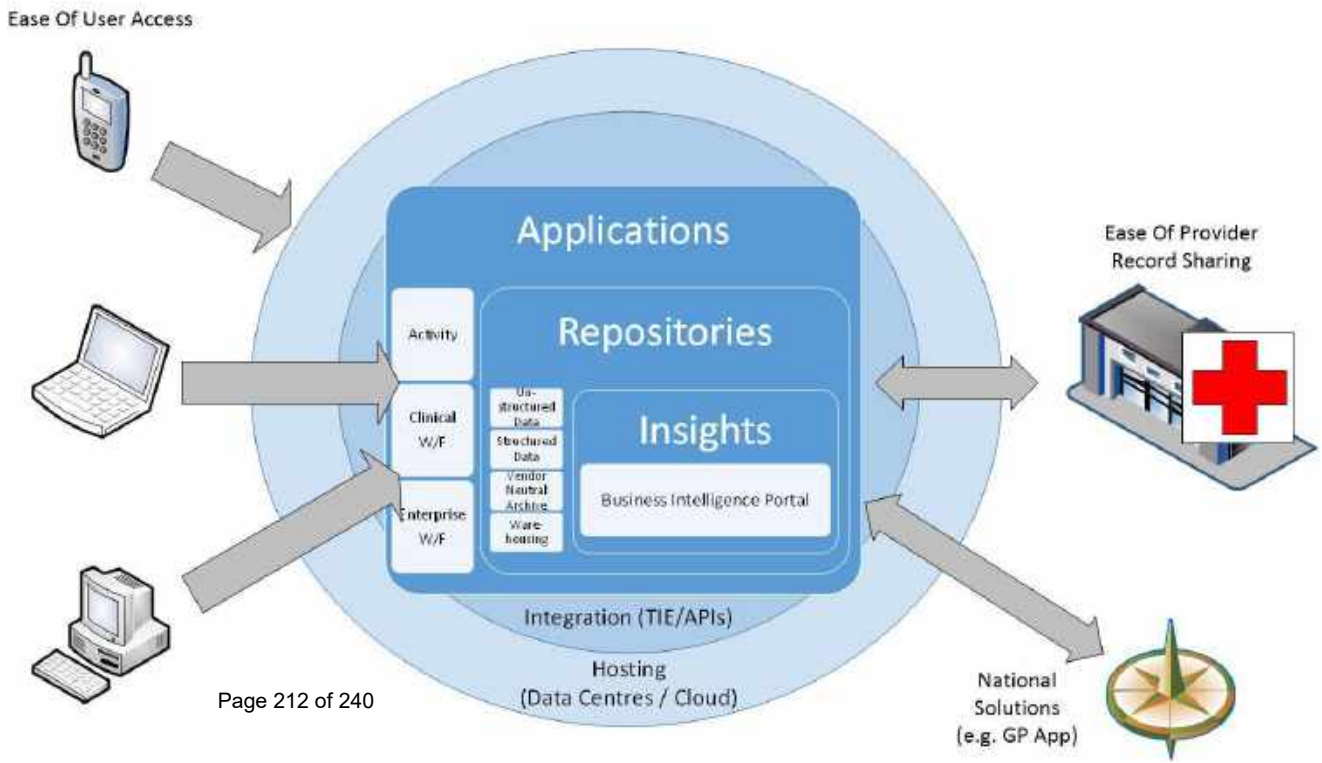
The Way To Outstanding

Moving To Outstanding – Forward Looking Architecture

Our technical architecture will revolve around key clinical and enterprise systems built upon open datasets to remove legacy barriers. We will further develop our integration capabilities to support modern healthcare messaging and embrace flexible hosting options (on premise / cloud / shared services) to improve accessibility, reduce risk, increase value and enhance our agility. Our approach will support greater collaboration and the emerging forms of healthcare providers.

A well architected infrastructure will facilitate our aims of improved data quality and thus greater access to insights and more effective decision making for outstanding care. Our aim is to provide the right information in the right format at the right time, on a live or retrospective basis, all assured from a single version of the truth. Our developing Business Intelligence (BI) environment will have a direct and positive impact on the Trust's performance by improving the ability to accomplish the mission by making more informed decisions at every level of the Trust from corporate strategy to operational processes. We have successfully deployed new real-time dashboards for A&E patient management and patient flow but there remains much more to do as we unlock the data.

Our associated staff skills will ensure we harness the available technology and spot opportunities to introduce more capable tools. As our infrastructure and repositories becomes more "open", so will the opportunities to bring datasets together for reporting as one and thus surfacing of new insights, all on the terms of the user.



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Inclusive Workforce Planning

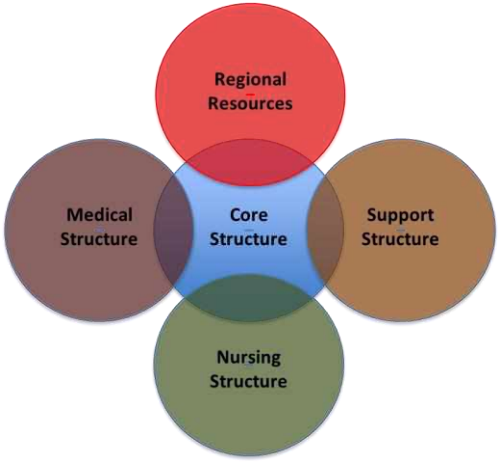
The success of Digital healthcare is now reliant upon culture, capability and capacity of our entire workforce and the populations we serve.

International research confirms the acceptance of digital solutions is significantly influenced by delivery capability over product choice. We have assessed our department structure (see right) and identified the skills gaps we must address (red) and existing skills where capacity issues are known to exist (orange). Recent investments in Business Intelligence have proven to be effective.

Frontline Stakeholders	Programme Management	Enterprise Solutions	Operations	Business Intelligence	Compliance
Chief Nursing Information Officer	DevOps Programme Management	Solutions Development	Architecture		Cyber
Wider Workforce Skills	Data Quality Co-Ordination		Chief Technician		
Deputy CCIOs	Benefits Management		Data Centres		
	Communications		Asset Management		
			Security		

We are committed to embracing the transformation opportunities available to all aspects of care by installing the correct blend of skills and influencing organisational culture. Our workforce capability is key to deriving maximum benefits from our enterprise and clinical services, whilst our patient skills and motivations are paramount to digitally enable holistic care.

We are committed to structuring our technology and governance to promote opportunities for colleagues to “own” their digital services in pursuit of agile and responsive service developments. Our “Clinical Digital” team will harness their energy and passion to co-ordinate a structured response to these aims and objectives, bringing our digital teams front of house. We will embrace and nurture a co-operative culture where our core Digital Services team has



the tools and skills to work closely with our wider colleagues - Digital Champions - with their deeper understanding of digital needs and nuances in their respective field, or greater resources across the region. This strategy is borne on a belief that all staff and patient skills and knowledge are vital to instilling a can-do culture that eases the burden on the Digital Services department whilst protecting their good governance and administration values.

Inclusion extends to the ability to utilise the services as much as owning the developments. Usability is a key barrier to adoption and optimisation relies upon the right inputs to be successful. #WHHDigital will succeed as a whole Trust initiative with Digital Services directing operations from the centre. Colleagues and stakeholders will be invited to contribute to our governance regime.

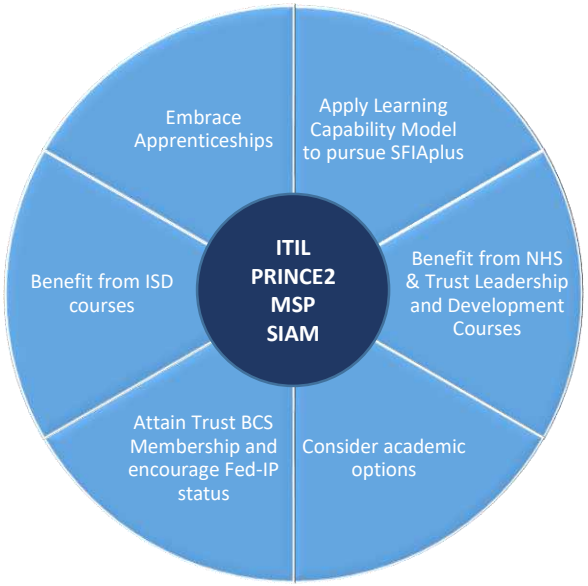
The Way To Outstanding

The Way To Outstanding

Nurturing Outstanding Capabilities

Outstanding digital relies greatly upon our digital personnel. We will target 6 areas which together aim to re-energise our service in readiness for the programme of work. We will consult on structure changes to align our staff capabilities and capacity with the demands of the vision. We will address gaps by assessing our department against the recognised BCS Learning Capability Model in line with the SFIAplus definitions. Moving to a high performing service will require a mix of apprenticeship opportunities for new and existing staff alike, with access to NHS, academic and vocational courses.

Fed-IP is being promoted by NHS Digital and the NHS Digital Academy as a marker of an outstanding digital workforce. We will support our staff to become accredited, recognising that this is a cornerstone of raising the professionalism of digital roles and their growing influence on safe patient care. We will build upon our successful Informatics Skills Development Network Level 1 accreditation to pursue Level 2 at pace and leverage the associated benefits.



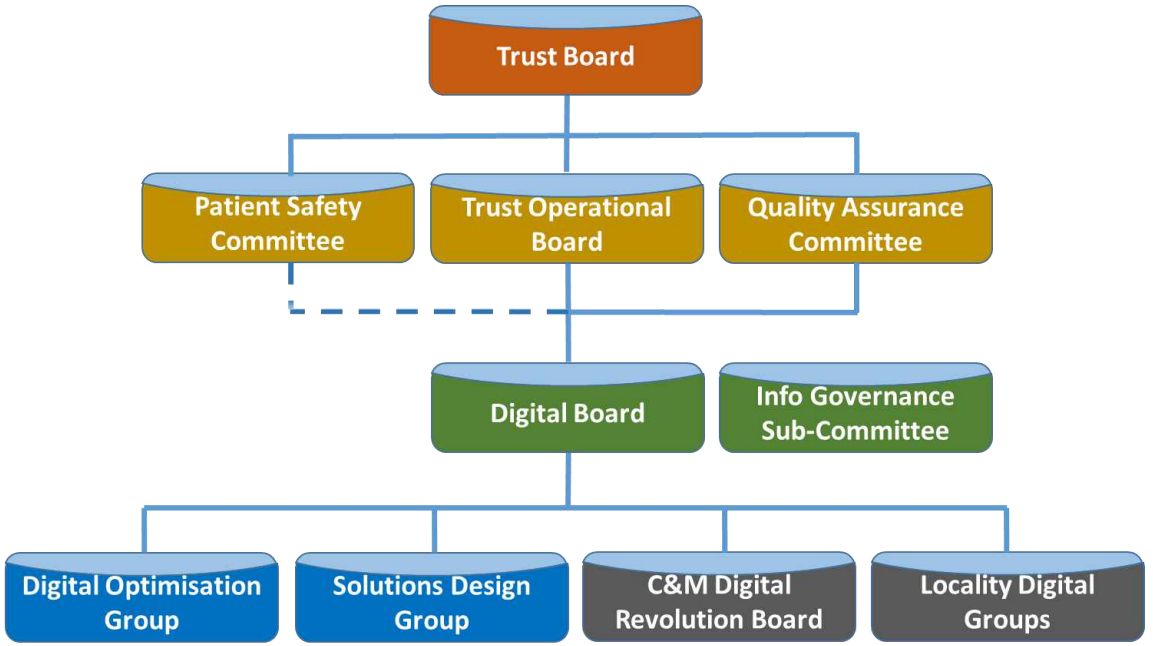
We will also align our on-call capabilities with the increasing demands of the programme to continuously optimise and enhance the Electronic Patient Record. As we deploy Electronic Prescribing, Electronic Observations and Clinical Decision support to name a few, our services now impact directly upon patient care and our traditional 24/7/365 infrastructure support must be made fit for purpose.

Our use of resources metrics are now a key indicator of appropriate investment in capability and capacity and encourage us to think SMART as we align digital services with growing clinical needs. Working closer with peer organisations will provide options to protect UoR outcomes as we widen and deepen capabilities but local skills and expertise will continue to lead.

To assure the value and performance of our services we must re-enforce basic responsibilities such as contract/vendor management (via the Service Integration and Management (SIAM) model), customer relationship management and license management whilst nurturing emerging skills such as robotic process automation, cyber security, cloud services and new ways of delivering agile application developments including open data. Whilst we will not develop complex software in-house, we will enhance our skills in workflow / business process management developments to aid efficient and effective support and corporate services. Where possible, we will maintain separation between clinical and non-clinical solutions to protect clinical services.

Outstanding Governance

Seeking assurance in the right forum is key to strong delivery. Our digital activity includes a Digital Optimisation Group for prioritising a large range of competing initiatives on a needs and resources basis. Our Solutions Design Group assesses requests for solutions and directs the owner to the correct path. This group will utilise frameworks to consistently optimise the digital experience. As we strive to deploy technology that touches ever more directly upon patient experience and safety we must continually assess the robustness of our governance.



We will seek assurance through Quality Assurance and Patient Safety committees as necessary. As we look to the Cheshire & Merseyside Health & Care Partnership to access national digital funding and collaboration at scale initiatives and apply those opportunities to our localities, we look to our Digital Board to orchestrate all internal and external Digital proceedings. We will seek to develop more robust project boards and vendor management meetings to aid the management of the large range of change and operational services activities.

We will remain active contributors in the Cheshire & Merseyside footprint to influence and benefit from shared digital opportunities that abide by the shared Digital Roadmap. The 5 key Digit@LL themes remain important enablers to all trusts within the region. We will continue to report upon all such live schemes including cyber security, patient portal, sharing of patient records for direct care, enhancing our infrastructure towards a common standards and innovating to deliver the best services possible whilst assuring value for money.

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The Way To Outstanding

The Way To Outstanding

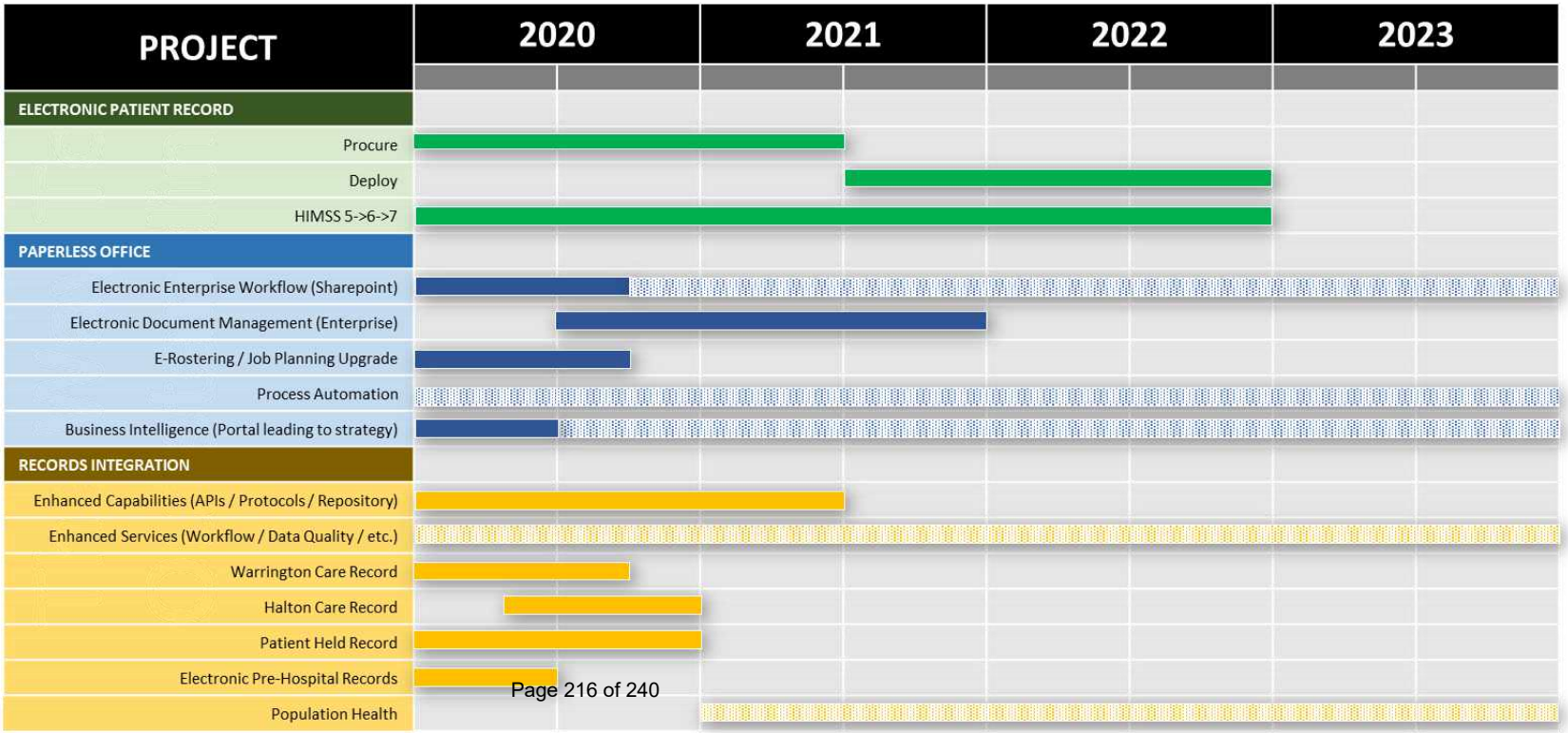
A Portfolio To Deliver The Vision

The success of Digital is highly reliant upon the culture, capability and capacity of our entire workforce and the populations we serve. As clinical and personal data merges, so does the challenge of the right skills to do the right things. There are many examples of the same digital services succeeding and failing in alternative environments. We are committed to embracing the transformation opportunities available to all aspects of care by virtue of the skills and willingness of all contributors and beneficiaries. We will work to identify funding sources to deliver this vision.

Our ambition is set out in the high level programme of work outlined over the following 2 pages, broken down into 5 themes of:

- Electronic Patient Record – Identifying an EPR solution fit for the future.
- Paperless Office – Ensuring we digitise all areas of our organisation.
- Records Integration – Technology and services to underpin our system level vision for connected care.
- Infrastructure – Getting our basics right to underpin our outstanding services
- Paperless Care – Digitising care pathways for high quality, safe care.

Shaded bars indicate ongoing, evolving activities with no end date.



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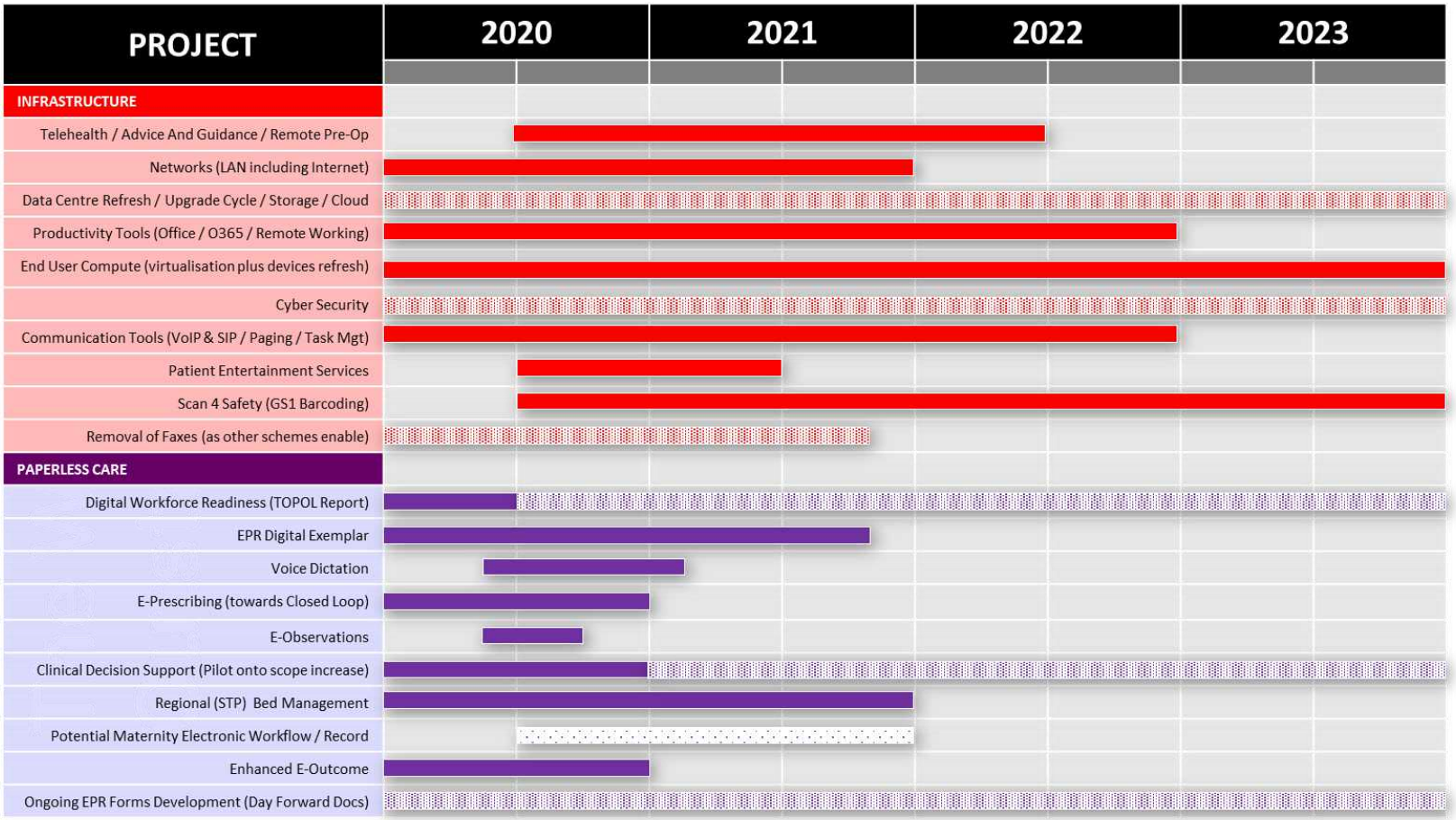

The Way To Outstanding

Outstanding Outcomes

Our Outstanding Picture – Supporting Targets Through Technology

Outstanding digital services will contribute to the delivery of outcomes that directly support Trust objectives. Dedicated benefits management, customer relationship management and greater change management capacity will aid the realisation of the outcomes that deliver the benefits.

Our Outstanding Vision Of Experiences

Our Patient's

Our patient's will be able to see their medical history including records and appointments from the comfort of their residence and securely share with carers as required. They will receive one, accurate and informative communications via their preferred method and automatic reminders to ensure they don't forget, prepare themselves as required and are fully aware of what to expect. Only absolutely necessary visits to NHS facilitated will be made with others conducted via technology. When a visit is necessary it will be a stress free experience with apps to aid parking and way finding their destination. Their clinicians will be informed, only asking necessary questions once and providing clear advice and feedback without interruption or distraction. They will manage their condition in their daily lives with the full support of the Trust and its partners.

Our Allied Health Professionals

Our AHP's will be assured of ease of access to a computer to plan their daily workload. As they spend time with each patient digital tools will allow them to interact with their patients without distraction, making accurate notes with ease. Records will include accurate data from a range of NHS and home devices including photographic evidence. Automatic reminders and work plans, especially associated with colleagues within my multi-disciplinary environment, would be a bonus.

Our Nurses

Our Nurses will have the equipment they require to fulfil there caring duties without paper and without delay. Time sensitive processes such as E-Observations and Prescribing will be achieve via adequate mobile computing resources that perform at all times. Digital tools will be as reliable as the water, gas and electricity utilities. Communications will be seamless irrespective of their purpose, keeping busy staff informed whilst aiding the safe and effective management of the workload. High quality patient care and staff welfare will be supported.

Our MidWives

Our Midwives will feel assured that the digital tools they use are fit for the complexities and challenges of all stages of pregnancy services. Information will only be entered once, partners such as the GP will be kept informed in a timely manner and the relationship between mother and baby will be clear, supporting the right of choice. Women will feel informed of their planned home visits via their online record access and contributions. Their community based midwife will be aided by automated work plans including efficient routing and will be empowered to complete the comprehensive electronic record within the home environment.

Outstanding Outcomes

Outstanding Outcomes

Our Outstanding Vision Of Experiences

Our Doctors

Our Doctors will be able to rely upon responsive and efficient services beginning with a swift logon experience. Their ability to work wholly electronically will relieve them of unnecessary filing duties that interrupt their flow of ward work. Typing information once and once alone is a must, but limiting typing is paramount with the technology working in harmony with the doctors to maintain their concentration upon their patients. Decision support tools will be proven and reliable and the multiple systems will be presented as a seamless experience. Our outpatient teams will benefit from real-time visibility of on-site patient location to allow slots to be re-arranged rather than cancelled. The entire patient record picture will be available with minimal extra clicks to inform the most appropriate care interventions for the most complex of care requirements. Our doctors will be assured that end of life arrangements will be honoured by all carers irrespective of their host organisation.

Our Support Staff

Our support staff will benefit from digital inclusivity, able to access communications and their planning tools whilst on the move through right sized personal devices. Tracking technology will reduce the time required to locate vital equipment such as beds, wheelchairs, pathology samples, medications, medical devices and other items, plus the patients themselves! Automated audit trails will strengthen investigations and reviews including surgical items and equipment and infection control measures, contributing to lower costs and process improvement opportunities. More patient will receive the meal they ordered due to more timely online ordering whilst food waste will be reduced in our kitchens.

Our Corporate Staff

Systems access will be swift and reliable with no frustrating frozen screens and issues due to versions of productivity tools. An ability to work anywhere with no loss of digital features will be key to agile ways of working. The equipment we use must be fit for the purpose – so clinical coding personnel must feel supported to quickly find and code records accurately whilst facilities personnel must be able to read plans and maps with ease, HR personnel will be assured all personal records ae secure and retrievable whilst informatics personnel will have the power to turn information requests around quickly, and only where self service is not possible. Our data specialists will have unhindered access to all records databases, assured by open data standards as we re-procure our solutions, Our Use Of Resources will benefit from automation plus local user interface / workflow developments based upon robust and non-complex forms and app development technology that avoids specialist skillsets.

Acknowledgements

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

All contributors to the staff digital survey

The Trust Grand Round

Trust Corporate Business Unit Management Teams

Trust Deputy Chief Clinical Information Officers

Trust Medical Cabinet

Trust Governors Engagement Group

Trust Executive Management Team

Trust Board

Trust Corporate Services

Trust Operational Board

Trust Communications

Warrington & Halton Clinical Commissioning Groups

and many colleagues plus external individuals.

We recognise the following contributions to this strategy:

a) NHS (2014) *Five Year Forward View*
b) NIB Personalised Health and Care 2020 (2014) *Framework for action supported frontline staff, patients and citizens to take better advantage of the digital opportunity*
c) Department Of Health & Social Care (2018) *The future of healthcare: our vision for digital, data and technology in health and care, Policy Paper*.
d) Wachter, R. M. (2016) *Making IT Work: Harnessing the Power of Health Information Technology to Improve Care in England: Report of the National Advisory Group on Health Information Technology in England*
e) Health Education England (2019) *The Topol Review; Preparing The healthcare workforce to deliver the digital future.*

If you would like to receive this document in another format, please do not hesitate to contact us.

Cantonese:
如果你希望以另外一種格式接收該資訊，請和我們聯絡，不必猶豫。

Gujarati:
જો તમને આ માહિતી બીજી રચના કે ફોર્મેટમાં મેળવવાની ઈચ્છા હોય, તો કૃપા કરી અમારો સંપર્ક કરતા અચકાશો નહિ.

Hungarian:
Kérjük, vegye fel velünk a kapcsolatot, ha más formában kéri ezt az információt.

Polish:
Jeżeli chciał(a)by Pan/Pani otrzymać niniejsze informacje w innym formacie, prosimy o kontakt.

Punjabi:
ਜੇ ਤੁਸੀਂ ਕਿਸੇ ਹੋਰ ਫਾਰਮੈਟ ਵਿਚ ਇਹ ਜਾਣਕਾਰੀ ਲੈਣਾ ਚਾਹੁੰਦੇ ਹੋ ਤਾਂ ਸਾਡੇ ਨਾਲ ਸੰਪਰਕ ਕਰਨ ਤੋਂ ਨਾ ਝਿਜਕੋ।

Urdu:
اگر آپ اس معلومات کو کسی اور صورت میں حاصل کرنا چاہتے ہیں تو برائے مہربانی ہم سے رابطہ کرنے میں ہچکچاہٹ محسوس نہ کریں۔

Communications Team
Kendrick Wing
Warrington and Halton Hospitals
Lovely Lane, WA5 1QG email: whh.communications@nhs.net web: www.whh.nhs.uk tel: 01925 664222

Ratified: insert date for review insert date

Warrington and Halton Teaching Hospitals NHS Foundation Trust

WHH Digital Strategy 2020 – 2022

Strategy On A Page

#WHHDigital

Digital Services As A Clinical Tool

Our staff require an **outstanding** Electronic Patient Record at the heart of an optimised environment with the required functionality, performance and reliability.

Quality	People	Sustainability
Deliver a paperless environment to eradicate errors and provide the right information in the right place in the right manner. A marriage between user and technology for outstanding data compliance and accuracy enabling automation, reduced variation and safe integration of clinical services.	Reduce workload pressures by less duplication, avoidance of unnecessary effort and automation of repetitive tasks. Present key information accurately and in real time for ward to board actionable insights. Contribute to a "learning organisation" with digital services usability at the epicentre.	Enhance use of resources and eradicate costly mistakes. Assure the quality of data for local, regional and national decision making.

Aims & Objectives

We will use digital services to underpin Trust commitments to provide our patients with high quality, safe care. Our staff will have access to outstanding digital services with usability at the epicentre, supporting them to deliver a service fit for the future. Our digital service will be fully integrated both internally and with the wider health system to realise sustainable, connected models of care. This will be enabled through targeted local and national support with the requisite investment to support the Trust's aims and objectives.

Past and Present

Optimisation of our Electronic Patient Record led by a capable Digital Services team. We have connected people, devices, systems, and infrastructure to empower our staff to deliver an outstanding service for our patients. We improved quality through structured forms, datasets, business intelligence and EPMA.

Outstanding Future

Building upon our enhanced Informatics capabilities towards true Business Intelligence (BI), removing the reporting islands challenges to realise efficient and timely insights and dashboards. Our Information Transformation road map will continue to deploy real time dashboards via a planned BI Portal and support accuracy of data capture. We will assure basic performance and availability around our key Electronic Patient Record, allowing our staff to influence appropriate workflow functionality underpinned by open data and rich integration. We will derive benefits from existing investments whilst introducing flexibility and agility via latest standards, with extended thinking to the entire pre-hospital, primary, acute, community, mental health and social care domains including self actuation of patient behaviours and tightly coupled solutions. Our Digital Services and wider workforce planning, capabilities and governance will underpin these outstanding ambitions.

Strategic Alignment

In 2019 the Trust was successfully recognised as a "Good" organisation by CQC. Digital services will support the Trust aim to move to "Outstanding". This will be judged on the effectiveness of our clinical & corporate services and the experiences of our patients and staff, typified by optimisation, safe and secure remote care, patient empowerment, and our active role as an STP innovator to deliver Digital Excellence Genomics, Precision Medicine, Research, Process Automation and Clinical Decision Support including Artificial Intelligence.

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/20/01/11**	
SUBJECT:	**Trust Engagement Dashboard**	
DATE OF MEETING:	29th January 2020	
AUTHOR(S):	Pat McLaren, Director of Community Engagement + Fundraising	
EXECUTIVE DIRECTOR SPONSOR:	Pat McLaren, Director of Community Engagement + Fundraising	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future. SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.	
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	#145 (a) Failure to deliver our strategic vision.	
EXECUTIVE SUMMARY *(KEY ISSUES):*	The Trust has launched its first patient and public participation and involvement strategy in March 2019, a measure of the progress of the deployment of this strategy, which is one of the Trust's Quality Priorities for 2019-20, is the attached Engagement Dashboard. The Dashboard addresses: - Level of success in managing the Trust's reputation in the media and across digital and social platforms - Our engagement with patients, staff and public via our social media channels - The Trust's website and levels engagement with this key platform - Patient enquiries via our website - Patient/public feedback on the independent platforms - Engagement with the Trust through the Freedom of Information process. **Key items to note in Q3** • **Media** – Predominately neutral or positive in the quarter. Key media includes: ➢ **October:** Positive - cancer scanner, mouth cancer screening, CEO departure Negative – vermin in kitchen ➢ **November (pre-election period):** Positive – New CEO, new 1.5m birth centre, political candidates champion new hospital for Warrington, WG Inspiration Awards – 2 winners. Negative – income from parking charges ➢ **December**: SOS health visit, Santas on Scooters, Warrington Wolves community blitz, many festive stories. Negative: Car parking, re-run of 'top stories of 2019' – cake incident. • **Twitter** we continue to build our following and have reached 11.1K • **Facebook** likes were circa 15K in the quarter with reach exceeding 17K. We took part in the system 'Help Us to Help You' winter	

	campaign just prior to Xmas and did a social media takeover in ED and UCC which saw very high engagement around the *Choose Well* agenda. Our Mental'elf day saw huge engagement by our community, celebrating our healthcare professionals shining the light on good mental health • **Website visitors** peaked at 29K in October before falling back as is usual during December. • **Website accessibility** – mobile phone devices remain the most commonly used platform • **Website enquiries** – we dealt with 343 patient enquiries through our website • **FOI** We have received, processed and returned 114 Freedom of Information requests of varying degrees of complexity • **Patient Feedback:** We continue to be highly rated on independent feedback platforms, despite low numbers of ratings in the quarter the Trust retained its 4.5* rating on NHS Choices. ***To note*** *that NHS Choices has since ceased the publication of ratings for individual sites and are now only reporting on Trusts.*			
PURPOSE: ***(please select as appropriate)***	Information X	Approval	To note X	Decision
RECOMMENDATION:	The Board is requested to receive and note the Trust's engagement dashboard for Q3.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.			

HIGH QUALITY, SAFE HEALTHCARE
QUALITY PEOPLE SUSTAINABILITY

NHS
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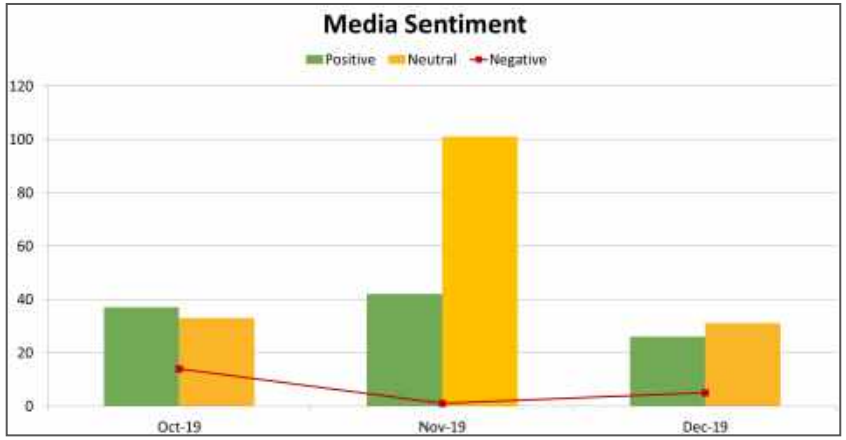
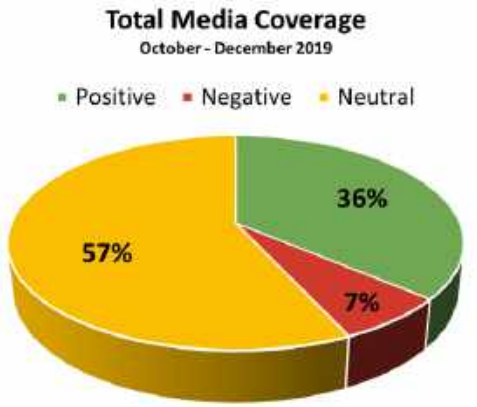
NHS Foundation Trust

WHH Engagement Dashboard

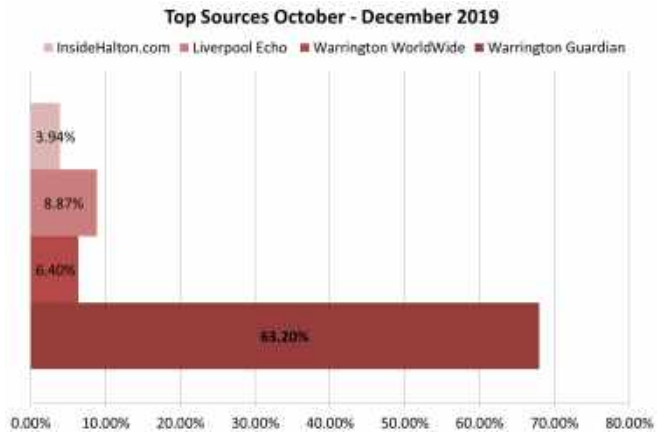
Q3: October – December 2019

Media Sentiment: Q3

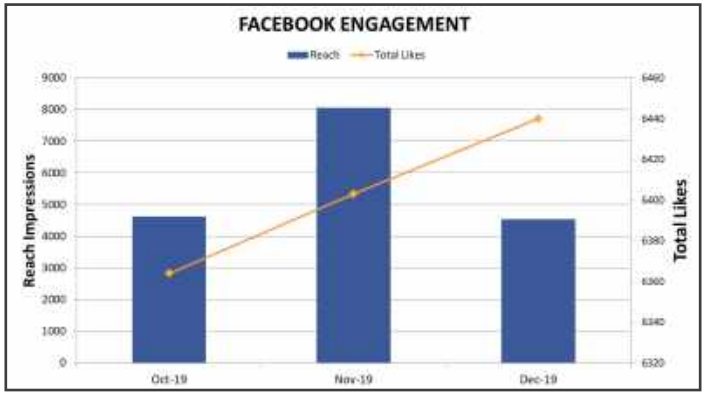


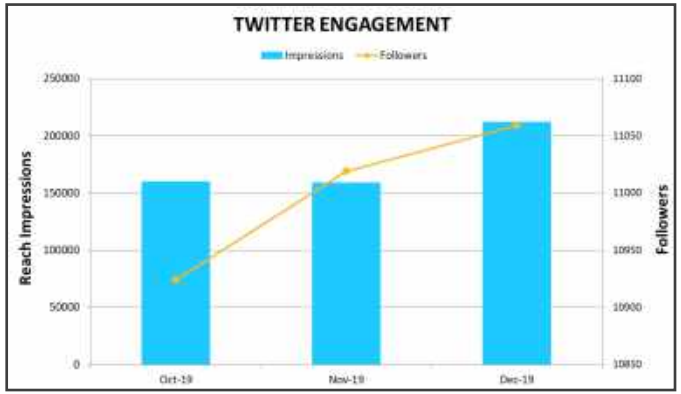


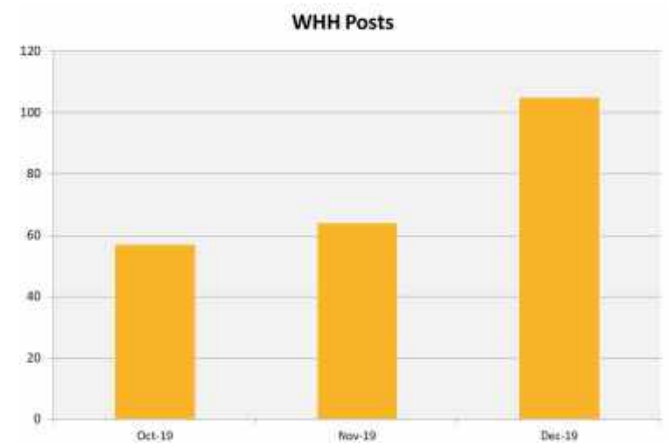
Total Media Coverage in 2019: 1,539

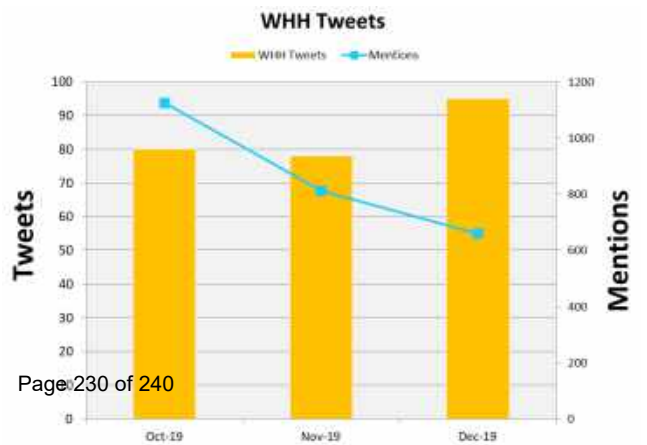


Social Media: Q3









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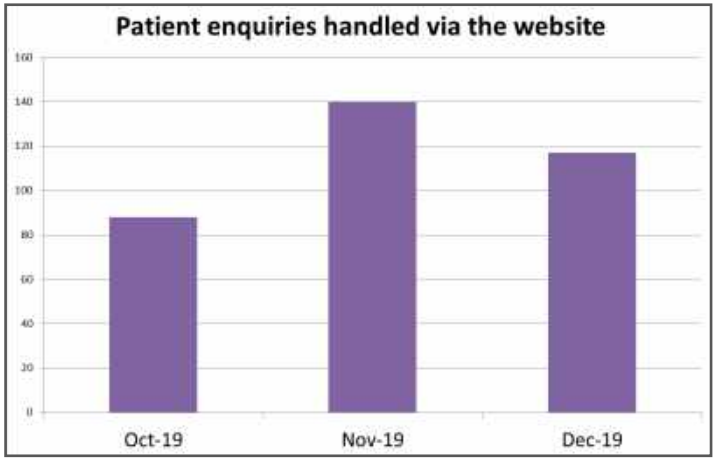
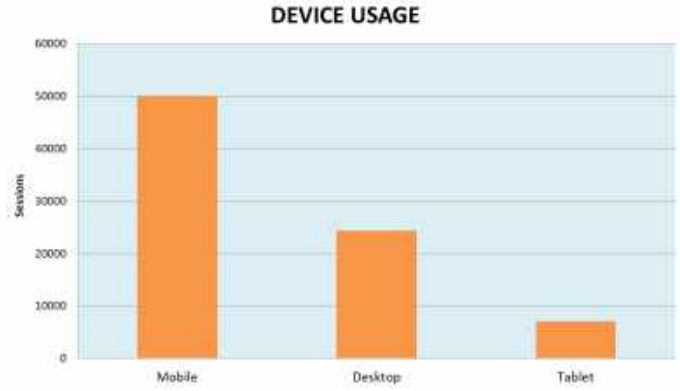
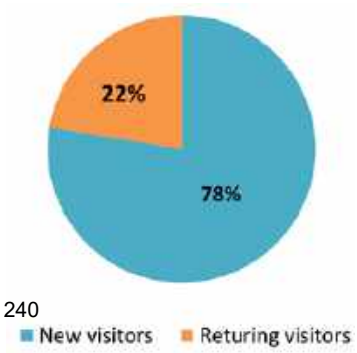
WHH Website: Q3







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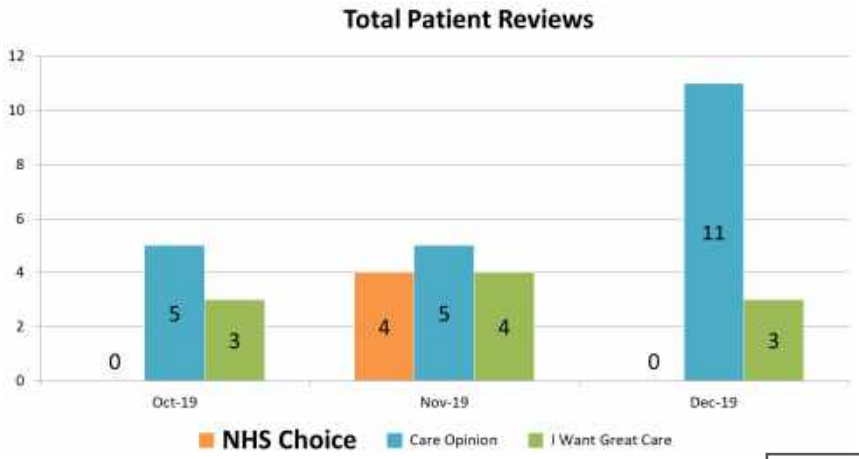
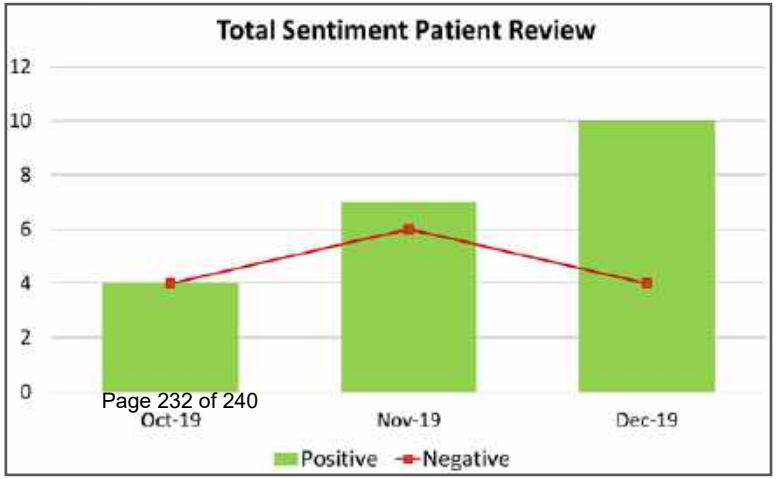
Patient Experience: Q3



Total online Patient Feedback in 2019: 207



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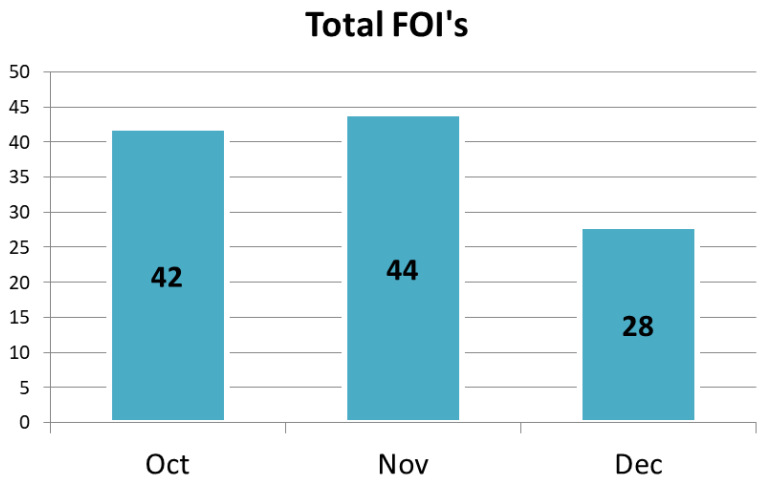
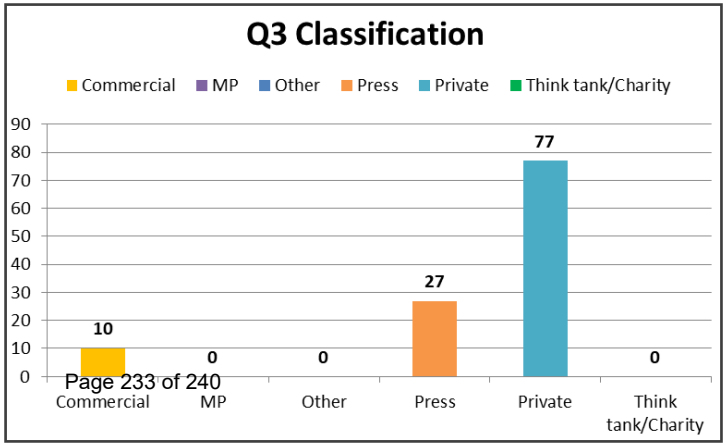
Freedom of Information: Q3



Total number of documented FOI requests in 2019: 569



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NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/20/01/12**	
SUBJECT:	**Board Assurance Framework**	
DATE OF MEETING:	29th January 2020	
AUTHOR(S):	John Culshaw, Head of Corporate Affairs	
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Chief Executive	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience.	✓
	SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future.	✓
	SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.	✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	All	
EXECUTIVE SUMMARY ***(KEY ISSUES):***	It has been agreed that the Board receives an update on all strategic risks and any changes that have been made to the strategic risk register, following review at Quality Assurance Committee. A Risk Review Group has been established reporting to Quality Assurance Committee, for oversight and scrutiny of strategic risks and for a rolling programme of review of CBU risks, to ensure risks are being managed and escalated appropriately. Since the last meeting: • There are no new risks that are proposed for addition to the BAF; • The rating of one risk has been reduced since the last meeting. • There are no proposed amendments to risk descriptions. • One risk is proposed for de-escalation from the BAF; Also included in the report are notable updates to existing risks.	

PURPOSE: ***(please select as appropriate)***	Information	Approval ✓	To note	Decision
RECOMMENDATION:	Discuss and approve the changes and updates to the Board Assurance Framework.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.	QAC 20/01/14		
	Date of meeting	7th January 2020		
	Summary of Outcome	The Committee reviewed, discussed and approved the amendments		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Board Assurance Framework and Strategic Risk Register report	AGENDA REF:	BM/20/01/12

1. BACKGROUND/CONTEXT

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

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

2. KEY ELEMENTS

2.1 New Risks

There are no new risks that are proposed for addition to the BAF.

2.2 Amendments to risk ratings

Since the last meeting, there has been one amendment to the rating of a risk on the BAF.

At the Quality Assurance Committee on 7th January 2020, it was agreed that the rating following risk be decreased from 16 (4x4) to 12 (4x3)

Risk 701 - *Failure to provide continuity of services caused by the scheduled March 2019 EU Exit resulting in difficulties in procurement of medicines, medical devices and clinical and non-clinical consumables and associated risk of increase in cost*.

Following the General Election, advice received is to maintain a minimum position as there is now a minimal risk of a 'no deal' Brexit. Further advice indicates that that there will be no change for the NHS between 1st Feb – 31st December 2020, which is described as the implementation period.

2.3 Amendments to risk titles

There are no proposals to amend the descriptions of any of the risks that are currently on the BAF.

2.4 Removal of Risks

Since the last meeting, there have been no risks de-escalated from the BAF.

However, further to the reduction of the risk rating of risk #701 as described in section 2.1, further advice has been received:

Following the vote at second reading of the Withdrawal Agreement Bill on 20 December, the government has stepped down preparations for a no-deal exit from the European Union. The Department of Health and Social Care has informed NHS England and NHS Improvement that for the health and care system this means that no-deal preparations should cease. As a result, staff working on no-deal preparations are being redeployed and other health and care organisations should do the same.

Advised that it is important to retain organisational memory gained from all the work to date; therefore, NHS organisations are to retain a key point of contact in case an operational response needs to be stood up if trade agreement not agreed by late 2020.

As the risk is linked to strategic objective 3:

We will … work in partnership to design and provide high quality, financially sustainable services

a discussion took place at the Finance & Sustainability Committee on 22nd January 2020. Following this discussion, the Committee proposes that the risk is closed.

The Board is ask to approve the closure of risk #701 following discussion at the Finance & Sustainability Committee on 22nd Janaury 2020.

2.5 Existing Risks - Updates

Detailed below are the updates that have been made to the risks since the last meeting.

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
115	Failure to provide adequate staffing levels in some specialities and wards, caused by inability to fill vacancies, sickness, resulting in pressure on ward staff, potential impact on patient care and impact on Trust access and financial targets.	• Burdett Nursing Trust award winners • Highly commended for nursing retention data provision <u>Recruitment Gaps</u> • 125 RN Vacancies • 89 Band 5 vacancies <u>Retention Gaps</u> • 17.06% B5 nursing turnover	No impact on risk rating
134	Risk: Financial Sustainability a) Failure to sustain financial viability, caused by internal and external factors, leading to potential impact to patient safety, staff morale and enforcement/regulatory action being taken. b) Failure to deliver the financial position and a surplus places doubt over the future sustainability of the Trust. There is a risk that current and future loans cannot be repaid and this puts into question if the Trust is a going concern.	• Reserve created to cover 1 year's cost of running the Charity • Support to be provided by Commissioners in 2019/20 and from NHSE/! – Additional Winter Capacity • Non-recurrent CIP presents a risk to in-year and future year financial position. • Extended Loan repayment confirmation of further extension from NHSi received and extended to May 2020	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
224	Failure to meet the emergency access standard caused by system demands and pressures. Resulting in potential risk to trust reputation, financial impact and below expected Patient experience	• Trajectory achieved in Month 1, Month 2, Month 3, Month 4, Month 5 (84.97%) and Month 6 (81.67%). Month 7 (80.04%). – The Trust were ranked 25 out of 123 w/e 1st December for Type 1 activity. Month 8 – 77.81%, Month 9 75.94% • U&EC Improvement Committee stepped down. All actions complete with 9 ongoing issues monitored at Moving to Outstanding CAU Business Case approved by Executives on 31st October 2019 with a plan to implement from 9th December 2019 • 10 additional beds on B3 supported by NHSE/I • Funding received for K25 beds and to support protecting GPAU / CAU • Combined Assessment Unit launched 16th December 2019 – 24/7 from 5th January 2020	No impact on risk rating
701	Failure to provide continuity of services caused by the scheduled March 2019 EU Exit resulting in difficulties in procurement of medicines, medical devices and clinical and non-clinical consumables. The associated risk of increase in cost.	• Following the extension to the Article 50 period to 31 January 2020, daily SitReps have been suspended. NHSE/I have amended Brexit preparation timetables to further enhance preparedness. Stand up monitoring to take place from 20/01/20 • Following the General Election, advice received is to maintain a minimum position as there is now a minimal risk of a 'no deal' Brexit. • Advice received that there will be no change for the NHS between 1st Feb – 31st December 2020, which is described as the implementation period. • Following the vote at second reading of the Withdrawal Agreement Bill on 20 December, the government has stepped down preparations for a no-deal exit from the European Union. The Department of Health and Social Care has informed NHS England and NHS Improvement that for the health and care system this means that no-deal preparations should cease. As a result, staff working on no-deal preparations are being redeployed and other health and care organisations should do the same. • Advised that it is important to retain	Recommend to close risk

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
		organisational memory gained from all the work to date; therefore, NHS organisations are to retain a key point of contact in case an operational response needs to be stood up if trade agreement not agreed by late 2020.	
145	Influence within Cheshire & Merseyside a. Failure to deliver our strategic vision, including two new hospitals and vertical & horizontal collaboration, and influence sufficiently within the Cheshire & Merseyside Healthcare Partnership and beyond, may result in an inability to provide high quality sustainable services may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position. b. Failure to fund two new hospitals may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position.	• Second Board to Board meeting held with Bridgewater with positive discussion on our shared intention to more formally collaborate. • Funding being secured via Halton Borough Council and Liverpool City Region Town Centre Fund to potentially provide some services within Shopping City in Runcorn. This contributes to a potential phased approach to delivering reconfiguration of the Halton site. • Risk that the Trust will not secure the provision of the Eastern Sector Cancer Hub on site at Halton	No impact on risk rating
143	Failure to deliver essential Digital services, caused by a successfully executed Cyber Attack, resulting in loss of access to data and vital IT systems, resulting in potential patient harm, loss in productivity and damage to the Trust reputation.	• Responses to MIAA IT Health Check and Vulnerability Assessment Application Vulnerability Technical Report successfully completed. • Upgrading of all assets to Windows 10 are reporting 83% complete by NHS Digital leaving 17% to complete.	No impact on risk rating
414	Failure to implement best practice information governance and information security policies and procedures caused by increased competing priorities due to an outdated IM&T workforce plan resulting in ineffective information governance advice and guidance to reduce information breaches.	• Accredited National Cyber Security training delivered to leadership audience.	No impact on risk rating
241	Failure to retain medical trainee doctors caused by lack of recruitment resulting in risk to reputation and service provision	• Appointment of DME and deputy DME • Established Junior Doctors forum with improving engagement • Development of Medical Education Quality Committee • Away Day for the Medical Education Faculty	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
		• Ongoing annual Educator awards to acknowledge teaching contributions from trainees as well as substantive medical staff • Educator of the month awards • Review of appraisal process for educational supervisors underway • Review of specialty action plans following 2019 survey results • Development of project to improve FY experience and training	

2.6 Risk Management Strategy Updates

We will continue to review the Board Assurance Framework, streamlining it to highlight focused strategic risks, against the Trust's revised clinical strategy and operational plan that will emphasise the matters that pose the most significant threat to the Trust. This process will continue to take place with appropriate input from the Committees of the Board and their Sub-Committees, with considerations of risk appetite and risk tolerance.

Corporate Risk Register (CRR)

The Corporate Risk registers is now being shared across several Committees and Groups.

The Corporate risk register is a list of all the risks which may prevent the Trust from achieving its' Corporate objectives.

The risk register is comprised of all risks on the CBU and corporate risk registers which are identified as likely to affect the organisation at a corporate level.

The risk register is produced on a monthly basis and is presented at the following Committees:

- Risk Review Group
- Finance and Sustainability Committee
- Strategic People Committee
- Quality Assurance Committee
- Patient Safety and Effectiveness Sub Committee
- Operational Board

along with any oversight Committees of Strategic/Corporate risks.

In the Strategic People Committee and Finance and Sustainability Committee that took place on 22nd January 2020, more detailed papers were received highlighting the risks on the Corporate Risk Registers for which the relevant Committees were the monitoring Committees. This subsequently led to more in depth discussion relating to these risks on the CRR; providing greater insight on possible emerging risks.

3 RECOMMENDATIONS

Discuss and approve the changes and updates to the Board Assurance Framework.

Trust Board

DATES 2020-2021

All meetings to be held in the Trust Conference Room

Date of Meeting	Agenda Settings	Deadline For Receipt of Papers	Papers Due Out
2020			
Wednesday 29 January	Thursday 9 January (EXECS)	Monday 20 January	**Wednesday 22 January**
Wednesday 25 March	Thursday 5 March (EXECS)	Monday 16 March	**Wednesday 18 March**
Wednesday 27 May	Thursday 7 May (EXECS)	Monday 18 May	**Wednesday 20 May**
Wednesday 29 July	Thursday 9 July (EXECS)	Monday 20 July	**Wednesday 22 July**
Wednesday 30 September	Thursday 10 September (EXECS)	Monday 21 September	**Wednesday 23 September**
Wednesday 25 November	Thursday 5 November (EXECS)	Monday 16 November	**Wednesday 18 November**
2021			
Wednesday 27 January	Thursday 7 January (EXECS)	Monday 18 January	**Wednesday 20 January**
Wednesday 31 March	Thursday 10 March (EXECS)	Monday 22 March	**Wednesday 24 March**