Warrington and Halton Hospitals
NHS Foundation Trust

# WHH Board of Directors Meeting Part 2

**Wednesday 29 November 2017**
**1.00pm- 4.45pm**
**Trust Conference Room**

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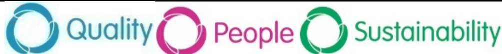
Warrington and Halton Hospitals
NHS Foundation Trust

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

Wednesday 29 November 2017, time 13:00 -4.45pm
Trust Conference Room, Warrington Hospital

| REF BM/17 | ITEM | PRESENTER | PURPOSE | TIME | |
|---|---|---|---|---|---|
| | Patient story (? A Perfect Day film from the Quality Strategy Day) | | Information | 1.00 | N/A |
| BM/17/11/111 | Guardian of Safe Working Quarterly Report | Dr Mark Tighe, Consultant | Assurance | 1.05 | Encl |
| BM/17/11/112 | Welcome, Apologies & Declarations of Interest | Steve McGuirk, Chairman | N/A | 1:15 | Verbal |
| BM/17/11/113 | Minutes of the previous meeting held on:<br>- 27th September 2017<br>- $6^{th}$ October 2017 (Extraordinary Board)<br>- $25^{th}$ October 2017 (Extraordinary Board) | Steve McGuirk, Chairman | Decision | 1.20 | Encl<br><br>Encl |
| BM/17/11/114 | Actions & Matters Arising | Steve McGuirk, Chairman | Assurance | 1.25 | Encl |
| BM/17/11/115 | Chief Executive's Report<br>- Including SOS Health Letter | Mel Pickup, Chief Executive | Assurance | 1.35 | Verbal/ Encl |
| BM/17/11/116 | Chairman's Report | Steve McGuirk, Chairman | Information | 1.45 | Verbal |




| REF BM/17 | ITEM | PRESENTER | PURPOSE | TIME | |
|---|---|---|---|---|---|
| BM/17/11/117 | Integrated Performance Dashboard M7 inc.<br>(b) Nurse staffing report<br>(c ) Trust Engagement Dashboard<br>(d) Key issues report - Quality & Assurance Committee 3.10.2017 & 07.11.17<br>(e) Finance & Sustainability Committee 18.10.207 + 22.11.2017<br>(f) Audit Committee 27.10.2017<br>(g) Charitable Funds Committee 2.11.2017<br>(h) Trust Operational Board (30.10.17 + 27.11.17) | All Executive Directors<br><br>d. Dr. Margaret Bamforth, Committee Chair<br>e. Terry Atherton, Committee Chair<br>f. Ian Jones, Committee Chair<br>g. Prof. Jean-Noel Ezingeard, Committee Chair<br>h. Mel Pickup, Committee Chair | Assurance | 1.50 | Encl |

| REF BM/17 | ITEM | PRESENTER | PURPOSE | TIME | |
|---|---|---|---|---|---|
| BM/17/11/118 | CQC Update Report<br>- Quality Report<br>- NHSi Leadership Development | Kimberley Salmon-Jamieson Chief Nurse | For Information | 2.30 | PPT |
| BM/17/11/119 | Quarterly Complaints Improvement Report | Kimberley Salmon-Jamieson Chief Nurse | Assurance | 2.50 | Encl |
| BM/17/11/120 | New Complaints Policy<br>- See Appendix 1 | Kimberley Salmon-Jamieson Chief Nurse | For Approval | 3.00 | Encl |
| BM/17/11/121 | Strategic Risks - M7 update | Kimberley Salmon-Jamieson Chief Nurse | Assurance | 3.05 | Encl |
| BM/17/11/122 | Mortality Review Report Q2 | Prof. Simon Constable Medical Director | Assurance | 3.15 | Encl |

| REF BM/17 | ITEM | PRESENTER | PURPOSE | TIME | |
|---|---|---|---|---|---|
| BM/17/11/123 | Freedom to Speak Up Bi-Annual report | Jane Hurst Deputy Director of Finance | Assurance | 3.25 | Encl |

| REF BM/17 | ITEM | PRESENTER | PURPOSE | TIME | |
|---|---|---|---|---|---|
| BM/17/11/124 | Quarterly response to Lord Carter (def fromOct) | Andrea McGee Director of Finance + Commercial Development | Ratification | 3.35 | Encl |
| BM/17/11/125 | NHS CARE Cyber Security | Jason DaCosta Director of IM&T | Assurance | 3.45 | Encl/ PPT |
| BM/17/11/126 | Emergency Preparedness, Resilience and Response (EPRR) 2017 Core Standards Assurance | Jan Ross Acting Chief Operating Office | Assurance | 3.55 | Encl |

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| Governance | | | | | |
|---|---|---|---|---|---|
| BM/17/11/127 | Halton Accountable Care System | Lucy Gardner<br>Director of Transformation | Assurance | 4.05 | Encl. |
| BM/17/11/128 | The New Well Led Framework – briefing note | John Culshaw<br>Head of Corporate Affairs | For Information | 4.15 | Encl. |
| BM/17/11/129 | WHH Charity Annual Report and Accounts 2016-17 for approval by the Corporate Trustee | Andrea McGee<br>Director of Finance + Commercial Development | Decision | 4.20 | Encl. |
| BM/17/11/130 | a. Corporate Calendar 2018 and<br>b. Trust Operational Board Terms of Reference | Pat McLaren<br>Director Community Engagement + Corporate Affairs | Decision | 4.30 | Encl |
| | | | | | |
| BM/17/11/131 | Any Other Business<br>- Update to Acting Up Arrangements notified to Board in September 2017 | Steve McGuirk, Chairman | | 4.35 | Encl |
| | Date of next meeting: 31st January 2018 | | | | |

Warrington and Halton Hospitals
NHS Foundation Trust

**BOARD OF DIRECTORS**

| AGENDA REFERENCE: | **BM/17/11/111** |
|---|---|
| SUBJECT: | **Guardian Quarterly Report on Safe Working Hours for Junior Doctors in Training** |
| DATE OF MEETING: | 29 November 2017 |
| ACTION REQUIRED | **The Board are requested to note the report and progress made with implementing the junior doctor contract and the level of assurance given that the junior doctors are working safely for their own health and wellbeing and the safety of patients.** |
| AUTHOR(S): | Mark Tighe, Guardian of Safe Working Hours and Mick Curwen, Associate Director of HR |
| EXECUTIVE DIRECTOR SPONSOR: | Alex Crowe, Deputy Medical Director |
| | |
| LINK TO STRATEGIC OBJECTIVES: | SO2: To have a committed, skilled and highly engaged workforce who feel valued, supported and developed and who work togther to care for our patients |
| LINK TO BOARD ASSURANCE FRAMEWORK (BAF): | BAF1.2: Health & Safety |
| | BAF2.1: Engage Staff, Adopt New Working, New Systems |
| | BAF2.3: Medical Staffing |
| | |
| STRATEGIC CONTEXT | The junior doctor contract was implemented in the trust on 7.12.16 but with national safeguards that the junior doctors should not be working excessive hours which could affect their health and wellbeing and the service they deliver to patients.<br><br>Each trust was required to appoint a Guardian of Safe Working whose primary role is to ensure that junior doctors do work safely and are able to access appropriate training and development opportunities.<br><br>A system of Exception Reports allows junior doctors to report areas of non-compliance and provides the opportunity for the Guardian to monitor trends and issues.<br><br>It is a requirement of the national contract that the Guardian submits a quarterly report to the Board so that the Board can gain this level of assurance. |

| | |
|---|---|
| | The first Report was submitted to the Trust Board and covered the period from December 2016 to May 2017. This is the second Report and covers the period from June to September 2017. |
| **EXECUTIVE SUMMARY** (KEY ISSUES): | The new Junior Doctors Contract has been in place since August 2016, and now all our Foundation Doctors have converted over, as well as the newer appointments on the CT and ST grade. There is good engagement from the doctors, who have worked well with rota managers, HR, postgraduate department, and the Clinical and Educational Supervisors.<br><br>Following a meeting with the Junior Doctors in early September, there was an early surge in number of exception reports submitted. The majority of the reports still relate to working late past their rotas. In some instances, this is due to sick patients, and is understandable. However, the majority relate to a reluctance to leave menial tasks eg TTOs and discharge summaries, to the busy on call staff. Again, a perception of understaffing on the medical wards and late senior ward rounds are contributing factors.<br><br>On the whole, our Educational Supervisors are very supportive of the juniors, although there has been some slippage in the timing of review meetings, and in timing of claims for TOIL and compensatory payment. There is still a preference for juniors to request compensatory payment rather than TOIL, presumably due to lower staffing levels on the wards. Most Supervisors are happy to discuss issues with the Guardian to ensure fair resolution<br><br>It is imperative to have continued training and engagement of the Supervisors, and possibly consolidate the numbers of Supervisors to ensure all the juniors have access to a quick and helpful review |
| **RECOMMENDATION:** | **The Board are requested to note the report and progress made with implementing the junior doctor contract and the level of assurance given that the junior doctors are working safely for their own health** |

| | | |
|---|---|---|
| | **and wellbeing and the safety of patients.**<br><br>**Any concerns that the Board have should be reported back to the Guardian for his attention.** | |
| **PREVIOUSLY CONSIDERED BY:** | **Committee** | |
| | **Agenda Ref.** | |
| | **Date of meeting** | |
| | **Summary of Outcome** | |
| **FREEDOM OF INFORMATION STATUS (FOIA):** | Release Document in Full | |
| **FOIA EXEMPTIONS APPLIED:** ***(if relevant)*** | None | |

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NHS Warrington and Halton Hospitals NHS Foundation Trust

**BOARD OF DIRECTORS**

| SUBJECT | Guardian Quarterly Report on Safe Working Hours for Junior Doctors in Training<br>Period: 18 May 2017 – 30 September 2017 | AGENDA REF: | |
|---|---|---|---|

## 1. Executive Summary

I am pleased to report that there has been a relatively seamless transition to the New Junior Doctors Contract. All our rotas remain compliant, and in general the juniors are happy with their allocations.

We have had a significant number of Exception Reports (ER) in the last 3 months, but this is considered a positive move, as the role of a Junior Doctor does involve additional and unpredictable work at times. The vast majority of ERs relate to our F1 doctors working past their allocated time, usually on an ad hoc basis, but there have been a large number of ERs from 2-3 individuals. This has alerted us to staffing and rota problems on individual wards (eg A7 and C21), which we have been able to address. There was a problem with the medical handover timing as well, leading to a lot of reporting, but this has now significantly reduced following review.

Again the majority of ERs are from the medical wards (72%), but this reflects the busier nature of their jobs, and sometimes lack of ward cover for more senior doctors. I have been impressed with the attempts to resolve the staffing shortages on the acute medical wards, and have had very few reports from AMU or A2, and in conversation, the F1s appear to be getting good support and teaching there.

There is good engagement from our Educational Supervisors in the majority of the ERs submitted. I have encouraged the F1s to contact me as Guardian, if they are unable to arrange a timely meeting with their ES. I have contacted a number of supervisors, and they are usually receptive to advice. There has been no escalation of an ER to a level 2 review or fine to the trust since the last Report

## 2. Introduction

Board members will recall that the first Guardian Report was received at the Trust Board on 31 May 2017. As a reminder, the role of the Guardian of Safe Working Hours under the Terms and Conditions of Service is to:

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

The new junior doctor contract went live in the trust on 7 December 2016 and the first report covered the period from 7 December 2016 to 17 May 2017. This Report covers the period from 18 May to 30 September 2017. Reports should be quarterly but by extending the review period to 30 September, this will allow future reports to match the traditional quarters in the year. The next Report will therefore cover the period from October to December 2017 and so on. This Report follows the format as recommended by NHS Employers.

High level data

Number of doctors / dentists in training (total): 72

Number of doctors / dentists in training on 2016 TCS (total): 70

Amount of time available in job plan for guardian to do the role: 1.5 PAs / 6 hours per week

Admin support provided to the guardian (if any): Nil WTE

Amount of job-planned time for educational supervisors: 0.125 PAs per trainee

The 72 doctors in training at the trust are made up of 36 FY1 trainees and 36 FY2 trainees. The 36 FY1 trainees transferred to the new contract on 7 December 2016 and from the August 2017 changeover all of the FY1 and FY2 trainees went on to the new contract (2 appointments on the FY2 intake were initially vacant but one was filled on a locum basis). In addition, the Lead Employer (St Helens and Knowsley) employ trainees at ST1+ and CT1+ who rotate to different trusts as part of their training. At any one time, the trust usually has c80 trainees from the Lead Employer. Since the implementation of the new contract, the trust has received 64 trainees from the Lead Employer and 54 of these commenced in August 2017.

## 3. Exception Reports (with regard to working hours)

| Specialty | No. exceptions carried over from last report | No. exceptions raised | No. exceptions closed | No. exceptions outstanding including those from last report |
|---|---|---|---|---|
| **General Medicine – FY1** | **2** | **83 (92)** | **57 (62)** | **26 (30)** |
| **General Surgery – FY1** | **4** | **22 (33)** | **16 (22)** | **8 (13)** |
| **Trauma and Orthopaedics – FY1** | | **7 (7)** | **1 (1)** | **6 (6)** |
| **Paediatrics – Alder Hey – FY1** | **3** | **3 (3)** | **0** | **6 (6)** |
| **ENT – ST3** | **1** | **1 (1)** | **0** | **2 (2)** |
| **Total** | **10** | **116 (136)** | **74 (85)** | **48 (57)** |

NB.

1. The figures in brackets denote the total number of reported incidents. In some instances one Exception Report has been used to report more than one incident/issue
2. Of the 136 incidents reported, these relate to a total of 26 trainees and 20 Educational Supervisors, only 6 of which do not appear to have yet engaged in the process.
3. Four of the Exception Reports (11 incidents) were originally classified as 'Immediate Safety Concerns' where there is a requirement for this to be reported/escalated within 24/48 hours. However, upon further examination it appears that these reports should not have received this classification, and were downgraded.

| Exception reports (response time) | | | | |
|---|---|---|---|---|
| | Addressed within 48 hours | Addressed within 7 days | Addressed in longer than 7 days | Still open |
| FY1 | 15 | 24 | 46 | 50 |
| ST3 | 0 | 0 | 0 | 1 |

The rules for exception reports state that reports should be completed by the doctor as soon as possible but no later than 14 days of the exception. If the doctor is seeking payment as compensation, the report should be submitted within 7 days. Upon receipt of a report, the Educational Supervisor should respond within 7 days.

The above table shows that 39 reports (29%) have been processed within 7 days but 46 reports (34%) were processed in more than 7 days and 51 reports (37%) still remain unprocessed. This latter figure is of some concern as the Educational Supervisors should have met to resolve the incident. All of the Exception Reports which have been resolved were resolved at the 'Initial Stage' but 6 Exception Reports are showing as having been escalated to 'Level 1 Review Stage'.

| **Exception reports (type of issue)** | | | | |
|---|---|---|---|---|
| | **Hours** | **Education** | **Service Support** | **Working Pattern** |
| **FY1** | **135** | **2** | **6** | **0** |
| **ST3** | **1** | **0** | **0** | **0** |

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

| | **Exception reports (Outcome)** | | | | |
|---|---|---|---|---|---|
| | **Overtime Payment** | **Compensation and Work Schedule Review** | **Compensation: Time Off in lieu** | **Prospective Changes to Work Schedule/Compensation or TOIL/Organisational Change** | **No Further Action** |
| **FY1** | **58** | **5** | **18** | **0** | **4** |

Given the number of issues raised which relate to hours and the staffing shortages amongst other grades of doctors, it is perhaps not surprising that overtime payments have been agreed as the most satisfactory outcome. However, in comparison with the previous report, the number of outcomes with time off in lieu has increased significantly from just 1 to 18. This is still at variance with many trusts around the country (as presented at the recent National Guardian Meeting), which suggest that the norm should be time-off in lieu (TOIL), rather than compensatory payments. Our juniors feel that they cannot take TOIL due to understaffing, and a perception they will be adding more work on their colleagues, if they were absent.

Another interesting observation is that no Exception Reports have been raised by the FY2 trainees despite the fact that they were familiar with the system having raised a number of exceptions when they were FY1 trainees.

Junior Doctors on the 2002 Contract

It is important to remember that some junior doctors (employed by the Lead Employer) will remain on the 2002 contract for a number of years and will require their rotas to be monitored in line with their terms and conditions so that assurance can be given for all doctors in training and not just those on the new contract. A monitoring exercise has been undertaken on these doctors but the results have not quite been finalised and will be reported in the next quarterly report.

## 4. Work Schedule Reviews

There have been 5 Work Schedule Reviews (WSR) recommended by the Education Supervisors at their initial meeting following submission of an exception report. All of these relate to the medical rota and primarily relate to the twilight shift not including medical handovers to the night staff and of particular concern are the cardiology areas. This is a vital part of the day to ensure ongoing continuity of patient care of the acute admissions overnight. Another issue is that on the 9-5 shift it is rare that the FY1s are able to leave on time. These issues have been brought to the attention of the Chief of Service in Acute Care who has discussed the issue with the senior ST in charge of the rota. The possible rota changes are being modelled on the Allocate system and will be fed back to the Chief of Service. The Work Schedule Reviews all relate to the FY1 trainees.

We have not had to escalate a Work Schedule Review to level 2, 3 or fine status yet.

| Work schedule reviews by grade | |
|---|---|
| **FY1** | **5** |

| Work schedule reviews by department | |
|---|---|
| **Acute medicine** | **5** |

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## 5. Locum Bookings

Bank and Agency

The normal arrangements for covering gaps on the rotas are for the trainees to be approached first to see what cover they can provide. Where gaps still remain, the shifts which need covering are submitted via the Divisions to the Medical bank which uses the TempRe system for filling shifts.

The tables below show the shifts which were escalated to the Medical bank for filling on the TempRe system The first table shows the total shifts by specialty and the second table shows the reason given for filling the shift, both split by FY1 and FY2.

| Locum bookings (bank and agency) by department | | | | | |
|---|---|---|---|---|---|
| **Specialty** | **Number of shifts requested** | **Number of shifts worked** | **Number of shifts given to agency** | **Number of hours requested** | **Number of hours worked** |
| **FY1** | | | | | |
| Acute Medicine | 14 | 0 | 14 | 175 | 0 |
| **TOTAL FY1** | **14** | **0** | **14** | **175** | **0** |
| **FY2** | | | | | |
| Acute Medicine | 36 | 2 | 2 | 436 | 23 |
| Cardiology | 15 | 6 | 6 | 120 | 46.25 |
| Care of the Elderly | 496 | 285 | 385 | 3968 | 2172.58 |
| Diabetes/Endo | 14 | 3 | 3 | 157.5 | 34.5 |
| Gastroenterology | 10 | 0 | 0 | 80 | 0 |
| Women’s | 5 | 3 | 3 | 49 | 25 |
| Trauma & Ortho | 289 | 209 | 244 | 2901.5 | 2399.25 |
| **TOTAL FY2** | **865** | **508** | **643** | **7712** | **4700.58** |

| Locum bookings (bank) by reason* | | | | | |
|---|---|---|---|---|---|
| **Specialty** | **Number of shifts requested** | **Number of shifts worked** | **Number of shifts given to agency** | **Number of hours requested** | **Number of hours worked** |
| **FY1** | | | | | |
| Sickness | 14 | 0 | 14 | 175 | 0 |
| **TOTAL FY1** | **14** | **0** | **14** | **175** | **0** |
| **FY2** | | | | | |
| Annual Leave | 3 | 3 | 3 | 24 | 25 |
| Extra | 1 | 1 | 1 | 8 | 7.5 |
| Unknown | 222 | 0 | 0 | 2074.5 | 0 |
| Vacancy | 639 | 504 | 639 | 5605.5 | 4668.08 |
| **Total FY2** | **865** | **508** | **643** | **7712** | **4700.58** |

1. At FY1 level only a small number of shifts were escalated to be filled by agency and these were all in medicine and related to sickness.
2. The above tables show that the main reason, by far, for requesting cover was due to vacancies.
3. Two specialties stand out in terms of requiring cover and these relate to Care of the Elderly and Trauma and Orthopaedics with the prime reason known to be other vacancies with the specialties. Not surprisingly, these two specialties also account for the highest use of agency staff.
4. The reason for the difference between requested shifts and the number of shifts given to agencies, is due to subsequent cancellations from the Divisions.

## 6. Locum Work Carried Out by Trainees

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

| **Locum work by trainee** | | | | | | |
|---|---|---|---|---|---|---|
| **Specialty** | **Grade** | **Number of shifts worked** | **Number of hours worked** | **Number of hours rostered per week** | **Actual hours worked per week** | **Opted out of WTR?** |
| **General Medicine** | **FY1** | **c9** | **85** | **757** | **757** | **N/K** |
| **General Surgery** | **FY1** | **c17** | **128.5** | **544** | **544** | **N/K** |
| **TOTAL** | **FY1** | **c26** | **213.5** | **1306** | | |
| **Psychiatry** | **FY2** | **c21** | **167** | **1468** | **1468** | **N/k** |
| **Accident and Emergency** | **FY2** | **c37** | **290.08** | **352** | **352** | **N/K** |
| **General Medicine** | **FY2** | **c8** | **56.5** | **464.5** | **464.5** | **N/K** |
| **Trauma and Orthopaedics** | **FY2** | **c9** | **67.5** | **325.15** | **278.7** | **N/K** |
| **General Surgery** | **FY2** | **c21** | **166.25** | **464.5** | **418.05** | **N/K** |
| **Total** | **FY2** | **c96** | **747.33** | **3074.15** | **2981.25** | **N/K** |

NB.

1. The number of shifts worked has been estimated as records only show the number of hours worked and have been based on 8 hour shifts
2. The number of hours worked per week takes account of vacancies and trainees on maternity leave but excludes sickness or other absences such as annual leave.

3. It is not known whether any of the trainees exceeded an average of 48 hours per week under WTR and whether they completed an opt-out form.
4. The table reflects the fact that FY1 trainees are happier to cover locum shifts in surgery than medicine although the difference is much less than the previous report. On discussion with our trainees at the regular Junior Doctors Forums, and informally on the wards, this is because they feel the medical on call is particularly onerous, and at times feel unsupported by their seniors out of hours.
5. At the FY2 level the trainees are far more attracted to work in A&E which can give them useful experience.
6. None of the extra shifts worked relate to Exception Reports.
7. The volume of locum work does not correspond to the number of Exception Reports which reached an outcome of 'Overtime Payment'. This would suggest that there are still a significant number of payments yet to be made. All of the trainees have received information on how to make claims and this was reiterated at the Junior Doctors Forum meeting in October 2017

## 7. Vacancies

The table below shows the vacancies at **FY1 level only** from **May – July 2017**:

| Specialty | Grade | May17 | Jun 17 | July 17 | Total gaps (average) | Number of shifts uncovered |
|---|---|---|---|---|---|---|
| **General Medicine** | **FY1** | **0** | **0** | **0** | **0** | **0** |
| **General Surgery** | **FY1** | **0** | **0** | **0** | **0** | **0** |
| **General Psychiatry** | **FY1** | **0.4** | **0.4** | **0.4** | **0.4** | **26** |
| **Total** | **FY1** | **0.4** | **0.4** | **0.4** | **0.4** | **26** |

NB.

1. One of the trainees is LTFT and works 60% which leaves a gap of 40%
2. Over the period from May – July 2017 there were two trainees who were on maternity leave. One was on maternity leave in General Medicine (Gastroenterology) and the other was on maternity leave in General Psychiatry.
3. It does need to be recognized that there were other medical vacancies at different grades which would have had some impact on the resources available on wards and departments which could have contributed to difficulties in some trainees leaving wards on time.
4. Another caveat relates to the national reduction in supply of CT1/2 and ST3+ doctors, which will undoubtedly lead to insufficient doctors to enable compliant rotas in the future. As well as rota management, this will have a deleterious effect on training and educational opportunities for those left on the rota.

The table below shows the vacancies at **FY1 and FY2** level from **August – September 2017** when the FY2 trainees commenced on the new contract:

| Specialty | Grade | Aug17 | Sept 17 | Total gaps (average) | Number of shifts uncovered |
|---|---|---|---|---|---|
| General Medicine | FY1 | 0 | 0 | 0 | 0 |
| General Surgery | FY1 | 0 | 0 | 0 | 0 |
| General Psychiatry | FY1 | 0.4 | 0.4 | 0.4 | 16 |
| Total FY1 | FY1 | 0.4 | 0.4 | 0.4 | 16 |
| Public Health | FY2 | 1.0 | 1.0 | 1.0 | 40 |
| Total FY2 | FY2 | 1.0 | 1.0 | 1.0 | 40 |

NB.

1. One of the trainees at FY1 is LTFT and works 60% which leaves a gap of 40%
2. Although there was another vacancy at FY2 this was mitigated by being able to appoint a LAT to cover.
3. Over the period from Aug – Sept 2017 there were two trainees who were on maternity leave. One was on maternity leave in General Surgery and the other was on maternity leave in Trauma and Orthopaedics.

## 8. Fines

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

## 9. Qualitative Information

**Junior Doctors Forum**: Following extensive advertisement and encouragement, the last JDF was very well attended and led to healthy debate. The joint meeting with medical director and chief executive appears to be appreciated by the juniors. Hopefully, we can continue to develop this meeting in the future. For examples, issues were raised with the medical handover (now resolved), ward C21 with timing of consultant ward rounds leading to late departures of juniors (and their patients), and ward A7 with workload and senior support (excellent input from Dr Murthy has sorted this effectively).

**Education supervisors**: good engagement from the majority of ES consultants. However, there has been a significant delay in some cases with the review meeting, and as Guardian, I will intervene with certain ES if persistent problems in this regard. I would prefer to consolidate the number of ES to around 15, so that the interested consultants could have more juniors receiving their support.

**Exception reports**: There has been an increase in the number of Exception Reports over the last 3 months, but this is not unduly concerning. The numbers mirrors other trusts of our size, and at our Regional Guardian meeting, was thought to represent healthy engagement of our juniors! There

have been 4 submissions of Immediate Safety Concerns (ISC). However, on subsequent review, and discussion with the relevant F1, they were all downgraded.

**Compensation for extra duties worked**: Our juniors still tend to favour compensatory payment rather than TOIL. This is because they feel taking more time off will lead to a further reduction of staff on the wards, and as such, they prefer payment. There have been 5 work schedule reviews, to attempt to correct problems for future F1s in the post.

**Allocate training**: there has been drop-in sessions available for ES to develop their skills in completion of ER reviews, with fair attendance. As Guardian, I still do not have access to edit any reports, until they come to Level 2 review.

## 10. Issues Arising

1) Our volume of exception reports (ER) still compare favourably with other trusts across the country. Like incident reporting, it is vital the juniors engage with the process. The vast majority of Exception Reports at WHH relate to working excess hours, to ensure their work is completed, and not handed over to busy on call staff.
2) We have no immediate safety concerns of note since the last report
3) We still outlie on the outcomes of the meeting following submission of an Exception Report. Most trusts resolve overtime hours with TOIL, but the overwhelming majority of ours lead to compensatory time payments. This is generally because the juniors do not want to overburden their colleagues, especially in understaffed specialties. The downside of this is that our juniors may come dangerously close to exceeding their maximum working hours, or having insufficient rest periods between shifts. It is difficult to accurately monitor the number of extra hours our juniors are undertaking across a full rota cycle.
4) We do rely heavily on in-house locum cover for outstanding shifts, exaggerated by recent changes to IR35 legislation and agency usage. Whilst coverage of shifts in the surgical specialties is usually manageable, this is more difficult in medicine where the juniors are less inclined to cover extra work. In-house cover again has repercussions on the maximum hours that the juniors are permitted to work.
5) We need ensure continued engagement of our Education supervisors with their junior doctors, and look to consolidate numbers if persistent delays in review meetings occur.

## 11. Action Taken to Resolve Issues

1) Training sessions for all Educational Supervisors and Guardian of Safe Working in Allocate have taken place.
2) Liaison with HR to calculate average hours for juniors across a rota cycle. The planned in house locum bank should help to spread the extra hours across the juniors to ensure they remain compliant.
3) There has been success in increasing staffing and junior support in high intensity areas, eg A2 and AMU. C21 and A7 are still busy units with limited staff. This has been well recognized by the trust, and where further doctors are unavailable, use of nurse specialists and physician associates have been encouraged.

4) There may need to be extra recognition of the workload of some of the Educational Supervisors, whose juniors are in the more challenging posts, with PA allocation adjusted accordingly.
5) Continue to try and encourage TOIL as a solution to excess hours rather than compensatory payments, to avoid possible breach in hours and increased costs.
6) Work schedule reviews have been successfully implemented in the medical rota (to incorporate handover times), and medicine/surgery to allow regular attendance at educationally beneficial sessions (formal teaching, theatre, clinics).

## 12. Summary

I continue to believe there has been a successful implementation of the new Junior Doctors Contract across WHH trust. All our rotas remain compliant, the juniors are generally satisfied and engaged, and our HR department, rota managers, and Educational Supervisors have been supportive and responsive to any concerns amongst the junior doctors.

The majority of the exception reports still relate to juniors staying late after a particularly onerous shift, partly due to insufficient juniors and middle grades being available, but also being unwilling to transfer this work to the busy on call out of hours doctors. This reflects a healthy work ethic from our cohort of junior doctors. There have been no immediate safety concerns reported by junior doctors from any of the wards. In general, our juniors have been able to attend educational and teaching sessions, without having to return to ward duty.

The junior doctors have usually received expeditious response from the Educational Supervisors, and Exception Reports have been signed off without resort to level 2 or guardian reviews. This was one of the main concerns from the BMA prior to implementation of the contract, and it is pleasing to see this continuing in our trust.

There are still areas where there are limited numbers of junior staff covering busy wards. This will undoubtedly lead to extra burden on the incumbent doctors, in terms of workload, compliance to working hours, and opportunity to access educational sessions.

Adult medicine in particular still generates the majority of Exception Reports, and it is important that the trust continues to monitor and act on these concerns from our juniors.

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

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

## 13. Questions for Consideration

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

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

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

**Mark Tighe**
**Guardian of Safe Working Hours**

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**Warrington and Halton Hospitals NHS Foundation Trust**
**Minutes of the Board of Directors meeting held in Public (Part 2) on Wednesday 27 September 2017**
**Trust Conference Room, Warrington Hospital**

| **Present** | |
|---|---|
| Steve McGuirk (SMcG) | Chairman |
| Terry Atherton (TA) | Non-Executive Director |
| Mel Pickup (MP) | Chief Executive |
| Margaret Bamforth (MB) | Non-Executive Director |
| Andrea McGee (AMcG) | Director of Finance and Commercial Development |
| Michelle Cloney (MC) | Interim Director of HR + OD |
| Simon Constable (SC) | Medical Director + Deputy Chief Executive |
| Ian Jones (IJ) | Non-Executive Director / Senior Independent Director |
| Jan Ross (JR) | Acting Chief Operating Officer |
| Kimberley Salmon-Jamieson (KSJ) | Chief Nurse |
| Anita Wainwright (AW) | Non-Executive Director |
| Jean-Noel Ezingeard | Non-Executive Director |
| **In Attendance** | |
| Alex Crowe | Deputy Medical Director/Acting Medical Director |
| Lucy Gardner (LC) | Director of Transformation |
| Jason DaCosta (JDaC) | Director of IM&T |
| Jennie Delea (Presentation only) (JD) | Outpatients & Medical Records Service Manager |
| Lesley Taylor (Presentation only) | Nurse Manager Outpatients |
| Margaret Moran | |
| Janet Oxley | Executive Assistant (taking minutes) |
| **Apologies** | |
| Pat McLaren (PMcL) | Director of Community Engagement + Corporate Affairs |
| **Observing** | |
| Norman Holding | Governor |
| Sue Kennedy | Governor |
| 2 x members of the public | |

| *Agenda Ref BM/17/09/* | |
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| *BM 17/09/* | The Board meeting opened with a patient story from the Chief Nurse, Jenni Delea, the Outpatients and Medical Records Service Manager, Lesley Taylor, Outpatients Nurse Manager, Outpatients and Margaret Moran Outpatients Health Care Assistant. Jenni explained that within Outpatients they hold a Neurology Service provided by Walton Centre and during this particular clinic a patient Mrs A had made staff aware that she had suicidal thoughts. Lesley and Margaret acted quickly and took the necessary steps to offer her support and to escalate their concerns to the Safeguarding team, they then accompanied Mrs A to A&E for a crisis review. Jim Eatwell, Safeguarding Matron involved on the day highlighted the outstanding level of care and empathy shown by the Outpatient nursing staff.<br><br>Jenni pointed out that there were 35 clinics running both at Warrington and Halton and how this demonstrates the importance of staff developing an early rapport with patients visiting the department. The Chief Nurse pointed out that there could have been a very different outcome for this patient if both Lesley and Margaret had not stepped in. The Chief Nurse |

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| | explained that the purpose of presenting this story to Trust Board was for members to hear about it and to reply.<br><br>Members agreed that this story is linked to the CEO's message of 'doing the right thing'. Anita Wainwright, Non-Executive Director acknowledged that there is a difference in spotting the concerns and realising the impact that patients in distress can have not only to themselves but to others. The Chair agreed that it is about public protection and that processes are in place for patient safety. That people on the ground are delivering quality care and that there are interactions in many cases that go unnoticed. He highlighted that it is about the patient and having a professional structure to support the patient care.<br><br>Both Lesley and Margaret were commended by the Board for their quick thinking actions and the positive outcome for this patient. |
| *BM17/09/93* | **Welcome, Apologies & Declarations of Interest**<br>The Chairman opened the meeting, and welcomed those in attendance.<br>Apologies: as above. Declarations of Interest: none declared in respect of agenda items. |
| *BM17/09/94* | **Minutes of the Previous Meeting Held on 26 July 2017**<br>The minutes of the meeting held 26 July 2017 were agreed as an accurate record. |
| *BM17/09/95* | **Actions and Matters arising**<br>All actions were reviewed and progress noted since the last meeting. |
| *BM17/09/96* | **Chief Executive Report including Chair's Report from the Trust Operational Board and Terms of Reference for approval**<br>The Chief Executive updated the Board on matters that had occurred or progressed since the July Board meeting.<br><br>- The CEO reported that she is now in her role of STP Lead supporting the work of the STP for Cheshire and Merseyside and part time CEO. Andrew Gibson is now in his role and looking at proposals to refresh and refocus across the patch. The CEO explained that this organisation is her priority and informed that Simon Constable, Medical Director and Deputy CEO will assume full-time CEO duties to support her during the initial secondment period. Alex Crowe, Deputy Medical Director will take the role of Acting Medical Director. The CEO explained that the interest of this organisation is at the heart of the continuity over the next 12 months.<br>- The CEO informed that at the recent Overview and Scrutiny Committee, Warrington Local Authority Partners were there to talk about the STP. There were discussions about the new hospital and they showed a lot of interest and support to where/when and if Warrington could have a new hospital, which she felt was very pleasing.<br>- The CEO had recently attended an NHSI Manchester Expo conference. A two day event designed to celebrate and promote the use of technology and to push innovative design which she felt was quite refreshing. She explained that there was a massive emphasis on technology. The CEO attended to present and talk about Halton Healthy New Town which will be created and future proofed for the next 20-30 years. A company named Cities Mode the winners of the global design challenge are working on the project on innovations and technologies that can be incorporated into the design and work is gathering momentum. The CEO explained that Simon Stevens, CEO, NHS England is the |

brainchild for the concept and new models of care and he states this to be the solution in respect of the current demand and desire to prevent ill-health.

- The CEO advised that the Winter Challenges will be challenging to meet and she pointed out that there had been a particular issue with flu in Australia. Therefore staff will need to be prepared here and that there needs to be a huge promotion to vaccinate and that the organisation will be working closely with the Boroughs to make this happen.
- There are other changes to the organisation with the introduction of PC Streaming Services which will run from October. It is a bespoke unique frailty service as it is proven that there is a negative impact of patients coming into hospital. The CEO indicated that there are three clear milestones to aim for: i. service in the home, ii. a service pickup from home to hospital and iii. the final bastion being that A&E prevent older people from being admitted. People's overall outcomes will be better and the better the organisation gets at deploying this method the more ready staff will be at identifying patients who are ready to be discharged. The system with community providers needs to be strengthened and the CEO informed that there had recently been a meeting with joint Respiratory Services to discuss how to improve the process of patients coming in and out of hospital quickly. The Acting COO explained that frailty patients presenting in A&E are streamed to the Frailty unit and not admitted into the bed base but into the unit.

The Chair informed of the impressive services at the new Lymm Fire Station and that it would be worth a visit to take a look at how they are set up.

Ian Jones, Non-Executive Director asked if part of the CEO's discussions around Halton Healthy New Town had involved talks with Warrington New Town on the proposed new housing scheme and for the organisation to explore what it can provide and what it can learn. The CEO advised that she had not as yet had conversations but acknowledged that there is house building regeneration and there would need to be a new health facility in Warrington. This was an opportunity for Warrington and the public to speak out on what it wants in particular for the location for the new facility. The Chair added that there is a big footprint close to the Town Centre and that the public are concerned about the future health aspects.

<u>Chairs Report Trust Operational Board and Terms of Reference</u>

The Terms of Reference were discussed and the following points noted:

Ian Jones, Non-Executive Director asked that the minutes of the Trust Operational Board (TOB) be circulated to the Non-Executive Directors on a monthly basis.
**Action: Secretary to the Board to circulate the TOB minutes on a monthly basis**

The membership was debated particularly around deputies attending and whether a different level would be required involving a tighter group to meet when necessary. The Director of Finance and Commercial Development advised that the membership level was correct as it had emanated from the Well Led Review and the people listed on the membership were required to attend.

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| | Margaret Bamforth, Non-Executive Director informed of the relationship now with the TOB and the Quality Committee; its two way process; the wider agenda and impact on quality. She informed that with regard to the Integrated Performance Report the divisions were presenting the exceptions to the Committee and that Directors were invited to challenge them if they were not adequately explained.<br><br>It was noted that the Divisions are presenting their reports in the same style format and there are two way flows from the relevant groups that feed into the TOB.<br>It was suggested that there needs to be a comms sent out informing of this.<br><br>Terry Atherton, Non-Executive Director (TA) explained that at the last Finance and Sustainability Sub-Committee (FSC) they had looked at their own work plan to avoid any duplication. It was agreed that the IM&T and Estates would be removed from the FSC cycle of business bearing in mind that they will report into the TOB. Any issues or impact on performance issues or significant impact on finance would still need to be reported to the FSC. It was noted that the Terms of Reference for the FSC will be revised to reflect the changes and would have the appropriate approval by the FSC for these changes.<br><br>**The Board noted the Chief Executive's report**. |
| *BM17/09/97* | **Chairman's Report**<br><br>- The Chair informed of the recent Trust AGM. He thanked all those who added input and showed his appreciation for the huge amount of work that had been prepared and acknowledged the challenges in achieving this.<br>- The latest Newsletter was excellent and impressive with all the news included on the Halton Healthy New Town.<br>- Chair noted that the industrial action carried out by Theatre Staff had now concluded.<br>- Chair noted that as part of the Warrington Local Plan it was disappointing that the health aspects had not as yet been addressed in particular with the future implication of 20k homes being built.<br>- Chair noted that the new Runcorn Bridge will be opening shortly and drew attention to the toll charges that could have an impact on the Hospital. |
| *BM17/09/98* | **Integrated Performance Report Dashboard (August)**<br><br>The Board noted The Integrated Performance Report Dashboard (August).<br><br>The Chief Nurse highlighted areas for the Board to note relating to the Quality KPIs:<br><br>- 6 indicators rated red decreased to 5 the five are as follows:<br>(1) 1 reported MRSA in July therefore indicator will remain red for the remainder of 2017/18<br>(2) Nice compliance - the Trust achieved 63.52% in August against a target of 100% an improvement in month from 61.75% in July<br>(3) Complaints - 16 open for over 6 months. There is a trajectory to hit plan.<br>(4) Friends and Family - recommend to AED. 85% achieved against target of 87% |

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(5) Mixed Sex Accommodation (MSA) - 10 breaches in month a reduction from 17 in July.

The Chief Nurse reported that the Quality indicator had moved from red to green in August which relates to Duty of Candour.

The Safety Thermometer has moved from amber to green as the reporting overall harm free care is above the 95% target. 1 remaining amber indicator is the staffing average fill rate currently at 86.63% in month for registered nurse/midwives in the day against a target of 90%. Plans are in place to ensure the delivery of safe patient care.

Margaret Bamforth, Non-Executive Director pointed out that as illustrated from the graphs the number of Serious Incidents had increased. The Chief Nurse agreed that there had been an increase and explained that she was assured of reporting now.

Anita Wainwright, Non-Executive Director indicated that with regard to the newly qualified staff coming in there would be a time-lag. The Chief Nurse agreed and advised that some staff nurses had started in the Trust already and she informed that there is an October recruitment external event happening soon which include the recruitment of experienced/Registered Nurses who may be interested in a specialist clinical review. The Chief Nurse informed that approximately 30 staff had been taken on and explained that there was a 3 week time delay due to the preceptorship and induction process.

The Director of Finance and Commercial Development advised and noted that there was a recommendation that the indicators Patient deaths and CHPDD (as noted in the paper) should not have a RAG rating attached to them.

The Acting COO highlighted areas for the Board to note relating to Access and Performance KPIs

- 5 indicators rated as red in August the same as July.
  (1) A&E waiting times 4 hour - the Trust achieved 94.39% against the national standard of 95%.
  (2) Ambulance handovers 30 minutes - the Trust has remained static in month for the number of delayed handovers between 30 and 60 minutes reporting 124 in August the same as July. The challenging time period being evening to the early hours when medical staffing levels is reduced which is being reviewed to address the issue.
  (3) Ambulance handovers 60 minutes - improvement in performance shown in the number of delayed handovers over 60 minutes down from 31 in July to 15 in August.
  (4) Discharge summaries - 87.30% in month against target of 95%. A financial penalty of £15k will be incurred per quarter from Commissioners.
  (5) Number of Cancelled Operations of the day - 24 breaches in month an increase compared to 14 in July. All patients who had operations cancelled were offered new dates within 28 days in line with the national target. The industrial action of Theatres was separate to these cancellations and some operations were cancelled in advance. There have been more issues surfacing over the last few months. The action plan is being

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reviewed and there is confidence that the changes in Theatres will show improvements.

The Interim Director of HR and OD highlighted key points within the People KPIs:

- Of the 12 indicators 4 indicators are rated as red.
  (1) Return to Work Interviews (RTW) indicator from amber (78.75%) July to red (73.58%) August. An audit has taken place extended for a further 2 months and the attendance management toolkit will be reviewed. There is collaboration with Occupational Health staff to target areas of high sickness. The Directorate is also looking at introducing a new scheme – Mental Health First Aiders – which will require training and investment but would also support the Trust to enable staff to be more resilient to stress, anxiety and mental health related issues.
  (2) Recruitment - time taken to recruit improved from 86.3 days to 66.5 days in a 3 month period against Trust target of 65 days. The indicator remains on red.
  (3) Non Contracted Pay remains above budget in August at 6.6% of the Trust's overall pay bill compared to 6.27% in July. The indicator remains on red. It has been most challenging during the holiday period and there has been difficulty in achieving nursing fill rates with NHS Professionals.
  (4) Average cost of top 10 highest cost agency works - the RAG parameters have now been set and the indicators are in red in August. A Recruitment Strategy has been presented to FSC. The Breach Cap Approval processes have been reviewed and presented to Trust Operational Board. In addition Medical Staffing Agency Spend and Top Earners information is being reported to the Medical Staffing HR group to enable greater scrutiny and challenge.

There is 1 Workforce indicator rated amber in August compared to 2 in July that being the PDR compliance which has shown a slight improvement at 77.13% in August compared to 76.14% in July against the Trust target of 85%.

Anita Wainwright, Non-Executive Director stated that out of the 5 indicators, 3 are multi-factorial and the ones in the Trust's control are the RTW and PDR indicators. These show to the staff that they are important and it is essential that the Trust gets a grip of these indicators. She added that having the HR Business Partners out in the Divisions will help to improve in these areas.

The Interim Director of HR & OD updated that the Chief Nurse and herself had worked on a new Ward Manager Development Programme which incorporated a component on the techniques required to effectively engage with their teams. 'Permission to act' is a critical element to the programme and it is about changing the culture in each ward and department.

It was noted that 25% of spend is related to medical locums with 90% breaching the NHSI cap.

The Director of Finance and Commercial Development added that the Trust has an agency target threshold set by NHS Improvement which is set at the same level as last year. The Trust should aim to spend less than this target accepting that this is a challenging position to achieve.

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It was recommended that an Allied Health Professional (AHP) indicator be included in the dashboard and be year to date rather than in month as the other indicators show.

The Acting Medical Director added that as part of the work of the Medical Staffing HR Group; the Pay, Spend and Review Group and the Workforce Committee rota rosters are being reviewed. It has been found that Allocate are not being used to full extent which could, if utilised fully, be of benefit to the Trust. There will be further exploration into the recruiting of middle grade doctors and Consultants from overseas, subject to service requirements and appropriate funding.

The Director of Finance and Commercial Development highlighted key points within the Finance Sustainability KPIs:

- 6 finance sustainability indicators rated red in August the same number as in July:
  (1) Financial position - the cumulative deficit of £4.4m is £0.5m worse than the planned deficit of £3.9m. The Director of Finance and Commercial Development explained the reasons behind this and explained that a reduction in anticipated PDC dividends was supporting the position. There remains a pressure on the cash position which impacts on the Trust's ability to pay creditors promptly. Agency spend is a key issue. Action plans have been prepared in the key areas of financial risk which have improved the forecast, however plans are still required for the Trust to deliver the control total. NHSI are sighted on the risk and meeting with the Trust on a regular basis. A meeting has been set up to specifically discuss the cash and loan position.
  (2) Cash balance - cash continues to be a challenge and is being monitored daily. The balance at the end of August was £1.2m.
  (3) Better Payment Practice Compliance -underperforming year to date at 36% against a 95% target due to cash challenges.
  (4) Fines and penalties - £18k for the period April-June 2017.
  (5) Agency spending - the cumulative agency spend of £4.5m is £0.3m (8%) above the cumulative agency ceiling of £4.2m.
  (6) Cost Improvement Programme - the Director of Transformation noted an amendment to the CIP not reflected in the report. Of the £2.38m delivered she highlighted that this was not just CIP. The financial impact of transformation activities reported as £2.4m in Month 5 should be amended to £2.8m and of that £2.1m is CIP. The forecast has also moved and improved, a total of £9.3m previously at £7.2m.

Jean Noel-Ezingeard asked whether the increased CIP delivery may be masking the underlying position. The Director of Finance and Commercial Development explained that although the CIP had improved it remained behind plan and therefore was not masking the issues. She clarified that the use of reserves and improvement in PDC dividend had however improved the position year to date and there remain a number of issues to address around CIP delivery, nurse staffing and medical locums in order to deliver the control total.

The Medical Director and Deputy Chief Executive drew attention to the Length of Stay (LOS)

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| | review which had shown there to be 114 medically fit patients in the bed base which adds to the pressures the Trust is encountering currently.<br><br>The Chair added that there will be a deep dive into the key drivers of the position and a review of the forecast out turn at the Executive/Non-Executive Time Out meeting forthcoming.<br><br>The Board approved the 2 indicators with no RAG/threshold and continue to be reported with no RAG rating. They approved the additional Workforce indicator showing AHP agency spend, and approved the changes to the capital programme.<br><br>**The Board noted the contents of the report.** |
| *BM17/09/98* | **(b) Nurse Staffing Report**<br>The Chief Nurse highlighted key areas for the Board to note in the report which highlights areas where average fill rates fall below 90% of actual versus planned.<br><br>**The Board noted the report.** |
| *BM17/09/98* | **(c) Trust Engagement Dashboard**<br>The Director of Communications and Corporate Affairs highlighted key areas for the Board to note:<br><br>**The Board noted the report.** |
| *BM17/09/98* | **(d ) Key Issues Report from August Quality Committee**<br>The Key Issues Reports were taken as read and Margaret Bamforth, Chair of Committee highlighted the following area for escalation to the Board.<br><br>- Positive developments in Quality and the transition to a Quality Assurance Committee with key concerns being managed by the Patient Safety and Clinical Effectiveness Committee is progressing.<br>- The September meeting had been cancelled and therefore no key issues report submitted.<br>- A definite trend of data coming through the Quality Committee showing better practice and action plans in place.<br><br>There are no further areas of escalation to be noted by the Board.<br><br>**The Board noted the report.** |

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| *BM17/09/98* | **(e) Key Issues Report from August and September Finance and Sustainability Committee (FSC)**<br>The Key Issues Reports were taken as read and Terry Atherton, Chair of the Finance & Sustainability Committee highlighted the following:<br><br>- The Trusts financial and cash position was discussed in detail at the private Board.<br><br>There are no further areas of escalation to be noted by the Board.<br><br>**The Board noted the report.** |
| *BM17/09/98* | **(f) Key Issues Report from July Audit Committee**<br>The Key Issues Reports were taken as read and Ian Jones, Chair of the Audit Committee highlighted the following:<br><br>- 4 reports presented by Internal Audit (MIAA)<br>- 3 reports with limited assurance - follow up procedure in place and the Audit Committee will monitor to ensure that these are resolved.<br><br>- The Chief Nurse explained that in respect of Patient Falls there are actions in place to address the identified shortcomings. A Candour improvement column will be placed on the IPR dashboard and there will be improvement programmes underneath this where required.<br><br>**The Board noted the report.** |
| *BM17/09/98* | **(g) Key Issues Report from August Strategic People Committee**<br>The Key Issues Reports were taken as read and Anita Wainwright, Chair of the Strategic People Committee the following:<br><br>- The Strategic People Committee will become the Workforce Committee<br>- Specific risk now closed in relation to the Theatres Industrial action<br>- Proposed New Risk: We are planning to ensure we have some OD support for change programmes in order to support new ways of working and mitigate difficult employee relations.<br><br>**The Board noted the report.** |
| *BM17/09/98* | **(h) Key Issues report from July Charitable Funds Committee**<br><br>The Key Issues Reports were taken as read and Jean Noel Ezingeard, Chair of the Charitable Funds Committee highlighted the following:<br><br>- The Trustee Checklist was designed to help the CFC evaluate the charity's performance at suitable intervals against the legal requirements and good practice recommendations set out in the guidance it is on green without change since its last review.<br>- There will be further discussion in the CFC in respect of restricted funds.<br>- The workplan was not able to be approved fully as there were no KPIs linked and will be |

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| | updated and referred to the November CFC meeting.<br><br>**The Board noted the report.** |
| *BM17/09/99* | **Strategic Risk and BAF**<br>- The Chief Nurse noted that there were no new strategic risks added to the Strategic Risk Register.<br>- The infection control risks were being reviewed.<br>- Most risks had not had impact on ratings as yet.<br>- Meetings taking place with Clinical Business Units (CBUs) in detail checking and getting a better knowledge of the risks.<br>- Some risks are being taken off the register and archived.<br>- Piloting an internal risk assessment tool as part of the Risk Review Group<br>- Procurement of Datix to manage risks in the future and phasing out of CIRIS.<br>- The BAF to be reviewed at the Risk Review Group which then reports into the Quality Committee and communicated to the Medical Director and CBU members.<br>- The Board agreed that the report needs to be reduced and that the risk register be circulated separately from the agenda.<br>- There will be more interrogation of the risks particularly the ones with no change.<br><br>**The Board noted the report.** |
| *BM/17/09/ 100* | **Quarterly Complaints Improvement Report**<br>The Chief Nurse highlighted key points for the Board to note:<br>- There has been a 50% reduction in the complaints backlog since April 2017 and an 82% reduction in cases over 6 months old since April 2017.<br>- The datix system is being utilised on a daily basis by CBUs to manage and keep track of complaints.<br>- The Chief Nurse is Chair of the Performance meetings held on a weekly basis<br>- There is good progress being made and PALS is functioning again.<br><br>**The Board noted the report.** |
| *BM/17/09/ 101* | **Quarterly Mortality Report**<br><br>The Medical Director/Deputy Chief Executive highlighted key points for the Board to note:<br>- A new Trust policy will be available from the end of Quarter 2 2017/18. This will include processes for the deaths which have been subjected to a case record review and the estimates of how many of those deaths were judged to be: "more likely than not to have been due to problems in care". The learning and actions taken from the reviews will be incorporated into the report.<br>- Screening reviews are currently carried out by Consultants for all deaths; this approach will be phased out.<br>- Secondary reviews are currently carried out for particular groups of patients reviewed at the Mortality Review Group. The narrative from the secondary reviews is escalated to the Trust Board. Assessment will be undertaken to ascertain if the deaths were avoidable or not.<br>- A report will be provided in respect of Focused Reviews at the next Quarter. |

| | **The Board noted the report.** |
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| *BM/17/09/ 102* | **Learning From Deaths Policy**<br><br>The Medical Director/Deputy Chief Executive highlighted key points for the Board to note:<br><br>- The Trust to adopt and publish a Learning from Deaths Policy by the end of September 2017.<br>- It will be a 6 months pilot with data published on the dashboard.<br>- Any comments related to the policy have been and will be taken through the Quality Committee.<br><br>The Chair advised of comments in Private Board around NHSI guidance – role of NEDs etc. and template of future reporting and mechanisms of this to board.<br><br>The Chair informed that all have a view and opportunity for learning once information gets published it is believed that it may be used as a story of deaths increasing in the NHS - it may be difficult to explain to the public and it could be mis-interpreted or published in a way that is not helpful.<br><br>The Board agreed that the Trust needs to be proactive with its Comms and to be upfront. The Director of Community Engagement and Corporate Affairs is to prepare a press statement that the Trust intends to publish data and to be open and transparent that this information will be published in 6 months' time. The Chair added that it is helpful to publish patient stories which illustrate the positive side but it is most important to ensure relatives of patients are well aware of the information. The Chair will continue to discuss aspects in relation to these matters with the Director of Community Engagement and Corporate Affairs.<br>**Action: Chair to discuss matters around communication with the Director of Community Engagement and Corporate Affairs.**<br><br>Jean Noel-Ezingeard added that one of the good questions that arose from a member of the public at the AMM was around our action planning and mortality and 2013 and why it has taken the Trust longer to improve compared to other Trusts; the question was answered in that mortality rates are in relation to other Trusts so if there is general national improvement as there has been it can be harder to demonstrate an individual trust's improvement.<br><br>**The Board noted the Policy.** |

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| *BM/17/09/ 103* | **GMC Revalidation Annual Report**<br>The Medical Director/Deputy Chief Executive highlighted key points for the Board to note:<br><br>- The information links back to the Integrated Performance Report (IPR) with respect to appraisals.<br>- In order to meet the GMC requirements for Revalidation, every Doctor must participate in an annual appraisal ensuring five consecutive appraisals are completed within their revalidation cycle and have acquired a 360 patient/colleague feedback report. The Trust Board is obliged to assure themselves of the medical appraisal and revalidation process through an annual report.<br>- The report provides assurances to the Board that the Trust's Medical Appraisal System and Process for monitoring the completion of Annual Appraisals to support GMC Revalidation for the Medical Workforce are robust.<br>- The Trust is in the last year of the 5 year cycle and will start its new 5 year cycle in the new year.<br>- There are robust systems in place and they are improving all the time; this is overseen through the Appraisal and Revalidation Group.<br>- The same processes will be adopted with the job planning and to make fit for purpose in a responsive way.<br>- This is the last report of this current cycle.<br><br>Jean-Noel Ezingeard pointed out that in relation to deferral there was not enough information and that it appeared a very benign action with no recommendation and questioned if this was a concern. The Medical Director and Deputy Chief Executive explained that it is indeed a neutral act usually made in the absence of enough information to make a positive recommendation and there was a robust panel with Terry Atherton, Non-Executive Director on this panel and that all elements were being addressed in detail. A Triangulation Meeting has also been set up looking at all elements around incidents, complaints and claims involving doctors as well as medical appraisal and revalidation.<br><br>**The Board noted the content of the report.** |
| *BM/17/09/ 104* | **NHSI Board Temporary Staff Self Certification Checklist**<br>The Interim Director of HR & OD highlighted key points:<br>- NHS Improvement has developed a Board self-certification checklist to ensure enhanced scrutiny on Trust performance on management of agency spend.<br>- The checklist is scrutinised by the Finance and Sustainability Committee and that a quarterly update be brought to Trust Board.<br>- The HR & OD Directorate have identified an opportunity to develop an in-house Medical Bank function as a 'proof of concept' approach before seeking additional funding for a full in-house bank function for all staff groups.<br>- NHSI have indicated that there needs to a centralised bank in place and the Trust is working with a company called Liaison around the establishment of the process for Medical Staff.<br><br>The Chair emphasised that the report did not highlight or provide assurance on the 'control |

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| | and grip' around agency spend. Trust Board acknowledged the origins of the NHSI Self-Assessment checklist template and that the original intention of the checklist was to localise a view held by NHSI that by adopting all aspects of the checklist would lead to agency spend reductions. Jean-Noel Ezingeard declared that he could not give his assurance to the current reported checklist in light of the information presented in the Integrated Performance Report which appeared contradictory.<br><br>The Trust Board concluded that they no longer considered the checklist report fit for purpose and that despite the work undertaken to date to reduce agency spend the report did not provide assurance.<br><br>The Board advised that the report be provided through Workforce Committee. The Director of Finance and Commercial Development advised that agency spend information should be presented to Trust Board.<br><br>The Director of HR & OD (Interim) was asked to review the Checklist and present a viable alternative checklist report to Finance and Sustainability Committee for approval. The new format would be reported to Trust Board every six months.<br><br>**The Board noted the report with a recommendation to review and make changes.** |
| *BM17/09/ 105* | **Theatres Industrial Action**<br>The Interim Director of HR & OD highlighted key points:<br>- The Trust entered into negotiations with Unite and a number of offers were made. On 15 September 2017 the Trust was notified by Unite that theatres staff had voted 'overwhelmingly' in favour of accepting the Trust offer and therefore the dispute was closed.<br>- A night shift staffing model will be implemented on 1 November 2017. The Trust is working in partnership with Theatre staff to improve the culture and support to ensure a positive place to work.<br>- A Working Group is being set up and the Regional Officer for Unite will be attending to support with the process.<br><br>The Chair informed that there was disappointment that the Trust was forced into industrial action but advised that it is lawful and legitimate. He commended the work put into this by the Interim Director of HR and OD and the Acting COO. It was noted that there were contingency plans in place with minimal disruption to patients. |
| *BM17/09/ 106* | **Any other business**<br><br>**i. NHSI - Application for lifting of Licence enforcement conditions - update**<br>The Director of Finance and Commercial Development updated the Board following informal feedback from NHSI relating to their meeting on 20th September to consider the lifting of enforcement conditions. NHSI while satisfied these enforcements could be lifted advised that they will now be considering the application of enforcements across the provider sector relating to A&E Performance and Cash / Borrowing. At this stage therefore the enforcement undertakings have not been lifted. It is anticipated that NHSI will consider the current |

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| | enforcement undertakings and may apply additional undertakings at their next meeting in November. |
| | **ii. Governance - to note voting privileges for Deputy/Acting/Interim positions**<br><br>- As the Chief Executive will be taking up a part-time secondment as STP Lead for Cheshire and Merseyside Sustainability and Transformation partnership with effect from 18th September the Board is requested to approve the interim acting up arrangements and to address the quoracy and voting privileges for the individuals noted in the briefing report.<br>- The Director of Finance and Commercial Development advised that as the Trust will be taking over the hosting arrangements for the STP. Meetings will be taking place with Alder Hey to arrange the transfer. The Interim Director of HR & OD is to take an action to provide an overview of Acting Arrangements for internal staff to support the release of CEO to conduct STP work via NARC. The Director of Finance and Commercial Development stated that a process of due diligence will be undertaken which will be scrutinised via the Audit Committee. This is a piece of work that needs to be done at pace and the Trust cannot be left in a position to carry any detrimental financial impact from these arrangements.<br>**Action: Interim Director of HR & OD to do provide an overview of Acting Arrangements for internal staff to support the release of CEO to conduct STP work via NARC.**<br><br>**The Board noted the report.** |
| | **iii. Other business to note**<br><br>- The Board agreed to cancel Trust Board on 25th October due to the vast amount of meetings during this period.<br>- The Board agreed that the Trust Board scheduled for 20th December will also be cancelled.<br>- The Finance and Sustainability Committee is scheduled for 19th December but will be used for a Trust Board on this date if needed to.<br>- The Director of IM&T informed that the e-prescribing business case was due for submitting for approval. He was advised that this could go through FSC in October for approval there. |
| | Next Meeting: **Wednesday 29th November 2017, Full Trust Board Meeting, Trust Conference Room.** |

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# D R A F T

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**Warrington and Halton Hospitals NHS Foundation Trust**
**Minutes of Extra Ordinary Board of Directors meeting held Friday 6 October 2017, 9:00am-10:10am**

| **Present** | |
|---|---|
| Steve McGuirk (SMcG) | Chairman |
| Mel Pickup (MP) | Chief Executive |
| Margaret Bamforth (MB) | Non-Executive Director |
| Andrea McGee (AMcG) | Director of Finance and Commercial Development |
| Simon Constable (SC) | Deputy Chief Executive - Interim Acting Chief Executive |
| Alex Crowe (AC) | Deputy Medical Director - Interim Acting Medical Director |
| Ian Jones (IJ) | Non-Executive Director / Senior Independent Director |
| Jan Ross (JR) | Acting Chief Operating Officer |
| Kimberley Salmon-Jamieson (KSJ) | Chief Nurse |
| Anita Wainwright (AW) | Non-Executive Director |
| **In Attendance** | |
| Michelle Cloney (MC) | Interim Director of HR + OD |
| Lucy Gardner (LC) | Director of Transformation |
| Jason DaCosta (JDaC) | Director of IM&T |
| **Apologies** | |
| Terry Atherton (TA) | Non-Executive Director |
| Pat McLaren (PMcL) | Director of Community Engagement + Corporate Affairs |
| Jean-Noel Ezingeard (JNE) | Non-Executive Director |

| *Agenda Ref PBM/17/10/* | |
|---|---|
| | **Spinal Services** |
| | Following the CEO's report to the Trust Board meeting on 27 September, the Acting Chief Executive provided a current position statement relating to Spinal Services.<br><br>The Acting CEO presented a series of 8 slides which gave an overview of the four index cases leading up to the service suspension, as well as the subsequent events and action taken by Warrington CCG.<br><br>The rationale for the action taken by the Trust was explained. It was acknowledged that the Trust had to proceed at "risk" in seeing the new patients and follow-ups in spite of the service suspension notice issued by the CCG because it was considered clinically unsafe to do otherwise.<br><br>The Board supported this approach in putting our responsibility to the patients first. It was noted that following a statement of case by the Trust, the CCG had rescinded part of the original suspension notice on two occasions. AM said the Trust would be seeking legal advice on a number of matters arising from the CCG action and the Contracts Team had been collating a list of questions. There was discussion about the future of relationships with Warrington CCG that were being tested by this event as well as the potential long term future of Spinal Surgery at WHH. SC said that we were being a full and active partner in the development of a single Spinal Service for Cheshire and Merseyside in a likely hub and spoke arrangement |

The agenda and minutes of this meeting may be made available to public and persons outside of Warrington and Halton Hospitals NHS Foundation Trust as part of the Trust's compliance with the Freedom of Information Act 2000.

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**Warrington and Halton Hospitals NHS Foundation Trust**
**Minutes of the Extraordinary Trust Board held on 25th October 2017**
**Held at Warrington Hospital, Trust Conference Room**

| **Present** | |
|---|---|
| Steve McGuirk (SMcG) | Chairman |
| Terry Atherton (TA) | Non-Executive Director |
| Ian Jones (IJ) | Non-Executive Director / Senior Independent Director |
| Jean-Noel Ezingeard | Non-Executive Director |
| Mel Pickup (MP) | Chief Executive |
| Andrea McGee (AMcG) | Director of Finance and Commercial Development |
| Simon Constable (SC) | Medical Director + Deputy Chief Executive |
| Jan Ross (JR) | Acting Chief Operating Officer |
| | |
| **In Attendance** | |
| Lucy Gardner (LC) | Director of Transformation |
| Jason DaCosta (JDaC) | Director of IM&T |
| Michelle Cloney (MC) | Director of HR + OD |
| Pat McLaren (PMcL) | Director of Community Engagement + Corporate Affairs |
| | |
| **Observing** | |
| Norman Holding | Lead Governor |
| | |
| **Apologies** | |
| Margaret Bamforth (MB) | Non-Executive Director |
| Anita Wainwright (AW) | Non-Executive Director |
| Kimberley Salmon-Jamieson (KSJ) | Chief Nurse |
| Alex Crowe | Deputy Medical Director/Acting Medical Director |

| *Agenda Ref* | |
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| BM/17/10/108 | The Chairman welcomed all to this extra-ordinary Board meeting<br>There were no declarations of interest in any of the items<br>Apologies noted as above |
| **BM/17/10/109** | **Business Case for e-Prescribing**<br><br>The Director of IM&T introduced the clinical team who made a presentation on e-prescribing (inpatient prescribing and medicines administration IPPMA) in support of the Business Case. By introduction, TA noted that FSC had received this presentation at the previous week's meeting where the Committee felt that while more work and clarification was needed, it was supportive pending other governance routes for approval of business cases.<br>The Trust has an opportunity to access central funding to deploy Lorenzo e-prescribing software. Benefits include increased patient safety and lower costs through reducing |

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| | transcription errors and forcing adherence to agreed medication formulary. JDC noted that the Trust did have this opportunity last year but we had deferred given the priority of fully embedding Lorenzo across the organisation. This second opportunity to access central funding closes at end March 18, another Trust scheduled for the rollout has dropped out. Service charges for Lorenzo, therefore ePMA for years 15-16 to 20-21 will be met by DH and paid directly to DXC. Charges will transfer to the Trust at 2021-22.<br><br>IJ questioned about ease of training, induction etc. Dr Roy Bhati advised that since we already use this process for TTOs there should be minimal impact. He noted that there is no real solution for locum medics but will include in local induction. For nurses it will be a matter of hours to train rather than days, Pharmacy impact will be minimal.<br><br>JDC described the deployment using existing resources and the 'soft go live' in selected areas which will fulfil obligations by 31st March 2018. He noted that the Trust will be able to capitalise the asset across a maximum two year time frame and that costs presented are budgeted, the actual costs will be clearer following soft go live and can then be pursued through capital programme.<br><br>AMcG advised that the two £250K development costs will come from the existing capital allocation for IM&T which have been ring-fenced. She noted that for 2017-18 the team is looking technically at the costs to examine if that funding should be capital and that an asset under construction won't be depreciated until it is complete. She confirmed that she believes that the budget presented is a worst case scenario.<br><br>The Chairman observed that there are clearly significant patient safety benefits as well as financial benefits to be realised in this initiative but impossible to quantify at this stage. TA noted that we have delivered the cash-releasing benefits from Lorenzo so the track record is positive. He also noted that in the wider STP system other partners did have different technologies and that we don't expect a resolution around harmonisation of IM&T across the patch in the near future.<br><br>**The Trust Board approved the Business Case and the Trust's engagement with DXC through the NHS Digital centrally funded contract.** |
| BM/17/10/110 | **Financial Position and Forecasting Year End**<br><br>The Director of Finance and Commercial Development gave a presentation following up from an in-depth session at the Board timeout on 6th October 2017 where it was agreed to: Monitor the forecast position monthly at Trust Board, Continue to forecast delivery of the control total, Maintain regular correspondence with NHSI, Review control total at the end of Q3, Continue with performance management and Review all actions on the NHS Checklist.<br><br>In the summary position at M6 AMcG noted that the STP for Q2 was achieved but that everything had been put in to get to that position. She advised that in the Q3 position the forecast outturn at M6 is £15.37m deficit which is a variance of £11.72m – based on the |

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| | assumption that the full STF for the year is NOT received. She advised that Pay is currently £7.6m off plan and that each time forecasts are set with the CBUs they worsen each time and this is where the targeted work is taking place. Total variance from forecast is £3.78m between M3 and M6.<br><br>TA commented that as Warrington CCG is in self-imposed turnaround, and that there is a history of the Trust being challenged around payments for activity he fully expects that these efforts will be intensified this year.<br><br>AMcG noted that the cumulative pay position is £4m overspent resulting in a net overspend of £5.2m after taking out the use of current and future reserves. MP questioned why the pay profile appeared that less staff had been planned for towards the end of the year – AMcG noted that this is being looked into. JR advised that the biggest issue is vacancies yet people need to take leave over the summer. In addition there were more escalation beds open as the situation is mirrored in the community domiciliary care is not always available.<br><br>MP advised that in common with other hospitals, on any given day, there are emerging problems with patients requiring one to one care – ie if this is the emerging situation then the Chief Nurse should bring forward a business case for more nurses. MC advised that processes had been really tightened up and a more robust Establishment Control Panel is now ensuring that posts can only be filled to funded positions.<br><br>The Chairman stated that by M6 of the financial year we should be confident in our forecast and asked that the DoF+CD leads an urgent review around pay, AMcG confirmed that this is already underway.<br><br>AMcG observed that the forecast is not reliable enough to be able to make an accurate prediction on when we need to approach NHSI for cash support, adding that the plan was always going to be extremely pressured and that the control total was going to be much more challenging. She concluded that there will be a really clear narrative around the Trust's position, describing where some elements, such as industrial action, spinal services suspension, were not anticipated.<br><br>The Chairman summarised that by the next Board meeting in November 2017 a comprehensive plan and forecast is required so that the request for cash support is accurate. He requested Executive colleagues to support the CBUs to with forecasting and tightening up on processes. He noted that collectively Board colleagues are responsible for this and appreciates the actions that have been and are being taken to deal with this.<br>He asked that Board be clear about drift from plan, the reasons why and what actions are being taken. He noted that the Trust is not out of control and that there are a number of factors that are common to the overall health economy.<br><br>**The Board noted the presentation contents, risks and actions and noted the submission of a planned forecast outturn at Q2 and a forecast review at Q3.** |

The agenda and minutes of this meeting may be made available to public and persons outside of Warrington and Halton Hospitals NHS Foundation Trust as part of the Trust's compliance with the Freedom of Information Act 2000.

Warrington and Halton Hospitals
NHS Foundation Trust

## BOARD OF DIRECTORS ACTION LOG

| AGENDA REFERENCE: | BM/17/11/113 | SUBJECT: | TRUST BOARD ACTION LOG | DATE OF MEETING | 29th November 2017 |
|---|---|---|---|---|---|

### 1. ACTIONS ON AGENDA

| Minute ref | Meeting date | Item | Action | Owner | Due Date | Completed date | Progress | RAG Status |
|---|---|---|---|---|---|---|---|---|
| BM/17/09/106 | 27 September 2017 | Governance – to note voting privileges for Deputy/Acting/Interim positions | An overview of Acting Arrangements for internal staff to support the release of CEO to conduct STP work via NARC | Director of HR & OD | 29 November 2017 | | | |

### 2. ACTIONS COMPLETED AND CLOSED SINCE LAST MEETING

| Minute ref | Meeting date | Item | Action | Owner | Due Date | Completed date | Progress | RAG Status |
|---|---|---|---|---|---|---|---|---|
| BM/17/09/96 | 27 September 2017 | Trust Operational Board report to Chair | Secretary to Board to ensure TOB minutes are circulated on a monthly basis to Non-Executives | Secretary to Board | ASAP | | Ratified minutes to follow after each TOB meeting. | |

### ROLLING TRACKER OF OUTSTANDING ACTIONS

| Minute ref | Meeting date | Item | Action | Owner | Due Date | Completed date | Progress | RAG Status |
|---|---|---|---|---|---|---|---|---|
| BM/17/01/08 | 25 January 2017 | Integrated Dashboard - Mortality | Follow-up workshop Learning through Transparency with Board and Governors | Medical Director | 6 October 2017 (see progress) | | Added to Joint Exec/NED timeout agenda in October 20.9.17. Postponed to 2018. Replaced with Quality Strategy day on 24 October 2017. | |
| BM/17/04/49 | 26 April 2017 | Proposal to change Trust Name | Process to commence to incorporate 'teaching' element into its Brand. | Director of Communications + Corporate Affairs | ASAP | | 24.5.17. This process has commenced. 20.9.17. Shared at Annual Members meeting in September. | |
| BM/17/01/12 | 25 January 2017 | Charitable Funds Commission | Board to receive refreshed strategy to maximise income streams as workshop | Director of Community Engagement | 25 October 2017 | 31 January 2017 | 7.7.2017. Deferred to Part 1 Board on 26 July 2017. 26.7.17. Deferred to Part 1 Board 25 October | |
| BM/17/09/102 | 27 September 2017 | Learning from Deaths Policy | Transparent with the data and to have the | Director of Communications | 29 November 2017 | | | |

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| | | | Comms in place prior to document being published | + Corporate Affairs | | | | |

**RAG Key**

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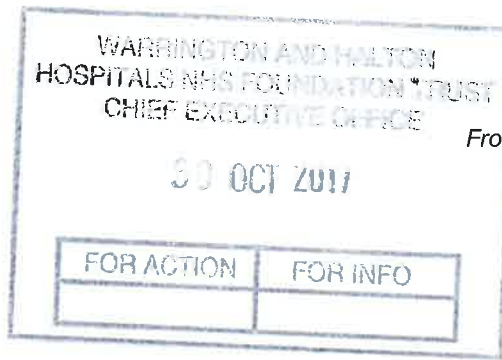
|---|---|---|---|
| | Action overdue or no update provided | | Update provided and action complete |
| | Update provided but action incomplete | | |

Department of Health




*From the Rt Hon Jeremy Hunt MP*
*Secretary of State for Health*

*Richmond House*
*79 Whitehall*
*London*
*SW1A 2NS*

*020 7210 4850*

Steve McGuirk, Chairman
Melany Pickup, Chief Executive
Warrington and Halton Hospitals NHS Foundation Trust
Warrington Hospital Lovely Lane
Warrington WA5 1QG

24 OCT 2017

Dear Steve and Melany,

I am writing to congratulate you and your team on the exceptional improvement at Warrington and Halton Hospitals NHS Foundation Trust, that has come together to mean that you improved the proportion of cancer patients receiving definitive treatment within 62 days of referral in the period June 2017 to August 2017 compared with the March 2017 to May 2017.

Moving from 74.2% to 81.4% is an achievement to be proud of. In this sense, the trust is a real example to others, demonstrating how to improve performance in a short space of time and ensure that your patients get the care that they deserve. Whilst it is encouraging that you have improved in the latest published data on cancer 62 day performance, I note that overall there is room for further and continued improvement during 2017/18 in respect of your CQC ratings.

From visiting organisations throughout the country, I know that the immense amount of work that will have been behind this outcome cannot be underestimated. Improvement like this are impressive and testament to the hard work and dedication of the trust's staff. Please do pass on my congratulations to all those who work at the trust; the service they give makes a real difference to the lives of many of the area's sickest and most vulnerable patients.

I hope that you will share your learning and experiences with other trusts as the whole NHS strives to improve its cancer service over the course of the next year. Again, please pass on my personal congratulations and thanks to everyone who has made this happen.

Yours ever – and thanks for a great visit!

Jeremy

**JEREMY HUNT**

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**BOARD OF DIRECTORS**

| **AGENDA REFERENCE:** | **BM/17/11/117 i** |
|---|---|
| **SUBJECT:** | **Integrated Performance Dashboard** |
| **DATE OF MEETING:** | 29th November 2017 |
| **ACTION REQUIRED** | **For Discussion** |
| **AUTHOR(S):** | Marie Garnett – Head of Contracts and Performance |
| **EXECUTIVE DIRECTOR SPONSOR:** | Kimberley Salmon-Jamieson, Chief Nurse<br>Alex Crowe – Medical Director (Acting)<br>Jan Ross – Chief Operating Officer (interim)<br>Michelle Cloney – Director of Human Resources & Organisational Development<br>Andrea McGee - Director of Finance & Commercial Development<br>Lucy Gardner – Director of Transformation |
| | |
| **LINK TO STRATEGIC OBJECTIVES:** | All |
| **LINK TO BOARD ASSURANCE FRAMEWORK (BAF):** | All |
| | |
| | |
| | |
| **STRATEGIC CONTEXT** | To provide the Trust Board with assurance in relation to performance in the following areas:<br>• Quality<br>• Access and Performance<br>• Workforce<br>• Finance Sustainability |
| **EXECUTIVE SUMMARY** (KEY ISSUES): | At the end of month 7 the Trust has a financial deficit of £6.1m which is £2m worse than plan. This poses a risk to the Trust's forecast outturn and cash position. Remedial action plans are required to improve the financial position. The Trust is meeting with NHSI to discuss the potential of additional cash support.<br><br>The Trust has seen improvements in the position of several quality indicators which have moved from Red to Amber (safety thermometer and healthcare |

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NHS Warrington and Halton Hospitals NHS Foundation Trust

<table>
<tr><td rowspan="1"></td><td colspan="2">acquired infections) or Red to Green (duty of candour and friends and family). However a number of indicators have moved from Green to Red (safer surgery, total falls/harm and pressure ulcers).<br><br>Access and Performance Red indicators have increased from 8 in September to 9 in October. The 8 indicators that were Red in September have remained Red in October. The 1 additional Red indicator for October relates to cancelled operations (for non- clinical reasons). One patient was not offered a readmission date within 28 days. This has resulted in the indicator moving from Green to Red.<br><br>Workforce Red indicators have increased in month from 3 in September to 6 in October. The 3 indicators that were Red in September have remained Red in October. The 3 additional Red indicators for October are Nursing agency spend, AHP agency Spend and the Average Length of Service for top 10 agency workers. All 3 indicators have moved from Green to Red in month.</td></tr>
<tr><td>RECOMMENDATION:</td><td colspan="2">he Trust Board is asked to:<br>1. Support the request to add two additional indicators to this Integrated Performance Report (IPR) - Readmissions within 28 days and Average Length of Stay (Elective and Non-Elective).<br>2. Note the amendments to the NHSI SOF.<br>3. Note the contents of this report.</td></tr>
<tr><td rowspan="4">PREVIOUSLY CONSIDERED BY:</td><td>Committee</td><td>Choose an item.</td></tr>
<tr><td>Agenda Ref.</td><td></td></tr>
<tr><td>Date of meeting</td><td></td></tr>
<tr><td>Summary of Outcome</td><td></td></tr>
<tr><td>FREEDOM OF INFORMATION STATUS (FOIA):</td><td colspan="2">Choose an item.</td></tr>
<tr><td>FOIA EXEMPTIONS APPLIED:<br>(if relevant)</td><td colspan="2">Choose an item.</td></tr>
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| SUBJECT | Integrated Performance Dashboard | AGENDA REF: | |
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## 1. BACKGROUND/CONTEXT

The RAG rating for all 64 indicators from April to October 2017 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 KPI's across the following areas:

- Quality
- Access and Performance
- Workforce
- Finance Sustainability

## 2. KEY ELEMENTS

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

- Red -24 in September increased to 30 in October.
- Amber – 7 in September decreased to 6 in October.
- Green – 31 in September decreased to 26 in October.

**Quality**

**Quality KPIs**
There are 9 Red indicators in October the same number as September; however there has been RAG movement between indicators as follows:

Of the 9 indicators that were Red in September 6 have remained Red in October:

- VTE Assessment – The Trust achieved 92.51% against a target of 95%, a slight decrease from September's performance of 92.90%.
- Nice Compliance – The Trust achieved 63.45% against a target of 75%, a slight increase from September's performance of 64.37%.
- Complaints – The Trust is currently behind the agreed improvement trajectory and has plans in place to bring this back in line.
- Friends & Family Test (A&E and UCC) – The Trust achieved 79% against a target of 87% a decrease from September's performance of 84%.

- Mixed Sex Accommodation Breach – there were 15 Mixed Sex Accommodation Breaches in October a decrease from 16 in September. There is a national threshold of zero tolerance for this indicator.
- Healthcare Acquired Infections – the Trust reported 1 case of MRSA in July 2017 against a national threshold of zero tolerance, therefore this indicator will remain Red for the remainder of the year.

The 3 additional Red indicators for October are:

- Safer Surgery – the Trust achieved 99.92% against a target of 100%, therefore this indicator moved from Green to Red.
- Total Falls & Harms Levels – the Trust has not achieved the 10% reduction in falls for this month with 76 falls reported in October. There has been 1 moderate harm fall during the month, therefore this indicator has moved from Green to Red.
- Pressure Ulcers – There were 7 grade 2 pressure ulcers reported during October 2017, therefore this indicator moved from Green to Red.

1 Quality indicator has moved from Red to Amber:

- Safety Thermometer – 97.5% of adult patients and 92.30% of children received harm free care in month, an improvement on September's position.

2 Quality indicators have moved from Red to Green:

- Duty of Candour – The Trust achieved 100% compliance for October.
- Friends & Family Test – Inpatient & Day Cases – the Trust achieved 95% for October against a target of 95%.

The Chief Nurse has requested that two additional indicators are added to this Integrated Performance Report as follows:

1. Readmissions within 28 days
2. Average Length of Stay (Elective and Non-Elective)

**<u>Access and Performance KPIs</u>**

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

The 7 indicators that were Red in September have remained Red in October as follows:

- A&E Waiting Times 4 hour national target – the Trust achieved 89.47% in October, a decrease from 90.93% in September.

- A&E STP Trajectory – the Trust fell slightly short of the STP Improvement Trajectory in October with performance at 89.74% against a target of 90.22%.
- Cancer 62 Days Urgent – the Trust achieved 84.51% against a target of 85%.
- Ambulance Handovers 30>60 minutes – the Trust seen a slight increase in the number of patients experiencing a delayed handover in month rising from 189 in September to 192 in October.
- Ambulance Handover at 60 minutes or more – the Trust seen a slight increase in the number of patients experiencing a delayed handover in month rising from 50 in September to 53 in October.
- Discharge Summaries % sent within 24 hours – the Trust failed to achieve the target of 95% of discharge summaries within 24 hours for quarters 1 and 2 resulting in a penalty of £15k per quarter. The Trust has achieved 89.24% in October. Whilst this is an improvement from 85.29% in September, a significant improvement in performance is required for November and December if the Trust is to deliver the quarter 3 target.
- Cancelled operations on the day (for non-clinical reasons) – the Trust has a zero tolerance approach to breaches. There were 13 reported breaches in month compared to 31 in September.

The 1 additional Red indicator for October is as follows:

- Cancelled operations on the day (for non-clinical reasons) not offered a readmission date within 28 days – the Trust has a zero tolerance approach to breaches. There was 1 reported breach in October. This will result in a penalty from Commissioners for the total cost of the episode of care.

**People**

**Workforce KPIs**
There are 6 indicators rated Red in October, an increase of 3 in month.

The 3 red indicators that were rated Red in September have remained Red in October as follows:

- Recruitment – average time taken to recruit reamains unchanged for October at 75.5 days against a target of 65 days.
- Non-Contracted Pay – remains unchanged for October at 12.26%
- Average cost of top 10 agency workers – in October the average cost of top 10 agency workers has increased from £22k in September to £28k in October.

The 3 additional Red indicators for October are:

- Agency Nurse Spend – has increased from £193k in October 2016 to £197k in October 2017, therefore this indicator has moved from Green to Red.
- Agency AHP Spend – has increased from £75k in October 2016 to £98k in October 2017, therefore this indicator moves from Green to Red.
- Average length of service for top 10 agency workers – has increased from 16 months in September to 21 months in October.

**Sustainability**

**Finance Sustainability KPIs**

There are 7 Finance Sustainability indicators rated red in October an increase of 1 in month.

The 6 indicators rated Red in September have remained Red in October as follows:

- Financial Position – The cumulative deficit of £6.1m is £2.0m worse than the planned deficit of £4.1m.
- Cash Balance – cash continues to be a challenge and is under daily monitoring and management. The balance at the end of October was £1.2m. The Trust is meeting with NHSI to discuss the potential requirement for additional cash support.
- Capital Programme – cumulative capital spend is £1.2m below planned capital spend of £4.5m.
- Better Payment Practice Code – continues to underperform with year to date performance of 35% which is 60% below the national standard of 95%, this is due to the challenging cash balance.
- Fines and Penalties – it is estimated that fines and penalties totalling £13k were in incurred in October due to non-achievement of the 95% Discharge Summaries target and non-achievement of CQUIN.
- Cost Improvement Programme Plans In Progress - £5.5m below the target of £10.5m.

The 1 additional Red indicator for October is as follows:

- Cost Improvement Programme Performance To Date - £0.6m below month 7 CIP target of £4.7m. This indicator has moved from Amber to Red in month.

The Income Statement, Statement of Financial Position and Cash flow, as presented at the November Finance and Sustainability Committee, are attached in Appendix 3. This highlights the challenge to delivery of the control total of £3.7m. The forecast is under review with significant risks to delivery. A number of actions are being taken to address the risk including mandated support in 6 of the CBUs. Should the actions not be sufficient to assure recovery, the Trust will need to consider a revision to the forecast in line with NHSI guidance.

**Single Oversight Framework**

The Single Oversight Framework (SOF) was published by NHS Improvement (NHSI) in September 2016. The purpose of the SOF is to help NHSI identify where NHS Trusts and NHS Foundation Trusts may benefit from, or require improvement support to meet the SOF standards in a safe and sustainable way. In response to national developments, NHSI identified a small number of updates and amendments that were required to SOF information and indicators.

In August 2017 NHSI went out to consultation on the proposed amendments. During that period the Trust's Contracts and Performance Team met with members of the Executive Team to understand the proposed changes and any impact they would have on the Trust.

The updated SOF was published in November 2017 and the following changes have come in to effect during quarter 3:

**Quality**

*Additional Indicators to be measured:*

- E. coli bacteraemia bloodstream infection (BSI)
- Meticillin-sensitive staphylococcus aureus (MSSA)

Both of these indicators are already measured as part of this Integrated Performance Report (IPR).

*Removal of Indicator:*

- Hospital Standardised Mortality Ratio – Weekend (DFI)

**Access and Performance**

*Additional Indicator to be measured:*

- Dementia assessment and referral standards (Acute) - this is an existing indicator on the Quality Committee Dashboard.

*Removal of indicator:*

- Emergency readmissions (Acute) – Whilst this indicator no longer forms part of the SOF, the Chief Nurse has requested this indicator be added to the IPR to ensure the Trust continues to measures performance.

*Amended in the SOF:*

- For operational performance standards NHSI will use performance against the absolute national standards as a trigger, not performance against STF trajectories.

**Workforce**
There are no changes to workforce indicators.

**Finance and Sustainability**

*Added to the SOF:*

- The SOF now makes reference to the new Use of Resources (UoR) framework, with explanation of how UoR assessments will be used under the SOF.
- NHSI will use the UoR report/rating alongside the finance score to inform our consideration of the provider's support needs.

*Amended in the SOF:*

- NHSI have replaced the existing term 'finance and use of resources score' with 'finance score' to make a clear distinction between this and the new UoR ratings. However there has been no change to any of the metrics or underlying calculations.

In addition to the above there are two further amendments to the SOF as follows:

**Leadership**

*Added to the SOF:*

- Reference to NHSI and CQC's new, fully joint well-led framework and guidance on how providers should carry out developmental reviews of their leadership and governance as part of their own continuous improvement.

**Strategic Change:**

*Added to the SOF:*

- NHSI will review the assessment of system-wide leadership in relevant sustainability and transformation partnership (STP) ratings when considering providers' performance under this theme.

## 3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

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

## 4. ASSURANCE COMMITTEE

The following committees provide assurance to the Trust Board:

- Finance and Sustainability Committee
- Audit Committee
- Quality Committee
- Trust Operational Board

## 5. RECOMMENDATIONS

The Trust Board is asked to:

1. Support the request to add two additional indicators to this Integrated Performance Report (IPR) - Readmissions within 28 days and Average Length of Stay (Elective and Non-Elective).
2. Note the amendments to the NHSI SOF.
3. Note the contents of this report.

# Appendix 1 – KPI RAG Rating April 2017 – March 2018

| | KPI | Apr 17 | May 17 | Jun 17 | Jul 17 | Aug 17 | Sep 17 | Oct 17 | Nov 17 | Dec 17 | Jan 18 | Feb 18 | Mar 18 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | QUALITY | | | | | | | | | | | | |
| 1 | Incidents | | | | | | | | | | | | |
| 2 | Duty of Candour | | | | | | | | | | | | |
| 3 | Safety Thermometer | | | | | | | | | | | | |
| 4 | Healthcare Acquired Infections | | | | | | | | | | | | |
| 5 | VTE Assessment | | | | | | | | | | | | |
| 6 | Safer Surgery | | | | | | | | | | | | |
| 7 | CQUIN Sepsis AED Screening | | | | | | | | | | | | |
| 8 | CQUIN Sepsis Inpatient Screening | | | | | | | | | | | | |
| 9 | CQUIN Sepsis AED Antibiotics | | | | | | | | | | | | |
| 10 | CQUIN Sepsis Inpatient Antibiotics | | | | | | | | | | | | |
| 11 | CQUIN Sepsis Antibiotic Review | | | | | | | | | | | | |
| 12 | Total Falls & Harm Levels | | | | | | | | | | | | |
| 13 | Pressure Ulcers | | | | | | | | | | | | |
| 14 | Medication Safety | | | | | | | | | | | | |
| 15 | Staffing – Average Fill Rate | | | | | | | | | | | | |
| 16 | Staffing – Care Hours Per Patient Day | | | | | | | | | | | | |
| 17 | Mortality ratio - HSMR | | | | | | | | | | | | |
| 18 | Mortality ratio - SHMI | | | | | | | | | | | | |
| 19 | Total Deaths | | | | | | | | | | | | |
| 20 | NICE Compliance | | | | | | | | | | | | |
| 21 | Complaints | | | | | | | | | | | | |
| 22 | Friends & Family – Inpatients & Day cases | | | | | | | | | | | | |
| 23 | Friends & Family – A&E and UCC | | | | | | | | | | | | |
| 24 | Mixed Sex Accommodation Breaches | | | | | | | | | | | | |
| | ACCESS & PERFORMANCE | | | | | | | | | | | | |
| 25 | Diagnostic Waiting Times 6 Weeks | | | | | | | | | | | | |
| 26 | RTT - Open Pathways | | | | | | | | | | | | |
| 27 | RTT – Number Of Patients Waiting 52+ Weeks | | | | | | | | | | | | |
| 28 | A&E Waiting Times – National Target | | | | | | | | | | | | |

# Appendix 1 – KPI RAG Rating April 2017 – March 2018

| 29 | A&E Waiting Times – STP Trajectory |
|---|---|
| 30 | Cancer 14 Days |
| 31 | Breast Symptoms 14 Days |
| 32 | Cancer 31 Days First Treatment |
| 33 | Cancer 31 Days Subsequent Surgery |
| 34 | Cancer 31 Days Subsequent Drug |
| 35 | Cancer 62 Days Urgent |
| 36 | Cancer 62 Days Screening |
| 37 | Ambulance Handovers 30 to <60 minutes |
| 38 | Ambulance Handovers at 60 minutes or more |
| 39 | Discharge Summaries - % sent within 24hrs |
| 40 | Discharge Summaries – Number NOT sent within 7 days |
| 41 | Cancelled Operations on the day for a non-clinical reason |
| 42 | Cancelled Operations on the day for a non-clinical reason – Not offered a date for readmission within 28 days of the cancellation |
| | WORKFORCE |
| 43 | Sickness Absence |
| 44 | Return to Work |
| 45 | Recruitment |
| 46 | Turnover |
| 47 | Non Contracted Pay |
| 48 | Agency Nurse Spend |
| 49 | Agency Medical Spend |
| 50 | Agency AHP Spend |
| 51 | Essential Training |
| 52 | Clinical Training |
| 53 | PDR |
| 54 | Average cost of the top 10 highest cost Agency Workers |
| 55 | Average length of service of the top 10 longest serving agency workers |
| | FINANCE |
| 56 | Financial Position |
| 57 | Cash Balance |

## Appendix 1 – KPI RAG Rating April 2017 – March 2018

| | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 58 | Capital Programme | | | | | | | | | | | | |
| 59 | Better Payment Practice Code | | | | | | | | | | | | |
| 60 | Use of Resources Rating | | | | | | | | | | | | |
| 61 | Fines and Penalties | | | | | | | | | | | | |
| 62 | Agency Spending | | | | | | | | | | | | |
| 63 | Cost Improvement Programme – Performance to date | | | | | | | | | | | | |
| 64 | Cost Improvement Programme – Plans in Progress | | | | | | | | | | | | |

Warrington and Halton Hospitals NHS
NHS Foundation Trust

# Integrated Dashboard - October 2017

Appendix 2

Key Points/Actions

## Quality Improvement



At the time of writing this report there are 888 open incidents that require review and sign off. Acute Care Services have 562 open incidents, SWC have 215, the remaining incidents are for Corporate or External organisations. Duty of Candour for Serious Incidents has improved and we can see 100% compliance across the CBU's. We do not have any data submitted for the maternity safety thermometers. We have seen an increase regarding hospital acquired infections, specifically relating to C-diff. Actions to improve VTE compliance are still in place, with daily monitoring. The Trust has remains on track with the complaints improvement trajectory.

## Access & Performance



In October, 8 out of the 18 indicators are RAG rated as Red these are mainly related to the achievement of the four hour standard and the associated targets of ambulance turn around times. We continue to fail the target of discharge summaries being sent within 24 hours of a patients discharge, however do achieve the second element of the target, sending in 7 days. We have pulled together an action plan to support improvements with cancelled operations, and now have an interim support manager within theatres.

## Workforce



The Trust target for sickness absence was achieved in month. There is work still to be done in achieving the Return to Work Interview compliance target but this is achievable and support is in place from HR. The Trust target for turnover was achieved in month. There is work still to be done in achieving the PDR compliance rates and managers must place real focus on this to achieve the required 85%. Both clinical divisions have increased their PDR compliance rates in month while Corporate Division has reduced. Compliance for Essential and Clinical Training were above target. There needs to be a continued focus on reducing agency spend. It is still above target but is reducing. Plans are in relation to the high cost and longest serving agency workers.

## Finance



In the month the Trust recorded a deficit of £1.6m, assuming no receipt of STF monies of £0.7m. This increases the year to date deficit to £6.1m, which is £2.0m worse than the planned deficit. Year to date income is £0.2m above plan, expenses are £2.5m above plan and non-operating expenses are £0.3m below plan. CIP remains at risk. Remedial action plans are required to improve the financial position. The Trust held a cash balance of £1.2m at the end of the month in line with the loan requirement. The current position is putting additional strain on cash. The Trust is meeting with NHSI to discuss the potential for additional cash support. The year to date performance against the Better Payment Practice Code is 35% which is 60% lower than the 95% target due to the challenging cash position. The Trust has recorded a Use of Resources Rating of 3 which is in line with the planned rating.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

# Integrated Dashboard - October 2017

## Quality Improvement - Trust Position

| Description | Aggregate Position | Trend | Variation |
|---|---|---|---|

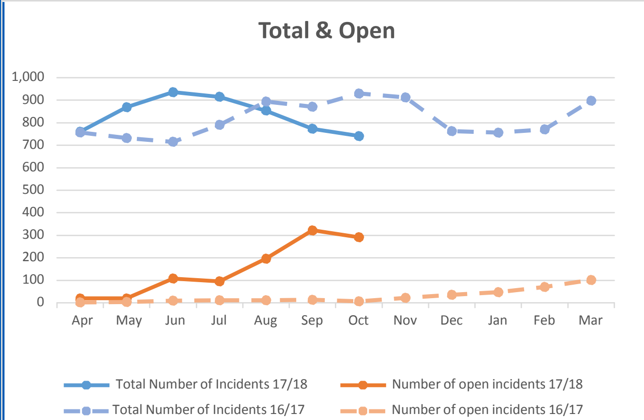
### Patient Safety

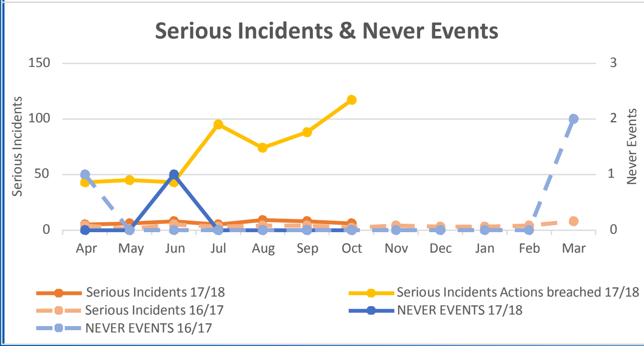
**Incidents**

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

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

The target for Never Events is a zero tolerance. During October 2017, the number of Serious Incident actions that are overdue within plans is 117, this has increased from last month.



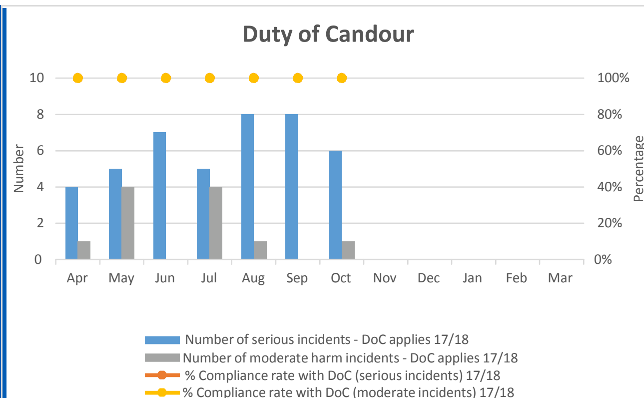

A workshop has been planned in November chaired by the Deputy Director of Governance to scrutinise and review all open SI actions with the services. At the time of writing this report there are 888 open incidents that require review and sign off. Acute Care Services have 562 open incidents, SWC have 215, the remaining incidents are for Corporate or External organisations. This has improved in the last 2 weeks following an improvement plan being put in place; however it is recommended now given the backlog that the metric monitored at Board changes to the following. Green: open incidents within timeframe i.e. 20 working days, Amber; open incidents outside of timeframe (within 40 working days); Red: open incidents outside of timeframe (over 40 working days old). The Trust would be 'red' not' green' on incidents when applying this metric

**Duty of Candour**

Red: <100%
Green: 100%

Every healthcare professional must be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress. Duty of Candour is where we contact the patient or their family to advise of the incident; this has to be done within 10 working days.

Duty of Candour has to be completed within 10 working days.




Duty of Candour remains a focus of work and improvement. From week commencing 19/6, this has been monitored at the weekly Serious Incident Meeting and weekly in a report sent to all Board members. Of the 6 Serious Incidents where Duty of Candour applied in October; 2 for Acute Care Services, 4 for Surgery and Women & Children's and 0 for Corporate Services, we are 100%. The Divisions now receive a breakdown by CBU of DoC performance and have been requested to review and improve compliance rates.

# Integrated Dashboard - October 2017

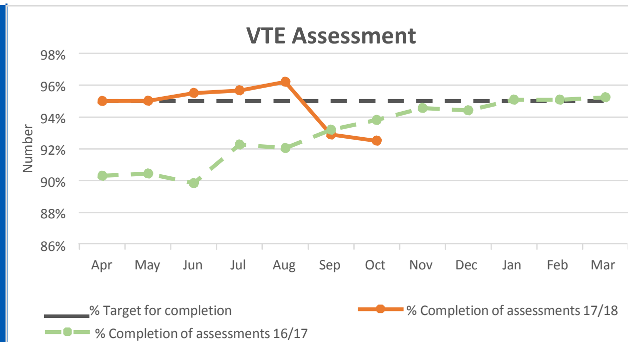
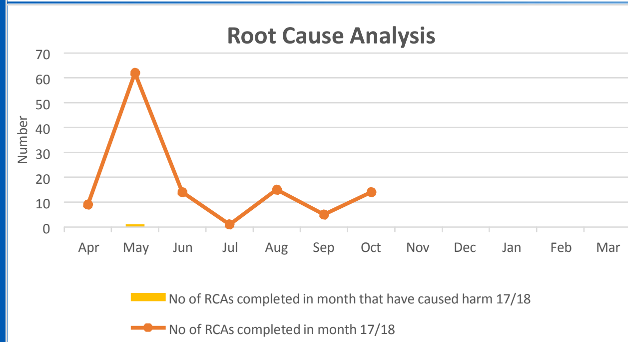
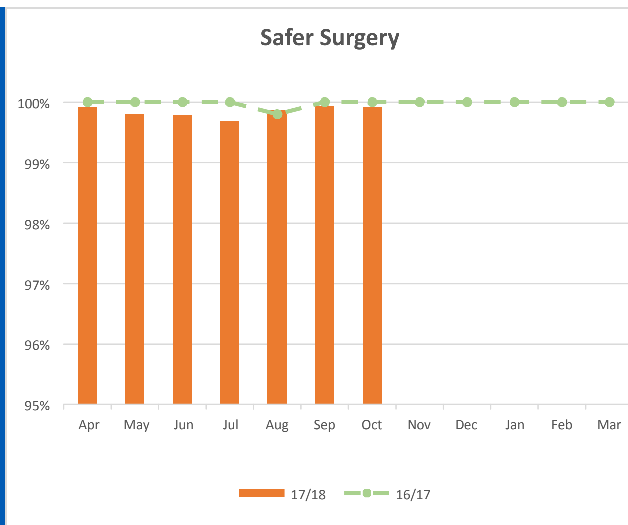
## Quality Improvement - Trust Position

| | Description | Aggregate Position | Trend | Variation |
|---|---|---|---|---|
| Safety Thermometer<br><br>Red: Less than 90%<br>Amber: 90% to 94%<br>Green: 95% or more | Measures % of adult patients who received "harm free care" defined by the absence of pressure ulcers, falls, catheter-acquired UTI's and VTE ( Safety Thermometer). Children's and Maternity data has been requested. Measures % of child patients who have received an appropriate PEWS (paediatric early warning score), IV observation, pain management, pressure ulcer moisture lesion. Measures % of maternity patients who received "harm free care" in relation to defined by proportion of women that had a maternal infection, 3rd/4th perineal trauma, that had a PPH of more than 1000mls, who were left alone at a time that worried them, term babies born with an Apgar of less than 7 at 5 minutes, mother and baby separation and women that had concerns about safety during labour and birth not taken seriously. | The target for all areas is to achieve over 95%. | Safety Thermometer (chart) | The overall Harm free care % is above the target of 95%; Areas of harm caused in the Adult Thermometer related to a small number of pressure ulcers and falls. Children's services scored lower due to a small number of patients not having a complete EWS recorded. The Maternity safety thermometer has not been completed at the time of writing this report. |
| Healthcare Acquired Infections<br><br>MRSA<br>Red: 1 or more<br><br>Green: 0<br><br>C-Difficile<br>Red: More than 2<br>Amber: 1 to 2<br>Green: 0 | 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 A national objective has been set to reduce gram negative bloodstream infections (GNBSI) by 50% by March 2021.The focus for 2017/18 will be on Escherichia coli (E. coli) bacteraemia which is one of the largest GNBSI groups. Data reported is for hospital apportioned cases. | Healthcare Acquired Infections - MRSA, MSSA, E-Coli (chart); Healthcare Acquired Infections - C-Difficile (chart) | Clostridium difficile – 1 hospital apportioned Clostridium difficile case was reported in October 2017. YTD the Trust has reported 12 hospital onset cases against the annual threshold of 27 cases. The CCG review panel will meet on 7th December to review cases from Q2.<br><br>MRSA bacteraemia – one hospital apportioned case was reported in July 2017.<br><br>MSSA bacteraemia – YTD the Trust has reported 11 HAI cases. These are under review to identify any areas for care improvement.<br><br>E. coli bacteraemia – YTD the Trust has reported 27 HAI cases. Partnership working is in place across the health economy. The Trust is working with community partners to progress the action plans.<br><br>The Trust remains 'Red' in the overall metric as we have had 1 MRSA against a zero tolerance target<br>In month (October) we are performing 'Amber' given we have had 1 hospital acquired C DIff |

Warrington and Halton Hospitals NHS
NHS Foundation Trust

# Integrated Dashboard - October 2017

## Quality Improvement - Trust Position

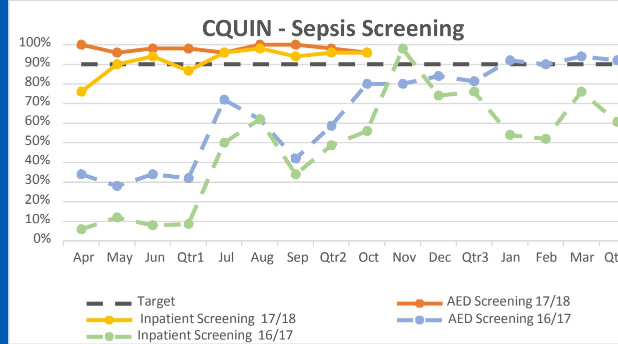
| | Description | Aggregate Position | Trend | Variation |
|---|---|---|---|---|
| VTE Assessment<br><br>Red: <95%<br>Green >=95% | Venous thromboembolism (VTE) is the formation of blood clots in the vein. This data looks at the % of assessments completed in month and the incidents of preventable harm. We also look at the number of RCA's completed in relation to VTE's. | The target for completion and documentation of VTE risk assessment on admission is 95%. The Trust achieved 95.09% in January, 95.08% in February and 95.23% in March following manual validation of patient level records and data. Technical issues with Lorenzo are being worked through with the relevant teams to ensure accurate VTE data going forward. Regarding the VTE backlog, weekly meetings are being held, chaired by the Medical Director where it has been agreed that additional capacity to clear the backlog from 15/16, 16/17 (risk assessed by harm and occurrence of PE). A revised process has been put in place for April 17 onwards. This has been communicated to Divisions. | <br><br><br> | Weekly data is sent from the Information Team where patients have been admitted from ED and are showing as missing VTE risk assessment. This data is validated and sent back to the Information Team. This is required to ensure inclusion of patients where the DTA (decision to admit time) has not been recorded in ED. Some patients are showing as missing VTE risk assessment where cohort logic needs to be applied to exclude these patients from the requirement to have a VTE risk assessment. |
| Safer Surgery<br><br>Red: <100%<br>Green: 100% | The Safe Surgery check list is monitored through OMIS BI and checked and validated via 20 case per month by Head of theatre services. | The target is to achieve 100%. | <br> | Previously the Board reviewed information on 20 surgical cases taken at random and whether checklist was completed. However, we have now reviewed ALL surgical procedures conducted since April 2017 as to whether a checklist was completed and backdated the data. Year to date we have reviewed 10088, of which 1256 were for the month of October. In addition to this check the Head of Theatre Services has audited 28 patient procedures in October. |

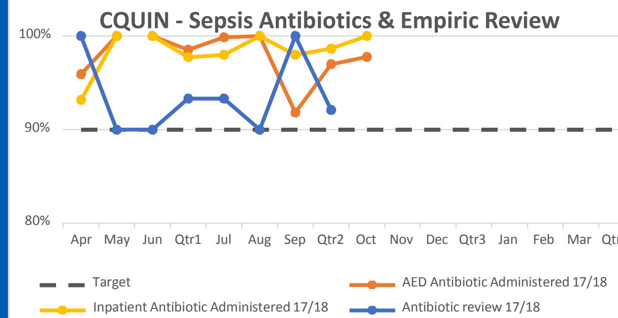
Warrington and Halton Hospitals NHS
NHS Foundation Trust

# Integrated Dashboard - October 2017

## Quality Improvement - Trust Position

| | Description | Aggregate Position | Trend | Variation |
|---|---|---|---|---|
| CQUIN - Sepsis AED Screening Red: Less than 90% Green: 90% or more<br>CQUIN - Sepsis Inpatient Screening Red: Less than 90% Green: 90% or more<br>CQUIN - Sepsis AED Antibiotics Administration Red: Less than 90%<br>CQUIN - Sepsis Inpatient Antibiotics Administration Red: Less than 90%<br>CQUIN - Sepsis Antibiotic Review | Screening of all eligible patients - acute inpatients. Screening of all eligible patients admitted to emergency areas AED. Inpatient received treatments and empiric review within three days of prescribing antibiotics. Emergency patients received treatment and empiric review within three days of prescribing the antibiotics. | The target is to achieve 90% | (see charts below) | Winter pressures are a potential risk to achieving ED targets, initiatives have been implemented to facilitate timely treatment of patients. At the time of writing this report the October antibiotic data has not been validated. |

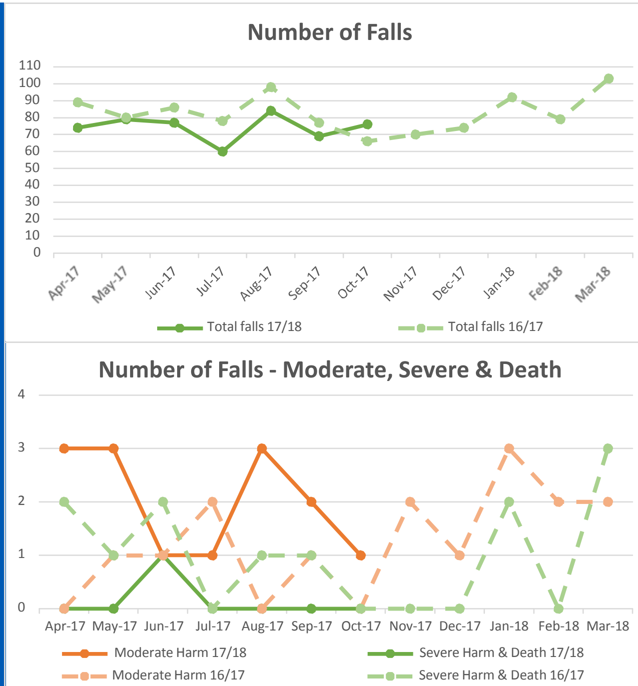
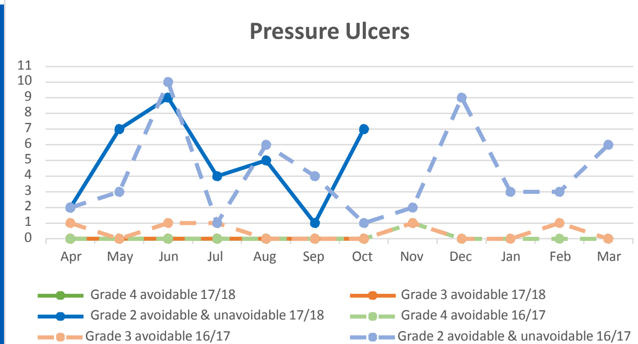


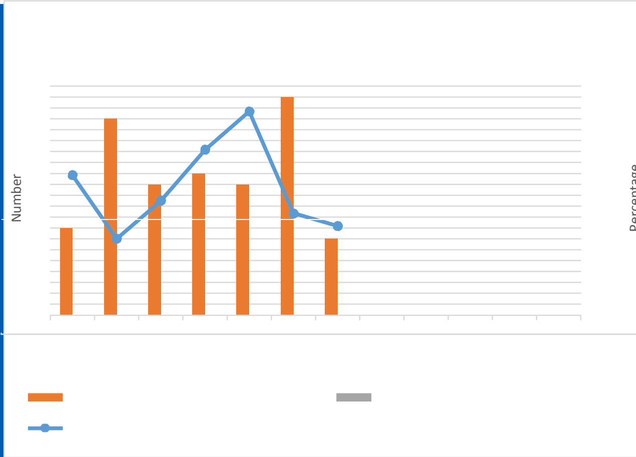
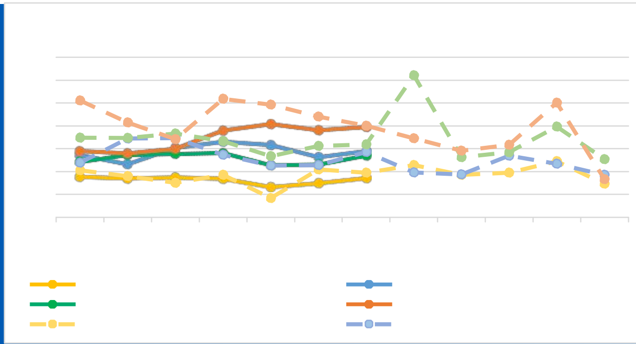
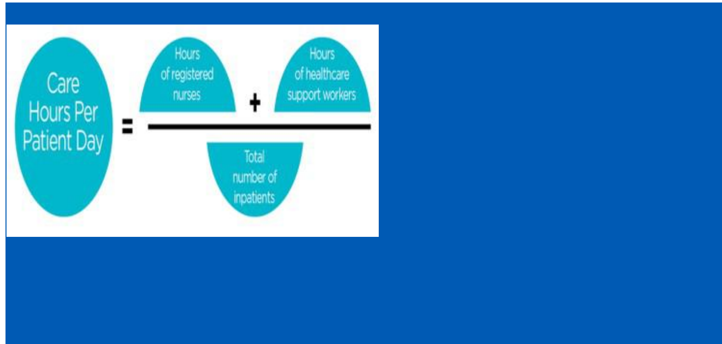
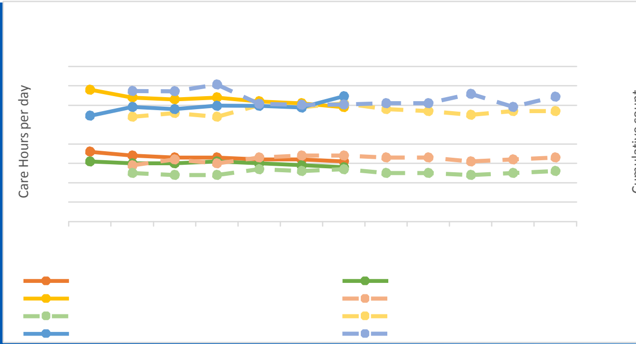
Warrington and Halton Hospitals NHS
NHS Foundation Trust

# Integrated Dashboard - October 2017

## Quality Improvement - Trust Position

| | Description | Aggregate Position | Trend | Variation |
|---|---|---|---|---|
| **Total number of Falls & harm levels** | Total number of falls per month and their relevant harm levels. | 10% reduction in falls in 2017/18 using 2016/17 data as a baseline. |   | There has been 1 moderate harm fall reported during October. The overall number of reported falls in month has increased from 69 to 76 in October. There have been no Serious Incident falls reported for two months. |
| **Pressure Ulcers**<br>**Grade 4**<br>**Red: 1 or more**<br>**Grade 3**<br>**Red: More than 3**<br>**Green: 3 or less**<br><br>**Grade 2**<br>**Red: More than 7**<br>**Green: 7** | Pressure ulcers, also known as pressure sores, bedsores and decubitus ulcers, are localised damage to the skin and/or underlying tissue that usually occur over a bony prominence as a result of pressure, or pressure in combination with shear and/or friction. | Grade 4 hospital acquired (avoidable)<br>Grade 3 hospital acquired (avoidable)<br>Grade 2 hospital acquired (avoidable and unavoidable) |   | The pressure ulcer targets for the Trust are derived from national quality improvement indicators. Following RCA panel with Deputy Chief Nurse on 31/10/17 the Hospital acquired grade 3 pressure ulcers from Ward A8 and ITU were deemed as Unavoidable.<br>From November 2018 the Deputy Chief Nurse and Tissue Viability team will be holding monthly hearings for hospital acquired grade 2 pressure ulcers with all wards who have had a hospital acquired grade 2 that month to enable shared learning. |

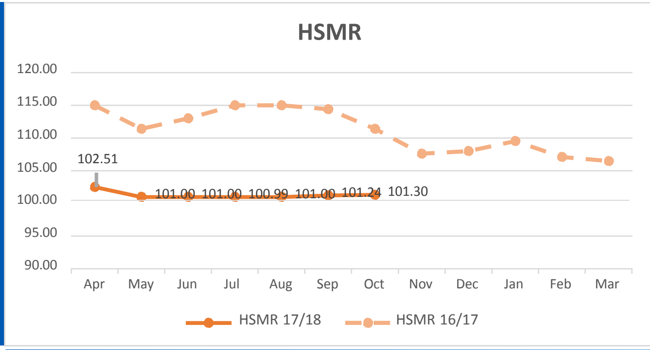
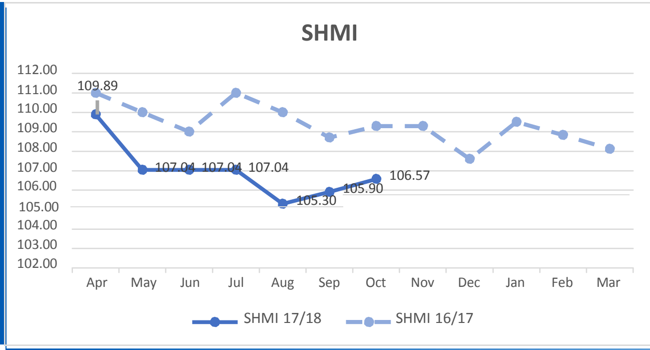
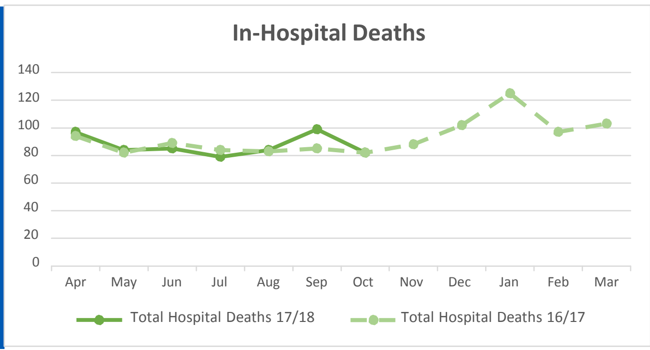
## Quality Improvement - Trust Position

| | Description | Aggregate Position | Trend | Variation |
|---|---|---|---|---|
| **Medication Safety Red - any incidents of harm. Green - no incidents of harm.** | | |  | |
| **Staffing - Average Fill Rate Red: 0-79% Amber: 80-89% Green: 90-100%** | | |  | |
| Staffing - Care Hours Per Patient Day (CHPPD) |  | |  | |

Warrington and Halton Hospitals NHS
NHS Foundation Trust

# Integrated Dashboard - October 2017

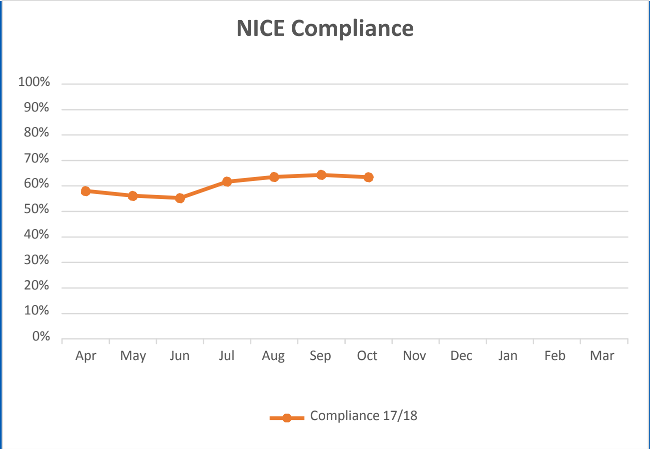
## Quality Improvement - Trust Position

| | Description | Aggregate Position | Trend | Variation |
|---|---|---|---|---|
| Mortality ratio - HSMR<br><br>Red: Greater than expected<br>Green: As or under expected | Hospital Standardised Mortality Ratio (HSMR 12 month rolling). The HSMR is a ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in- hospital deaths (multiplied by 100) for 56 specific Clinical Classification System (CCS) groups. | Target for Green would be to be within expected ranges. |  | Our HMSR for the period August 2016 to July 2017 is 101.50. For HSMR we are currently alerting in four diagnosis groups:<br>Cardiac Dysrythmias (report due at MRG Dec 17)<br>Cancer of the Rectum & Anus (report due at MRG Dec 17)<br>Liver Disease; alcohol-related (report due at MRG Feb 18)<br>Urinary Tract Infections (Report completed May 17 - UTI pathway to be taken to PSCESC |
| Mortality ratio - SHMI<br><br>Red: Greater than expected<br>Green: As or under expected | Summary Hospital-level Mortality Indicator (SHMI 12 month rolling). SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. | Target for Green would be to be within expected ranges. |  | Our SHMI for October is 106.87; again our SHMI is within expected ranges. |
| Total Deaths | Total Deaths (including A&E) - We screen all deaths within the Trust to ascertain if any harm has been caused. If harm has been caused it is subject to a further review by the Mortality Review Group. | The Trust will be publishing data on deaths in October; this data will then be reviewed for targets to be set and sent to Quality Committee. Targets will be set on the IPR in January 2018. |  | All the reviews are being tracked through Mortality Review Group, reporting to Patient Safety & Effectiveness Sub Committee. |

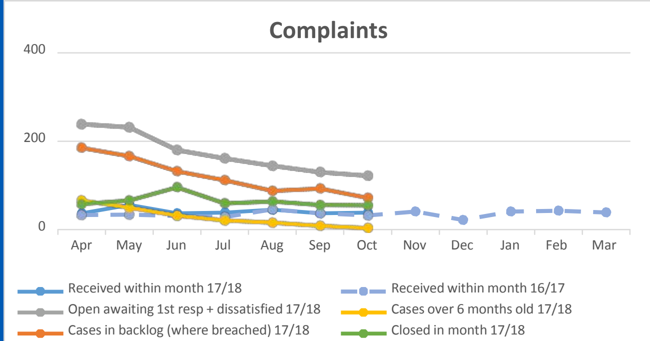
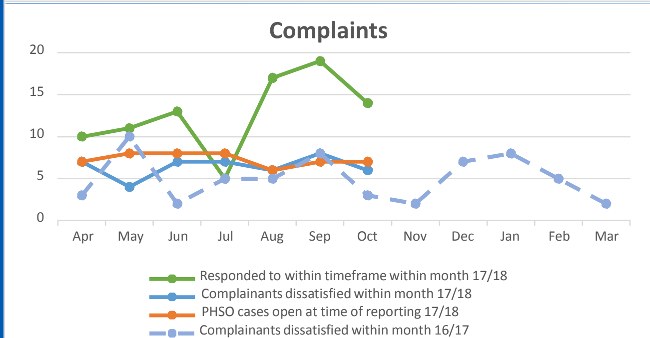
Warrington and Halton Hospitals NHS
NHS Foundation Trust

# Integrated Dashboard - October 2017

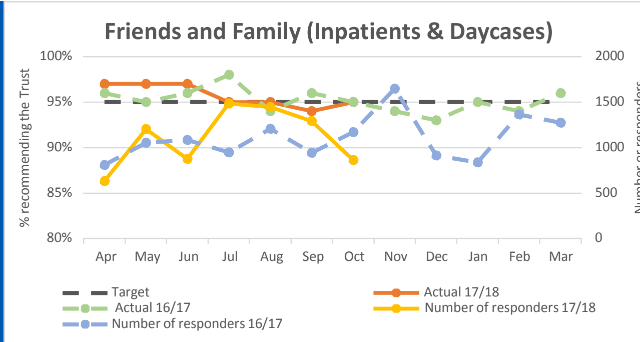
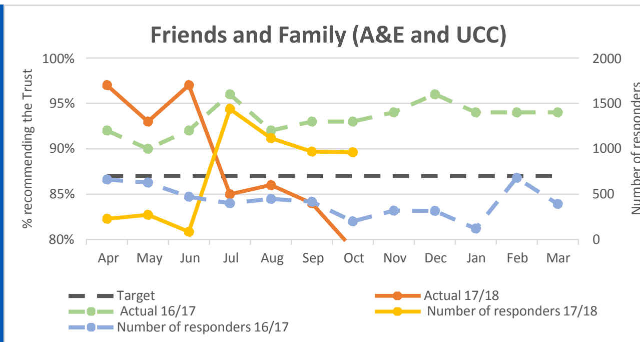
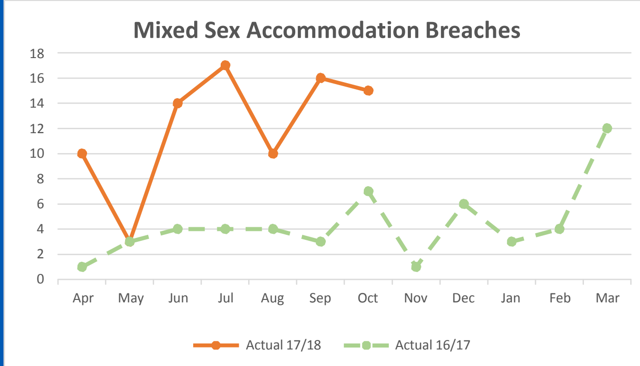
## Quality Improvement - Trust Position

| | Description | Aggregate Position | Trend | Variation |
|---|---|---|---|---|
| NICE Compliance<br>Red: <75%<br>Amber: 75% to <100%<br>Green: 100% | The National Institute for Health and Clinical Excellence (NICE) is part of the NHS and is the independent organisation responsible for providing national guidance on treatments and care for people using the NHS in England and Wales and is recognised as being a world leader in setting standards for high quality healthcare and are the most prolific producer of clinical guidelines in the world. | The target is to achieve 100% compliance against all NICE guidance. |  | There has been a small increase in reporting on where we stand on compliance with NICE guidance. We have moved 13 pieces of guidance we were formerly partially compliant with to full compliance and 20 pieces of NICE Guidance where we will be partially compliant with due to external and internal factor.<br>A report is due at November's Patient Safety & Clinical Effectiveness Sub Committee which will detail the factors influencing the above partial compliance and seek to obtain agreement as agreed partial compliance. |

## Patient Experience

| | Description | Aggregate Position | Trend | Variation |
|---|---|---|---|---|
| Complaints | Overall review of the current complaints position, including; Number of complaints received, number of dissatisfied complaints, total number of open complaints, total number of cases over 6 months old, total number of cases in backlog where they have breached timeframes, number of cases referred to the Parliamentary and Health Service Ombudsman and the number of complaints responded to within timeframe. | Red - Trust not meeting improvement trajectories or complaints open over 6 months old.<br>Amber - No complaints over 6 months old, Trust meeting backlog improvement targets<br>Green - No backlog, complaints responded to within agreed timescales.<br>Please note that the above RAG rating will be reviewed following the completion of the complaints improvement plan. |  | The number of complaints received is based on those cases "opened" in month, and not date "first received", in order to ensure a more accurate picture given the historic issues with missed cases. The Trust wide figure will not always match the total cases assigned to ACS or SWC as there are additional complainants assigned to the Corporate Directorate. In month 6 cases were treated as "high" risk and therefore the subject of a 72hr review. The Trust tracks performance against a trajectory to ensure the backlog is cleared by end Dec. The Trust is currently behind the Trajectory for completion of this target and has a plan to get back on track. |

# Quality Improvement - Trust Position

| | Description | Aggregate Position | Trend | Variation |
|---|---|---|---|---|
| Friends and Family (Inpatients & Day cases)<br><br>Red: Less than 95%<br>Green: 95% or more | Percentage of Inpatients and daycase patients recommending the Trust. Patients are asked - How likely are you to recommend our ward to friends and family if they needed similar care or treatment? | The target set is to achieve over 95%. |  | We have achieved the 95% target of our patients recommending the Trust. The overall number of responders had dropped compared to the previous month, 1292 to 863 from 4514 eligible responders. |
| Friends and Family (A&E and UCC)<br><br>Red: Less than 87%<br>Green: 87% or more | Percentage of AED (Accident and Emergency Department) patients recommending the Trust : Patients are asked - How likely are you to recommend our AED to friends and family if they needed similar care or treatment? | The target set is to achieve over 87%. |  | The target set is to achieve over 87% and 79% of our patients recommending the Trust in October. The overall number of responders has remained relatively the same going from 969 to 962 from 6553 eligible responders. |
| Mixed Sex Accommodation Breaches<br><br>Red: 1 or more<br>Green: Zero | We submit data to NHS England in relation to the number of occurrences of unjustified mixing in relation to sleeping accommodation. | There is a target of zero tolerance. |  | SA breaches continue to be closely monitored by the operational teams. It should be noted that only Critical Care & Coronary Care step down breaches occur due to capacity challenges within the Trust. The CCG's have now agreed that an RCA is not required for each MSA breach, they have requested the breach information in the form of a spreadsheet each month. |

Warrington and Halton Hospitals NHS
NHS Foundation Trust

# Integrated Dashboard - October 2017

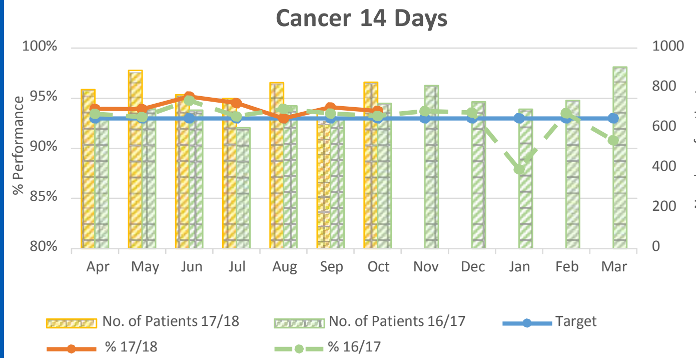
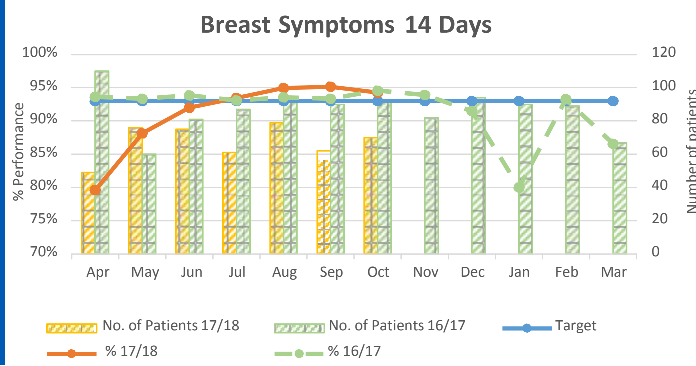
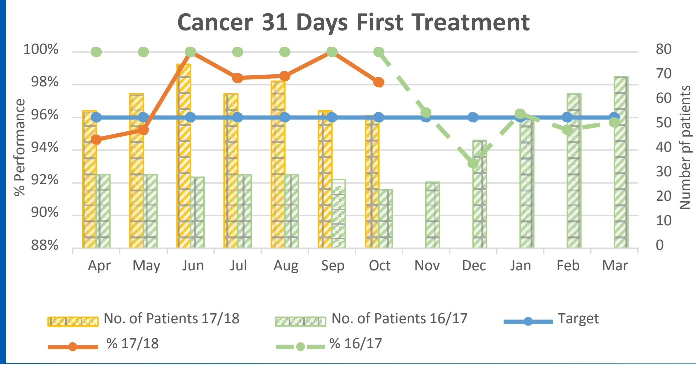
## Mandatory Standards - Access & Performance - Trust Position

| | Description | Aggregate Position | Trend | Variation |
|---|---|---|---|---|
| Diagnostic Waiting Times 6 Weeks<br><br>Red: Less than 99%<br>Green: 99% or above | All diagnostic tests need to be carried out within 6 weeks of the request for the test being made. The national target is 99% or over within 6 weeks.<br><br>This metric also forms part of the Trust's Sustainability and Transformation Plan (STP) Improvement trajectory.<br><br>The proposed tolerance levels applied to the improvement trajectories are also illustrated. | The national target of 99% for Diagnostic waiting times has been achieved with actual performance at 100%. The Trust has also met the STP Improvement trajectory. | Diagnostic Waiting Times 6 Weeks<br>% Performance: 90%–100%; Number of patients: 0–7000<br>Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar<br>No. of Patients 17/18; No. of Patients 16/17; Target; % 17/18; % 16/17 | The Trust again achieved this target fro October. |
| Referral to treatment Open Pathways<br><br>Red: Less than 92%<br>Green: 92% or<br><br>RTT - Number of patients waiting 52+ weeks Green = 0, otherwise Red | Percentage of incomplete pathways waiting within 18 weeks. The national target is 92%<br><br>This metric also forms part of the Trust's STP Improvement trajectory.<br><br>The proposed tolerance levels applied to the improvement trajectories are also illustrated. | Open pathways continue to perform above the 92% target. The Trust has also met the STP improvement trajectory. | Referral to treatment Open Pathways<br>% Performance: 80%–100%; Number of patients: 0–25000<br>Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar<br>No. of Patients 17/18; No. of Patients 16/17; Target; % 17/18; % 16/17 | The Teams throughout the Trust have done a fantastic job in achieving this difficult target despite operational pressures and catching up with patients cancelled due to industrial action. The processes that are in place now track and validate daily and concerns and solutions are escalated promptly. |
| Four Hour Standard - National Target<br><br>Red: Less than 95%<br>Green: 95% or above<br><br>Four Hour Standard Waiting Times - STP Trajectory<br><br>Red: Less than 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%<br><br>This metric also forms part of the Trust's STP improvement trajectory.<br><br>The proposed tolerance levels applied to the improvement trajectories are also illustrated. | The Trust is not achieving the 95% national 4 hour target and has not met the improvement trajectory for October 2017. | A&E Waiting Times - 4hr target<br>% Performance: 80%–100%; Number of patients: 8000–11500<br>Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar<br>No. of Patients 17/18; No. of Patients 16/17; % 17/18; National Target; Improvement Trajectory; % 16/17 | September and October have been very difficult months operationally. We have seen a reduction in discharges and an increase in Delayed Transfers of care (DToC) for a variety of reasons, the main the reason has been unfilled domiciliary care hours. The Trust narrowly missed the NHSI trajectory of 90% for October achieving 89.47% and is working hard on pulling this back to ensure delivery of Q3's trajectory of 90%. We have several MADE events planned and the bed reconfiguration will support flow and safe use of escalation areas. |

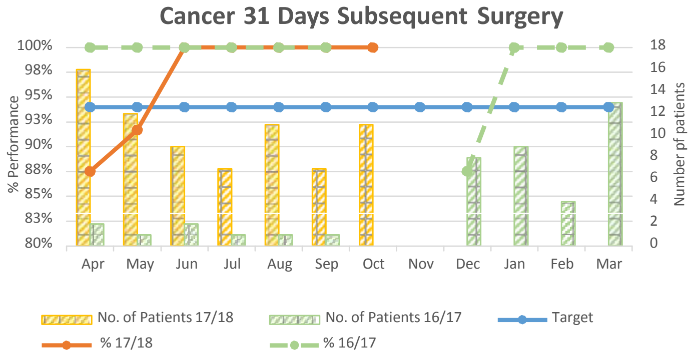
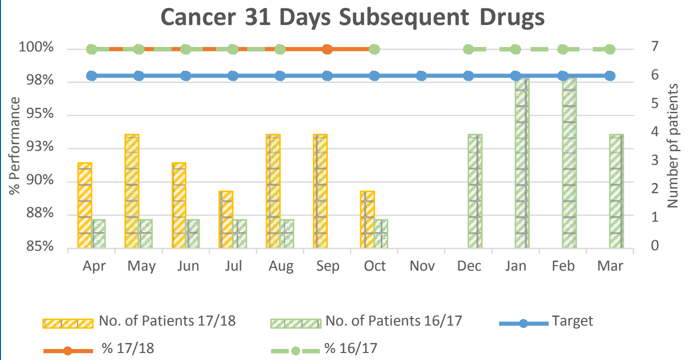
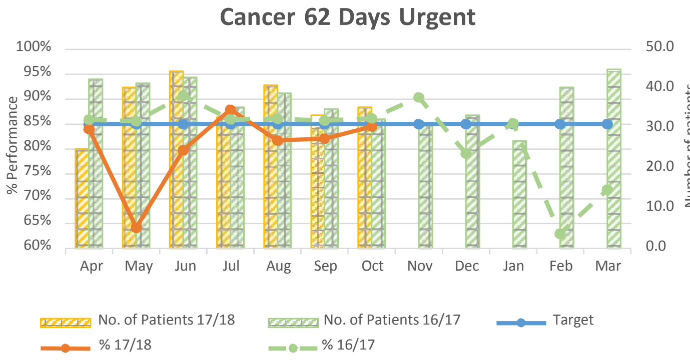
Warrington and Halton Hospitals NHS
NHS Foundation Trust

# Integrated Dashboard - October 2017

## Mandatory Standards - Access & Performance - Trust Position

| | Description | Aggregate Position | Trend | Variation |
|---|---|---|---|---|
| Cancer 14 Days<br><br>Red: Less than 93%<br>Green: 93% or above | **All patients need to receive first appointment for cancer within 14 days of urgent referral. The national target is 93%. This target is measured and reported on a quarterly basis.** | The Trust achieved 97.73% in October 2017 |  | **This target has been consistently delivered.** |
| Breast Symptoms 14 Days<br><br>Red: Less than 93%<br>Green: 93% or above | **All patients need to receive first appointment for any breast symptom (except suspected cancer) within 14 days of urgent referral. The national target is 93%. This target is measured and reported on a quarterly basis.** | The Trust achieved 94.29% in October 2017 |  | **The team have worked hard to ensure all patients receive their first appointment within 14 days of a referral this is a challenging target as patient choice has been an issue in previous months we have worked closely with our partners and OPD department to ensure we offer choice.** |
| Cancer 31 Days First Treatment<br><br>Red: Less than 96%<br>Green: 96% or above | **All patients to receive first treatment for cancer within 31 days of decision to treat. This national target is 96%. This target is measured and reported on a quarterly basis.** | **The Trust achieved 98.15% in October 2017** |  | **The Trust achieved this target.** |

## Mandatory Standards - Access & Performance - Trust Position

| | Description | Aggregate Position | Trend | Variation |
|---|---|---|---|---|
| Cancer 31 Days Subsequent Surgery<br><br>Red: Less than 94%<br>Green: 94% or above | All patients to receive a second or subsequent treatment for cancer within 31 days of decision to treat/surgery. The national target is 94%. This target is measured and reported on a quarterly basis. | The Trust achieved 100% in October 2017 |  | The Trust achieved this target. |
| Cancer 31 Days Subsequent Drug<br><br>Red: Less than 98%<br>Green: 98% or above | All patients to receive a second or subsequent treatment for cancer within 31 days of decision to treat – anti cancer drug treatments. The national target is 98%. This target is measured and reported on a quarterly basis. | The Trust achieved 100% in October 2017 |  | The Trust achieved this target. |
| Cancer 62 Days Urgent<br><br>Red: Less than 85%<br>Green: 85% or above | All patients to receive first treatment for cancer within 62 days of urgent referral. The national target is 85%.<br><br>This metric also forms part of the Trust's STP Improvement trajectory.<br><br>The proposed tolerance levels applied to the improvement trajectories are also illustrated. | The Trust achieved 84.51% in October 2017. |  | 62 day cancer has been a concern year to date for a number of different reasons. The Trust has achieved 86.15% for October against a target of 85%. However will not have achieved Q2 target despite the Trust making good progress since Q1 and a robust action plan, the Trust achieved 82.2% against the target of 85%. Nationally the overall performance was 82.1% there were 8 patients who breached internally the rest of the breaches were related to tertiary centres. |

Warrington and Halton Hospitals NHS
NHS Foundation Trust

# Integrated Dashboard - October 2017

## Mandatory Standards - Access & Performance - Trust Position

| | Description | Aggregate Position | Trend | Variation |
|---|---|---|---|---|
| Cancer 62 Days Screening<br><br>Red: Less than 90%<br>Green: 90% or above | All patients must wait no more than 62 days from referral from an NHS screening service to first definitive treatment for all cancers. The national target is 90%. This target is measured and reported on a quarterly basis. | The Trust achieved 90.91% in October 2017. | Cancer 62 Days Screening | The Trust achieved this target. |
| Ambulance Handovers 30 to <60 minutes<br><br>Red: More than 0<br>Green: 0 | Number of ambulance handovers that took 30 to <60 minutes (based on the data record on the HAS system). | There were 192 patients where the ambulance handover was between 30 and 60 minitues in October 2017. | Ambulance Handovers at 30 to <60 minutes | Ambulance handovers remain a challenge. The trust has taken part in an improvement event which concluded this month. The team have now implemented 'fit to sit' for appropriate patients as well as moving the ambulance handover desk, to support improvement against this target. |
| Ambulance Handovers at 60 minutes or more<br><br>Red: More than 0<br>Green: 0 | Number of ambulance handovers that took 60 minutes or more (based on the data record on the HAS system). | There were 13 patients where the ambulance handover was more 60 minitues in October 2017. | Ambulance Handovers at 60+ minutes | This target has been difficult to achieve throughout October due to the reduction of flow throughout the Trust mainly due to an increase in DToC. |

Cancer 62 Days Screening

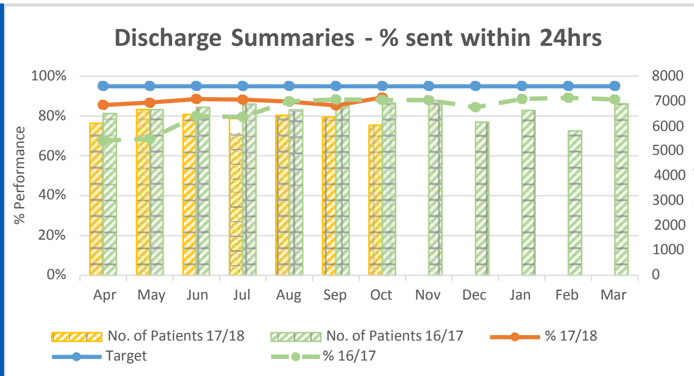
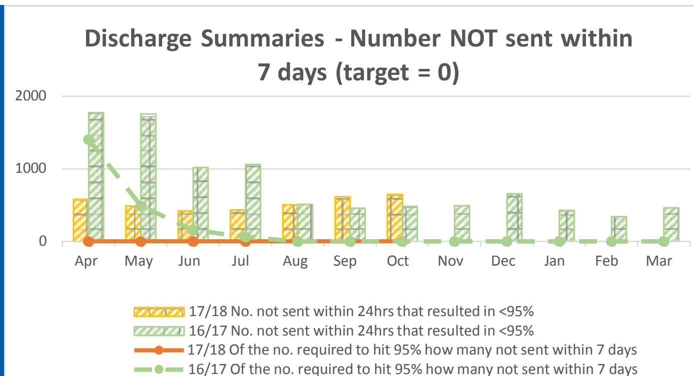
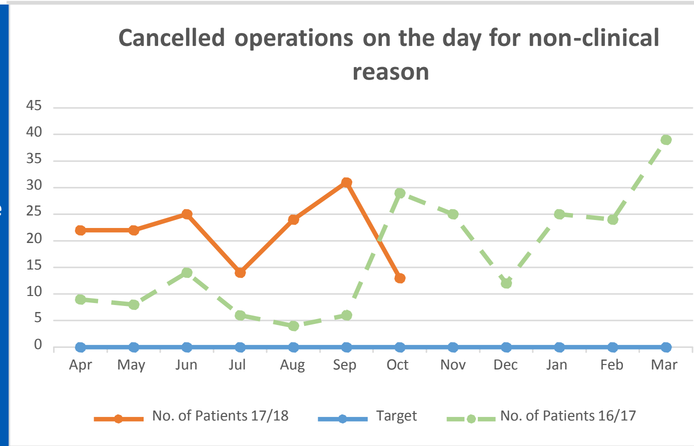

Ambulance Handovers at 30 to <60 minutes


Ambulance Handovers at 60+ minutes

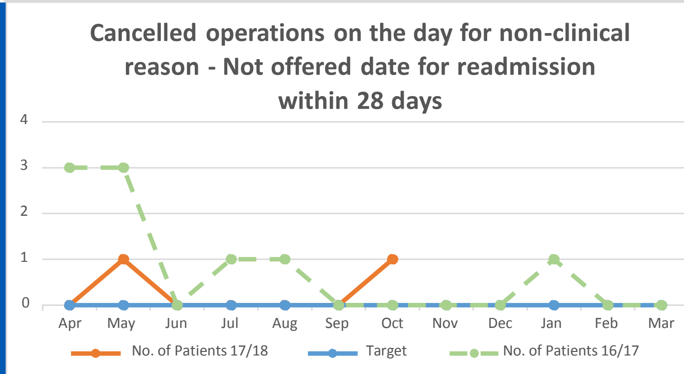
Warrington and Halton Hospitals NHS
NHS Foundation Trust

# Integrated Dashboard - October 2017

## Mandatory Standards - Access & Performance - Trust Position

| | Description | Aggregate Position | Trend | Variation |
|---|---|---|---|---|
| Discharge Summaries - % sent within 24hrs<br><br>Red: Less than 95%<br>Green: 95% or above | The Trust is required to issue and send electronically a fully contractually complaint Discharge Summary within 24 hrs of the patients discharge. | The Trust achieved 89.24% in October 2017. |  | The Trust has made significant improvements against this target however we remain below the 95% target. |
| Discharge Summaries - Number NOT sent within 7 days<br><br>Red: Above 0 | If the Trust does not send 95% of discharge summaries within 24hrs, the Trust is then required to send the difference between the actual performance and the 95% required standard within 7 days of the patients discharge. | All discharge summaries were sent within 7 davs in October 2017. |  | The Trust achieved this target. |
| Cancelled Operations on the day for a non-clinical reason<br><br>Red: Above zero | Number of operations cancelled on the day or after admission for a non-clinical reason. | There were 13 operations cancelled due to non clinical reasons in October 2017. |  | The Trust continues to have challenges with cancelled operations. We have formalised the cancelled operations meeting and attendance is mandatory for either CBU managers or assistant CBU managers. We have implemented a proforma which requires the relevant service to complete a mini RCA for each cancellation as well as to develop plan to avoid it in the future. This is now forwarded to the Acting COO weekly. |

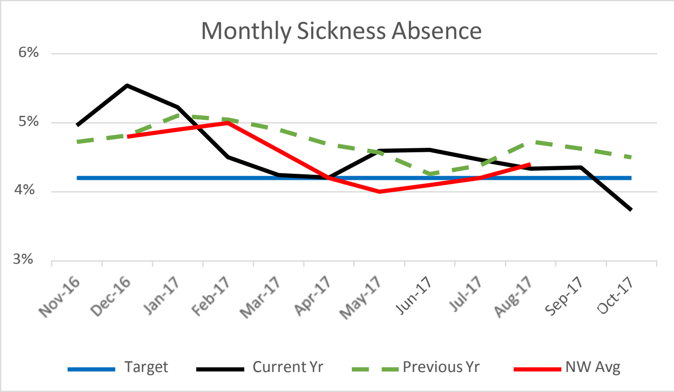
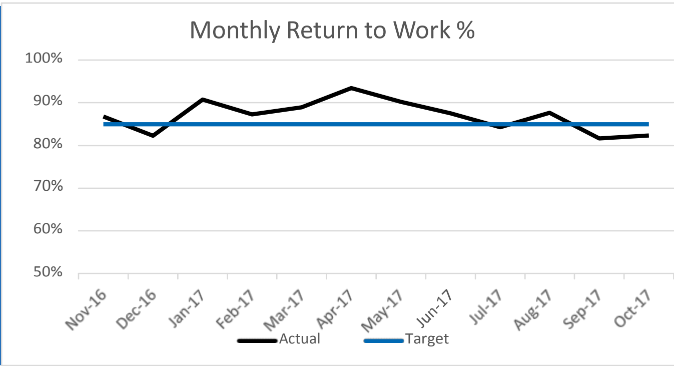
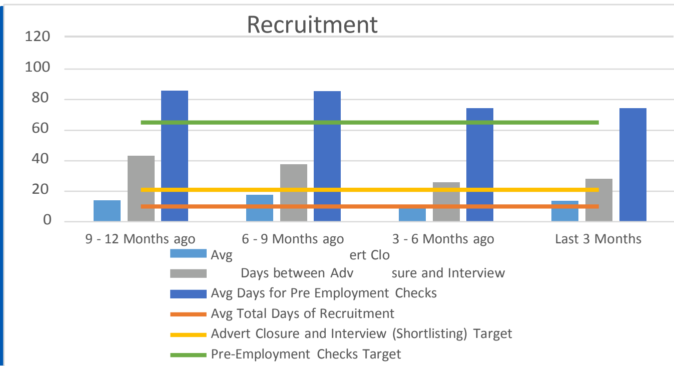
## Mandatory Standards - Access & Performance - Trust Position

| | Description | Aggregate Position | Trend | Variation |
|---|---|---|---|---|
| Cancelled Operations on the day for a non-clinical reason - Not offered a date for readmission within 28 days of the cancellation | **All service users who have their operation cancelled on the day or after admission for a non-clinical reason, should be offered a binding date for readmission within 28 days.** | |  | **There was one patient who was cancelled and was not readmitted in the required 28 days, this was related to patient choice.** |

Warrington and Halton Hospitals NHS
NHS Foundation Trust

# Integrated Dashboard - October 2017

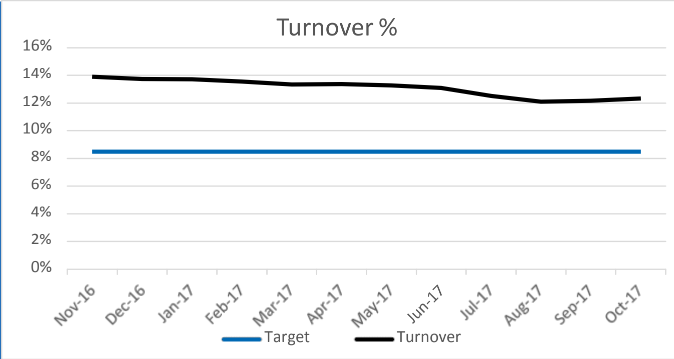
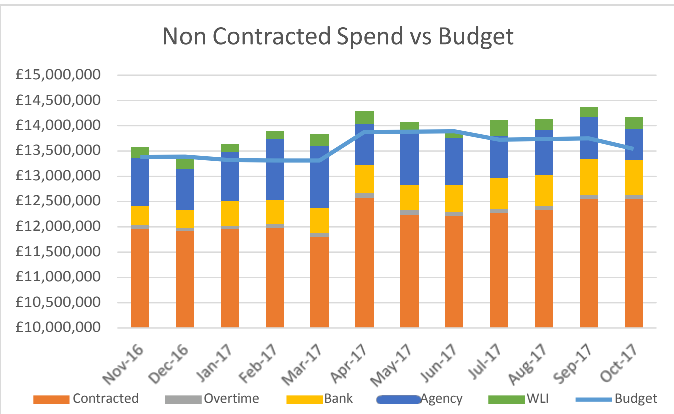
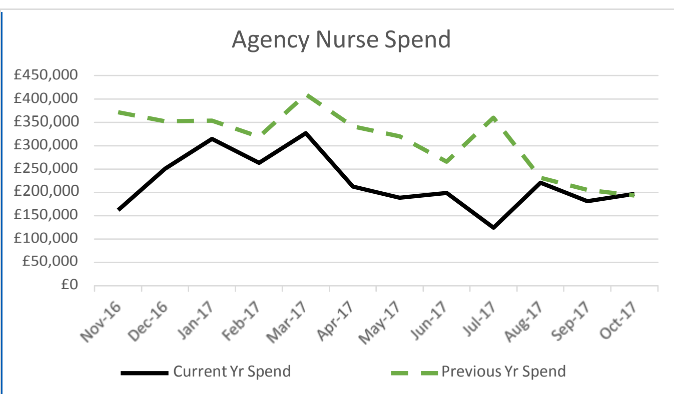
## Workforce

| | Description | Aggregate Position | Trend | Variation |
|---|---|---|---|---|
| Sickness Absence<br><br>Red: Above 4.5%<br>Amber: 4.2% to 4.5%<br>Green: Below 4.2% | Comparing the monthly sickness absence % with the Trust Target (4.2%) previous year, and North West average | Sickness absence reduced to 3.73% in October 2017 meaning that the Trust target was achieved. |  | Sickness absence has continued to reduce and key actions are in place to support this, following an audit of compliance with the Trust Attendance Management policy. The audit has been extended in order to obtain sufficient data to report at CBU level. This data will be reported throughout November 2017 and targeted action managed locally. Stress/Anxiety/Depression remains the highest occurring reasons for absence. The Trust is training Mental Health First Aiders in February 2018.<br>There will be a particular focus on long term sickness absence and on supporting staff via Occupational Health and welfare meetings. |
| Return to Work<br><br>Red: Below 75%<br>Amber: 75% to 85%<br>Green: Above 85% | A review of the completed monthly return to work interviews. | Return to Work Interview compliance was 82.33% in October 2017 which is below the Trust target of 85% |  | The RTW Interview data confirms the trend of managers failing to record the interview in a timely manner, i.e. September 2017 figure was previously reported as 77.1% - this has now increased to 81.6%. However, this is still below the compliance target. In October 2017, RTW Interview compliance rose to 82.3%. The increase indicates that the dedicated resource within HR to issue recording reminders to managers is working, however unfortunately, the number of interviews completed is lower than expected. |
| Recruitment<br><br>Red: Above Target<br>Green: On or Below Target | A measurement of the average number of days it is taking to recruit into posts.<br><br>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<br><br>number of days for which it takes successful candidates to complete their pre-employment checks | The average total days to recruit over the last 3 months was 74.5 Whilst this is above the Trust target of 65 days, it does represent a significant reduction from previous months. |  | Recent feedback from applicants on the Trust recruitment process has been very positive and the Trust have improved across all measures. In addition, there has been a reduction in Staff Nurse vacancies of circa. 25%. Further recruitment open days are planned across the coming months to build on recent<br><br>successes. |

# Warrington and Halton Hospitals NHS
NHS Foundation Trust

## Integrated Dashboard - October 2017

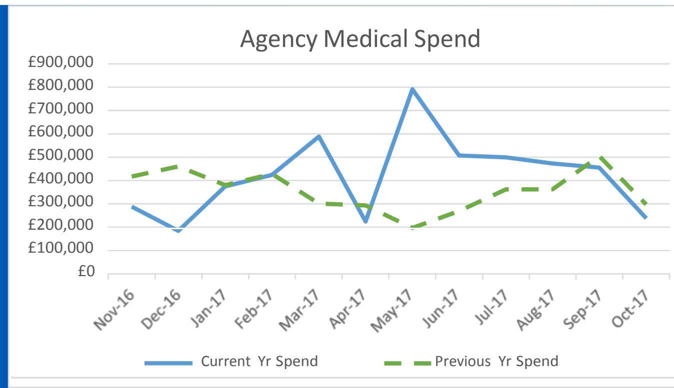
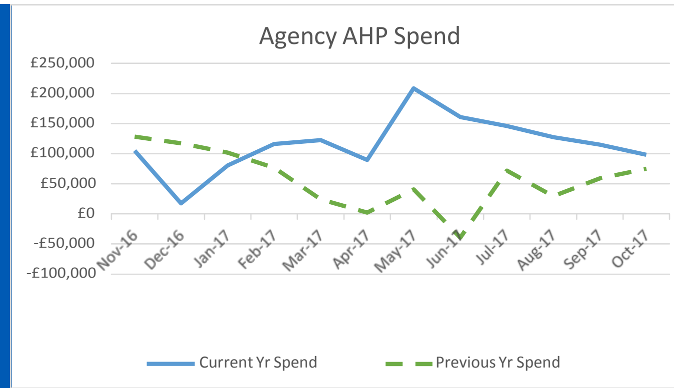
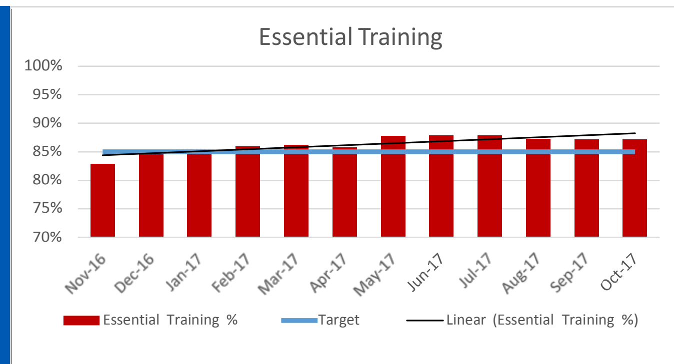
## Workforce

| | Description | Aggregate Position | Trend | Variation |
|---|---|---|---|---|
| Turnover<br><br>Red: Above 15%<br>Amber: 13% to 15%<br>Green: Below 13% | A review of the turnover percentage over the last 12 months | Turnover was 12.33% in October 2017, meaning that the Trust target was achieved. |  | Turnover has increased slightly in recent months however it remains below the target, evidencing the work done to recruit and retain staff. This work will continue across all staff groups, with targeted support offered to areas experiencing a high level of turnover. |
| Non Contracted Pay<br><br>Red: Greater than Budget<br><br>Green: Less than Budget | A review of the Non-Contacted pay as a percentage of the overall pay bill year to date | Non-contracted spend remains above budget at 12.26%. Agency spend is the highest element of non-contracted pay at 6.16%, followed by bank spend at 4.11% |  | Key actions are in place to address agency spend for Nursing, Medical and Dental, and Allied Health Professionals, and are outlined below. Non-contracted pay is reviewed via the Premium Pay Spend Review Meeting and key actions are in place including a review of overtime usage and authorisation, exit strategies for off payroll workers and a review of on-call across the Trust. |
| Agency Nurse Spend<br><br>Red: Greater than Previous Yr<br>Green: Less then Previous Yr | A review of the monthly spend on Agency Nurses | There has been an increase in Nurse Agency Spend to £197k in October 2017. |  | The Recruitment and Retention Plan for Nursing continues to be implemented. There will need to be a continued focus on maintaining this, particularly over the Winter period. Both substantive and bank recruitment has continued to drive down agency requirement, however bank expenditure has increased as a consequence. |

Warrington and Halton Hospitals NHS
NHS Foundation Trust

# Integrated Dashboard - October 2017

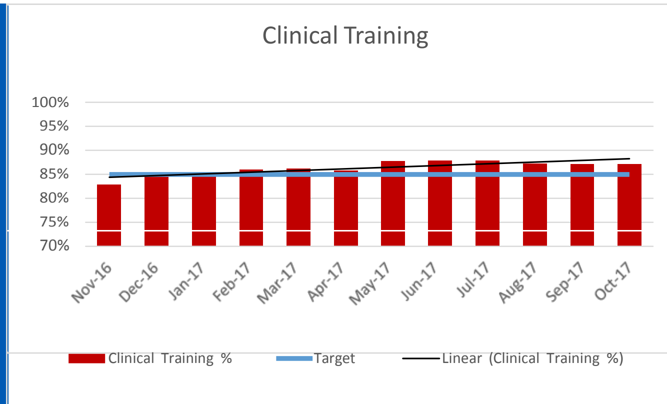
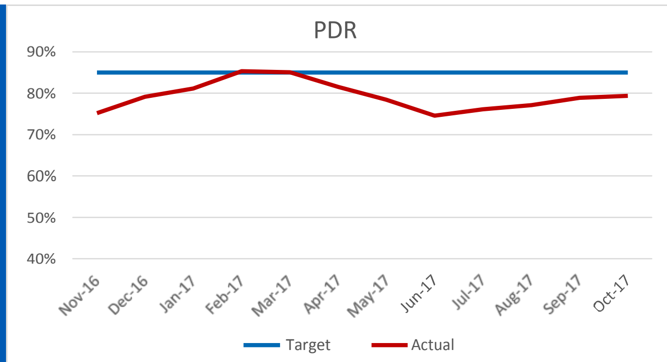
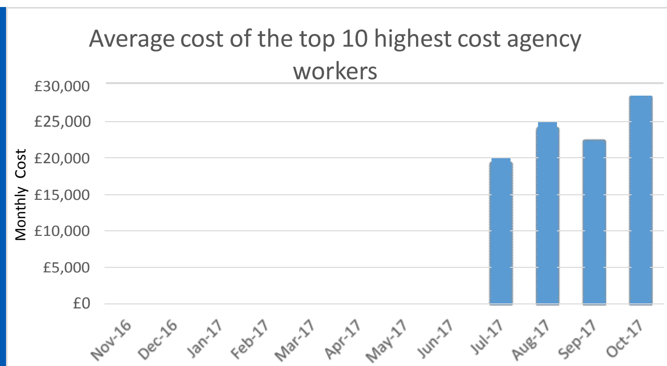
## Workforce

| | Description | Aggregate Position | Trend | Variation |
|---|---|---|---|---|
| Agency Medical Spend<br><br>Red: Greater than Previous Yr<br>Green: Less then | **A review of the monthly spend on Agency Locums** | **Agency Medical Spend has reduced significantly to £236k in October 2017, which follows the trend from the same period last year.** |  | **The current focus on Breach Form Compliance continues. It is recognised as a key process to exerting grip and control on Medical agency spend. The position has improved in Specialist Surgery to 100% but has deteriorated in Diagnostics (74.1%) and Women's and Children's (48.1%). Consistency is the key and this is not yet being achieved.** |
| Agency AHP Spend<br><br>Red: Greater than Previous Yr<br>Green: Less then Previous Yr | **A review of the monthly spend on AHP Locums** | **Whilst still above the Trust target, Agency AHP Spend has continued to reduce and was £98k in October 2017.** |  | **The reduction in AHP agency spend evidences the work done to recruit and retain AHPs, particularly within Therapies. Reducing the number of NHSI Cap breaches is the current key focus in an attempt to reduce the agency spend in the AHP staff group. October has seen an overall reduction but there was a significant increase in Digestive Diseases.** |
| Essential Training<br><br>Red: Below 70%<br>Amber: 70% to 85%<br>Green: Above 85% | **A summary of the Essential Mandatory Training Compliance, this includes:**<br><br>**Corporate Induction**<br>**Dementia Awareness,**<br>**Fire Safety**<br>**Health and Safety**<br>**Moving and Handling** | **Essential Training compliance was 89.19% in October 2017 meaning that the Trust target was achieved.** |  | **Essential Training compliance will continue to be reported at divisional, CBU and ward level, with additional monitoring and support in place for any areas with low compliance rates.** |

Warrington and Halton Hospitals NHS
NHS Foundation Trust

# Integrated Dashboard - October 2017

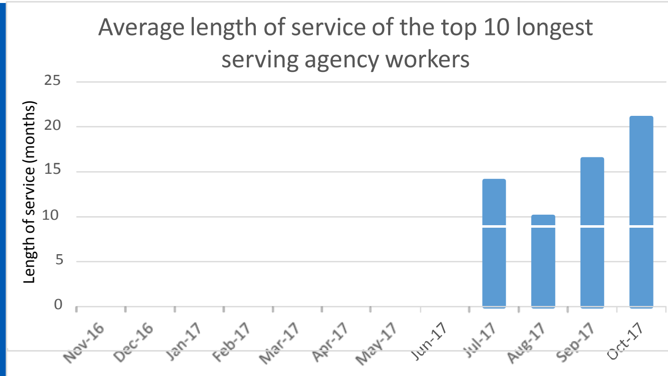
## Workforce

| | Description | Aggregate Position | Trend | Variation |
|---|---|---|---|---|
| Clinical Training<br><br>Red: Below 70%<br>Amber: 70% to 85%<br>Green: Above 85% | A summary of the Clinical Mandatory Training Compliance, this includes:<br><br>Infection Control<br>Resus<br>Safeguarding Procedures (Adults) - Level 1<br>Safeguarding Procedures (Adults) - Level 2<br>Safeguarding Procedures (Children) - Level 1<br>Safeguarding Procedures (Children) - Level 2<br>Safeguarding Procedures (Children) - Level 3<br>SEMA | The upward trend continues and the compliance rate for June is 87.87% which is above the trust target of 85%. |  | Clinical Training compliance will continue to be reported at divisional, CBU and ward level, with additional monitoring and support in place for any areas with low compliance rates. |
| PDR<br><br>Red: Below 70%<br>Amber: 70% to 85%<br>Green: Above 85% | A summary of the PDR Compliance rate | PDR compliance was 79.41% in October 2017, which is below the Trust target of 85%. |  | PDR Compliance for October 2017 was 79.4%, a very slight increase on last month. Both clinical divisions increased compliance rates in month; ACS from 74.6% to 75.8% and SWC from 77% to 78.8%), Corporate Services have reduced from 86.7% to 84.6%. Key areas which require improvement include Estates and Nursing and Governance. |
| Average cost of the top 10 highest cost Agency Workers<br><br>Red: Greater than previous month<br><br>Green: Less than | Average cost of the top 10 highest cost agency workers | The average cost of the top 10 highest cost agency workers has increased in October 2017 to £28k. |  | All of the top 10 highest cost agency workers are within the Medical and Dental staff group. This data is reported to the Deputy Medical Director via Medical HR meeting and plans are in place to reduce spend in relation to each worker. |

Warrington and Halton Hospitals NHS
NHS Foundation Trust

# Integrated Dashboard - October 2017

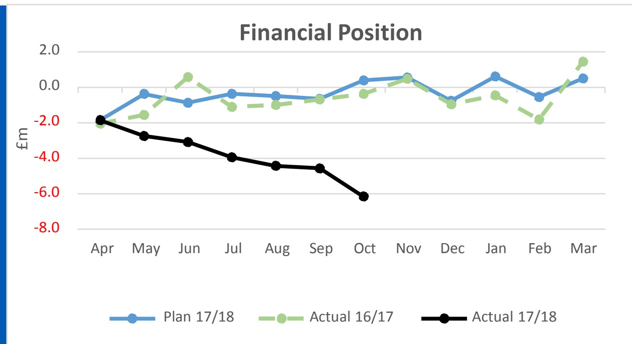
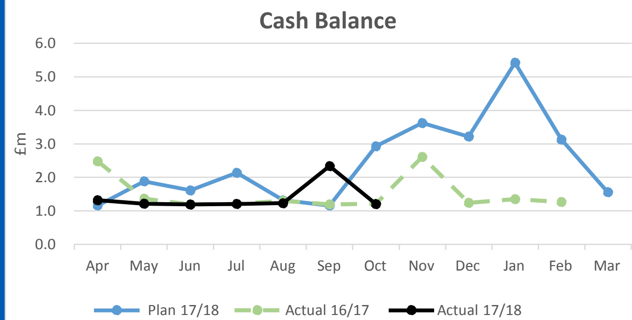
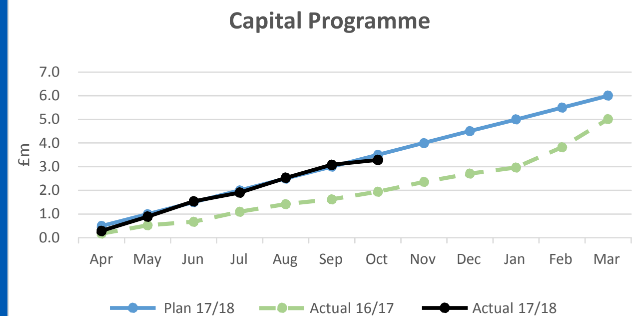
## Workforce

| | Description | Aggregate Position | Trend | Variation |
|---|---|---|---|---|
| Average length of service of the top 10 longest serving agency workers<br><br>Red: Greater than previous month<br><br>Green: Less than | An average length of service (months) of the Top 10 agency workers who have been working at the trust for a minimum of 3 shifts per week for a consecutive period of 6 weeks. | The average length of service of the top 10 longest serving agency workers has increased in October 2017. |  | Of the 10 workers, 4 are within the Medical and Dental staff group and this data is reported to the Deputy Medical Director via Medical HR meeting in order to ensure plans are in place to reduce usage and mitigate risk. 4 workers are Nursing and Midwifery and 2 are Allied Health Professionals. |

# Warrington and Halton Hospitals NHS Foundation Trust

## Integrated Dashboard - October 2017

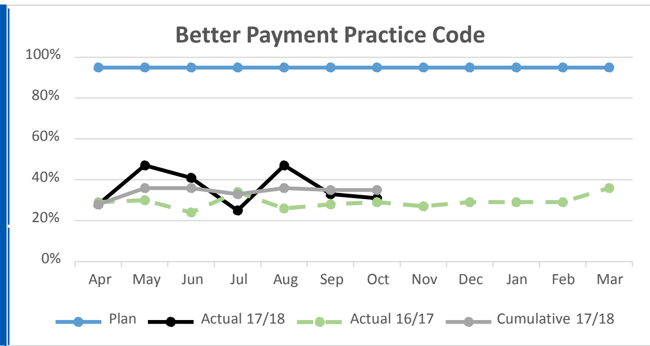
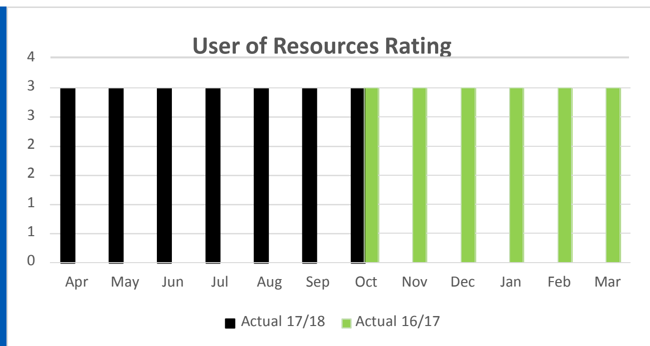
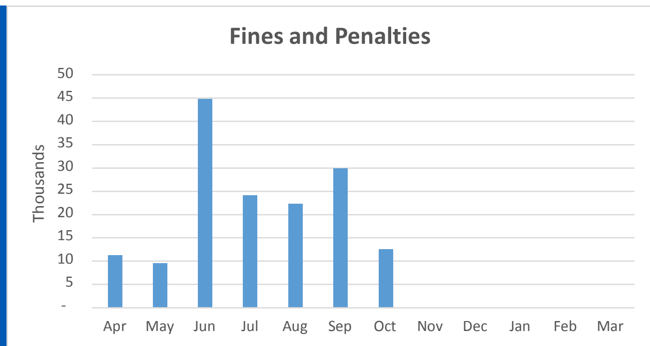
### Sustainability & Mandatory Standards - Finance

| | Description | Aggregate Position | Trend | Variation |
|---|---|---|---|---|
| Financial Position<br><br>Red: Deficit Position<br>Amber: Actual on or better than planned but still in deficit<br>Green: Surplus Position | Surplus or deficit compared to plan | The actual deficit in the month is £1.6m which increases the cumulative deficit to £6.1m. |   | The cumulative deficit of £6.1m is £2.0m worse than plan. |
| Cash Balance<br><br>Red: Less than 90% or below minimum cash balance per NHSI<br>Amber: Between 90% and 100% of planned cash balance<br>Green: On or better than plan | Cash balance at month end compared to plan | Under the terms and conditions of the working capital loan the Trust is required to have a minimum cash balance during the month of £1.2m. The current cash balance of £1.2m equates to circa 2 days operational cash. |   | The current cash balance of £1.2m is £1.7m below the planned cash balance of £2.9m, however the balance of £1.2m at month end is required to comply with the terms and conditions of the working capital loan. |
| Capital Programme<br><br>Red: Off plan <80% - >110%<br>Amber: Off plan 80-90% or 101 - 110%<br>Green: On plan 90%-100% | Capital expenditure compared to plan (The capital plan has been increased to £7.3m as a result of additional funding from the Department of Health for A&E Primary Care Streaming and WiFi infrastructure upgrade and capital donations from Can treat, Health Education England and Charitable Funds. | The actual capital spend in the month is £0.2m which increases the cumulative capital spend to £3.3m. |   | The cumulative capital spend of £3.3m is £1.2m below the planned capital spend of £4.5m. |

Warrington and Halton Hospitals NHS
NHS Foundation Trust

# Integrated Dashboard - October 2017

## Sustainability & Mandatory Standards - Finance

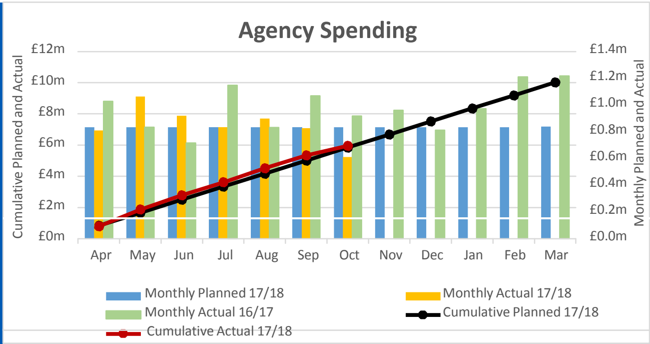
| | Description | Aggregate Position | Trend | Variation |
|---|---|---|---|---|
| Better Payment Practice Code<br><br>Red: Cumulative performance below 85%<br>Amber: Cumulative performance between 85% and 95%<br>Green: Cumulative performance 95% or better | Payment of non NHS trade invoices within 30 days of invoice date compared to target. | In month the Trust has paid 31% of suppliers within 30 days which results in a year to date performance of 35%. |  | The cumulative performance of 35% is 60% below the national standard of 95%, this is due to the low cash balance and the need to manage cash very closely. |
| Use of Resources Rating<br>Red: Use of Resource Rating 4<br>Amber: Use of Resource Rating 3<br>Green: Use of Resource Rating 1 and 2 | Use of Resources Rating compared to plan. | The current Use of Resources Rating is 3. Capital Servicing Capacity, Liquidity and I&E margin are scored at 4 whilst Agency Ceiling and Variance to Control Total are scored at 2. |  | The current Use of Resources Rating of 3 is in line with the planned rating of 3. |
| Fines and Penalties<br><br>Red: Greater than zero<br>Green: Zero | Monthly fines and penalties | |  | During October 2017, the Trust received a penalty of £5k for discharge summaries, and £7.5k for penalties relating to potential non delivery of CQUIN. |

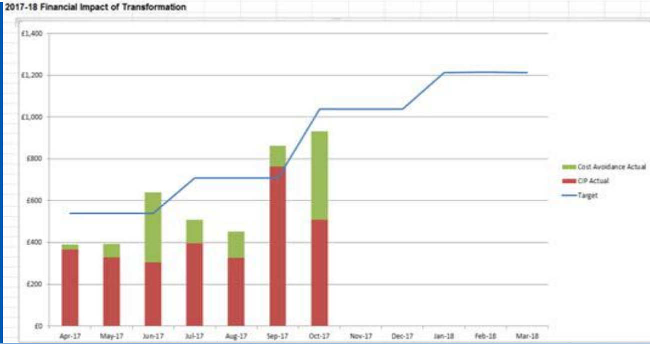
Warrington and Halton Hospitals NHS
NHS Foundation Trust

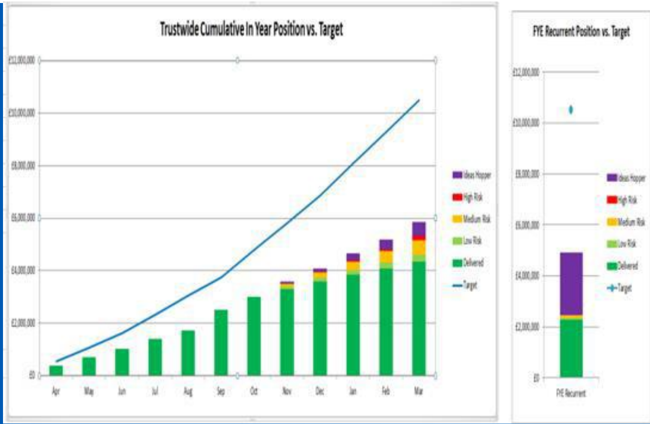
# Integrated Dashboard - October 2017

## Sustainability & Mandatory Standards - Finance

| | Description | Aggregate Position | Trend | Variation |
|---|---|---|---|---|
| Agency Spending<br><br>Red: More than 105% of ceiling<br>Amber: Over 100% but below 105% of ceiling<br>Green: Equal to or less than agency ceiling. | **Agency spend compared to agency ceiling** | **The actual agency spend in the month is £0.6m which increases the cumulative spend to £6.0m.** | See chart 1 below | **The cumulative agency spend of £6.0m is £0.2m (2%) above the cumulative agency ceiling of £5.8m.** |
| Cost Improvement Programme - In year performance to date<br>Red: 0-70% Plan delivered YTD<br>Amber: 70-90% Plan delivered YTD<br>Green: >90% Plan delivered YTD | **Cost savings delivered year to date compared to year to date plan.** | **CIP savings delivered in M7 are £0.5m against the M6 target of £1m, a further £0.3m was delivered in cost avoidance. The YTD M7 position for CIP is £3m against a YTD plan of £4.8m with a further £1.2m YTD M7 delivered in cost avoidance / income recovery.** | See chart 2 below | **The financial impact of transformation activities YTD M7 was £4.2m (£3m CIP & £1.2m cost avoidance) this is £0.6m below the Trust M7 CIP target of £4.8m.** |
| Cost Improvement Programme - Plans in Progress - In Year/Recurrent<br>Red: Forecast is less than 50% of annual target<br>Amber: Forecast is between 50% and 90% of the annual target<br>Green: Forecast is more than 90% of the annual target | **Planned improvements in productivity and efficiency - In Year & Recurrent forecast vs £10.5m target** | **In Year**<br>**The best case forecast for Trust CIP schemes in year is £5.8m. Best case assumes full delivery of all schemes on the tracker including all hopper ideas.**<br>**The worst case forecast for CIP in year is around £5m.**<br>**Worst case assumes the risk adjusted value of all schemes on the tracker and excludes all hopper ideas.**<br>**Recurrent**<br>**The best case forecast for recurrent CIP is around £5m which leaves a gap of £5.6m against the CIP target**<br>**The worst case forecast for recurrent CIP is around £2.4m which leaves a gap of £8m against the CIP target** | See chart 3 below | **The worst case current in year forecast for Trust CIP schemes is £5m which is £5.5m below the CIP target of £10.5m. The best case for CIP in year is £5.8m which is still £4.7m below the CIP target.**<br>**Best case cost avoidance of £3.3m will help mitigate the position but would still leave a bottom line shortfall of £1.4m.** |



**Warrington & Halton Hospitals NHS Foundation Trust** **Appendix 3a**

**Income Statement, Activity Summary and Use of Resources Ratings as at 31st October 2017**

| 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 | 3,224 | 2,719 | -505 | 21,389 | 19,764 | -1,625 |
| Elective Excess Bed Days | 14 | 6 | -7 | 91 | 91 | 0 |
| Non Elective Spells | 4,962 | 4,916 | -45 | 34,062 | 35,448 | 1,386 |
| Non Elective Excess Bed Days | 184 | 175 | -8 | 1,260 | 1,147 | -113 |
| Outpatient Attendances | 2,966 | 2,915 | -51 | 19,916 | 19,203 | -714 |
| Accident & Emergency Attendances | 1,112 | 1,035 | -77 | 7,712 | 7,599 | -113 |
| Other Activity | 5,251 | 5,473 | 222 | 36,763 | 38,082 | 1,320 |
| **Sub total** | **17,712** | **17,241** | **-471** | **121,193** | **121,334** | **141** |
| **Non NHS Clinical Income** | | | | | | |
| Private Patients | 9 | 0 | -9 | 63 | 59 | -4 |
| Other non protected | 107 | 143 | 36 | 749 | 662 | -87 |
| **Sub total** | **116** | **143** | **27** | **812** | **721** | **-91** |
| **Other Operating Income** | | | | | | |
| Training & Education | 641 | 641 | 0 | 4,487 | 4,487 | 0 |
| Donations and Grants | 0 | 19 | 19 | 0 | 19 | 19 |
| Sustainability & Transformation Fund | 703 | 0 | -703 | 3,163 | 2,460 | -703 |
| Miscellaneous Income | 845 | 1,053 | 208 | 5,816 | 6,682 | 866 |
| **Sub total** | **2,189** | **1,713** | **-476** | **13,466** | **13,647** | **182** |
| **Total Operating Income** | **20,017** | **19,097** | **-920** | **135,471** | **135,702** | **231** |
| **Operating Expenses** | | | | | | |
| Employee Benefit Expenses | -13,544 | -14,520 | -976 | -96,409 | -99,047 | -2,637 |
| Drugs | -1,438 | -1,375 | 63 | -10,108 | -9,561 | 547 |
| Clinical Supplies and Services | -1,500 | -1,678 | -178 | -10,830 | -11,700 | -870 |
| Non Clinical Supplies | -2,374 | -2,340 | 34 | -16,924 | -16,543 | 381 |
| Depreciation and Amortisation | -463 | -487 | -24 | -3,241 | -3,161 | 80 |
| Restructuring Costs | 0 | 0 | 0 | 0 | -14 | -14 |
| **Total Operating Expenses** | **-19,319** | **-20,400** | **-1,081** | **-137,513** | **-140,026** | **-2,514** |
| **Operating Surplus / (Deficit)** | **698** | **-1,304** | **-2,001** | **-2,042** | **-4,325** | **-2,283** |
| **Non Operating Income and Expenses** | | | | | | |
| Profit / (Loss) on disposal of assets | 0 | -13 | -13 | 0 | 0 | 0 |
| Interest Income | 2 | 1 | -1 | 14 | 10 | -4 |
| Interest Expenses | -34 | -49 | -15 | -243 | -269 | -26 |
| PDC Dividends | -273 | -222 | 51 | -1,910 | -1,560 | 350 |
| Impairments | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total Non Operating Income and Expenses** | **-305** | **-283** | **22** | **-2,139** | **-1,819** | **320** |
| **Surplus / (Deficit)** | **393** | **-1,586** | **-1,979** | **-4,181** | **-6,143** | **-1,962** |
| Depreciation on Donated and Granted Assets | 12 | 12 | 0 | 84 | 86 | 2 |
| **Control Total** | **405** | **-1,574** | **-1,979** | **-4,097** | **-6,057** | **-1,960** |

| Activity Summary | Planned | Actual | Variance | Planned | Actual | Variance |
|---|---|---|---|---|---|---|
| Elective Spells | 3,589 | 2,928 | -661 | 23,615 | 20,877 | -2,738 |
| Elective Excess Bed Days | 64 | 26 | -38 | 431 | 369 | -62 |
| Non Elective Spells | 3,288 | 2,902 | -386 | 22,575 | 21,594 | -981 |
| Non Elective Excess Bed Days | 877 | 731 | -146 | 6,022 | 4,713 | -1,309 |
| Outpatient Attendances | 28,863 | 27,353 | -1,510 | 193,785 | 185,751 | -8,034 |
| Accident & Emergency Attendances | 8,999 | 9,636 | 637 | 62,394 | 66,910 | 4,516 |

| Use of Resources Ratings | Planned Metric | Actual Metric | Variance Metric | Planned Metric | Actual Metric | Variance Metric |
|---|---|---|---|---|---|---|
| **Metrics** | | | | | | |
| Capital Servicing Capacity (Times) | | | | 0.55 | -0.17 | -0.72 |
| Liquidity Ratio (Days) | | | | -49.9 | -39.8 | 10.1 |
| I&E Margin (%) | | | | -3.02% | -4.46% | -1.44% |
| Variance from control total (%) | | | | 0.00% | -1.44% | -1.44% |
| Agency Ceiling (%) | | | | 0.00% | 1.93% | 1.93% |
| **Ratings** | | | | | | |
| Capital Servicing Capacity (Times) | | | | 4 | 4 | 0 |
| Liquidity Ratio (Days) | | | | 4 | 4 | 0 |
| I&E Margin (%) | | | | 4 | 4 | 0 |
| Variance from control total (%) | | | | 1 | 3 | 2 |
| Agency Ceiling (%) | | | | 1 | 2 | 1 |
| **Use of Resources Rating** | | | | **3** | **3** | **0** |

**Cash Flow Statement For 2017/18**

| | Actual April £000's | Actual May £000's | Actual June £000's | Actual July £000's | Actual August £000's | Actual September £000's | Actual October £000's | Forecast November £000's | Forecast December £000's | Forecast January £000's | Forecast February £000's | Forecast March £000's | Annual Position £000's |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **CASH FLOW FROM OPERATING ACTIVITIES** | | | | | | | | | | | | | |
| **Operating Surplus/(deficit)** | **(1,535)** | **(586)** | **(30)** | **(551)** | **(424)** | **106** | **(1,304)** | **868** | **(451)** | **929** | **(237)** | **3,103** | **(112)** |
| Non-cash income and expense | 463 | 463 | 381 | 475 | 445 | 447 | 487 | 463 | 463 | 462 | 462 | 541 | 5,552 |
| **Operating cash flows before movement in working capital** | **(1,072)** | **(123)** | **351** | **(76)** | **21** | **553** | **(817)** | **1,331** | **12** | **1,391** | **225** | **3,644** | **5,440** |
| (Increase)/decrease in working capital | 1,911 | 657 | 306 | 497 | 1,495 | 1,002 | 961 | 1,270 | (183) | 1,305 | (1,967) | (2,015) | **5,239** |
| **Net cash generated from/(used in) operations** | **839** | **534** | **657** | **421** | **1,516** | **1,555** | **144** | **2,601** | **(171)** | **2,696** | **(1,742)** | **1,629** | **10,679** |
| **CASH FLOW FROM INVESTING ACTIVITIES** | | | | | | | | | | | | | |
| Interest received | 1 | 2 | 1 | 1 | 2 | 1 | 1 | 2 | 2 | 2 | 4 | 7 | **26** |
| Purchase of property, plant and equipment and investment property | (291) | (604) | (645) | (368) | (623) | (552) | (206) | (463) | (463) | (463) | (463) | (1,859) | **(7,000)** |
| Proceeds from sales of property, plant and equipment and investment property | | | | | | 13 | (13) | | | | | | - |
| **Net cash generated from/(used in) investing activities** | **(290)** | **(602)** | **(644)** | **(367)** | **(621)** | **(538)** | **(218)** | **(461)** | **(461)** | **(461)** | **(459)** | **(1,852)** | **(6,974)** |
| **CASH FLOW FROM FINANCING ACTIVITIES** | | | | | | | | | | | | | |
| Public dividend capital received | - | - | - | - | 166 | 183 | 68 | 315 | 268 | - | - | - | **1,000** |
| Public dividend capital repaid | - | - | - | - | - | - | - | - | - | - | - | - | **-** |
| Loans from DH - received | 1,603 | - | - | - | 1,054 | 1,503 | - | - | - | - | - | 551 | **4,711** |
| Loans from DH - repaid | (2,000) | - | - | - | (2,053) | - | (1,054) | - | - | - | (53) | - | **(5,160)** |
| Capital element of finance lease rental payments | - | - | - | - | - | (172) | (29) | - | - | - | - | - | **(201)** |
| Interest paid | (30) | (33) | (36) | (37) | (36) | (30) | (45) | (32) | (33) | (31) | (33) | (8) | **(384)** |
| Interest elements of finance leases | (3) | (4) | (3) | (2) | (3) | (3) | (3) | (4) | (4) | (4) | (4) | (5) | **(42)** |
| PDC dividend (paid)/refunded | - | - | - | - | - | (1,387) | - | - | - | - | - | (1,888) | **(3,275)** |
| **Net cash generated from/(used in) financing activities** | **(430)** | **(37)** | **(39)** | **(39)** | **(872)** | **94** | **(1,063)** | **279** | **231** | **(35)** | **(90)** | **(1,350)** | **(3,351)** |
| **Increase/(decrease) in cash and cash equivalents** | **119** | **(105)** | **(26)** | **15** | **23** | **1,111** | **(1,137)** | **2,419** | **(401)** | **2,200** | **(2,291)** | **(1,573)** | **354** |
| **Cash and cash equivalents at start of period** | 1,201 | 1,320 | 1,215 | 1,189 | 1,204 | 1,227 | 2,338 | 1,201 | 3,620 | 3,219 | 5,419 | 3,128 | **1,201** |
| **Closing Cash and Cash equivalents less bank overdraft** | **1,320** | **1,215** | **1,189** | **1,204** | **1,227** | **2,338** | **1,201** | **3,620** | **3,219** | **5,419** | **3,128** | **1,555** | **1,555** |
| Forecast cash position as per Original Monitor plan | 1,160 | 1,881 | 1,609 | 2,135 | 1,313 | 1,160 | 2,924 | 3,620 | 3,219 | 5,419 | 3,128 | 1,555 | **1,555** |
| Actual cash position | 1,320 | 1,215 | 1,189 | 1,204 | 1,227 | 2,338 | 1,201 | 3,620 | 3,219 | 5,419 | 3,128 | 1,555 | **1,555** |
| **Variance** | **160** | **(666)** | **(420)** | **(931)** | **(86)** | **1,178** | **(1,723)** | **-** | **-** | **-** | **-** | **-** | **-** |

**Statement of Financial Position as at 31st October 2017**

| Narrative | Audited Position as at 31/03/17 £000 | Actual Position as at 30/09/17 £000 | Actual Position as at 31/10/17 £000 | Monthly Movement £000 | Forecast Position as at 31/03/18 £000 |
|---|---|---|---|---|---|
| **NON-CURRENT ASSETS** | | | | | |
| Intangible Assets | 2,308 | 2,513 | 2,516 | 3 | 1,047 |
| Property, Plant and Equipment | 117,890 | 118,100 | 117,808 | (292) | 124,091 |
| Trade and Other Receivables, non-current | 991 | 998 | 911 | (87) | 1,205 |
| **Total Non-Current Assets** | **121,189** | **121,611** | **121,235** | **(376)** | **126,343** |
| **CURRENT ASSETS** | | | | | |
| Inventories | 3,437 | 3,503 | 3,337 | (166) | 3,312 |
| Trade and Other Receivables, current | 13,163 | 10,967 | 11,480 | 513 | 8,398 |
| Cash and Cash Equivalents | 1,201 | 2,338 | 1,201 | (1,137) | 1,555 |
| **Total Current Assets** | **17,801** | **16,808** | **16,018** | **(790)** | **13,265** |
| **Total Assets** | **138,990** | **138,419** | **137,253** | **(1,166)** | **139,608** |
| **CURRENT LIABILITIES** | | | | | |
| Trade and Other Payables | (16,405) | (19,651) | (22,211) | (2,560) | (22,824) |
| Other Liabilities | (4,070) | (4,599) | (3,501) | 1,098 | (3,880) |
| Borrowings, current | (454) | (13,759) | (12,705) | 1,054 | (14,491) |
| Provisions | (279) | (238) | (234) | 4 | (256) |
| **Total Current Liabilities** | **(21,208)** | **(38,247)** | **(38,652)** | **(405)** | **(41,451)** |
| **TOTAL ASSETS LESS CURRENT LIABILITIES** | **117,782** | **100,172** | **98,601** | **(1,571)** | **98,157** |
| **NON-CURRENT LIABILITIES** | | | | | |
| Borrowings, non-current | (28,152) | (14,781) | (14,752) | 29 | (13,562) |
| Provisions | (1,377) | (1,348) | (1,324) | 24 | (1,198) |
| **Total Non Current Liabilities** | **(29,529)** | **(16,129)** | **(16,076)** | **53** | **(14,760)** |
| **TOTAL ASSETS EMPLOYED** | **88,253** | **84,043** | **82,525** | **(1,518)** | **83,397** |
| **TAXPAYERS' EQUITY** | | | | | |
| Public dividend capital | 87,742 | 88,091 | 88,159 | 68 | 88,742 |
| Income and expenditure reserve | (21,967) | (26,526) | (28,112) | (1,586) | (27,823) |
| Revaluation Reserve | 22,478 | 22,478 | 22,478 | 0 | 22,478 |
| **TOTAL TAXPAYERS' EQUITY** | **88,253** | **84,043** | **82,525** | **(1,518)** | **83,397** |

## BOARD OF DIRECTORS

| | |
|---|---|
| **AGENDA REFERENCE:** | **BM/17/11/117(b)** |
| **SUBJECT:** | **Safe Staffing Assurance Report** |
| **DATE OF MEETING:** | |
| **ACTION REQUIRED** | **The Board of Directors are asked to note the contents of the report** |
| **AUTHOR(S):** | John Goodenough – Deputy Chief Nurse |
| **EXECUTIVE DIRECTOR SPONSOR:** | Kimberley Salmon –Jamieson –Chief Nurse |
| | |
| **LINK TO STRATEGIC OBJECTIVES:** | SO1: To ensure that all care is rated amongst the top quartile in the North West of England for patient safety, clinical outcomes and patient experience |
| **LINK TO BOARD ASSURANCE FRAMEWORK (BAF):** | BAF2.2: Nurse Staffing |
| | BAF1.3: National & Local Mandatory, Operational Targets |
| | BAF1.1: CQC Compliance for Quality |
| | |
| **STRATEGIC CONTEXT** | SO1: To ensure that all care is rated amongst the top quartile in the North West of England for patient safety, clinical outcomes and patient experience. |
| **EXECUTIVE SUMMARY** (KEY ISSUES): | Ward staffing data continues to be systematically reviewed to ensure we safely staff our wards and provide mitigation and action when actual falls below 90% of planned staffing levels. |
| **RECOMMENDATION:** | It is recommended that the Board of Directors receive a monthly Safe Staffing paper highlighting areas where average fill rates fall below 90% of actual versus planned, along with mitigation to ensure safe, high quality care is consistently delivered. |
| **PREVIOUSLY CONSIDERED BY:** | **Committee** |
| | **Agenda Ref.** |
| | **Date of meeting** |
| | **Summary of Outcome** |
| **FREEDOM OF INFORMATION STATUS (FOIA):** | |
| **FOIA EXEMPTIONS APPLIED:** ***(if relevant)*** | |

## Safe Staffing Assurance Report

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

The Trust has a duty to ensure nursing and midwifery staffing levels are sufficient to maintain safety and provide quality care. This paper provides assurance that any shortfalls on each shift were reviewed and addressed as required with mitigating actions, including staffing levels and skill mix. It is well documented that nurse staffing levels make a difference to patient outcomes (mortality and adverse events, including levels of harm), patient experience, quality of care and the efficiency of care delivery.

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

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

The September & October Trust wide staffing data was analysed and cross referenced for validation by Divisional Matrons and Divisional Associate Director of Nurses.

The following tables identify the fill rates for staff across the Trust in September & October with Care Hours Per Patient Day (CHPPD). The table also triangulates this information by illustrating the harms reported within each area.

Mitigating actions that were taken in September and October in areas where the actual numbers of registered nurses and health care support staff were below 90% of the planned numbers of staff have been outlined. This report demonstrates the monthly CHPPD per ward across the Trust and provides assurance of the divisional actions taken to provide adequate staffing levels on a day to day / shift by shift basis.

**Appendix 1** MONTHLY SAFE STAFFING REPORT –September 2017

# Monthly Safe Staffing Report – September 2017

| | Day | | | | | | | Night | Night | Night | Night | Night | Night | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Division | Ward | Planned RN hours | Actual RN hours | Planned CS hours | Actual CS hours | % RN fill rate | % CS fill rate | Planned RN hours | Actual RN hours | Planned CS hours | Actual CS hours | % RN fill rate | % CS fill rate | Falls (Mod and Above) | Cdiff | MRSA | Pressure Ulcers |
| | | = above 100% | | = above 90% | | | = above 80% | | | = below 80% | | | | | | | |
| SWC | SAU | 930 | 877.5 | 697.5 | 631 | 95.5% | 90.5% | 0 | 0 | 0 | 0 | - | - | | | | |
| SWC | Ward A5 | 1782.5 | 1479.5 | 1314 | 1134 | 88.6% | 87.4% | 1069.5 | 989 | 713 | 690 | 97.1% | 100.0% | | | | |
| SWC | Ward A6 | 1782.5 | 1420.5 | 1426 | 1663 | 84.0% | 88.8% | 1069.5 | 954.5 | 713 | 701.5 | 97.8% | 110.0% | | | | |
| SWC | Ward C22 | 1069.5 | 1058 | 1069.5 | 966 | 97.9% | 100.1% | 713 | 713 | 713 | 713 | 100.0% | 108.3% | | | | |
| SWC | Ward B4 | 762 | 609.5 | 520.5 | 376 | 100.0% | 100.0% | 241.5 | 218.5 | 241.5 | 218.5 | 100.0% | 100.0% | | | | |
| SWC | Ward A9 | 1782.5 | 1410.5 | 1426 | 1489.5 | 81.9% | 104.4% | 1069.5 | 1046.5 | 1069.5 | 1069.5 | 94.4% | 96.8% | | | | |
| SWC | Ward B1 | 1552.5 | 1477 | 954.5 | 904 | 109.7% | 110.1% | 713 | 713 | 713 | 667 | 100.0% | 100.0% | | | | |
| SWC | Ward B11 | 1935.2 | 1935.2 | 784.2 | 773.8 | 92.7% | 94.6% | 1616.8 | 1616.8 | 0 | 0 | 98.6% | - | | | | |
| SWC | NCU | 1782.5 | 1511 | 356.5 | 293.5 | 95.7% | 20.0% | 1782.5 | 1380 | 356.5 | 264.5 | 82.6% | 63.3% | | | | |
| SWC | Ward C20 | 954.5 | 954.5 | 667 | 652 | 88.2% | 100.0% | 705 | 713 | 0 | 0 | 71.7% | - | | | | |
| SWC | Ward C23 | 1426 | 1230 | 713 | 563.5 | 81.6% | 62.3% | 713 | 713 | 713 | 621 | 100.0% | 71.7% | | 1 | | |
| SWC | Delivery Suite | 2495.5 | 2294 | 363.5 | 349 | 92.0% | 109.5% | 2495.5 | 2438 | 356.5 | 333.5 | 100.7% | 80.0% | | | | |
| ACS | Ward A1 | 2325 | 1857.5 | 1550 | 1550 | 77.7% | 100.0% | 1953 | 1543.5 | 651 | 672 | 72.0% | 103.2% | | | | |
| ACS | Ward A2 | 1426 | 1158 | 1594 | 1404.5 | 77.2% | 88.4% | 1069.5 | 1039 | 713 | 828 | 91.1% | 120.0% | | | | 1 |
| ACS | Ward A3 | 1426 | 1195.5 | 1426 | 1725.5 | 76.8% | 110.4% | 1069.5 | 977.5 | 713 | 1035 | 85.6% | 141.9% | | | | |
| ACS | Ward A4 | 1197 | 1164 | 1529.5 | 1443 | 79.9% | 104.8% | 920 | 862.5 | 1069.5 | 1023.5 | 104.9% | 90.8% | 1 | | | |
| ACS | Ward A8 | 1782.5 | 1327 | 2139 | 1730.5 | 76.3% | 92.2% | 1069.5 | 1046.5 | 1782.5 | 1368.5 | 93.3% | 92.7% | | | | |
| ACS | Ward B12 | 1069.5 | 1010 | 2495.5 | 2273 | 96.7% | 90.3% | 713 | 713 | 1426 | 1426 | 99.3% | 98.2% | | | | |
| ACS | Ward B14 | 1426 | 1318.5 | 1426 | 1985.5 | 79.1% | 104.0% | 713 | 713 | 713 | 1437.5 | 100.0% | 115.0% | | | | |
| ACS | Ward B18 | 1426 | 1255 | 1426 | 1398.5 | 73.3% | 99.2% | 1069.5 | 885.5 | 1069.5 | 977.5 | 75.6% | 96.7% | | 2 | | |
| ACS | Ward A7 | 1782.5 | 1573.5 | 2035.5 | 1787.5 | 84.8% | 85.0% | 1426 | 1378.5 | 1782.5 | 1357 | 87.9% | 86.7% | | | | |
| ACS | Ward C21 | 1069.5 | 1069.5 | 713 | 1106 | 100.0% | 100.0% | 713 | 713 | 713 | 988.9 | 100.0% | 150.0% | | | | |
| ACS | CCU | 1782.5 | 1338.25 | 372 | 272.5 | 92.1% | 63.8% | 1069.5 | 1030.5 | 0 | 0 | 97.8% | - | | | | |
| ACS | ICU | 4991 | 4807 | 1069.5 | 609.5 | 90.2% | 65.6% | 4991 | 4830 | 713 | 356.5 | 90.0% | 61.7% | | 1 | | |
| | | | | | | | | | | | | | | | | | |

## Appendix 2

## September 2017 Mitigating Actions

| | DAY | | NIGHT | | MITIGATING ACTIONS |
|---|---|---|---|---|---|
| | Average fill rate - registered nurses/midwives (%) | Average fill rate – Health Care support staff (%) | Average fill rate - registered nurses/midwives (%) | Average fill rate - Health Care support staff (%) | |
| **SAU** | 95.5 | 90.5 | - | - | SAU closes at 2.00hrs each night |
| **Ward A5** | 88.6 | 87.4 | 97.1 | 100.0 | All vacancies being recruited to on the rolling programme. LTS managed as policy |
| **Ward C22** | 97.9 | 100.1 | 100.0 | 108.3 | Enhanced care required at night during this month of September. All vacancies being recruited to. LTS managed as policy. |
| **Ward A9** | 81.9 | 104.4 | 94.4 | 96.8 | Band 5 vacancies - await 3 full time starters in October |
| **NCU** | 95.7 | 20.0 | 82.6 | 63.3 | High sickness levels amongst HCSWs. Acuity assessed against staffing on a daily basis. |
| **Ward C20** | 88.2 | 100.0 | 71.7 | - | All vacancies being recruited to on the rolling programme. LTS managed as policy |
| **Ward C23** | 81.6 | 62.3 | 100.0 | 71.7 | Increased sickness currently in the Maternity unit. Acuity assessed by the team daily and staff redeployed across the unit to meet activity |
| **Ward A1** | 77.7 | 100.0 | 72.0 | 103.2 | AP on ward to support the ward. Ward also has pharmacy technician to support with medications. HCSWs support with observations |
| **Ward A2** | 77.2 | 88.4 | 91.1 | 120.0 | Ward Manager assists on ward and Matron reviews staffing on daily basis and staff moved from other wards to ensure safety |
| **Ward A3 OPAL** | 76.8 | 110.4 | 85.6 | 141.9 | A3 opened 5 beds on the 20th September. Staffing has been escalated and all shifts out to NHSP. HCSWs have been increased to provide support. Senior nurse oversight in place |
| **Ward A4** | 79.9 | 104.8 | 104.9 | 90.8 | Ward escalated by 10 patients, currently 32 patients on the ward. All patients medically fit and screened by Ward Manager. AP to support on ward with nurses, extra HCSW to support when RN time falls short. All shifts out to NHSP and agency in advance. Matron support s ward cover across the CBU |
| **Ward A8** | 76.3 | 92.2 | 93.3 | 92.7 | Ward deescalated in part of month. Enhanced care required in month, RN vacancies filled by temporary staffing and HCSW |

| | | | | | |
|---|---|---|---|---|---|
| **Ward B12 Forget Me Not** | 96.7 | 90.3 | 99.3 | 98.2 | Ward risk assessed and enhanced care requested. Enhanced care reliant on temporary staffing. |
| **Ward B14** | 79.1 | 104.0 | 100.0 | 115.0 | Band 5 vacancy, increase in enhanced care in month, ward risk assessed by Matron and Lead Nurse |
| **Ward B18** | 73.3 | 99.2 | 75.6 | 96.7 | Short term sickness in month managed in line with policy, RNs moved to support safety |
| **Ward A7** | 84.8 | 85.0 | 87.9 | 86.7 | Increased establishment approved and posts out to advert. NHSP staff cover shortfall. Ward remains to have enhanced care / 1:1 patient support . Supported by Matron and Lead Nurse |
| **Ward C21** | 100.0 | 100.0 | 100.0 | 150.0 | Increased HCSW utilised for day and night due to increased medical patients requiring 1:1 / enhanced care . Ward supporting CCU due to staffing short falls. Reduced WM management time. |
| **CCU Coronary Care Unit** | 92.1 | 63.8 | 97.8 | - | 3x RN on Maternity Leave . C21 supporting . Reduced management time for WM due to staffing. |
| **ICU Intensive Care Unit** | 90.2 | 65.6 | 90.0 | 61.7 | Vacancies remain on the unit. Shift short falls supported by Ward Manager and Clinical Facilitator . Monitored and supported by Matron and Lead Nurse . |

**Appendix 1** **MONTHLY SAFE STAFFING REPORT –October 2017**

# Monthly Safe Staffing Report – October 2017

| | Day | | Day | Day | Day | Day | Day | Night | Night | Night | Night | Night | Night | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Division** | **Ward** | **Planned RN hours** | **Actual RN hours** | **Planned CS hours** | **Actual CS hours** | **% RN fill rate** | **% CS fill rate** | **Planned RN hours** | **Actual RN hours** | **Planned CS hours** | **Actual CS hours** | **% RN fill rate** | **% CS fill rate** | **Falls (Mod and Above)** | **Cdiff** | **MRSA** | **Pressure Ulcers** |
| | | = above 100% | | = above 90% | | | = above 80% | | | = below 80% | | | | | | | |
| SWC | SAU | 930 | 877.5 | 697.5 | 631 | 100.0% | 60.2% | 0 | 0 | 0 | 0 | - | - | | | | |
| SWC | Ward A5 | 1782.5 | 1479.5 | 1314 | 1134 | 84.1% | 95.1% | 1069.5 | 989 | 713 | 690 | 94.6% | 103.2% | | | | |
| SWC | Ward A6 | 1782.5 | 1420.5 | 1426 | 1663 | 85.6% | 89.3% | 1069.5 | 954.5 | 713 | 701.5 | 93.5% | 116.1% | | | | |
| SWC | Ward C22 | 1069.5 | 1058 | 1069.5 | 966 | 101.1% | 97.8% | 713 | 713 | 713 | 713 | 100.0% | 100.0% | | | | |
| SWC | Ward B4 | 762 | 609.5 | 520.5 | 376 | 97.0% | 96.0% | 241.5 | 218.5 | 241.5 | 218.5 | 100.0% | 100.0% | | | | |
| SWC | Ward A9 | 1782.5 | 1410.5 | 1426 | 1489.5 | 79.3% | 105.3% | 1069.5 | 1046.5 | 1069.5 | 1069.5 | 98.9% | 102.0% | | | | |
| SWC | Ward B1 | 1552.5 | 1477 | 954.5 | 904 | 85.2% | 90.0% | 713 | 713 | 713 | 667 | 100.0% | 98.4% | | 1 | | |
| SWC | Ward B11 | 1935.2 | 1935.2 | 784.2 | 773.8 | 96.8% | 98.5% | 1616.8 | 1616.8 | 0 | 0 | 99.3% | - | | | | |
| SWC | NCU | 1782.5 | 1511 | 356.5 | 293.5 | 100.8% | 43.0% | 1782.5 | 1380 | 356.5 | 264.5 | 92.9% | 71.0% | | | | |
| SWC | Ward C20 | 954.5 | 954.5 | 667 | 652 | 100.0% | 96.8% | 705 | 713 | 0 | 0 | 100.0% | 227.0% | | | | |
| SWC | Ward C23 | 1426 | 1230 | 713 | 563.5 | 86.3% | 89.9% | 713 | 713 | 713 | 621 | 100.0% | 75.8% | | | | |
| SWC | Delivery Suite | 2495.5 | 2294 | 363.5 | 349 | 91.5% | 98.3% | 2495.5 | 2438 | 356.5 | 333.5 | 94.9% | 98.9% | | | | |
| ACS | Ward A1 | 2325 | 1857.5 | 1550 | 1550 | 76.9% | 100.0% | 1953 | 1543.5 | 651 | 672 | 72.0% | 100.0% | | | | |
| ACS | Ward A2 | 1426 | 1158 | 1594 | 1404.5 | 80.8% | 92.3% | 1069.5 | 1039 | 713 | 828 | 91.2% | 116.1% | | | | |
| ACS | Ward A3 | 1426 | 1195.5 | 1426 | 1725.5 | 75.9% | 120.0% | 1069.5 | 977.5 | 713 | 1035 | 94.6% | 154.8% | | | | 3 |
| ACS | Ward A4 | 1197 | 1164 | 1529.5 | 1443 | 79.4% | 107.4% | 920 | 862.5 | 1069.5 | 1023.5 | 80.1% | 116.7% | | | | |
| ACS | Ward A8 | 1782.5 | 1327 | 2139 | 1730.5 | 79.6% | 93.4% | 1069.5 | 1046.5 | 1782.5 | 1368.5 | 95.7% | 91.6% | | | | 1 |
| ACS | Ward B12 | 1069.5 | 1010 | 2495.5 | 2273 | 99.5% | 99.1% | 713 | 713 | 1426 | 1426 | 100.0% | 95.3% | | | | 1 |
| ACS | Ward B14 | 1426 | 1318.5 | 1426 | 1985.5 | 83.5% | 95.2% | 713 | 713 | 713 | 1437.5 | 100.0% | 100.0% | | | | |
| ACS | Ward B18 | 1426 | 1255 | 1426 | 1398.5 | 81.8% | 92.0% | 1069.5 | 885.5 | 1069.5 | 977.5 | 77.4% | 89.2% | | | | |
| ACS | Ward A7 | 1782.5 | 1573.5 | 2035.5 | 1787.5 | 83.0% | 93.4% | 1426 | 1378.5 | 1782.5 | 1357 | 87.9% | 85.4% | | | | |
| ACS | Ward C21 | 1069.5 | 1069.5 | 713 | 1106 | 98.9% | 94.9% | 713 | 713 | 713 | 988.9 | 97.9% | 94.9% | | | | 3 |
| ACS | CCU | 1782.5 | 1338.25 | 372 | 272.5 | 91.2% | 72.2% | 1069.5 | 1030.5 | 0 | 0 | 93.1% | - | | | | |
| ACS | ICU | 4991 | 4807 | 1069.5 | 609.5 | 94.7% | 67.1% | 4991 | 4830 | 713 | 356.5 | 97.7% | 59.7% | | | | |
| | | | | | | | | | | | | | | | | | |

## Appendix 2

## OCTOBER 2017 Mitigating Actions

| | DAY | | NIGHT | | MITIGATING ACTIONS |
|---|---|---|---|---|---|
| | Average fill rate - registered nurses/midwives (%) | Average fill rate – Health Care support staff (%) | Average fill rate - registered nurses/midwives (%) | Average fill rate - Health Care support staff (%) | |
| **SAU** | 100.0% | 60.2% | - | - | SAU closed overnight. AP on long term sick and CSW down. LTS managed as per policy |
| **Ward A5** | 84.1% | 95.1% | 94.6% | 103.2% | Ongoing recruitment to vacancies . Sickness managed as per policy |
| **Ward A6** | 85.6% | 89.3% | 93.5% | 116.1% | Ongoing recruitment to vacancies. Additional HCSW used for 1:1's as required. Sickness managed as per policy |
| **Ward C22** | 101.1% | 97.8% | 100.0% | 100.0% | Ongoing recruitment to vacancies. Additional HCSW used for 1:1's as required. Sickness managed as per policy |
| **Ward A9** | 79.3% | 105.3% | 98.9% | 102.0% | 3 RNs off sick. 1 resuming 06/11/17. 1 RN on Mat leave, 1 long term. 3 F/T vacancies - on-going recruitment program. Additional staff via NHSP for enhanced care |
| **NHDU / NITU** | 100.8% | 43.0% | 92.9% | 71.0% | Long term sickness of nursery nurse affected care staff figures. This was managed as per policy. |
| **Ward C20** | 100.0% | 96.8% | 100.0% | 227.0% | Ongoing recruitment to vacancies. Ward escalated during the month to 18 patients, bank and agency used via NHSP and staff moved from Digestive Diseases CBU to help and Ward Manager in numbers |
| **Ward C23** | 86.3% | 89.9% | 100.0% | 75.8% | Staff sickness managed as per policy and locum staff sued to support safety requirements |
| **Delivery Suite** | 91.5% | 98.3% | 94.9% | 98.9% | Staff sickness managed as per policy and locum staff sued to support safety requirements |
| **Ward A1** | 76.9% | 100.0% | 72.0% | 100.0% | Long term sickness increased in month, staff redeployed to other areas to support short fall in trust after assessment by Lead Nurse |
| **Ward A2** | 80.8% | 92.3% | 91.2% | 116.1% | 2.89 vacancies currently, RNs moved from other areas to support safety requirements |
| **Ward A3 OPAL** | 75.9% | 120.0% | 94.6% | 154.8% | Ward reliant on temporary staffing to fill vacancy, increase in enhanced care and 1:1 in month. Ward staffing reviewed by Lead Nurse daily. Recruitment to RNSI's commenced for A3 |
| **Ward A4** | 79.4% | 107.4% | 80.1% | 116.7% | Ward escalated and back filled with |

| | | | | | |
|---|---|---|---|---|---|
| | | | | | temporary staffing, ward staffing reviewed by Lead Nurse daily |
| **Ward A8** | 79.6% | 93.4% | 95.7% | 91.6% | Matron based on ward to support from the 23rd October. Ward reliant on temporary staffing to fill vacancy, increase in enhanced care and 1:1 in month. Recruitment to RNSI's commenced for A8 |
| **Ward B12 – Forget Me Not** | 99.5% | 99.1% | 100.0% | 95.3% | Ward has risk assessment in place as increased number of enhanced care patients and 1:1 reliant on temporary staffing |
| **Ward B14** | 83.5% | 95.2% | 100.0% | 100.0% | RNs and locum staff utilised to support gaps in shift rotas |
| **Ward B18** | 81.8% | 92.0% | 77.4% | 89.2% | Vacancies RN 1.28 / HCA 1.16, RNs and locum staff utilised to support gaps in shift rotas |
| **Ward C21** | 98.9% | 94.9% | 97.9% | 94.9% | Ward Manager & 2 RNs on long term sickness , RNs and locum staff utilised to support gaps in shift rotas |
| **CCU – Coronary Care Unit** | 91.2% | 72.2% | 93.1% | - | Ward Manager supported rota gaps to ensure safety. 3 x RN maternity on leave, HCSW vacancies and reduced HCSW due to moves to support other wards |

b

Warrington and Halton Hospitals
NHS Foundation Trust

**BOARD OF DIRECTORS**

| AGENDA REFERENCE: | **BM/17/11/XXX** |
|---|---|
| SUBJECT: | **Engagement Dashboard 2017-18 – Half Year Report** |
| DATE OF MEETING: | 29th November 2017 |
| ACTION REQUIRED | **For Assurance** |
| AUTHOR(S): | Pat McLaren |
| EXECUTIVE DIRECTOR SPONSOR: | Pat McLaren, Director of Community Engagement |
| | |
| LINK TO STRATEGIC OBJECTIVES: | All |
| LINK TO BOARD ASSURANCE FRAMEWORK (BAF): | BAF2.4: Engaging & Involving Workforce |
| | |
| | |
| | |
| STRATEGIC CONTEXT | The Trust is required to engage with its patients, public, staff and partners and many other stakeholders as set out in the Foundation Trust's membership and engagement strategy. |
| EXECUTIVE SUMMARY (KEY ISSUES): | This half year Dashboard provides a high-level overview of how well the Trust is engaging and involving key stakeholder groups i.e. those who use, work, visit, volunteer, support, commission, partner or donate to our hospitals. It shows clear trends and progress against our key communication and engagement objectives.<br><br>Key items to note:<br>a. Positive and neutral media coverage outweighs negative, but issues in October 2017 relating to Suspension of Spinal Surgery has affected overall balance<br>b. The Warrington Guardian continues to be the main publisher of WHH news with online reporting being the dominant medium<br>c. While average Facebook 'likes' remain relatively static (circa 4K) per story reach increases sharply when sharing and re-posting high profile stories (eg WHH Dragon Boat Race in June)<br>d. Twitter followers continue to grow and in the first half of the year our Twitter community has increased by 6% (compared with 15% for whole year in 2016-17) Twitter reach is highly variable and predominately linked to traditional media reporting<br>e. Website engagement has risen steadily in year with |

Warrington and Halton Hospitals
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| | 178K visitors (more than all of the previous year) but dwell time remains static at 1.31mins. We recognise that this is due to the templated build of our existing site which is not mobile enabled and therefore visitors move on quickly – a new website has been commissioned and staff, patient and public engagement has commenced. Almost two thirds of our website visitors arrived via mobile device (smart phone or tablet)<br>f. Engaging staff through Team Brief remains challenging, as for all Trusts, where 'Core Brief' is a proven large-organisation information cascade tool. The creation of People Champions disseminating the 'Brief in Brief' will assist with staff engagement even if actual attendance remains static<br>g. In terms of patient engagement we continue to evaluate the NHS Choices overall 'Star' rating for the Trust recognising that the ratings are assigned on extremely small numbers. The new FFT system is allowing us to collate ward/service level feedback and we intend to promote this through our website. |
| **RECOMMENDATION:** | The Board is asked to note the half year Engagement Dashboard |
| **PREVIOUSLY CONSIDERED BY:** | **Committee** |
| | **Agenda Ref.** |
| | **Date of meeting** |
| | **Summary of Outcome** |
| **FREEDOM OF INFORMATION STATUS (FOIA):** | Release Document in Full |
| **FOIA EXEMPTIONS APPLIED:** ***(if relevant)*** | |

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**BOARD OF DIRECTORS CHAIR'S KEY ISSUES REPORT**

| AGENDA REFERENCE: | | COMMITTEE OR GROUP: | Quality Assurance Committee | DATE OF MEETING | 29th November 2017 |
|---|---|---|---|---|---|

| Date of Meeting | 3rd October 2017 |
|---|---|
| Name of Meeting + Chair | Quality Assurance Committee Chaired by Margaret Bamforth |
| Was the meeting quorate? | Yes |

| REF | AGENDA ITEM | ISSUE AND LEAD OFFICER | Recommendation / Assurance/ mandate to receiving body | Follow up/ Review date |
|---|---|---|---|---|
| | **Serious Incidents Monthly Report** | The Committee received the Serious Incident Monthly Report which provides an update on the status of all open incidents.<br>• Discussion focussed on falls and Pressure Ulcers, which make up a significant number of the SIs reported.<br>• Progress is being monitored against the falls action plan. However, it remains the highest category for incidents.<br>• There is also a piece of work underway looking at diagnostic pathways as there have been 2 SIs in July/August.<br>• An improvement programme has been developed which will ensure learning from SIs investigations and findings is shared Trust-wide. 40 members of staff will have undertaken RCA analysis training to support future learning. | • Findings of clinical audit report relating to RCAs to be presented to next QC and quarterly thereafter?<br>• Diagnostic Pathways action plan to be presented to next QC.<br>• The Committee noted that CBUs are to review outstanding actions from SI investigations to ensure learning and action is implemented. | **Q&A Ctte November** |

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| | **Pressure Ulcer Action Plan** | The Committee received the Pressure Ulcer Action Plan. Pressure Ulcers remain an area of concern and the Committee reviewed the progress being made to reduce harm in this area. The external review of the tissue viability team was reported in the Key Issues Report to the September Board.<br><br>- 22 actions contained within the Action Plan, 16 reported as 'green', 6 reported as 'amber'.<br>- RB reported that an additional 6 nurses are working with TV nurses to enable training of front line staff.<br>- MC shared with the QC that the appointment of a registered nurse with specialist interest had been supported at the recent JNCC meeting | • The Committee discussed and noted the report.<br>• The Committee were not fully assured at this stage of plans in place to manage PUs due to a number of factors, i.e. community acquired PUs, current staffing ratios.<br>• The Committee was re-assured of governance processes and action plans in plan to support training and education and monitor progress through the PSCE with matters escalated to QC. | |
| | **Paediatric Care A&E Review action plan** | The Committee received the Paediatric Urgent Care Review and Action Plan. This is a comprehensive document looking at urgent care provision for children across the Emergency Department, Paediatric Assessment Unit and Community Paediatric Acute Response Team. Current staffing levels do not reflect attendance patterns or respond to predictable peak activity, which is fluid between ED and Paediatrics. An implementation plan for a new model of staffing for Paediatric Emergency Care was proposed. A Consultant Paediatrician for urgent care has now been appointed and the new management arrangements progressed. | • **The Committtee were assured that the current provision is safe but recognised that there is a considerable amount of work still to do to fully implement all the recommendations from the review.** | |
| | **Complaints Bi-monthly report** | The Committee received the Bi-Monthly Complaints Report<br>- Datix Web system to be rolled out from mid November to | • **The Committee discussed and reviewed the report and the** | |

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| | | support reporting of complaints across the Trust.<br>- 33 open complaints, 9 over six months, which is a significant improvement reducing from 160 over 6 months<br>- 33 complaints over 100 days and renewed focus and effort to clear backlog before winter demand begins. Trajectory to clear backlog by end of December.<br>- Improvement noted in relation to resolution of complaints and response rates particularly resolution at local/ward level to avoid escalation to a full complaint.<br>- The QC noted the potential for escalation of complaints due to recent decision by the Trust to suspend Spinal Surgery and demands of winter. | **significant improvement in the complaints handling process and the reduction in the original backlog.** | |
| | **Dementia Strategy 6 month update report** | John Goodenough presented the Dementia Strategy 6 month up-date report and shared the feedback from the Royal College of Psychiatrists National Audit. This report shows the Trust's performance against 199 Trusts nationally in specific areas:<br>• Governance – 1st out of 199;<br>• Nutrition – 153rd out of 199 (67.5% lower quartile) – areas identified included access to finger foods;<br>• Discharge of patients – ranked 2nd out of 195 (97.5%); Assessment – ranked 3rd out of 195 ( 96.9%);<br>• Carer rating of information provided – 12th out of 148 (80%);<br>• Care rating of patient care – 8th of 148 (87.5%). | • **This was excellent external confirmation of good performance in this area.**<br>• **Where the Trust performance was in the lower quartile, improvement plans are to be developed.** | |
| | **Quality Dashboard and** | A Quality Dashboard is presented for each Division. This is way of ensuring governance at Divisional and CBU level. Each | • **The Committee reviewed and** | |

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| | **risk register** | division provides a report as well as presenting their dashboard. A number of issues were highlighted for Surgery, Women and Children's which included, a focus on duty of candour, 3 CBUs in mandated support, 19 falls (no harm) and work on NICE compliance. For Acute Care Services, staffing problems and difficulty discharging from ICU were highlighted. | **discussed the reports and noted staffing pressures and mortuary review had been added to the Risk Register** | |
| | **Risk Register** | Since the report had been produced, 1 risk had been removed - Theatre risk replaced by a risk to reflect potential risk from future organisational change.<br>- Anaesthetic staffing challenges to be reported in the next CRR.<br>- The Risk Review Group chaired by the Chief Nurse meetings monthly to review all risks above 15 and to identify areas for a deep dive into areas of concern.<br>- Deep dive is to be undertaken into critical care /diagnostics to identify trends and themes which will be linked through the Divisional Risk Registers and the CRR.<br>- External review commissioned by KSJ relating to adequate isolation facilities and surveillance rooms and will be reported through PSCE and IC Sub Committee. | • **The Committee noted the updates to the Strategic Risks and the Board Assurance Framework.**<br>• **The Committee noted the significant improvement in reduction of complaints.**<br>• **The Committee noted the quarterly Risk Management report a progress and plans in place.** | |

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**BOARD OF DIRECTORS CHAIR'S KEY ISSUES REPORT**

| AGENDA REFERENCE: | BM/17/11/1 7 (d) i | COMMITTEE OR GROUP: | Quality Assurance Committee | DATE OF MEETING | 29th November 2017 |
|---|---|---|---|---|---|

| Date of Meeting | 7th November 2017 |
|---|---|
| Name of Meeting + Chair | Quality Assurance Committee  Chaired by Margaret Bamforth |
| Was the meeting quorate? | Yes |

| REF | AGENDA ITEM | ISSUE AND LEAD OFFICER | Recommendation / Assurance/ mandate to receiving body | Follow up/ Review date |
|---|---|---|---|---|
| | **Halton CQC Local System Published Review** | Jan Ross, Acting COO presented the CQC local system published review report to the Committee. The Review team was led by Ann Ford and Wendy Dixon and the team reviewed three key areas:<br>1. Maintaining the wellbeing of a person in usual place of residence<br>2. Crisis management<br>3. Step down, return to usual place of residence and/or admission to a new place of residence.<br>WHH did not feature greatly in the Review that focussed mainly on Primary Care and Community services, as well as the CCG and Local Authority. It is difficult to summarise the report which contains many important findings and recommendations for the healthcare system in Halton. There will be an opportunity for WHH to contribute to a Local Summit arranged to bring together the system leaders and partners. WHH will be | **The Committee noted the report.** | |

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| | | contributing to the delivery of the action plan. | | |
| | **Learning from Incidents** | The Committee received a number of related papers and reports, which address how the Trust is learning from incidents. These included:<br>• Serious Incident Monthly Report<br>• Diagnostic cluster analysis and action plan<br>• Lessons learned audit report quarterly report<br>• Learning from experience quarterly report<br>• Lessons Learned Framework<br>The diagnostic cluster analysis was presented by Dr Alex Crowe, Acting Medical Director. This piece of work demonstrates how analysis of incidents has resulted in an investigation of an important area of practice. Several areas that need to be addressed have been identified and that has led to recommendations and an action plan. The recommendations, not all are listed here, include, the implementation of an electronic handover system, further audit of the MDT process and a review of the Trust diagnostic systems, ICE/MOLLIS. | **The Committee agreed that this report should be disseminated widely to medical staff.** | |
| | | The Lessons Learned: Audit of action plans focuses on the completion of action plans and is important in providing assurance that lessons have been learned. The audit demonstrates that the Trust can evidence full completion of learning in 39% of the 48 actions audited. This indicates that the Trust needs to improve its action plan management in a number of ways. | **Report noted and will be monitored through the Quality Assurance Committee.** | **Q&A Committee December** |

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| | | The Lessons Learned Framework was presented and **approved.** This framework sets out the processes that will embed the learning from SIs, Complaints, claims, mortality reviews and all other processes that identify learning. | **Lessons Learned Framework approved** | |
| | **DIPC Infection Control Quarterly Report** | The Committee received the Infection Prevention and Control Report. This report provides a summary of infection control activity for Quarter 2 of the financial year. For the Board to note is the initiative to reduce the number of gram-negative bloodstream infections. The initial focus will be on E Coli bacteraemia. WHH has carried out an audit which looks at the 2016/17 hospital onset cases and aims to identify any preventable causes. An action plan has been developed to address the findings of the audit. The source of infection is most commonly urinary. The Trust reported 61 cases of E Coli bacteraemia in Quarter 2, 9 of which were classed as hospital onset. (Year to date 23 cases)<br>A review has been commissioned to explore options to improve surveillance systems. This is an issue that is currently identified as a risk and the outcome of the review will be received by the Patient Safety and Clinical Effectiveness sub-committee. | **Report noted and Committee assured.** | |
| | **Quarterly Quality Report** | The Committee received the Quarterly Quality Report. This report focuses on quality improvement and monitors the progress against the Quality Improvement priorities. It also includes the summary of the Quarter 2 statutory reporting and any significant quality initiatives. Foe example, this Quarter’s report highlighted the initiative “Daring to make a difference”. | **The Committee noted the Report.** | |

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| | | This is a leadership development programme for ward managers and 15 Ward managers attended the first of 6 sessions.<br>Progress has been made against the 9 QI priorities:<br>• Patient Safety – includes, Safer Surgery, Falls and Sepsis.<br>Highlights include a Safety Culture Survey to support the safer surgery priority, which has led to some interesting findings and recommendations.<br>• Clinical Effectiveness – includes, Safe Discharge, Mortality and Lessons Learned Framework.<br>• Patience Experience – Complaints, Patient Experience Strategy, Patients who attend A&E with Mental health problems. | | |
| | **Mortality Review Quarterly report** | The Committee received the Mortality Review Quarterly Report.<br>In Summary:<br>• SHMI is not an outlier for the last 12 months<br>• HSMR is not an outlier for the last 12 months<br>• Weekend/weekday mortality is not an issue for WHH<br>• Cancer of the rectum and anus is statistically high for SHMI, although it is based on only a small number of cases. A review of deaths is underway.<br>• Intestinal infection category had significant results for August – September 2016 and Jan 2017. August – September may merit a review.<br>• A new category of Pleurisy has been highlighted this | **The Committee received the report and was assured.** | |

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| | | month but on closer inspection the cause of death may be more related to a diagnosis of malignancy.<br>There was some concern expressed that actions developed following secondary reviews are breaching and more medical capacity to conduct the Structured Judgement Reviews is required. | | |
| | **Complaints Bimonthly Report** | The backlog, at the time of the report, was 121 outstanding against a target of 103. There had been a number of operational pressures. Although, there is greater recognition where the bottlenecks are occurring, especially at Ward level. However, the overall picture is encouraging. There has been a 60% reduction in the complaints backlog since April 2017 and a 96% reduction in cases over 6 months old. PALS service has been reviewed and the PALS office has been reopened. | **The new Complaints Policy was approved.** | |
| | **Corporate Risk Register and Board assurance Framework** | An update was presented by Ursula Martin, Deputy Director of Integrated Governance and Quality, and reported one new risk added – Spinal Service for local population. The Risk Register will be evaluated at the next meeting of the PSCE on 21st November and the Risk Review Group has been established and will meet for a deep dive into selected risks. | **The Committee agreed that the risk relating to the spinal service should be added and that consideration should be given to downgrading the risk regarding complaints handling.** | |

**BOARD OF DIRECTORS**

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| **AGENDA REFERENCE:** | **BM/17/10/117 (e)** |
| **SUBJECT:** | **Key Issues Report from the Finance and Sustainability Committee held 18 October 2017** |
| **DATE OF MEETING:** | **29 November 2017** |
| **ACTION REQUIRED** | **For Assurance** |
| **AUTHOR(S):** | Terry Atherton, Committee Chair |
| **DIRECTOR SPONSOR:** | |
| | |
| **LINK TO STRATEGIC OBJECTIVES:** | All |
| **LINK TO BOARD ASSURANCE FRAMEWORK (BAF):** | BAF1.1: CQC Compliance for Quality<br>BAF1.2: Health & Safety<br>BAF2.2: Nurse Staffing |
| | |
| **FREEDOM OF INFORMATION STATUS (FOIA):** | Release Document in Full |
| **FOIA EXEMPTIONS APPLIED:** ***(if relevant)*** | None |
| | |
| **EXECUTIVE SUMMARY** (KEY ISSUES): | This report provides a high level summary of business at the October meeting. |
| **RECOMMENDATION:** | The Trust Board is asked to approve the amendment to the Finance and Sustainability Committee terms of reference in respect of Emergency Planning, Estates and Information Management and Technology in line with recent changes to governance arrangements in the Trust. |

| **PREVIOUSLY CONSIDERED BY:** | | |
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| | **Committee** | Not Applicable |
| | **Agenda Ref.** | |
| | **Date of meeting** | |
| | **Summary of Outcome** | |

# KEY ISSUES REPORT
# FINANCE AND SUSTAINABILITY COMMITTEE

| **Date of meeting:** | **18 October 2017** |
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| **Standing Agenda Items** | The Meeting was quorate.<br><br>A presentation was delivered on the progress with the Electronic Prescribing Business Case (an integral part of the Trust's pharmacy transformation plan). The opportunity has arisen to obtain financial support via NHS Digital should the Trust be able to go live in one area of the Trust by the end of this financial year.<br><br>The presentation demonstrated the potential benefits from a quality, safety and financial perspective. The business case was still in draft form, and requires support from the Executive Team prior to Trust Board later in the month once the financial case is completed.<br><br>The Minutes of the F&SC of 20 September were approved.<br><br>The Director of Community Engagement and Corporate Affairs presented the revised terms of reference for the committee. This was approved with some minor amendments. **The Trust Board is asked to approve the updated terms of reference.**<br><br>The Interim Director of HR & OD supported by the Deputy Chief Executive, Medical Director and Director of Nursing presented the Pay Assurance Dashboard alongside a comprehensive and detailed Report.<br><br>NHSI has recently published a list of recommended financial improvement measures and has also set out changes to the weekly collection of data now to include bank usage as well as agency spend.<br><br>The NHSI Self Certification Checklist reported to Trust Board has been reviewed further to a request at Trust Board in September 2017. A revised template for reporting agency and bank spend has now been produced which was supported by the committee.<br><br>The use of agency staff continues and overall pay expenditure is one of the biggest issues for the Trust.<br><br>Pay for Month 6 was £0.3m above plan; ytd £1.7m above plan.<br><br>In Month 6, the Trust incurred a deficit of £0.1m against a planned deficit of £0.6m taking the ytd deficit to £4.6m against a planned loss of £4.6m. In order to deliver the position to date, reserves have been utilised & the delivery of the Annual Plan is at risk.<br><br>Capital expenditure to date is £3.1m, some £0.7m behind plan.<br><br>The cash balance at the end of September was £2.3m due to the receipt of £1.1m STF relating to Quarter 1 on 30 September. Better payment practice code performance remains significantly below target.<br><br>F&SC received a presentation around income, expenditure, the financial forecast |

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| | and likely impact on cash. Whilst it was pleasing to note that the mandated support has had some impact on the income plans further work is urgently required to focus on the expenditure. Particular attention to the forecast element of the presentation, the risks and assumption were also discussed. The F&SC will discuss the forecast further with the Trust Board, including risk, STF assumptions and potential shortfall of cash. F&SC will continue to receive these reports on a monthly basis for the time being. Staffing levels is clearly an issue that requires further exploration, given the impact on expenditure as well as patient safety and experience. The costed winter plan will be reviewed at the F&SC next month.<br><br>The Director of Transformation presented a Month 6 revised CIP summary showing that the Trust has delivered CIP, cost avoidance and income recovery to a total of £3.2m against a ytd CIP target of £3.7m. Recurrent CIP delivery is £2.1m full year effect. The recurrent nature of CIP will impact on the Trust's ability to deliver plan in the next financial year.<br><br>The Corporate Performance Report for Month 6 was presented. In terms of the 4 hour performance, the Trust needed to deliver a Quarter 2 performance of 93.5%, however achieved 92.71%. However the overall position is adjusted to include Bridgewater as there is an overall target for the footprint. This means the STF funding has been secured for Quarter 2. This is a good achievement as it is recognised that the Trust had the most stretching target in this quarter.<br><br>Patient flow and delayed transfers of care have been especially challenging with Private providers ceasing to trade. Ambulance handovers remain difficult at times but our performance compares favourably. Diverts from other Trusts continue to impact on the Trust.<br><br>RTT and Diagnostic targets continue to be met. We continue to be on track to deliver cancer indicators.<br><br><br>Finally a number of Sub Committee Reports were considered. |

# BOARD OF DIRECTORS

| AGENDA REFERENCE: | BM 17 11 117f | |
|---|---|---|
| SUBJECT: | Key Issues Report from the Audit Committee | |
| DATE OF MEETING | 27th October 2017 | |
| ACTION REQUIRED | For Assurance | |
| AUTHOR(S): | Ian Jones, Committee Chair | |
| DIRECTOR SPONSOR: | | |
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| LINK TO STRATEGIC OBJECTIVES: | ALL | |
| LINK TO BOARD ASSURANCE FRAMEWORK (BAF): | | |
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| FREEDOM OF INFORMATION STATUS (FOIA): | Release Document in Full | |
| FOIA EXEMPTIONS APPLIED: *(if relevant)* | None | |
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| EXECUTIVE SUMMARY (KEY ISSUES): | This report provides a high level summary of business at the January meeting. | |
| RECOMMENDATION: | The Board note the report and the matters arising for escalation. | |
| PREVIOUSLY CONSIDERED BY: | Committee | Not Applicable |
| | Agenda Ref. | |
| | Date of meeting | |
| | Summary of Outcome | |

# KEY ISSUES REPORT
# AUDIT COMMITTEE

| **Date of meeting:** | **27th October 2017** |
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| **Standing Agenda Items** | The meeting was quorate.<br>Minutes of the meeting held on 10th July 2017 were approved as a correct record. |
| **Formal Business** | • Internal Audit (MIAA) presented three reports:<br>(1) Significant Assurance was given in respect of the Outpatients Review.<br>(2) Significant Assurance was given in respect of the Capital Assets Review.<br>(3) Limited Assurance was given in respect of the Medical Equipment Review. A number of different management systems were in use in various departments, which has led to a dilution in the efficiency of the centralised process and oversight. Also, weaknesses were identified in the self-certification recording relating to staff in respect of competences to utilise some equipment. Internal Audit has made 9 improvement recommendations, of which 3 were high level. The implementation of these recommendations will be monitored and reported on to Audit Committee.<br>• Internal Audit also provided a Follow Up report, in line with the rolling action log, in respect of the implementation of recommendations contained in eight previous reports. All except one were on track, the exception being DNACPR, where a particular issue was low compliance with Staff Mandatory Training. This stood at 65% for Resus and 94% for SEMA.<br>• The MIAA Follow Up reporting system sits alongside a control system implemented by the Director of Finance and Commercial Development, which is also reported on to each Audit Committee. The latest report highlighted a few areas with outstanding recommendations which should, by now, have been closed off. These will continue to be the subject of close scrutiny.<br>• MIAA Anti-Fraud Service presented their Progress Report which showed satisfactory trends, with just one new case reported between April and September 2017.<br>• Routine business completed at Committee included reviews of (1) Special Payments and Losses (2) Quotations and Tender Waivers, (3) Bad Debt Write-offs, (4) the Trust's Compliance with its Provider Licence in Q2.<br>• The NHS Foundation Trust Code of Governance Arrangements were reviewed and the Declaration updated for inclusion in the Annual Report |

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| | • The Conflict of Interest Register was reviewed. Progress is being made in collecting the required data but 229 returns are awaited from a total of 563 individuals. Action is in hand to complete the register and the position will be reviewed at the next Audit Committee in Feb'18.<br>• The first Freedom to Speak Up Guardian Report was presented to the Committee. It showed a low level of seven disclosures in the 4 months to 30/9/17 but the Committee was satisfied with the procedures which are in place and being developed to ensure that the appropriate FTSU culture is embedded in the Trust.<br>• a Draft Terms of Reference for the Audit Committee was agreed for recommendation to the Board for approval.<br>• In keeping with routine procedures, triangulation of relevant information with the Chairs of Board Committees took place and assurance gained that appropriate monitoring was in place. |

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# CHAIR KEY ISSUES REPORT

| AGENDA REF | BM 17 11 117g | COMMITTEE OR GROUP: | Charitable Funds Committee | DATE OF MEETING | 2nd November 2017 | CHAIR: | Jean-Noel Ezingeard |
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| REF | AGENDA ITEM | LEAD OFFICER | Issue / Exception Report | Recommendation / Assurance/ Action/Decision | Follow up/ Review date |
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| CFC17/11/28 | Action plan & Matters Arising | JNE | a) ITU bid – it was noted that this bid for an Interactive Training Suite in ITU is on hold due to problems with finding a location<br>b) Investment Policy to be considered given the reserves position of the charity and the amounts held in reserved funds. | a. To raise this with the new Associate Director of Estates and Facilities<br>b. Director of Finance and Commercial Development to look at this | a) Next CFC 1st March 2018<br>b) Next CFC |
| CFC 17/11/30 | Fundraising Report | PMc | a) TESCO Bags of Help Campaign – WHH Charity received the second highest number of votes and was awarded £2k for 'horticulture' related projects.<br>b) Aviva in the Community scheme has been launched and the Charity has submitted a bid for £10k for the Halton Urgent Care Centre's Paediatric Department to enhance the environment.<br>c) We welcome the Year 7 WHH Charity ambassadors from Hope Academy, Newton-Le-Willows which starts in the New Year term as part of their curriculum.<br>d) The Knit4Hal knitted hand puppet project for our Paediatric areas is continuing with strong support from knitters in the community.<br>e) We were delighted to be successful in our bid to the DM Thomas Foundation (Hilton in the Community) a pledge of £16k has been received for the Children's Ward project and must be match-funded by WHH Charity by 31 March 2018. | a-h For Information | Next CFC 1st March 2018 |

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| | | | f) The final amount raised by the WHH Dragon Boat Event was £18.2k, the 2018 event will be held in July to coincide with the NHS 70th birthday.<br>g) The Skating Midwife Carys raised £2,500 for the Halton-Warrington skate and abseil for the Maternity unit's makeover.<br>h) The Committee approved the use of the Forget Me Not dementia garden fund to commence work on the garden now rather than waiting for the target to be raised to enable some enjoyment now for patients<br>i) A risk was escalated to the Committee with the return to the USA of the Charity's sole administrator. | Recruitment process already commenced, interviews 20 November 2017 | 20 November 2017 |
| **CFC 17/11/30** | Annual Work plan | PMc | The CFC received and reviewed the WHH Charity Annual Work plan, monitored progress of KPIs for -18 and the WHH Charity Income Performance overview | Assurance | Next CFC 1st March 2018 |
| **CFC17/11/31** | Financial Report Q3 | AMcG | The Committee received and noted the draft financial position of Charitable Funds as at 30th September 2017 and noted efforts to boost fundraising for the General Purpose fund. | Assurance | Next CFC 1st March 2018 |
| **CFC 17/11/32** | Approved bids | PMc | a) A retrospective bid for Digital Reminiscent Therapy software and kit for the Dementia Unit was approved, the CFC noted the actions that had been taken to ensure that no further retrospective bids were approved and that wards/departments follow Bid Approval and Procurement processes.<br>b) The bid to launch a 'Much Loved' Tribute Fund Platform via the Charity website was approved together with a Legacies campaign. | Assurance | Next CFC 1st March 2018 |
| **CFC 17/11/33** | Annual Report and Accounts | AMcG | WHH Charity DRAFT Annual Report and Accounts were received and reviewed and approved subject to updating of strategy and committee members and terms – to be presented to the Corporate Trustee for approval. | Assurance | Trust Board Nov 2017 |

Warrington and Halton Hospitals NHS Foundation Trust

# CHAIR'S KEY ISSUES REPORT

| AGENDA REF | BM 17 11 XXX | COMMITTEE OR GROUP: | Trust Operational Board | DATE OF MEETING | 30th October 2017 |
|---|---|---|---|---|---|

| Name of Meeting + Chair | **Trust Operational Board, Simon Constable Deputy Chief Executive** |
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| Was the meeting quorate? | **Yes** |

| REF | AGENDA ITEM | LEAD OFFICER | Issue / Exception Report | Recommendation / Assurance/ Action/Decision | Follow up/ Review date |
|---|---|---|---|---|---|
| 1 | TOB 17/09/14 | Dir CE&CA | Trust Operational Board Terms of Reference approved | For ratification by Trust Board | 29.11.17 |
| 2 | *TOB/17/10/22* | Deputy CEO | Cancer Care Eastern-sector hub – specification has been circulated. A Cancer Hub Clinical Summit will take place on 29th November, good representation from WHH to discuss Estate and future developments around Radiotherapy provision among other items, to ensure the Trust is a strong contender. | For Information | Jan 2018 |
| 3 | *TOB/17/10/22* | Deputy CEO | Temporary Suspension of Spinal Services: The Trust voluntarily suspended spinal surgeries on 22nd September which was followed by a further suspension notice from WCCG to include ALL spinal services including outpatient appointments and injections. This has been a very challenging time but WHH patients' safety remains paramount and we continue to work through our patient cohorts and referrals to ensure safe transition of care. | For Assurance | Ongoing |
| 4 | *TOB/17/10/23* | Assoc Dir Ops SW&C | The SW&C Division has seen the impact of the theatre industrial action which resulted in an adverse position in cancelled operations and in RTT. This has been compounded by lack of anaesthetic cover due to changes in rotas and vacancies. SW&C are working on a recovery plan to ensure that all of the patients who have been cancelled are seen at the earliest opportunity. | For Assurance | December 2017 |
| 5 | *TOB/17/10/23* | Assoc Dir Ops SW&C | Outpatient activity is overall down by 1,093 episodes – particularly evident in specialist surgery, ophthalmology and breast care. Deep dive being undertaken with | For Assurance | Dec 2017 |

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| | | | focus on RTT sensitive areas. Capacity and job plans need realigning to clinics and work is ongoing on this. | | |
| 6 | *TOB/17/10/23* | Assoc Dir Ops SW&C | Agency expenditure –To note that Therapies have successfully recruited 13 new members of staff and there are exit plans in place for agency/bank staff. | For Assurance | - |
| 7 | *TOB/17/10/23* | Assoc Dir Ops Acute Care | To note A7 Recruitment of newly funded RGN Posts | For Information | |
| 8 | *TOB/17/10/23* | Assoc Dir Ops Acute Care | Delayed discharges from Critical Care – being impacted by high DTOC and occupancy - Situation being closely monitored | For information - | Dec 2017 |
| 9 | *TOB/17/10/23* | Assoc Dir Ops Acute Care | Primary Care Streaming – negotiations on GP service reconfiguration continue with CCG and Community Provider. All other aspects of project on target. | For Information | Dec 2017 |
| 10 | *TOB/17/10/23* | Assoc Dir Ops Acute Care | Stoke phase 2 discussions now commenced with STHK – WHH inputting into joint stroke strategy through provider board. Repatriation under review and much improved. | For Assurance | Dec 2017 |
| 11 | *TOB/17/10/23* | Assoc Dir Ops Acute Care | New Interventional Radiology OOH agreement with COCH formally signed off and agreed. Chester consultant rotation to commence. Joint post to now be discussed further | For Assurance | - |
| 12 | *TOB/17/10/23* | Assoc Dir Nursing Acute Care | 1 case MSSA and I CDIFF under investigation, been some issues with the timeliness of sampling; the senior nurse walk-arounds had been reinstated and divisional infection control meetings to commence | For Assurance | Dec 2017 |
| 13 | *TOB/17/10/23* | Assoc Dir Ops Acute Care | Reduction in Medication errors – trialling a Pharmacy Technician on ward A8 | For Information | Jan 2018 |
| 14 | *TOB/17/10/23* | Assoc Dir Ops Acute Care | Work Urgently required by division to bring in new cohort of Physician Associates – being pursued through Workforce Committee | For Information | Dec 2017 |
| 15 | TOB/17/10/24 | Deputy CEO | New CBU QPS Partnership Forum met for first time in October, to meet monthly thereafter | For information | - |
| 16 | TOB/17/10/27 | DHR&OD | NHSI now require a report on bank staff spend as well as agency – also includes the Trust's own internal staff e.g. zero hours, NHSP, TempRE spend | For Assurance | - |
| 17 | TOB/17/10/30 | AD Estates & Facilities | Roof repairs to Kendrick Wing ongoing following Storm Doris | For Information | - |
| 18 | TOB/17/10/32 | Deputy Dir Quality Governance | Considerable investment in Datix which is being rolled out across the Trust in 8 work streams to replace Ciris. The Risk Management and Complaints modules are rolling out first and IM&T and Finance are pilot non-clinical sites for pilot risk management | For Assurance | - |
| 20 | TOB/17/10/32 | Deputy Dir | Complaints backlog – reduced open complaints by 60%, a 96% reduction in the | For Assurance | |

| | | Quality Governance | >6months open complaints | | |
|---|---|---|---|---|---|
| 21 | TOB/17/10/33 | Deputy Dir Finance | In September the Finance team achieved the North West Finance Skills Development Network Towards Excellence – Level 2 Accreditation Award. The Finance team will now pursue Level 3 Accreditation (top award). | For Assurance | |
| 22 | OB/17/10/43 | Dof&CD | An additional paper submitted to TOB relating to Financial Governance for TOB to note: Only Trust Board can approve any over-spend on expenditure, recirculated Trust’s SFIs and SORD, Tender Waivers to be used for exceptions only - Trust Ops Board hold individuals to account for breaches of financial governance. | For Assurance | |

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# BOARD OF DIRECTORS

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|---|---|
| **AGENDA REFERENCE:** | **BM/17/11/119** |
| **SUBJECT:** | **Complaints Improvement Report** |
| **DATE OF MEETING:** | November 2017 |
| **ACTION REQUIRED** | **Review, Discuss and approve** |
| **AUTHOR(S):** | Ursula Martin, Deputy Director of Governance & Quality |
| **EXECUTIVE DIRECTOR SPONSOR:** | Kimberley Salmon-Jamieson, Chief Nurse |
| | |
| **LINK TO STRATEGIC OBJECTIVES:** | SO1: To ensure that all care is rated amongst the top quartile in the North West of England for patient safety, clinical outcomes and patient experience |
| | |
| **EXECUTIVE SUMMARY** (KEY ISSUES): | The following are key issues to highlight within the report:<br>• There has been a 60% reduction in the complaints backlog since April 2017 and a 96% reduction in cases over 6 months old since April 2017.<br>• KPI performance continues to show an improvement in the timeliness of complaints responses.<br>• The Trust is working with Datix to improve the functionality even further and has purchased Datix Web. There is a "kick-off" date set to discuss implementation with Datix.<br>• A further full time Complaints Officer has been recruited and will be starting in November 2017.<br>• Performance meetings with divisions continue to be held.<br>• PALS service has been reviewed and the PALS Office has now been re-opened.<br>• The Complaints Improvement Lead has completed the Pilot Review (Appendix 2) and has drafted a new Complaints and Concerns Policy (Appendix 3).<br>• There is a rolling program of Complaints Investigation training taking place. To date 38 senior staff have been trained and individual sessions are now taking place. |
| **RECOMMENDATION:** | Note the Report |

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| PREVIOUSLY CONSIDERED BY: | **Committee** | Quality Committee |
|---|---|---|
| | **Date of meeting** | November 2017 |
| | **Summary of Outcome** | Noted and approved |
| FREEDOM OF INFORMATION STATUS (FOIA): | Release Document in Full | |
| FOIA EXEMPTIONS APPLIED: *(if relevant)* | None | |

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**BOARD OF DIRECTORS**

| SUBJECT | Complaints Improvement | AGENDA REF: |
|---|---|---|

## 1. BACKGROUND/CONTEXT

The Board of Directors and Quality Committee received a report in February 2017, outlining an improvement plan, following a review of the Trust's complaint handling function. A high level review identified deficiencies in performance against the two national targets (time taken to acknowledge and time taken to respond) and a significant accumulated backlog of historic complaints. In addition the review identified a need to review systems and processes in managing complaints within the Trust.

This paper notes progress against a series of comprehensive indicators, outlines the current position and actions completed to improve complaints handling at Warrington and Halton Hospitals (WHH) NHS Foundation Trust.

## 2. KEY ELEMENTS

### 2.1 Improvement Work

**Since the last report, the following additional actions have been taken:**

- The Trust is working with Datix to improve the functionality even further and has purchased Datix Web. There is a "kick-off" date set to discuss implementation with Datix. From this date Datix Web modules will be installed over the next 12 months with a training program for each for staff.
- A further full time Complaints Officer has been recruited and has started in post. This will further improve timeliness of responses and the quality improvement in complaints responses.
- KPI performance continues to show an improvement in the timeliness of complaints responses.
- Performance meetings with divisions continue to be held. The meetings are now more effective with the Senior Complaints officers reviewing the weekly Divisional position and aiding Investigators complete complaints responses.
- PALS has been reviewed and the PALS Office has now been re-opened. A further review of the resource is being undertaken by the Complaints Improvement Lead to allow for further allocation of time to PALS.

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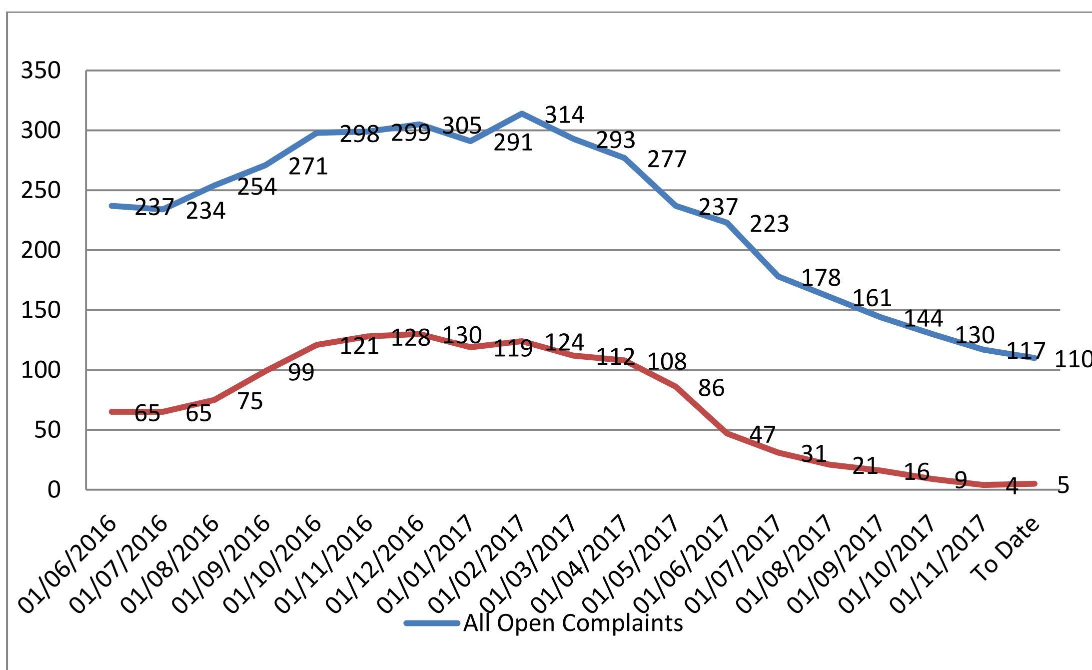
- The Complaints Improvement Lead has completed the Pilot Review and has drafted a new Complaints and Concerns Policy. The policy has been approved by Quality Committee and the Complaints Improvement lead is currently devising a rollout plan.
- There is a rolling program of Complaints Investigation training taking place. To date 38 senior staff have been trained and individual sessions are now taking place.
- There has been a 60% reduction in the complaints backlog since April 2017 and a 96% reduction in cases over 6 months old since April 2017 (Graph 1).
- The Trust is slightly behind on its target to reach 75 open complaints by January 2018.

**The current position is as follows (as at 17 November 2017):**

| | Awaiting Acknowledgement | 72 Hour Review Required | Awaiting Consent | Awaiting Investigation By CBU | Meeting To Be Arranged | Meeting Date Set | Further Information Required From CBU | Awaiting Divisional Approval | Awaiting Executive Sign Off | Amendments Required | Dissatisfied - Awaiting Investigation By CBU | Dissatisfied - Further Information Required from CBU | Total | Number Breached Due Date | Total Over 100 Days | Over 6 Months |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Acute Care Services | 0 | 1 | 0 | 31 | 4 | 1 | 16 | 2 | 0 | 0 | 1 | 1 | 57 | 30 | 20 | 4 |
| Corporate Departments | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 2 | 1 | 1 | 1 |
| Surgery and Women's and Children's | 3 | 5 | 1 | 25 | 1 | 1 | 5 | 3 | 1 | 1 | 4 | 1 | 51 | 30 | 15 | 0 |
| Totals | 3 | 6 | 1 | 57 | 5 | 2 | 22 | 5 | 1 | 1 | 5 | 2 | 110 | 61 | 36 | 5 |

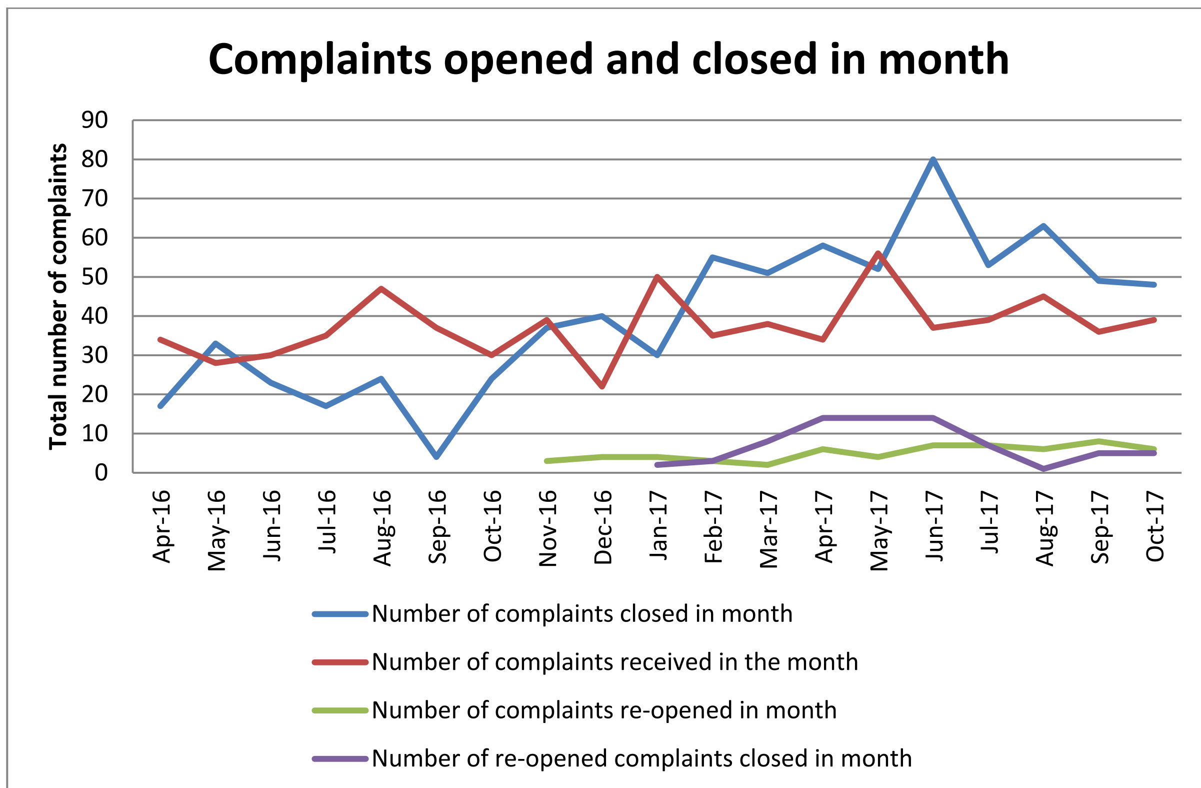
**Graph 1 below shows the trend over time of open cases and those over 6 months old:**



**The data below shows the decrease in complaints over the last 6 months, as detailed in the Graph 1:**

| **Dates** | 01/04/ 2017 | 01/05/ 2017 | 01/06/ 2017 | 01/07/ 2017 | 01/08/ 2017 | 01/09/ 2017 | 01/10/ 2017 | 01/11/ 2017 | To Date |
|---|---|---|---|---|---|---|---|---|---|
| **Total** | 277 | 237 | 223 | 178 | 161 | 144 | 130 | 117 | 110 |
| **Over 6 months old** | 108 | 86 | 47 | 31 | 21 | 16 | 9 | 4 | 5 |

**Since 1 April 2017 – 17 November 2017 the Trust has closed 470 complaints and has received 314. Graph 2 below shows the complaints receveied against those closed:**



**Graph 3 below shows the Trust targets for open complaints:**

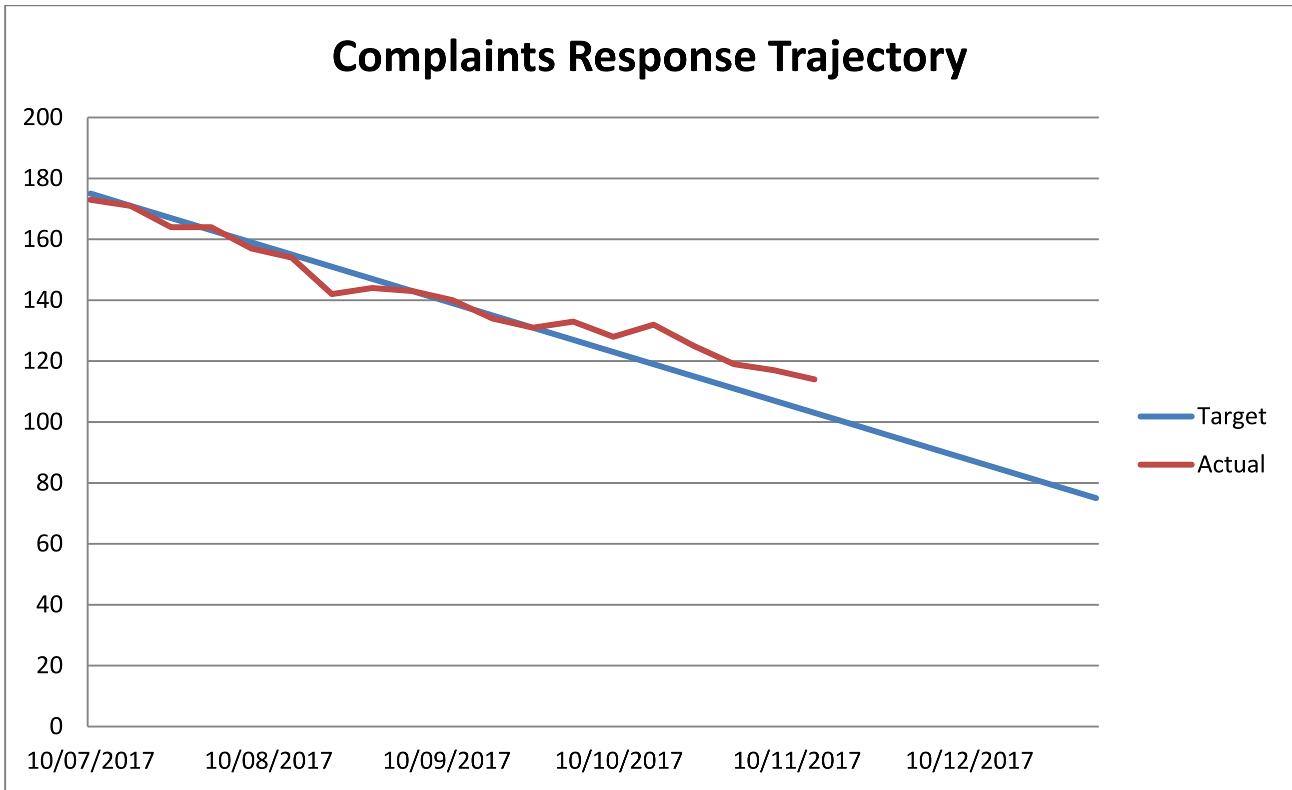



**Table 4 below shows the timeliness for complaints responses:**

| | Jul-17 | | | Aug-17 | | | Sep-17 | | | Oct-17 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Division** | **Due** | **Done** | **% on time** | **Due** | **Done** | **%** | **Due** | **Done** | **%** | **Due** | **Done** | **%** |
| ACS | **20** | **3** | **15.0** | **14** | **3** | **21.4** | **18** | **6** | **33.3** | **18** | **8** | **44.4** |
| Corporate | **3** | **0** | **0.0** | **1** | **1** | **100.0** | **2** | **0** | **0.0** | **1** | **1** | **100.0** |
| SWC | **24** | **10** | **41.7** | **31** | **9** | **29.0** | **25** | **7** | **28.0** | **14** | **5** | **35.7** |
| ***Total*** | 47 | 13 | **27.7** | 46 | 13 | **28.3** | 45 | 13 | **28.9** | 33 | 14 | **42.4** |

**Key actions going forward:**

- The new process and policy will be rolled out across the Trust having undergone a successful pilot in 4 clinical areas.
- Training in complaints handling will continue with scheduled one-to-one sessions with staff.
- The actions recorded in the Datix system will continue to be monitored and a report will be designed to send to staff for the review of actions aligned to them.

- Datix Web implementation will continue over the next 12 months with a training program and communications being developed.
- Continued work on the backlog and new complaints timeliness in order to improve the Trust KPI and improve complainants' satisfaction with the complaint process.
- We are completing an audit of actions taken following complaints and using observational studies supported by volunteers regarding changes following patient feedback being implemented. At the request of the Complaints Quality Assurance Group, this will also involve Trust Governors.
- With the support of Workforce and Organisational Development, we are looking at how to address attitudinal complaints with customer care training and roll out of initiatives such as ambassadors of first impressions etc.

## 3 RECOMMENDATIONS

Whilst significant work has been undertaken regarding complaints handling, further work continues.

The Board are therefore asked to:

- Note the position in terms of complaints handling and the actions taken to date;
- Note the update with regard to the complaints improvement plan;
- Delegate updates on the Complaints Improvement Plan to Quality Assurance Committee, with reports through Chair's High Level Briefing;
- The Board are also asked to ratify the Trust Complaints Policy.

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# REPORT TO BOARD OF DIRECTORS

| | |
|---|---|
| AGENDA REFERENCE: | **BM/17/11/120** |
| SUBJECT: | **Complaints and Concerns Policy** |
| DATE OF MEETING: | |
| ACTION REQUIRED | **Review and approve.** |
| AUTHOR(S): | Ursula Martin, Deputy Director Integrated Governance + Quality |
| EXECUTIVE DIRECTOR SPONSOR: | Kimberley Salmon-Jamieson, Chief Nurse |
| | |
| LINK TO STRATEGIC OBJECTIVES: | SO1: To ensure that all care is rated amongst the top quartile in the North West of England for patient safety, clinical outcomes and patient experience |
| LINK TO BOARD ASSURANCE FRAMEWORK (BAF): | All |
| | All |
| | All |
| | |
| STRATEGIC CONTEXT | In order to improve the way the Trust responds to complaints, the new policy and process have been developed in line with best recognised national guidance. |
| EXECUTIVE SUMMARY (KEY ISSUES): | The new policy includes a new process for responding to complaints. |
| RECOMMENDATION: | To review and approve the policy. |
| PREVIOUSLY CONSIDERED BY: | **Committee**: Quality + Assurance Committee |
| | **Agenda Ref.**: |
| | **Date of meeting**: |
| | **Summary of Outcome**: |
| FREEDOM OF INFORMATION STATUS (FOIA): | Release Document in Full |
| FOIA EXEMPTIONS APPLIED: *(if relevant)* | None |

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**NAME OF COMMITTEE**

| SUBJECT | Complaints and Concerns Policy | AGENDA REF: | |
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## 1. BACKGROUND/CONTEXT

The Board of Directors and Quality Committee received a report in February 2017, outlining an improvement plan, following a review of the Trust's complaint handling function. A high level review identified deficiencies in performance against the two national targets (time taken to acknowledge and time taken to respond) and a significant accumulated backlog of historic complaints. In addition the review identified a need to review systems and processes in managing complaints within the Trust.

This paper contains the new Complaints and Concerns policy under which all complaints and concerns should be managed and processed.

## 2. KEY ELEMENTS

The policy has been formulated on the back of a successful pilot review of the new process detailed in the policy. This policy is in line with best national guidance around complaints handling.

## 3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

All staff should read and make themselves familiar with the new policy and process.

## 4. MEASUREMENTS/EVALUATIONS

Ongoing review of the compliance with the policy will be completed by the Complaints Improvement Lead reviewing the Datix system. Reports for compliance will be sent to Quality Committee.

## 5. MONITORING/REPORTING ROUTES

Quality Committee.

## 6. RECOMMENDATIONS

The Board are asked to review and approve the policy.

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**BOARD OF DIRECTORS**

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|---|---|---|
| **AGENDA REFERENCE:** | **BM/17/11/128** | |
| **SUBJECT:** | **Board Assurance Framework and Strategic Risk Register** | |
| **DATE OF MEETING:** | November 2017 | |
| **ACTION REQUIRED** | **Review, Discuss and approve** | |
| **AUTHOR(S):** | Ursula Martin, Deputy Director of Governance & Quality | |
| **EXECUTIVE DIRECTOR SPONSOR:** | Kimberley Salmon-Jamieson, Chief Nurse | |
| | | |
| **LINK TO STRATEGIC OBJECTIVES:** | All | |
| | | |
| **STRATEGIC CONTEXT** | Risk Management is a mechanism for managing exposure to risk that enables the Trust to recognise the events that may result in harm and/or loss. The Trust has a legal and moral duty to patients, visitors and staff to ensure that their safety and wellbeing is not compromised as a result of hospital activities, processes or procedures, as well as regulatory implications. | |
| **EXECUTIVE SUMMARY** (KEY ISSUES): | There is an update of a new risk that has been approved to be added to the Strategic Risk Register by Quality Assurance Committee.<br><br>There is also an update from the Trust Risk Review Group and potentially escalated risks for consideration at the next Quality Assurance Committee.<br><br>Notable existing risk updates are given, with any impact of risk scores.<br><br>In addition an update of the roll out of the revised risk management strategy | |
| **RECOMMENDATION:** | Discuss and approve the changes and updates to the Board Assurance Framework and Strategic Risk Register | |
| **PREVIOUSLY CONSIDERED BY:** | **Committee** | Not Applicable |

| | | |
|---|---|---|
| | **Date of meeting** | |
| | **Summary of Outcome** | |
| **FREEDOM OF INFORMATION STATUS (FOIA):** | Release Document in Full | |
| **FOIA EXEMPTIONS APPLIED:** ***(if relevant)*** | None | |

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**BOARD OF DIRECTORS**

| SUBJECT | Board Assurance Framework | AGENDA REF: | |
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## 1. BACKGROUND/CONTEXT

This is an update of strategic risks on the Board Assurance Framework. It has been agreed that the Board receives a monthly update on all strategic risks and any changes that have been made to the strategic risk register, following review at Quality Committee. The Board Assurance Framework and full strategic risk register will be presented on a quarterly basis.

The strategic risk register is outlined in Appendix 1. The following gives notable updates since the strategic risks were last presented to the Board of Directors.

## 2. KEY ELEMENTS

2.1 **New Risks** – there is one new risk which has been added to the strategic risk register.

| Risk | **Failure to provide a spinal service for the local population, caused by a voluntary suspension of the service amid potential governance concerns, resulting in poor patient experience, potential safety concerns for those patients with delayed procedures or follow ups, reputational damage and potential regulatory and contractual issues.** |
|---|---|
| Controls and Assurances | ▪ The Trust proposed a voluntary suspension of the service whilst jointly commissioning (with commissioners) the Royal College of Surgeons to undertake a review of the service<br>▪ There are a number of Serious Incidents (4) that have occurred since January – these incidents have been/are being externally reviewed<br>▪ A weekly spinal meeting has been established by the Medical Director to ensure there is an oversight of operational, patient experience, regulatory and contractual impacts.<br>▪ The Trust is working with commissioners and other spinal providers to ensure that there is alternative arrangements in place regarding patient procedures. Most inpatient procedures have had alternate providers identified. Currently reviewing outpatient procedures and follow up clinics.<br>▪ Communications team working across commissioning and regulators to ensure patients and the public are kept up to date. |
| Gaps | ▪ Currently working with commissioners regarding those patients who have follow up procedures and spinal injections, to ensure suitable alternative providers are found.<br>▪ CQC is investigating one of the Serious Incident Cases – this is awaited |

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| | ▪ The Trust is starting to see increased concerns from patients raised through PALS/Complaints regarding having notification of delay to their procedures.<br>▪ Significant financial pressures emerging regarding the suspension and associated costs |
| Residual Risk Score | 16 (4x4) |
| Actions | Ensure that continued discussions are had with commissioners and alternative providers regarding patients (outpatients/follow ups/spinal injections) – ongoing and urgent<br>**Medical Director/Chief Operating Officer/Senior Management MSK ongoing**<br><br>Ensure the Trust prepares for the forthcoming Royal College of Surgeons review – by 31st October 2017<br>**Chief of Service Surgery, Woman's and Children Services COMPLETED**<br><br>Set up a weekly spinal governance meeting<br>**Medical Director**<br>**COMPLETED**<br><br>Ensure additional capacity is put in place within the Trust to manage the outcome form the spinal review<br>**Medical Director by end November 2017**<br><br>Ensure a budget line is established for spinal service, to monitor and track associated costs<br>**Director of Finance**<br>**COMPLETED**<br><br>Develop an action plan regarding ongoing actions following on from Royal College Review<br>**Medical Director by end November 2017** |

Risks currently being scoped out include

- Failure to have insufficient anaesthetic cover on critical care, due to insufficient middle grade/registrar doctors to cover the 2nd and 3rd tier on calls, resulting in potential patient safety issues, operational impact and financial pressures due to locum costs.
- Insufficient assurance in place regarding contractual and governance requirements in Sexual Health Services, resulting in potential patient safety issues, organisational and reputational risk.

These risks were escalated through our governance processes- it was agreed at Risk Review Group 14th November 2017 that both risks should be recommended for inclusion on Trust Strategic Risk Register. The fully scoped out risks will be presented to November 2017 Quality & Assurance Committee and then Board.

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## 2.2 Existing Risks – updates

| Strategic Risk | Update since last Risk review | Impact of update on risk rating |
|---|---|---|
| Failure to provide adequate staffing levels in some specialities and wards caused by inability to fill vacancies, sickness which may result in pressure on ward staff, potential impact on patient care and impact on Trust access and financial targets. | Enhanced leadership and practice reviews have taking place in those areas where we know there to be staffing concerns and safety incidents.<br><br>The financial impact of locum and agency staff is being tracked through the Trust's workforce, nursing and medical governance structures. | No impact on risk rating |
| Failure to identify and manage patients' risk of sustaining a fall; caused by inadequate risk assessment and implementation of appropriate care plans. This may cause patient harm, has a negative effect on the patient's experience, may prolong their length of stay, and give rise to complaints and claims against the trust. | Bed replacement business case discussed at Executive Directors 28th September 2017. A programme was agreed across 4 years for replacement.<br><br>The numbers of falls reported in Q2 slightly decreased. The number of Serious Harm falls has also decreased with 2 reported in Q2 and none reported in September 2017.<br><br>Trials of falls equipment (falls mats/sensors) remain underway. | No impact on risk rating |
| Lack of assurance regarding complaints handling within the Trust, caused by ineffective systems and processes, resulting in a poor experience for complainants, the Trust not meeting statutory and contractual complaints targets and not having effective systems in place to learn lessons from complaints | There has been a 60% reduction in the complaints backlog since April 2017 and an 96% reduction in cases over 6 months old since April 2017. The Trust is on trajectory to meet the complaints backlog target (end December).<br><br>The risk has reduced as the Trust has made significant progress in implementing the complaints improvement plan. The risk of sustaining this performance through winter will be monitored and the risk score will be reviewed as appropriate. This was agreed at Quality Assurance Committee | Reduced risk |
| Failure to meet the standards relating to administration of blood, caused by non completion of this role specific training, resulting in potential harm to patients, and non compliance with regulatory standards, thereby increasing the risk of reputational harm and litigation for the organisation | All actions on the BAF have been completed regarding this risk- an update was given at Patient Safety and Effectiveness Sub Committee November 2017- and the sub committee wanted to await the outcome of an audit regarding blood competencies prior to reduction of the risk. | No impact on risk rating |
| Failure to comply with the Thromboprophylaxis procedure/policy caused by poor completion of thromboprophylaxis risk assessments and follow up investigation (Root Cause Analysis) of hospital associated | All actions on the BAF have been completed regarding this risk- an update was given at Patient Safety and Effectiveness Sub Committee November 2017- a meeting is planned for 29th November regarding reviewing this risk with the clinical leads for the Trust. | No impact on risk rating |

| Strategic Risk | Update since last Risk review | Impact of update on risk rating |
|---|---|---|
| VTE in some areas, resulting in the risk of patients not receiving the appropriate, preventative treatment for VTE in hospital. | | |
| 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. | Additional controls have been put in place by the Executive Team – vacancy control processes<br><br>The Trust has also had notification that there are in Segment 3 rating with NHSI. | No impact on risk rating |
| Failure to prevent harm to patients, caused by lack of timely and quality discharge summaries being sent to primary care, resulting in a lack of appropriate handover of care, with patient safety, operational, financial and reputational consequences. | An update will be given at Patient Safety and Effectiveness Sub Committee November 2017- the Sub Committee reviewed thia risk and have asked that this remains at the current level. | No impact on risk rating |
| Review required of paediatric urgent and emergency care due to escalated staffing issues, which may impact on patient care | All actions on the BAF have been completed regarding this risk- an update will be given at Patient Safety and Effectiveness Sub Committee November 2017- the sub committee sought assurance that the actions were being implemented. Evidence to be sent to the Clinical Governance Dept. so the risk can be reviewed. | No impact on risk rating |
| Failure to achieve the highest level of corporate governance, caused by the requirement to review and embed new structures, which may impact on statutory and regulatory requirements | Two new actions have been added<br><br>Ensure the new corporate meetings structure is implemented and embedded<br>**Director of Communications – end March 2018**<br><br>Ensure preparatory work is undertaken regarding the new CQC well led assessment framework<br>**Director of Communications – end March 2018** | No impact on risk rating |

## 2.3 Risk Management Strategy Updates

With regard to the roll out of the revised risk management strategy the following has been undertaken:

- A pilot has commenced across wards and depts. In the Trust regarding an integrated risk assessment tool. This tool is aligned to the CQC domains and fundamental standards and will enable wards/depts. To assess risk against statutory, regulatory and professional requirements, in order to develop local risk registers.

- Training has been developed for senior managers on risk management and quality impact assessments and is due to roll out from November onwards. Training is also being put in place for risk assessment development.

- Datix Web for Risks is currently being scoped out, with configuration of the system to commence w/c 25th September 2017. Members of the governance team are visiting other Trusts to see how this is configured to support this roll out. Pilots are expected to commence on the new datix system in November 2017.

- The Risk review Group convened on 21st September 2017 and has met twice. Chaired by the Chief Nurse, this will provide overview and scrutiny of risk registers at Clinical Business Unit level and ensure any escalated risks are discussed.

The project plan to support the implementation of the risk management strategy will be tracked at Risk Review Group reporting to Quality & Assurance Committee and also as part of the action plan in response to the Trust's CQC report.

## 3 RECOMMENDATIONS

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

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**Appendix 1- Strategic Risk Register**

| Risk | Residual Risk Rating (Impact x Likelihood) March 2017 | Residual Risk Rating (Impact x Likelihood) April 2017 | Residual Risk Rating (Impact x Likelihood) May 2017 | Residual Risk Rating (Impact x Likelihood) June 2017 | Residual Risk Rating (Impact x Likelihood) July 2017 | Score at last review 21/09/17 | Score at last review 14/11/17 |
|---|---|---|---|---|---|---|---|
| Failure to provide adequate staffing levels in some specialities and wards caused by inability to fill vacancies, sickness which may result in pressure on ward staff , potential impact on patient care and impact on Trust access and financial targets. | 20 (5x4) | 20 (5x4) | 20 (5x4) | 20 (5x4) | 20 (5x4) | 20 (5x4) | 20 (5x4) |
| Failure to sustain financial viability, caused by internal and external factors, leading to potential impact to patient safety, staff morale and enforcement/regulatory action being taken. | 20 (5x4) | 20 (5x4) | 20 (5x4) | 20 (5x4) | 20 (5x4) | 20 (5x4) | 20 (5x4) |
| Failure to deliver national and local performance targets will impact on patient care, reputation and financial position. | 20 (4x5) | 20 (4x5) | 20 (4x5) | 20 (4x5) | 20 (5x4) | 20 (5x4) | 20 (5x4) |
| Failure to provide a spinal service for the local population, caused by a voluntary suspension of the service amid potential governance concerns, resulting in poor patient experience, potential safety concerns for those patients with delayed procedures or follow ups, reputational damage and potential regulatory and contractual issues. | N/A | N/A | N/A | N/A | N/A | N/A | 16 (4x4) |
| Failure to provide adequate and timely IMT system implementations & systems optimisation caused by either increasing demands and enhanced system functionality which results in pressure on staff; potential in systems being poorly used resulting in poor data quality. Impact on patient access to services, quality of care provided, potential patient harm and financial & performance targets. | 20 (5x4) | 16 (4x4) | 16 (4x4) | 16 (4x4) | 16 (4x4) | 16 (4x4) | 16 (4x4) |

| Risk | Residual Risk Rating (Impact x Likelihood) March 2017 | Residual Risk Rating (Impact x Likelihood) April 2017 | Residual Risk Rating (Impact x Likelihood) May 2017 | Residual Risk Rating (Impact x Likelihood) June 2017 | Residual Risk Rating (Impact x Likelihood) July 2017 | Score at last review 21/09/17 | Score at last review 14/11/17 |
|---|---|---|---|---|---|---|---|
| Failure to identify and manage patients' risk of sustaining a fall; caused by inadequate risk assessment and implementation of appropriate care plans. This may cause patient harm, has a negative effect on the patient's experience, may prolong their length of stay, and give rise to complaints and claims against the trust. | 16 (4x4) | 16 (4x4) | 16 (4x4) | 16 (4x4) | 16 (4x4) | 16 (4x4) | 16 (4x4) |
| Failure to provide timely information caused by increasing internal and external demands for datasets, implementation of new systems and a lack of skilled staff with capacity to respond. This may cause financial impact, external reputation damage and poor management decision making due to lack of quality data. | 16 (4x4) | 16 (4x4) | 16 (4x4) | 16 (4x4) | 16 (4x4) | 16 (4x4) | 16 (4x4) |
| Lack of assurance regarding the Trust's safeguarding agenda being implemented across the Trust due to gaps highlighted during external review may impact on patient safety and cause the Trust to breach regulations. | 16 (4x4) | 16 (4x4) | 16 (4x4) | 16 (4x4) | 16 (4x4) | 16 (4x4) | 16 (4x4) |
| Failure to influence sufficiently within the STP and LDS may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position. | 15 (5x3) | 15 (5x3) | 15 (5x3) | 15 (5x3) | 15 (5x3) | 15 (5x3) | 15 (5x3) |
| Failure to maintain an old estate could result in staff and patient safety issues, increased costs and unsuitable accommodation. | 15 (5x3) | 15 (5x3) | 15 (5x3) | 15 (5x3) | 15 (5x3) | 15 (5x3) | 15 (5x3) |
| Lack of assurance regarding complaints handling within the Trust, caused by ineffective systems and processes, resulting | 16 (4x4) | 16 (4x4) | 16 (4x4) | 16 (4x4) | 16 (4x4) | 16 (4x4) | 12 (3x4) |

| Risk | Residual Risk Rating (Impact x Likelihood) March 2017 | Residual Risk Rating (Impact x Likelihood) April 2017 | Residual Risk Rating (Impact x Likelihood) May 2017 | Residual Risk Rating (Impact x Likelihood) June 2017 | Residual Risk Rating (Impact x Likelihood) July 2017 | Score at last review 21/09/17 | Score at last review 14/11/17 |
|---|---|---|---|---|---|---|---|
| in a poor experience for complainants, the Trust not meeting statutory and contractual complaints targets and not having effective systems in place to learn lessons from complaints | | | | | | | |
| Failure to prevent harm to patients, caused by lack of timely and quality discharge summaries being sent to primary care, resulting in a lack of appropriate handover of care safety, operational, financial and reputational consequences. | N/A | N/A | N/A | N/A | 12 (4x3) | 12 (4x3) | 12 (4x3) |
| Failure to deliver essential services, caused by a Cyber Attack, resulting in loss of data and vital IT systems, resulting in potential patient harm, loss in productivity and Trust reputation | N/A | N/A | N/A | 12 (4x3) | 12 (4x3) | 12 (4x3) | 12 (4x3) |
| Failure to meet the standards relating to administration of blood, caused by non completion of this role specific training, resulting in potential harm to patients, and non compliance with regulatory standards, thereby increasing the risk of reputational harm and litigation for the organisation. | N/A | N/A | N/A | 12 (4x3) | 12 (4x3) | 12 (4x3) | 12 (4x3) |
| Failure to comply with the Thromboprophylaxis procedure/policy caused by poor completion of thromboprophylaxis risk assessments and follow up investigation (Root Cause Analysis) of hospital associated VTE in some areas, resulting in the risk of patients not receiving the appropriate, preventative treatment for VTE in hospital. | N/A | 12 (4x3) | 12 (4x3) | 12 (4x3) | 12 (4x3) | 12 (4x3) | 12 (4x3) |
| Clinical variation, caused by lack of systems/process or failure of | 12 (4x3) | 12 (4x3) | 12 (4x3) | 12 (4x3) | 12 (4x3) | 12 (4x3) | 12 (4x3) |

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| Risk | Residual Risk Rating (Impact x Likelihood) March 2017 | Residual Risk Rating (Impact x Likelihood) April 2017 | Residual Risk Rating (Impact x Likelihood) May 2017 | Residual Risk Rating (Impact x Likelihood) June 2017 | Residual Risk Rating (Impact x Likelihood) July 2017 | Score at last review 21/09/17 | Score at last review 14/11/17 |
|---|---|---|---|---|---|---|---|
| systems/to follow process leading to lack of evidence based practice, potential patient harm and reputational impact. | | | | | | | |
| Failure to successfully engage the Workforce, causing the potential for a negative working environment and the consequential loss of discretionary effort and productivity, or loss of talented colleagues to other organisations, which would impact patient care, staff morale and delivery of the Trust's strategic objectives | 12 (4x3) | 12 (4x3) | 12 (4x3) | 12 (4x3) | 12 (4x3) | 12 (4x3) | 12 (4x3) |
| Review required of paediatric urgent and emergency care due to escalated staffing issues, which may impact on patient care | 12 (3x4) | 12 (3x4) | 12 (3x4) | 12 (4x3) | 12 (4x3) | 12 (4x3) | 12 (4x3) |
| Failure to achieve the highest level of corporate governance, caused by the requirement to review and embed new structures, which may impact on statutory and regulatory requirements | 12 (4x3) | 12 (4x3) | 12 (4x3) | 12 (3x4) | 12 (3x4) | 12 (4x3) | 12 (4x3) |

Warrington and Halton Hospitals
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**BOARD OF DIRECTORS**

| | | |
|---|---|---|
| AGENDA REFERENCE: | **BM/17/11/122** | |
| SUBJECT: | **Quarter 2 Mortality Report** | |
| DATE OF MEETING: | Wednesday 29 November 2017 | |
| ACTION REQUIRED | **For ratification** | |
| AUTHOR(S): | Simon Constable, Medical Director + Deputy CEO | |
| EXECUTIVE DIRECTOR SPONSOR: | 1T | |
| | | |
| LINK TO STRATEGIC OBJECTIVES: | SO1: To ensure that all care is rated amongst the top quartile in the North West of England for patient safety, clinical outcomes and patient experience | |
| LINK TO BOARD ASSURANCE FRAMEWORK (BAF): | BAF1.1: CQC Compliance for Quality | |
| | BAF1.3: National & Local Mandatory, Operational Targets | |
| | | |
| | | |
| STRATEGIC CONTEXT | | |
| EXECUTIVE SUMMARY (KEY ISSUES): | This briefing paper overviews Trust mortality data and provides local and national context. It also outlines the actions in place to ensure robust oversight and monitoring, through a comprehensive mortality peer review process, as well as improvement plans to reduce Trust mortality rates and the Trust mortality ratio figures. | |
| RECOMMENDATION: | Note the contents of the briefing paper and discuss and approve the recommended options. | |
| PREVIOUSLY CONSIDERED BY: | **Committee** | Quality Committee |
| | **Agenda Ref.** | |
| | **Date of meeting** | |
| | **Summary of Outcome** | |
| FREEDOM OF INFORMATION STATUS (FOIA): | Release Document in Full | |
| FOIA EXEMPTIONS APPLIED: *(if relevant)* | None | |

Warrington and Halton Hospitals
NHS Foundation Trust

# REPORT TO BOARD OF DIRECTORS

| | | |
|---|---|---|
| **AGENDA REFERENCE:** | **BM/17/11/123 i** | |
| **SUBJECT:** | **Freedom to Speak up update** | |
| **DATE OF MEETING:** | 29 November 2017 | |
| **ACTION REQUIRED** | **For Assurance** | |
| **AUTHOR(S):** | Jane Hurst, Deputy Director of Finance and FTSU Guardian | |
| **EXECUTIVE DIRECTOR SPONSOR:** | Kimberley Salmon-Jamieson, Chief Nurse | |
| | | |
| **LINK TO STRATEGIC OBJECTIVES:** | SO2: To have a committed, skilled and highly engaged workforce who feel valued, supported and developed and who work togther to care for our patients | |
| **LINK TO BOARD ASSURANCE FRAMEWORK (BAF):** | BAF2.4: Engaging & Involving Workforce | |
| | BAF1.2: Health & Safety | |
| | Choose an item. | |
| | | |
| **STRATEGIC CONTEXT** | | |
| **EXECUTIVE SUMMARY** (KEY ISSUES): | This report will give an update on all Freedom To Speak Up (FTSU) disclosures in the last four months and going forward will be bi-annual report. | |
| **RECOMMENDATION:** | The Board is asked to note the content of the report and the progress being made to roll out the FTSU policy. | |
| **PREVIOUSLY CONSIDERED BY:** | **Committee** | Audit Committee |
| | **Agenda Ref.** | |
| | **Date of meeting** | 27 October 2017 |
| | **Summary of Outcome** | |
| **FREEDOM OF INFORMATION STATUS (FOIA):** | Release Document in Full | |
| **FOIA EXEMPTIONS APPLIED:** ***(if relevant)*** | None | |

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NHS Warrington and Halton Hospitals NHS Foundation Trust

**NAME OF COMMITTEE**

| SUBJECT | Freedom to Speak up update | AGENDA REF: | |
|---|---|---|---|

## 1. BACKGROUND/CONTEXT

This report will give an update on all Freedom To Speak Up (FTSU) disclosures in the last four months and going forward will be a bi annual report to the Board.

The Whistleblowing policy and Speak out safely have been superseded by the FTSU policy launched in May 2017. The FTSU policy is based on the 'standard integrated policy' was a recommendation of the review by Sir Robert Francis into whistleblowing in the NHS, that identified awful experiences of people being met with obstruction, defensiveness and hostility when they tried to raise concerns at work. The standard integrated policy (produced by Monitor, NHS Improvement and NHS England) is being adopted by all NHS organisations in England to help normalise the process of raising concerns for the benefit of all patients and staff. FTSU policy approval process included review by Executive Team, JNCC and the Quality Committee.

## 2. KEY ELEMENTS

In the last four months up to 30 September 2017 there have been seven disclosures which are broken down in the following table:-

| | 1 June 2017 – 30 September 2017 |
|---|---|
| Patient Safety | 4 |
| Staff dignity at work | 2 |
| Fraud | 1 |
| **Total** | **7** |

Of the seven, the fraud case is being investigated externally by Mersey Internal Audit Agency. Of the four patient safety issues two have been reviewed by the Medical Director and no further action is required and two by the Director of Nursing which resulted in closure of a number of beds on a ward. One of the staff - dignity at work disclosures was followed up by the HR team who organised some targeted training for the department and as a result the staff member was happy to close the case. The other staff dignity case has a follow up action for a review to take place when the new ward manager is in post and this case will remain open until this has been completed.

The seven cases have been across the Trust, but three relate to one ward, the Executive Team have been made aware of the issues and actions have been taken to address the concerns.

The number of disclosures remain low so to ensure everyone is aware of the FTSU policy the Communication Team has designed an information leaflet which has been attached to wage slips and posters are due to go out to all wards and departments. A dedicated FTSU email address has been set up, the website has been updated and information has been included in the team brief. The Freedom to Speak Up Guardian spoke at the Peoples Champions conference and is looking with the Communications Team for opportunities to speak at other events.

A recent national FTSU report highlighted 10 recommendations and the Trust has assessed itself against these recommendations in the following table:-

| **Area** | **Action** |
|---|---|
| 1. Appointment | Interview process followed |
| 2. Potential Conflicts of interest | Guardian and Champions have discuss potential conflicts of interest and the ability to pass cases to another lead |
| 3. Local Networks | Currently engaged with 5 Champions across the Trust and looking to expand this to up to 10. |
| 4. Diversity | Guardian linking in with BME group via HR hoping to get a Champion from this group. Similar approach is being taken with Junior Doctors. |
| 5. Communication and Training | Information shared on wage slips and added to induction, Team brief May and October, details will be added to The Week as a regular item and will appear on the desktop mid-November then quarterly. Later in the year it will be added to the Staff App.<br>Presentations given at Exec and JNCC in May, People Conference on the 13$^{th}$ October. Posters to be distributed by People champions in October. Meeting arranged to look at how we can include in Mandatory training or essential manager course. Plan to attend the Peoples Council in 6 months time. The Website will have additional information added over the next 3 months. |
| 6. Partnership | Currently engaged with 5 Champions across the Trust and looking to expand this. Close working with Quality Team and HR. |
| 7. Access to senior leadership | Quarterly update to exec team or more frequent if required. Issues raised to date have all been discussed with either HR or Nurse Exec and /or their senior team. |
| 8. Board Reporting | Update to the Board planned for twice a year through Quality Committee report. Consider in person update as per guidance. |
| 9. Feedback | Where disclosures have been made by named individuals feedback has been requested and they have said that they have felt listened to and supported. |
| 10. Time | Time is a concern at the moment there has only been a small number of disclosures, if this increases the Guardian will need to delegate more cases to the Champions.<br>A Champion attended regional meeting but no availability to attend October National meeting due to other commitments. |

Overall the Trust is working well towards developing the FTSU culture and will reach more staff over the next 3 to 6 months with the plans outlined in the table above.

In November the Quarter 2 national results were published showing the following key points:-

- 1,528 cases were raised to Freedom to Speak Up Guardians / ambassadors / champions.
- 491 of these cases included an element of patient safety / quality of care.
- 718 included elements of bullying and harassment.
- 83 related to incidents where the person speaking up may have suffered some form of detriment.
- 339 anonymous cases were received.
- 19 trusts did not receive any cases through their Freedom to Speak Up Guardian.
- 196 of the 233 trusts listed in our directory sent returns

The appended report (end of Board pack) shows that the Trusts number of disclosures is not dissimilar to other small Acute Trusts.

It should be noted that a local hospital has recently been reviewed by the National Guardians Office following information of bullying and discriminatory culture. The review has resulted in 22 recommendations for the Trust and 1 for the CQC.

## 3. RECOMMENDATIONS

The Board is asked to note the content of the report and the progress being made to roll out the FTSU policy.

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**BOARD OF DIRECTORS**

| | | |
|---|---|---|
| **AGENDA REFERENCE:** | **BM/16/11/125** | |
| **SUBJECT:** | **Progress on Carter Report Recommendations** | |
| **DATE OF MEETING:** | 29th November 2017 | |
| **ACTION REQUIRED** | **For Discussion** | |
| **AUTHOR(S):** | Marie Garnett, Head of Contracts & Performance | |
| **EXECUTIVE DIRECTOR SPONSOR:** | Andrea Mcgee, Director of Finance & Commercial Development | |
| | | |
| **LINK TO STRATEGIC OBJECTIVES:** | All | |
| **LINK TO BOARD ASSURANCE FRAMEWORK (BAF):** | BAF1.3: National & Local Mandatory, Operational Targets | |
| | BAF1.4: Business Continuity | |
| | BAF3.3: Clinical & Business Information Systems | |
| | | |
| **STRATEGIC CONTEXT** | The purpose of this report is to update the Trust Board on the latest position regarding the progress made against the recommendations contained in Lord Carter's report "Operational productivity and performance in English NHS acute hospitals" issued in February 2016. | |
| **EXECUTIVE SUMMARY** (KEY ISSUES): | The Trust has embraced the recommendations of the Carter Report and is already compliant with many of the key targets and performance indicators and making steady progress on the remaining recommendations. | |
| **RECOMMENDATION:** | The Trust Board is asked to:<br>**1.** Note the contents of the report. | |
| **PREVIOUSLY CONSIDERED BY:** | **Committee** | Not Applicable |
| | **Agenda Ref.** | |
| | **Date of meeting** | |
| | **Summary of Outcome** | |
| **FREEDOM OF INFORMATION STATUS (FOIA):** | Release Document in Full | |
| **FOIA EXEMPTIONS APPLIED:** ***(if relevant)*** | None | |

| SUBJECT | Integrated Performance Dashboard | AGENDA REF: | |
|---|---|---|---|

## 1. BACKGROUND/CONTEXT

**PURPOSE**

The purpose of this report is to update the Trust Board on the latest position regarding the progress made against the recommendations contained in Lord Carter's report "Operational productivity and performance in English NHS acute hospitals" issued in February 2016.

**BACKGROUND**

In June 2014 Lord Carter was asked by the Secretary of State for Health to assess what efficiency improvements could be generated in hospitals across England.

In June 2015 an interim report was published which outlined that potentially £5 billion of operational efficiency savings could be delivered in the Acute sector by 2020 by improving workforce costs, hospital pharmacy medicines optimisation and estates and procurement management.

In February 2016 the final report was published and based on the work of 32 Acute Trusts, it was estimated that if "unwarranted variation" was removed from Trust spend £5 billion could be saved by 2020 as summarised in the table below.

Table: The breakdown of the £5 billion savings:

| Narrative | £ billion |
|---|---|
| Improved workflow and containing workforce costs | 2.0 |
| Improved hospital pharmacy and medicines optimisation | 1.0 |
| Better estates management and optimisation | 1.0 |
| Better procurement management | 1.0 |
| **Total** | **5.0** |

## 2. KEY ELEMENTS

A quarter 2 progress update is attached - (see Appendix 1). The format of this report has been adapted in order to make progress against the recommendations more transparent. Feedback from the Trust Board is welcomed to improve future reporting.

## 3. RECOMMENDATIONS

The Trust Board is asked to:

1. Note the contents of this report.

## Appendix 1 - PROGRESS AGAINST LORD CARTER RECOMMENDATIONS

**Key**

| RAG | Meaning |
|---|---|
| Red | Significantly off track |
| Amber | Progress off - plans in place to get back on track |
| Green | On track/Complete |
| Grey | Not started/Awaiting further information/New actions parameters to be established |

| Requirement | Progress/Performance | RAG | Actions to improve position/Actions for the next quarter | Assurance | Status/ Expected Completion |
|---|---|---|---|---|---|
| **Recommendation 1** - NHS Improvement 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.<br><br>**Lead Director:** Director of Human Resources & Organisational Development | | | | | |
| Development and approval of people strategy and dashboard. | • The people strategy and dashboard has been developed. | Green | • The dashboard is reviewed monthly and any areas of concern are addressed. | Trust Board, TOB, Workforce Committee | Ongoing Monitoring |
| HR polices reviewed to ensure they are clear and simple and transparent. | • The HR & OD Directorate has a Policies and Procedures group with management and staff side members. All HR policies are taken through this group – new and then progress to JNCC and then to Workforce Committee. | Green | • HR policies are reviewed in line with agreed timescales or any significant change as requirements. | Workforce Committee | Ongoing Monitoring |
| "Fit to Care" Heath & Wellbeing Strategy | • As part of national CQUIN support for a wide range of wellbeing approaches aimed at supporting staff back into work including a range of exercise classes. | Green | • A programme of exercise classes has been implemented. | Workforce Committee | Rolling Programme |
| Development of Workforce Streaming Programme across the North West | • The Trust continues to work with colleagues across the North West to agree unified ways or working and to reduce bureaucracy. | Green | • Notice periods in line with the STP footprint have been approved by JNCC for new starters and implemented in October 2017. | Workforce Committee | Ongoing |

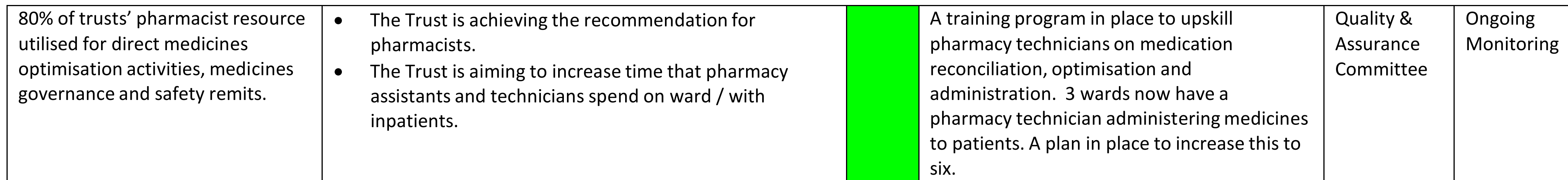
| | | | | | |
|---|---|---|---|---|---|
| Review of back office functions | • The Trust continues to lead on back office efficiencies through the Director of Finance and Commercial Development. A HRD is a member of the group from within the Alliance. | | • A visioning workshop was hosted on 21/07/2017 with a focus on HR, Finance & Procurement. An internal review of Payroll has been undertaken with an outcome that it is cost effective and provides a quality service. The provider will be retained by WHH. | STP | Project – expected completion TBC. |
| Staff Opinion Survey | • The Staff Opinion Survey (SOS) is currently open. A range of activities are underway to promote completion. A reminder to all staff who have not completed the survey is due to be sent w/c 20 November 2017. | | • The results from the SOS will be due in February / March 2018, and an action plan will be developed to present to Workforce Committee, TOB and Trust Board in March/April 2018. | Trust Board/TOB. | Rolling Programme |
| Reduction in the high rates of bullying and harassment with a sustained campaign led personally by each trust Chief Executive | • There has been an increase from 2016 in both BME and white staff suffering harassment from other staff members in 2017. It is relevant to note that this may not be racially motivated. There is a small % difference. However, the increase of harassment of all staff is cause for concern.<br>• It is anticipated this will reduce with a number of initiatives including "Freedom to Speak Up" Guardians and a long term communications campaign. | | Workforce Race Equality Scheme 2017:<br>• For the third year running BME applicants were more likely to be shortlisted in relation to the overall representative community of 12%. There was also a higher chance of selection than in previous years.<br>• Based on the figures there is no concern regarding the likelihood proportionally of BME staff being subjected to disciplinary procedures any more than white British member of staff.<br>• The Freedom to Speak Up Champion has a network of champions to support staff to raise concerns. Links have been made with Junior Doctors and the People Champions as this agenda continues to embed. | Workforce Committee | Ongoing Monitoring |
| Ensure Staff have regular performance reviews | • The number of staff with a valid PDR is 78.9% (September 2017) against a target of 80%. | | • HR Business Partners have worked with divisions to develop a recovery plan, although this people measure continues to create challenges across clinical and non-clinical staff groups with the exception of medical workforce. | Trust Board/TOB Workforce Committee | Ongoing Monitoring |

| | | | | | |
|---|---|---|---|---|---|
| Improving Sickness Absence | • Sickness absence was 4.20% in July, 4.18% in August and 4.58% in August 2017 the Trust target was achieved. Sickness absence has continued to reduce and is significantly lower than the same period last year. | | • An audit has been completed on compliance with the Trust Attendance Management Policy and a number of recommendations are being implemented.<br>• A communication on the importance of Return to Work Interviews was included in Team Brief in October 2017. | Trust Board/TOB Workforce Committee | Ongoing Monitoring |
| Restructure of HR Directorate | • Restructure of HR Department | | • HR restructure is complete.<br>• Relocation of HR business partners and their teams into clinical divisions. Acute Care Division is complete. We are currently working on finding an office in Surgery, Women & Childrens Division.<br>• Monthly meetings are being held to review levels of support. | Trust Board/ Workforce Committee | To be completed by 31st December 2017. |

| Requirement | Progress/Performance | RAG | Actions to improve position/Actions for the next quarter | Assurance | Status/ Expected Completion |
|---|---|---|---|---|---|
| **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.<br><br>**Lead Directors:** Medical Director & Chief Nurse | | | | | |
| Care hours per patient | • The Trust continues to systematically collect and submit Care Hours per Patient Day (CHPPD) data since the national changes in April 2016.<br>• The data is included in the monthly Safe Staffing and assurance report presented by the Chief Nurse at the Trust Board. | | • Care Hours are reviewed each month as part of the IPR at Trust and Divisional Level.<br>• Data is submitted monthly to NHS(I) via Trust Performance team. | Trust Board / Divisional level management | Ongoing Monitoring |
| Electronic roster and safe care module –<br>All trusts using an e-rostering system, with the following practices being implemented:<br>• Publishing rosters six weeks in advance, submitted to NHS Improvement<br>• Formal process to tackle areas that require improvement and developing associated cultural change and communication plans<br>• Implementing NHS Improvement guide on enhanced care by October 2016, to be monitored by NHS Improvement. | • Implementation of Electronic Roster & Safe Care – all core wards are now live on the system.<br>• Corporate nursing has taken over management of e-roster team.<br>• The e-roster team is now co-located within the Patient Flow team to ensure staffing is matched to operational demand. | | • E-Roster and Safe Care module fully implemented.<br>• The Interface between e-roster and NHS(P) is in progress to allow more timely booking of temporary staff. | Bi-Annual Staffing Assurance paper presented to Trust Board by Chief Nurse. | 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 | • 2017/18 Job planning underway.<br>• 2nd Job Planning round with Allocate inc specialty and associate specialists.<br>• 42% completed job plans for 2017/18.<br>• The project around a corporate budget for programmed activities medical leadership, education and research, quality governance and appraisal and revalidation is nearing conclusion with all non-core SPA and non-direct clinical care PAs being transferred from the CBUs/Divisions to one of four medical budgets. | | • Job planning progress monitored on a weekly basis.<br>• The Deputy Medical Director is sending out the report on a weekly basis to Clinical Directors.<br>• The absolute job planning deadline is 22/12/2017.<br>• An updated draft job plan is to be circulated to medical cabinet in September for comments and consistency.<br>• Proposed 2 sign offs for 2018/19: by CBU Managers/Clinical Directors in Jan/Feb (1st sign off) and again in March by Consistency Panel (2nd sign off).<br>• A draft updated job planning policy being completed. | Workforce Committee | 2017/18 Job Planning – final sign off March 2018. |
|---|---|---|---|---|---|

| Requirement | Progress/Performance | RAG | Actions to improve position/Actions for the next quarter | Assurance | Status/ Expected Completion |
|---|---|---|---|---|---|
| **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.<br><br>**Lead Directors:** Medical Director & Chief Operating Officer | | | | | |
| Hospital Pharmacy Transformation Programme - developing HPTP plans at a local level, with each trust board nominating a Director to work with their Chief Pharmacist to implement changes. | • Developed and approved HPTP Plan, nominate Directors, Board sign off and submission of final plan to NHS Improvement. | | • Completed in May 2017. | Trust Board | Completed |
| Moving prescribing and administration from traditional drug cards to Electronic Prescribing and Medicines Administration systems (EPMA). | • Electronic prescribing and medicines administration (EPMA) Business case and PID signed off by Trust Board and NHS Digital.<br>• A Project Board has been established with terms of reference.<br>• A draft project plan has been developed. | | • Business case and PID approved by the Trust board in October 2017.<br>• NHS Digital approved the business case in principle in November 2017.<br>• Project board terms of reference written and schedule of meetings developed.<br>• A draft project plan has been developed. | Trust Board | Completed |
| Ensuing that coding of medicines are accurately recorded. | • The JAC Pharmacy system has been upgraded to enable use of DM+D codes.<br>• Pharmacy drug files have been updated where possible with DM+D codes.<br>• Review of and improvement of quality of data sets submitted to NHS England, CCGs & PHE.<br>. | | • Completed July 2017<br>• Completed August 2017<br>• Review completed September 2017<br>• Findings: Work needed to improve data quality to ensure data fields show accurate and complete data.<br>• PHE SACT data update: Webex 15/11/17 | IM&T Board | Completed<br>Completed<br>Completed<br>Ongoing Monitoring |



| 80% of trusts' pharmacist resource utilised for direct medicines optimisation activities, medicines governance and safety remits. | • The Trust is achieving the recommendation for pharmacists.<br>• The Trust is aiming to increase time that pharmacy assistants and technicians spend on ward / with inpatients. | | A training program in place to upskill pharmacy technicians on medication reconciliation, optimisation and administration. 3 wards now have a pharmacy technician administering medicines to patients. A plan in place to increase this to six. | Quality & Assurance Committee | Ongoing Monitoring |
|---|---|---|---|---|---|

| Requirement | Progress/Performance | RAG | Actions to improve position/Actions for the next quarter | Assurance | Status/ Expected Completion |
|---|---|---|---|---|---|
| **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.<br><br>**Lead Directors:** Chief Operating Officer & Director of Transformation | | | | | |
| Establishment of a shared pathology across the local economy. | • NHSI have 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. The first meeting is on Tuesday 21st November. | | • First meeting of STP Pathology Board scheduled for 21st November 2017. | Strategic Projects - COO and Director of Transformation | Project – expected completion 2020 |
| 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, with NHS Improvement hosting the dashboard. | • PQAD developed has been developed. | | • Produced in "shadow" form from November 2016.<br>• Monthly data produced from April 2017. | COO and Trust Board. | Project – completed 14/12/2016 |

| Requirement | Progress/Performance | RAG | Actions to improve position/Actions for the next quarter | Assurance | Status/ Expected Completion |
|---|---|---|---|---|---|
| **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.<br><br>**Lead Directors:** Director of Finance & Commercial Development | | | | | |
| Provide data to NHSi for the NHS purchasing price index benchmarking tool (PPIB).<br><br>Trust to send all spend data to NHSI's appointed supplier - AdvisInc - for cleansing and incorporating into the PPIB tool. . | • The procurement team continues to provide the data to NHSI for the NHS Purchasing Price Index benchmarking tool on a monthly basis. | | | Associate Director of Procurement | Rolling Programme |
| Procurement and Transformation Plan<br><br>Developing PTP plans at a local level with each trust board nominating a director to work with their procurement lead to implement changes | • The Procurement Transformation Plan has been drafted and submitted to NHSI. To support this, a Procurement Dashboard has been established to measure Trust performance against the Carter metrics. | | | Associate Director of Procurement | Project Implementation – expected completion February 2018 |
| Adoption plan for Scan4Safety | • The Trust adoption plan for Scan4Safety (formally the Global Standard: GS1) and pan European Public Procurement Online (PEPPOL) standards is currently being updated that will require approval by the Trust Board. | | • The procurement department is currently in the process of restructuring with part of this restructure established to support, develop and implement the requirements of Scan4Safety. | Project Board | Project Implementation – expected completion TBC |

| NHS Standards of Procurement –<br><br>Trusts adopting NHS Standards of Procurement, with those that have already achieved Level 1 achieving Level 2 of the standards by October 2018; and those trusts that are yet to attain Level 1 achieving that level by October 2017. All trusts to produce a self-improvement plan to meet their target standard by March 2017. | • The Trust has achieved NHS Standards of Procurement Level 1 accreditation. | | • The Trust is working towards level 2 accreditation for review in 2018. | Associate Director of Procurement | Project Implementation – Expected Completion June 2018 |
|---|---|---|---|---|---|
| Benchmarking | • Trust currently ranked 46/136 Trusts – placing the Trust in the middle of upper quartile.<br>• Data submitted regarding the Model Hospital. | | • The criteria that contributes to the ranked position is to be reviewed to establish plans to improve the Trusts ranking. This is reported to the Finance Committee. | Associate Director of Procurement | Ongoing |
| Trust focusing on the measurement of Key procurement metrics and being responsible for driving compliance to the following targets by September 2017:<br><br>• 80% addressable spend transaction volume on catalogue<br>• 90% addressable spend transaction volume with a purchase order<br>• 90% addressable spend by value under contract. | • 92% of addressable spend transaction volume on catalogue.<br><br>• 83% of addressable spend transaction volume is covered by a purchase order.<br><br>• 82% of addressable spend by value under contract. | | • Spend that is not transacted on via a PO is monitored on a monthly basis and suppliers are placed on a 100% PO rule i.e. if they do not have an order number their invoice will be rejected.<br>• Enhancements have been made to the Contract Register held by the Procurement Team; this now incorporates an automatic trigger that highlights dates for the commencement of the procurement process in order to implement contracts in a timely manner. | Associate Director of Procurement | Ongoing Monitoring |

| Requirement | Progress/Performance | RAG | Actions to improve position/Actions for the next quarter | Assurance | Status/ Expected Completion |
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| **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.<br><br>**Lead Directors:** Director of Finance & Commercial Development and Chief Operating Officer | | | | | |
| Every trust has a strategic estates and facilities plan in place, including a cost reduction plan for 2016-17 based on the benchmarks, and in the longer term (by April 2017), a plan for investment and 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 options for delivering savings this financial year 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. | Green | • Phase one being monitored through Strategic Development and Delivery meeting. | Trust Board/ Estates and Facilities sub-Committee | Ongoing management of the plan |
| Investing in energy saving schemes such as LED lighting, combined heat and power units, and smart energy management systems, | • ADE&F is exploring the possibility of funding from Salix Finance, Salix Finance Ltd, (https://www.salixfinance.co.uk/) who provide interest-free Government funding to the public sector to improve their energy efficiency, reduce carbon emissions and lower energy bills. | Green | • ADE&F meeting with finance lead to understand how the funding application is made and to progress by December 2017. | Estates and Facilities sub Committee | Project Implementation – expected completion April 2018 |
| Estates and facilities costs embedded into trusts' patient costing and service line reporting systems. | • Estates and Facilities costs will be reviewed as part of service line reporting costs/systems. The costing teams use the estates system, MICAD, to export floor area and can allocate energy/facilities costs based on m2. | Amber | • Associate Director of Estates and Facilities to liaise with finance to review outputs. | Estates and Facilities Finance Meeting | Project Implementation – expected completion TBC |
| Model Hospital & Effectiveness of Estates | • The Trust continues to review the effectiveness of its estate and monitor cost efficiency metrics to ensure it provides value for money and take actions for any deviation from the benchmark values. When the 2016/17 Model Hospital metrics are available an update will be provided. | Green | • Whilst the trust benchmarks well against most metrics, (cost efficiency), there are some areas where meeting national benchmarks can prove challenging due to fixed costs and the condition of the estates and unavailability of capital | Estates and Facilities sub Committee/ Alliance and Mid Mersey LDS Estates Workstream | Ongoing Monitoring |

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| | | | expenditure. However where the Trust is not benchmarking well (productivity, quality and safety) and change is within our control, measures are in place to improve performance. Current figures on Model Hospital refer to 15-16 data. | | |
| All trusts (where appropriate) have a plan to operate with a maximum of 35% of nonclinical floor space and 2.5% of unoccupied or under-used space by April 2017 and delivering this benchmark by April 2020, so that estates and facilities resources are used in a cost effective manner. | • Current data states that the trust utilises 41% of its estate for non-clinical use and has 1.3% of under - utilised space | | • Current estate strategy aims to address the under-utilised space. | Strategic Development and Delivery Committee | Ongoing Monitoring |

| Requirement | Progress/Performance | RAG | Actions to improve position/Actions for the next quarter | Assurance | Status/ Expected Completion |
|---|---|---|---|---|---|
| **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.<br><br>**Lead Directors:** Chief Operating Officer and Director of Transformation | | | | | |
| NHSI Data Collection | • The Trust's corporate and administration functions current costs are 7.3% of income based on planned income.<br>• 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 were required. | | • LDS Corporate Services Collaboration programme of work launched in spring 2017 chaired by WHH Director of Finance. This is designed to create a formal structure for corporate function leads from all LDS partner organisations to discuss, develop and implement ideas to generate financial efficiency savings either individually or in collaboration with other partners.<br>• A workshop was held on 7th November for Communications and Legal Services workstreams which delivered a number of priorities and leads - this will be developed into firm action plans with agreed milestones over the coming months.<br>• The IT workstream is also planning to hold a meeting in the next quarter to collectively review benchmarking data and agree next steps. | Strategic Development and Delivery Committee. | Rolling Programme |
| Corporate CIP Targets | • All corporate divisions have been assigned costs savings targets in 2017/18. The targets and the progress to date in identifying schemes to meet the targets are summarised, along with CIP delivery at M6. The cost savings being delivered either reduce costs or increase income, thereby improving their respective percentage cost figures. | | • Corporate CIP targets total £1.47m and the forecast delivery across all corporate services stands at just over £1.5m in year (@ M07)<br>• Recurrent delivery stands at £0.78m with a further £0.5m potential savings linked to estates transformation (high risk). | ICIC | Rolling Programme |

| Corporate Services A&C Review | • All corporate functions have been sent the details of their A&C staffing (funded and in post) and asked to provide a response around how they intend to help the Trust address the challenge as set out in the Carter report. | | • Corporate functions are to be the focus of ICIC in December when they will each be asked to feedback their plans to reduce spend on A&C staffing over the next 3 to 4 years. | ICIC | Ongoing |
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| Requirement | Progress/Performance | RAG | Actions to improve position/Actions for the next quarter | Assurance | Status/ Expected Completion |
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| **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.<br><br>**Lead Directors:** Chief Operating Officer and Director of Transformation | | | | | |
| Variation in Theatres and Outpatients | • Unwarranted variation within theatres and outpatients is being addressed through the theatres and outpatient work streams of the transformation programme. | Green | • 1st set of data has been shared with CBU leads and opportunity to improve efficiencies identified.<br>• Plans for each CBU to standardise processes and to ensure efficient utilisation of both OPD and Theatres is in progress as well as several pieces of work taking place in both Theatres and OPD with CBU involvement. | Strategic Development and Delivery Committee. | Ongoing |
| Emergency Care Improvement Programme | • The Trust is working with the Emergency Care Improvement Programme around Improvements in patient flow and has agreed a number of key work streams across mid Mersey following a system review these work streams feed into the Mid Mersey A&E delivery board.<br>• The Trust has its own internal Flow board which focuses on 9 key work streams to support improvements in flow. | Green | • The Trust has an internal flow board which has 8 separate work stream supporting improvements in Emergency care and flow.<br>• Following the full system review the four key work streams have reported through A&E delivery board and have system leader updates monthly.<br>• In the last quarter it was agreed that frailty and transfer to assess would merge as one project. The Trust now has a frailty Nurse consultant, who in the next quarter will revise the PID for frailty and transfer to assess and ensure key priorities are identified.<br>• The trust is working across the system to ensure that we are collecting and sharing the same data set. | A&E Delivery Board<br><br>Flow Board | Ongoing |

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| Specialty level reviews across local delivery system. | • The Trust is participating in a series of specialty level reviews across the Local Delivery System (LDS).<br>• Agree and implement plans to reduce variation within pathways across the LDS.<br>• Initial specialty reviews have now been held in urology, trauma & orthopaedics and ophthalmology.<br>• A programme of workshops across priority specialties has been agreed, led by the LDS Director of Service Redesign. | | • The LDS Director of Service Redesign is pulling together data packs for the 3 specialties within the initial scope of this work (T&O, Urology & Ophthalmology). This data will blend the findings of the recent GIRFT reports with some other clinical and performance metrics to identify where the major opportunities lie for each of the LDS organisations.<br>• The Transformation Team will be supporting the development of PIDs following individual workshops to enable delivery of improvements identified. | Strategic Development and Delivery Committee. | Ongoing |

| Requirement | Progress/Performance | RAG | Actions to improve position/Actions for the next quarter | Assurance | Status/ Expected Completion |
|---|---|---|---|---|---|
| **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.<br><br>**Lead Director:** Director of Information Management & Technology | | | | | |
| Electronic Patient Record | • The Trust implemented Lorenzo in December 2015. | | • Ongoing optimisation of functionality. | Project Board/ IM&T Sub-Committee/ Trust Board | Project Implementation – expected completion – Plan up to 2020 on track. |
| Electronic Document Management System | • Business Case developed for EDMS solution. | | • Procurement & Implementation of EDMS. | IM&T Sub-Committee/ Trust Board | Project Implementation – expected completion – Full Business Case to be approved end March 2018 |
| e-Prescribing | • Business case in process of being developed for ePMA. | | • Procurement & Implementation of ePMA solution. | IM&T Sub-Committee/ Trust Board | Project Implementation – Trust Full Business Case approved deployment on track March 2018. |
| Structured clinical notes | | | • Roll out to Outpatients plans to be agreed. | IM&T Sub-Committee/ Trust Board | Project Implementation – expected completion – To be confirmed |

| Requirement | Progress/Performance | RAG | Actions to improve position/Actions for the next quarter | Assurance | Status/ Expected Completion |
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| **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.<br><br>**Lead Director:** Not Applicable | | | | | |
| Further information from national bodies is awaited. | | | | | |
| **Recommendation 11** - Trust boards to work with NHS Improvement and NHS England to identify where there are quality and efficiency opportunities for better collaboration and coordination of their clinical services across their local health economies, so that they can better meet the clinical needs of the local community.<br><br>**Lead Director:** Not Applicable | | | | | |
| Collaborative working across the healthcare economy | • The Trust is working in collaboration with external providers and commissioners within the STP and LDS to seek to address clinical and financial constraints through service, productivity and rationalisation opportunities.<br>• Pathway Integration and efficiency through the local health economy will be digitally enabled through the use of Care Record, risk stratification and patients accessing personal health records. | | | | |
| **Recommendation 12** - NHS Improvement should develop the Model Hospital and the underlying metrics, to identify what good looks like, so that there is one source of data, benchmarks and good practice.<br><br>**Lead Director:** Not Applicable | | | | | |
| Development of "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, analyse and respond will be prepared.<br>• 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 |

<table>
<tr><td colspan="6">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.<br><br>Lead Director: Not Applicable</td></tr>
<tr><td>Implementation of Single Oversite Framework</td><td>• NHS Improvement published the document Single Oversight Framework (SOF) effective from 1st October 2016.</td><td></td><td>• New SOF reviewed and indicators have been incorporated into IPR and other performance monitoring tools.</td><td>Trust Board</td><td>Ongoing Monitoring</td></tr>
<tr><td>Segmentation</td><td>• The Trust received verbal confirmation from NHSI on 15th November that it has been allocated to Segment 2 and is awaiting formal written confirmation.</td><td></td><td></td><td>Trust Board</td><td>Ongoing Monitoring</td></tr>
<tr><td colspan="6">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.<br><br>Lead Director: All Executive Directors</td></tr>
<tr><td>See individual recommendations.</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="6">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.<br><br>Lead Director: Not Applicable</td></tr>
<tr><td>Further information from national bodies is awaited.</td><td></td><td></td><td></td><td></td><td></td></tr>
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**REPORT TO BOARD OF DIRECTORS**

| AGENDA REFERENCE: | **BM/17/11/125** |
|---|---|
| SUBJECT: | **Cyber Security Preparedness and Relevant EU Legislation & Response to NHS Improvement Cyber Security Email** |
| DATE OF MEETING: | 29/11/2017 |
| ACTION REQUIRED | **In light of the requirements of the burgeoning information security and governance agendas the Board is asked to note the work undertaken to mitigate risk in this area. In addition the Board is asked to indicate a preferred option for nomination of a Data Protection Officer as required by the General Data Protection Regulation.** |
| AUTHOR(S): | Jason DaCosta, Director of IM&T |
| EXECUTIVE DIRECTOR SPONSOR: | Choose an item. |
| | |
| LINK TO STRATEGIC OBJECTIVES: | All |
| LINK TO BOARD ASSURANCE FRAMEWORK (BAF): | BAF3.3: Clinical & Business Information Systems |
| | BAF1.4: Business Continuity |
| | BAF1.1: CQC Compliance for Quality |
| | |
| STRATEGIC CONTEXT | To provide sustainable services for WHH service users. |
| EXECUTIVE SUMMARY (KEY ISSUES): | **As requested in the letter sent by NHS Improvement in October 2017 actions taken as a result of CareCERT bulletins issued will be documented on the CareCERT Collect portal.**<br><br>**The Board is asked to note the contents of this paper and the work undertaken to strengthen cyber security. It is also asked to note the impact of new legislation and the National Data Guardian's 10 data standards on the ability of the current IT/Information Governance staff to implement the requisite processes and procedures in order to achieve compliance.**<br><br>**The nomination of a Data Protection Officer (DPO) as required by the GDPR should be considered a high priority.** |

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| **RECOMMENDATION:** | • Nominate a DPO as required by the General Data Protection Regulation (Article 38 EU GDPR)<br>• Note the increasing demands in respect to the IT Department's capacity in relation to burgeoning cyber security demands and EU legislation changes in the area of Information law and cyber security | |
| **PREVIOUSLY CONSIDERED BY:** | **Committee** | Not Applicable |
| | **Agenda Ref.** | |
| | **Date of meeting** | |
| | **Summary of Outcome** | |
| **FREEDOM OF INFORMATION STATUS (FOIA):** | Release Document in Full | |
| **FOIA EXEMPTIONS APPLIED:** ***(if relevant)*** | Choose an item. | |

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**NAME OF COMMITTEE**

| SUBJECT | Cyber Security Preparedness and Relevant EU Legislation | AGENDA REF: | |
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## 1. BACKGROUND/CONTEXT

This report summarises the actions taken in response to the letter distributed by NHS Improvement in October 2017 in relation to CareCERT Information Security/Cyber Security alerts. It also summarises the challenges faced by IT and Information Governance staff in the face of the ever burgeoning area of information security and governance, particularly in light of the introduction of new EU data protection and cyber security legislation.

## 2. KEY ELEMENTS

**Introduction**

In the light of recent Cyber Security incidents which affected the NHS a letter (Appendix A) was distributed to Chairs and Chief Executives on 27th September 2017 regarding the CareCERT alert system. The CareCERT alerts system is operated by NHS Digital and alerts Trusts to IT security risks and the requisite controls to mitigate said risks.

The Trust's IT Department have been asked to register for the CareCERT collect portal in order to confirm that security alerts issued have been acted upon within 48 hours of release.

This paper is designed to provide assurance that WHH has strengthened arrangements we have in place to act upon critical and high alerts communicated via CareCERT Collect security bulletins.

**Increased Risks of Cyber Attack & Resulting Resource Implications**

The increased risk of Cyber-attack in recent years has coincided with increased pressures on the Server and Network Team from other areas. Over the last 4 years, the number of servers (physical and virtual) in operation across the Trust has increased from 120 to 205. In addition, the Network Team has taken on responsibility in relation to:

- the VOIP system
- an expansion of connectivity within Community Services
- an increase and reliance on Wi-Fi including the advent of guest Wi-Fi

Although some of the IT security-related activity is carried out as part of business as usual activity with existing resources the volume of work, and the burgeoning information security/information governance agendas, now means that satisfying NHS policy in this area to maintain an adequate level of security within existing resources. Additional resources may be required to reduce this risk and establish a dedicated IT security resource.

To illustrate the size of the issue, during the most recent major Ransomware attack (Wannacry -May 2017), the IT Department's Server team spent one full week (7 days) applying a single patch to all of the Trust's on site servers. More patches still need to be applied to bring the WHH server estate up to a safe level. Furthermore, new patches are released on a weekly basis. Whilst we try to prioritise those patches assessed as the most important, this is proving ever more difficult to achieve as we become more and more reliant on the IT infrastructure.

Furthermore, as software suppliers such as Microsoft attempt to keep at least one step ahead of the perpetrators of cyber-crime, they are increasing the number and complexity of their patches and upgrades. These upgrades effectively have mandatory status as failure to adopt them renders the software obsolete. Consistent patch maintenance adds significantly to the workload of the Server and Network Teams and bolsters the case for additional technical resources in order to augment the security work currently undertaken.

**Measures in Place to Mitigate Risks**

Most potentially malicious content will be blocked at a national level through the security measures offered by BT N3 (NHS Network). Malicious files which get through this initial barrier will be blocked by the Trust's own anti-virus security software, MacAfee, providing this software is operational on the device. The MacAfee anti-virus security suite has just been renewed for another 3 years in September 2017.

WHH firewalls and security hardware are due for a refresh in March 2018. We intend to upgrade the hardware and renew the firewalls in order to:

- include modules to help proactively block potential cyber-attacks (Intrusion prevention system)
- Use deep packet inspection products to analyse data that is entering the WHH network to ascertain whether it is malicious or benign
- Allow the IT Technical team to introduce a protective 'bubble' in order to protect medical devices that are connected to the WHH network. This is particularly relevant to devices that are still using Windows XP and will assist in preventing unwanted intrusion on the medical VLAN (virtual local area network)

The scale of the work involved in implementing the protective 'bubble' referred to above should not be underestimated. This piece of work will necessitate collaboration between IT, Radiology and the third party suppliers of the requisite medical equipment.

Senior IT staff routinely act upon CareCERT information security bulletins which are released by NHS Digital's Data Security Centre. Actions performed in response to such bulletins are documented as part of the actions resulting from meetings of the IT Services senior staff meetings. As requested in the letter sent by NHS Improvement in October 2017 actions taken as a result of CareCERT bulletins issued will be documented on the CareCERT Collect portal.

**Cyber Security & Information Governance Audits in 2017**

| Auditors | Audit | Findings |
|---|---|---|
| Mersey Internal Audit Agency | 2017 Information Governance Assurance Audit-March 2017 | Significant Assurance |
| Dionach on behalf on NHS Digital | Cyber Essentials/Cyber Essentials Plus-August 2017 | Fail |
| Stonegate (Firewall Supplier) | Firewall Health Check -September 2017 | Pass |
| Mersey Internal Audit Agency | Cyber Security Baseline Technical Controls Assessment | Ongoing |
| NCC Group | Cyber Essentials | Ongoing |

The findings of the NHS Digital audit of WHH readiness against the Cyber Essentials Plus standard must be qualified. Despite the fact that NHS Digital could not breach our network from the outside they did find some areas within the network domain that could be strengthened. In addition to the findings which can be addressed locally there are national issues which WHH cannot influence. These are:

- No NHS Trust can currently pass the Cyber Essentials Plus standard. At the time of the Trust's Cyber Essentials assessment in August 2017 28 Trusts had been assessed and 28 Trusts had failed.

- WHH is powerless to upgrade the current versions of national systems such as SBS and ESR The version of Java which is used to run these systems is out-of-date and is therefore vulnerable in terms of security. This is the key reason that the Cyber Essentials standard cannot be attained.

Areas of weakness that were identified in the NHS Digital review of WHH preparedness against the Cyber Essentials Plus standard include:

- Hidden insecure shared areas on the WHH network which potentially could be accessed by hackers in possession of the relevant software

- Discrepancy in the records held of active computers at WHH when compared with the centralised patch management software and active directory which is the database that allows users to logon to the WHH domain

- Excessive amounts of admin accounts with unnecessary privileges

- Missing non-Microsoft critical updates (Java)

The IT technical team are currently attempting to fix weaknesses identified and will be reporting progress made to NHS Digital in late November 2017.

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**General Data Protection Regulations (GDPR) & the Directive on Security of Network and Information Systems Directive (NIS Directive)**

Two pieces of European legislation will come into force in May 2018, the General Data Protection Regulation and the NIS Directive. The UK has until May 2018 to translate the NIS Directive into UK law and a further six months to identify which Operators of Essential Services (OESs) it applies to. The GDPR will be brought into UK law under the new Data Protection Bill and will repeal the Data Protection Act 1998.

The General Data Protection Regulation is the biggest change to UK Data Protection Law in 20 years and will become effective on May 25th 2018. Section 4 of GDPR introduces a statutory obligation upon the Trust to appoint a Data Protection Officer (DPO). The DPO can be employed by the Trust (internal DPO) or be appointed under contract (external DPO). The DPO must report to the highest level of management within the Trust and should have significant knowledge of data protection law and practices.

The tasks that a DPO will be expected to perform include the following:

- Inform and advise the organisation and its employees of their data protection obligations under the GDPR.
- Monitor the organisation's compliance with the GDPR and internal data protection policies and procedures. This will include monitoring the assignment of responsibilities, awareness training, and training of staff involved in processing operations and related audits.
- Advise on the necessity of data protection impact assessments (DPIAs), the manner of their implementation and outcomes.
- Serve as the contact point to the data protection authorities for all data protection issues, including data breach reporting.
- Serve as the contact point for individuals (data subjects) on privacy matters, including subject access requests.

Options for the appointment of a DPO include:

- External DPO-has the advantage of independence and therefore would not be deterred from investigating data protection concerns thoroughly and impartially.
- Internal DPO-has the benefit of understanding the Trust's organisational and IT structure
- Dual DPO-this provides resilience in the absence of one DPO

WHH must adhere to Article 32 of the General Data Protection Regulation which requires WHH to *"implement appropriate technical and organisational measures"* to protect data. Article 32 of GDPR, which is concerned with the security of the processing of data, states that such measures should include:

- *"the ability to ensure the ongoing confidentiality, integrity, availability and resilience of processing systems and services"*
- *"the ability to restore the availability and access to personal data in a timely manner in the event of a physical or technical incident"*
- "*a process for regularly testing, assessing and evaluating the effectiveness of technical and organisational measures for ensuring the security of the processing*"

In addition to the statutory requirements of GDPR the NIS Directive (EU Directive on Security of Network and Information Systems) will place further emphasis upon organisations to implement robust IT/Information Security controls. The NIS Directive is an EU wide piece of cyber security legislation which will introduce significant fines for organisations that cannot demonstrate that appropriate digital security risk mitigation measures are in place. The objective of the NIS Directive is to achieve a high level of network and information systems security across the EU in three ways:

- Improve cyber security at national level
- Increase cooperation on cyber security across member states
- Introduce security and incident reporting obligations for operators of essential services (OESs)

The UK Government will have 6 months after the NIS Directive is effective to identify OESs.

**National Data Guardian 10 Data Standards**

The UK Government accepted in full the recommendations contained in the National Data Guardian's review of data Security and the proposed 10 data security standards. The government also strengthened standard 6. The standards will form part of the CQC's well led inspection framework.

The NDG's 10 data standards will be incorporated into version 15.0 of the NHS Digital Information Governance Toolkit which will be released in April 2018.

| National Data Guardian Standards | |
|---|---|
| *1.* | All staff ensure that personal confidential data is handled, stored and transmitted securely, whether in electronic or paper form. Personal confidential data is only shared for lawful and appropriate purposes |
| *2.* | All staff understand their responsibilities under the National Data Guardian's Data Security Standards including their obligation to handle information responsibly and their personal accountability for deliberate or avoidable breaches |
| *3.* | All staff complete appropriate annual data security training and pass a mandatory test, provided through the revised Information Governance Toolkit |
| *4.* | Personal confidential data is only accessible to staff who need it for their current role and access is removed as soon as it is no longer required. All access to personal confidential data on IT systems can be attributed to individuals |
| *5.* | Processes are reviewed at least annually to identify and improve processes which have caused breaches or near misses, or which force staff to use workarounds |
| *6.* | Cyber-attacks against services are identified and resisted and CareCERT security advice is responded to. Action is taken immediately following a data breach or a near miss, with a report made to senior management within 12 hours of detection. |
| *7.* | A continuity plan is in place to respond to threats to data security, including significant data breaches or near misses, and it is tested once a year as a minimum, with a report to senior management. |
| 8. | No unsupported operating systems, software or internet browsers are used within the IT estate. |
| 9. | A strategy is in place for protecting IT systems from cyber threats which is based on a proven cyber security framework such as Cyber Essentials. This is reviewed at least annually. |
| 10. | Suppliers are held accountable via contracts for protecting the personal confidential data they process and meeting the National Data Guardian's Data Security Standard. |

NB-the UK government have strengthened standard 6 in their response to the standards. It should also be noted that compliance with standard 8 is currently not possible for the reasons outlined in section 4 of this report.

## 3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

**The Board is asked to note the current position in relation to cyber security and to indicate a preference for nomination of a DPO as required by the General Data Protection Regulation.**

## 4. IMPACT ON QPS?

**The Quality of services delivered could be seriously impacted by a successful cyber-attack.**

## 5. MEASUREMENTS/EVALUATIONS

**Both the Cyber Security Baseline Technical Controls Assessment and cyber essentials assessment are ongoing.**

## 6. TRAJECTORIES/OBJECTIVES AGREED

- **Implement controls in response to actions identified in cyber-security audits**
- **Report on progress of GDPR action plan to SIRO and Caldicott Guardian via the Information Governance and Corporate Records Sub-Committee**

## 7. MONITORING/REPORTING ROUTES

**All relevant issues affecting cyber-security and the implementation of the requisite processes and controls necessary for GDPR, NIS Directive and National Data Guardian's report compliance are monitored by the Information Governance and Corporate Records Sub-Committee which reports to the Quality Committee.**

## 8. TIMELINES

**General Data Protection Regulations (GDPR)-enforceable from May 2018**

**EU Network and Information Systems Directive-must be transposed into UK legislation by May 2018**
**National Data Guardian's data standards to be incorporated into version 15.0 of the NHS Digital Information Governance Toolkit in April 2018**

## 9. ASSURANCE COMMITTEE

**Quality Committee**

## 10. RECOMMENDATIONS

- **Express preference for one of the three options outlined for the nomination of a DPO (General Data Protection Regulation).**
- **Note the current position in relation to audits carried out against the Cyber Essentials Plus standard.**
- **Note the potential resource implications of the burgeoning information security/governance and cyber security agendas.**
- **Note that actions related to NHS Improvement communique dated October 2017 and the CareCERT registration has been completed.**

We are
WHH

Warrington and
Halton Hospitals
NHS Foundation Trust

17 October 2017

**To: Provider Chairs and Chief Executives**

(Via email)

NHS
Improvement

Dear Colleagues

**Cyber Security**

I would like to follow up on the letter you should have received on the 27 September regarding sign up to CareCERT Collect. As you may be aware, the NHS has reflected on the learning from the recent cyber security issues alongside the National Data Guardian recommendations. Your operational and IT teams responded brilliantly where Trusts were impacted, and they should be thanked and commended for this.

In our review it became clear that there were areas in which the NHS could have taken better preventative actions, and where Boards could have more overtly sought assurance about the implementation of actions required related to critical and high alerts from NHS Digital.

As the NHS becomes more reliant on IT to support the delivery of care to patients, this becomes an increasingly important issue for Boards of NHS Trusts. We have agreed with NHS Digital and NHS England that Trusts will now be asked to strengthen the arrangements they have in place to receive and act upon Critical and High alerts from NHS Digital, and to confirm that they have taken the required action, or have sought

support from NHSD.

Every NHS Trust and CCG is therefore being asked to register for CareCERT Collect to receive alerts and to then confirm that the appropriate action has been taken. This should streamline communication with Trusts as well as providing a better picture across the NHS.

Chief Executives are asked to identify an appropriate senior IT security lead to be responsible for this, and to register at http://nww.carecertcollect.digital.nhs.uk. Trusts will also be asked to provide assurance via this portal that requested actions have been implemented in response to priority CareCERT security alerts within 48 hours of them being issued. If your Trust has not yet registered please could you ensure this takes place **by the end of this week, cop, Friday 20th October 2017.**

Trust Chairs should ensure that Boards are provided with assurance that high and critical security alerts have been actioned, alongside the broader security requirements that form part of the NHS Information Governance Toolkit standards and the Government's Cyber Security recommendations.

If you are concerned about the robustness of cyber security arrangements NHS Digital are able to support risk assessments and provide advice.

Once again, many thanks for your ongoing support in this important area. Delivery & Improvement Directors will be discussing this with your teams in future Provider Oversight Meetings, and in the meantime if you have any questions or comments please don't hesitate to get in touch. There is a dedicated email account to support this - england.cyber@nhs.net

Yours sincerely

L. Simpson

**Lyn Simpson**

**Executive Regional Managing Director (North) NHS Improvement**

CC Delivery & Improvement Directors, NHS Improvement