We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

WHH Board of Directors Meeting Part 2

Wednesday 31 JANUARY 2018
1.30pm-4.20pm
Trust Conference Room

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

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

Wednesday 31 JANUARY 2018 1.30pm – 4.30pm
Trust Conference Room, Warrington Hospital

REF BM/18	ITEM	PRESENTER	PURPOSE	TIME	
BM/18/01/01	**PATIENT STORY** Staff Story – Partnership with King Edward Memorial Hospital Mumbai and Recruitment initiative – Dr Alex Crowe and Dr Ravi Badge	**Dr Alex Crowe Medical Director and Dr Ravi Badge** **Presentation**		**1.30**	**PPT**
BM/18/01/02	**Welcome, Apologies & Declarations of Interest**	**Steve McGuirk, Chairman**	**N/A**	**2.00**	**Verbal**
BM/18/01/03 PG 3	Minutes of the previous meeting held on 29 November and 20 December 2017	**Steve McGuirk, Chairman**	**Decision**	**2.02**	**Enc**
BM/18/01/04 PG 25	**Actions & Matters Arising**	**Steve McGuirk, Chairman**	**Assurance**	**2.05**	**Enc**
BM/18/01/05	**Chief Executive's Report** - Trust Operational Board Key Issues Report (29th January 2018)	**Mel Pickup, Chief Executive**	**Assurance**	**2.10**	**To be tabled**
BM/18/01/06	**Chairman's Report**	**Steve McGuirk, Chairman**	**Information**	**2.20**	**Verbal**

Quality People Sustainability

BM/18/01/07 (a) (b) (c) (d) (e)	**(Integrated Performance Dashboard M9 and Assurance Committee Reports PG 26** • **Quality Dashboard** • **PG 70 Key issues report – Quality Assurance Committee (05.12.2017 & 9.01.2018)** • **Sustainability Dashboard** • **PG 78 Key issues report - Finance & Sustainability Committee (19.12.2017) & 24.01.2018 to follow)** **People Dashboard**	**All Executive Directors** **Alex Crowe Medical Director** **Kimberley Salmon-Jamieson Chief Nurse** **Margaret Bamforth, Cttee Chair** **Andrea McGee DoF+Commercial Development** **Lucy Gardner Director of Transformation** **Terry Atherton, Cttee Chair** **Michelle Cloney Director of HR&OD**	**Assurance**	**2.25**	**Enc**

Quality

BM/18/01/08	**Spinal Services Update**	**Simon Constable, Deputy CEO** **Executive Medical Director**	**Assurance**	**3.10**	**Enc**

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Sustainability

BM/18/01/09 PG 82	Quarterly Response to Lord Carter	Andrea McGee DoF+Commercial Development	Assurance	3.15	Enc
BM/18/01/10	Forecast Outturn Position	Andrea McGee DoF+Commercial Development	Decision	3.20	Enc
BM/18/01/11 PG 105	Additional Working Capital	Andrea McGee DoF+Commercial Development	Decision	3.35	Enc

People

BM/18/01/12 PG 109	Nurse Staffing Report	Kimberley Salmon-Jamieson Chief Nurse	Assurance	3.45	Enc
BM/18/01/13 PG 118	Nurse Staffing Report – Bi Annual Report	Kimberley Salmon-Jamieson Chief Nurse	Assurance		Enc
BM/18/01/14 PG 136	Trust Engagement Dashboard inc half year report 2017-18	Pat McLaren Director Community Engagement & Corporate Affairs	Assurance	3.50	Enc

GOVERNANCE					
BM/18/01/15 PG 153	Bi-Monthly Strategic Risk Update	Pat McLaren Director Community Engagement & Corporate Affairs	Assurance	3.55	Enc
BM/18/01/16	Any other Business			4.05	
BM/18/01/17	One Halton Update	Director of Transformation		4.10	
	Date of next meeting: 28 March 2018			Close 4.20	

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D R A F T

Warrington and Halton Hospitals NHS Foundation Trust

Warrington and Halton Hospitals NHS Foundation Trust Minutes of the Board of Directors meeting held in Public (Part 2) on Wednesday 29 November 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)	Executive 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 (JNE)	Non-Executive Director
In Attendance	
Lucy Gardner (LC)	Director of Transformation
Pat McLaren (PMcL)	Director of Community Engagement + Corporate Affairs
Jason DaCosta (JDaC)	Director of IM&T
Dr Mark Tighe	Consultant / Guardian of Safe Working
John Culshaw	Head of Corporate Affairs
Jane Hurst	Deputy Director of Finance (Strategy)
Apologies	
Alex Crowe	Medical Director
Observing	
Norman Holding	Governor
Alison Kinross	Governor
Phil Chadwick	Governor

Agenda Ref BM/17/11/	
BM 17/11/	The Board meeting opened with a patient story from the Chief Nurse. The film titled 'The Perfect Day' demonstrated the excellent care and treatment a patient who had suffered a stroke received. The film demonstrates that a that a patient's perfect day involves contact with a variety of staff, all aiming to ensure that the patient is cared for in a safe and therapeutic environment and that the patient had a voice. The film included the following: a junior doctor or nurse placing fluids within reach, Housekeeper asking about food choice, named nurse details above the bed, staff talking to the patient about his care, a medication round, a therapy session; including time in the patient's flat for Occupational Health rehabilitation, discharge planning, comments from patient as to how they felt about their time on the ward, a member of the PALS/Complaints team putting leaflets on the ward, a Housekeeper cleaning and a tea round.
BM 17/11/111	**Guardian of Safe Working Quarterly Report** Dr Mark Tighe, Consultant / Guardian of Safe Working presented the report in line with the 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.
Dr Tighe reported that there had been a relatively seamless transition to the New Junior Doctors Contract. All the rotas remained compliant, and in general the juniors are happy with their allocations.

Dr Tighe reported that there had been a significant number of Exception Reports (ER) in the last 3 months, but that this was considered to be positive, as the role of a Junior Doctor involves additional and unpredictable work at times. The vast majority of ERs related to 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 acted as an alert to staffing and rota problems on individual wards (e.g. A7 and C21), which were addressed. It was further explained that there was a problem with the medical handover timing as, leading to a lot of reporting, but this has now significantly reduced following review.

It was highlighted that the number of ERs relating to Junior Doctors staying late due to them being unwilling to transfer work to on call out of hours doctors was reflective of a healthy work ethic of our Junior Doctors.

It was highlighted that the majority of ERs were from the medical wards (72%), but that this reflects the busier nature of their jobs, and sometimes lack of ward cover for more senior doctors. Dr Tighe explained that previous problems on AMU and A" had been resolved and reports relating to support and teaching in those areas were good.

Dr Tighe explained that there is good engagement from the Educational Supervisors in the majority of the ERs submitted. The F1s have been encouraged to contact Dr Tighe, as Guardian, if they are unable to arrange a timely meeting with their Educational Supervisor. Dr Tighe also highlighted that there has been no escalation of an ER to a level 2 review or fine to the trust since the last Report.

The Chairman thanked Dr Tighe for the report and commented that it was an encouraging report and that it was very helpful to receive the regular feedback.

SC commented that it was helpful to triangulate with other areas.

TA congratulated Dr Tighe and stated that the Board offered its support.

The Chair further thanked Dr Tighe for his contribution in his day job.

AW asked where the Trust was in in relation to arrangements with Lead Employer and what the financial implications were.

SC stated that consultation was on-going.

MP explained that Health Education England (HEE) were to raise the proposal of withdrawing funding. Junior Doctors are employed by St Helens and Knowsley Teaching Hospitals NHS

	Trust (StHK) and the scenario in the North West is unique. Responsibilities fall to the employer to fulfil and be absorbed by their own processes. There is a £100,000 estimate for the cohort of Doctors at WHH but that this will not occur until 2018/19.
BM 17/11/112	**Welcome, Apologies & Declarations of Interest** The Chairman opened the meeting, and welcomed those in attendance. Apologies: as above. Declarations of Interest: none declared in respect of agenda items.
BM 17/11/113	**Minutes of the Previous Meeting Held on 26 July 2017** The minutes of the meetings held on 27th September 2017, 6th October 2017 (Extraordinary Board) and 25th October 2017 (Extraordinary Board) were agreed as an accurate record.
BM 17/11/114	**Actions and Matters arising** All actions were reviewed and progress noted since the last meeting.
BM 17/11/115	**Chief Executive Report** The Chief Executive updated the Board on matters that had occurred or progressed since the previous Board meeting. - The CEO explained that the Trust had attended the Quarterly review meeting with NHSi on Friday 10 November 2017, and discussed the Single Oversight Framework (NHSi's performance assessment tool). The CEO explained that Trusts are placed in segments that relate to the amount of formal oversight and intervention NHSi will impose on them relative to their performance against key measures. The CEO further explained that the best performing Trusts were placed in segment one and Trusts under the closest scrutiny and enforcement measure were placed in segment four. The CEO described how the Trust was placed in segment three in 2015 as a consequence of the financial deterioration in that year; however, following a very detailed review by the NHSi, the CEO was pleased to say that it was felt that the Trust had complied with the necessary requirements and had subsequently been moved from segment three to segment two. - The CEO delivered an update on Spinal Services. It was explained that following four serious incidents having been reported following patients undergoing spinal surgery, the Trust took the decision to suspend all surgical procedures, and subsequently in conjunction with Commissioners, all outpatient activity. It was further detailed that an external service review was commissioned, jointly by the Trust and the CCG, and was undertaken by the Royal College of Surgeons (RCS) on 2 November 2017. The CEO explained that following the preliminary feedback, the service was to remain suspended and that the Trust was working closely with other spinal surgery providers to transfer the care of patients awaiting procedures or outpatient appointments to them. The CEO explained that the full report is expected in December/January when the position in respect of the future service model for specialist spinal surgery will be reviewed and determined. - The CEO explained that two days previously, Monday 27 November 2017, The CQC had published its report following the inspection of the Trust in March 2017. The CEO explained that the report rated the Trust as requiring improvement. The CEO expressed her disappointment that the Trust were unable to demonstrate sufficient improvement since its last inspection, in order to be rated good, although the Chief Inspector did note the many improvements made since 2015. - The CEO provided details of the Beat the Scrum campaign. It was explained that in June

	2017, in conjunction with Halton CCG, the Trust worked with Widnes Vikings Rugby League Club to produce a short video featuring two of their star players, the Chapelhow twins, to promote awareness and utilisation amongst the local population of the two urgent care centres in Widnes and Halton. The CEO explained how the film received a huge amount of coverage in the local and national media, BBC and Sky Sports as examples, and that it was shortlisted for several PR and marketing awards. The CEO detailed that the social media and club reach meant that the film had received 96,000 views which was equivalent to 18 weeks' worth of the total visitors to the Halton CCG website. The CEO informed the Board that in 2018, the NHS is the primary club partner and that there will be four more videos, including pharmacy and flu immunisations. Further to this, the Beat the Scrum Campaign won the NHS Academy for Fabulous Stuff Rosa Parks Award. - The CEO shared with the Board a letter received from Jeremy Hunt, Secretary of State for Health, congratulating the Trust on its exceptional improvement in the proportion of cancer patients receiving definitive treatment within 62 days of referral in the period June 2017 to August 2017, compared with the period March – May 2017. **The Board noted the Chief Executive's report**.
BM 17/11/116	**Chairman's Report** - The Chairman informed the Board that he had recently attended the NHS Providers Conference with the CEO where many NHS leaders came together in Birmingham to discuss solutions to many of the health service's most pressing challenges. The conference covered a range of critical issues, including quality of care, NHS finances and the workforce challenge. The conference included speakers such as Simon Stevens, Chief Executive of NHS England; Jim Mackey, Chief Executive of NHS Improvement and Jeremy Hunt, Secretary of State for Health. The Chairman explained that Simon Stevens, called for additional funding in the upcoming Budget, warning that hospital waiting lists could grow by a quarter to five million by 2021. The Chairman commented that the subsequent budget had indeed allocated additional funding. The Chairman commented that attending the conference had been a useful exercise to understand what other Trusts were doing to help overcome their respective challenges. - The Chairman highlighted that the recent Governor Elections had closed which had seen six new Governors elected. - The Chairman informed the Board that the Governors had visiting the Trust's new Primary Care streaming facilities. NH commented that the visit had been very good.
BM 17/11/117	**Integrated Performance Report Dashboard (October)** The Board noted The Integrated Performance Report Dashboard (October). The Chief Nurse highlighted areas for the Board to note relating to the Quality KPIs: Of the 9 indicators that were Red in September 6 have remained Red in October:

1. VTE Assessment – The Trust achieved 92.51% against a target of 95%, a slight decrease from September's performance of 92.90%;
2. Nice Compliance – The Trust achieved 63.45% against a target of 75%, a slight increase from September's performance of 64.37%;
3. Complaints – The Trust is currently behind the agreed improvement trajectory and has plans in place to bring this back in line;
4. Friends & Family Test (A&E and UCC) – The Trust achieved 79% against a target of 87% a decrease from September's performance of 84%;
5. 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;
6. 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 Chief Nurse also reported that there were three additional Red indicators for October which were:

1. Safer Surgery – the Trust achieved 99.92% against a target of 100%, therefore this indicator moved from Green to Red.
2. 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.
3. Pressure Ulcers – There were 7 grade 2 pressure ulcers reported during October 2017, therefore this indicator moved from Green to Red.

The Chief Nurse informed the Board that she 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)

The Chairman commented that Readmissions was key data.

MB commented that some indicators such as VTE were moving backwards. MB asked what progress was taking place in this area.

SC responded that VTE was not actually red but green and that after validation the figures were 95.76% and 95.11% for September and October respectively. SC explained that there was a problem with cohorting and that data is currently behind in reporting due to validation. SC commented that he hoped this would not always be the case

JDaC confirmed that there was an open ticket relating to data capture.

IJ highlighted that on page 3 of the report (Page 41 of the binder); it should read 'decrease' as

opposed to 'increase' in relation to NICE compliance.
The Board noted the Nurse Staffing report

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

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:

1. A&E Waiting Times 4 hour national target – the Trust achieved 89.47% in October, a decrease from 90.93% in September.
2. 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%.
3. Cancer 62 Days Urgent – the Trust achieved 84.51% against a target of 85%.
4. 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.
5. 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.
6. 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.
7. 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.

The Chairman commented that there had been a good presentation at the conference in relation to Ambulance Handover. The Chairman explained that the Chair of NWAS had sent information to him that highlighted that WHH were about average but he was complimentary and stated that ambulance were diverted to WHH more regularly than some other Trusts. The Chairman asked if we could compare our data to that of others.

JR confirmed that FSC compares data.
The Chairman commented that some other Trusts were struggling.

JR confirmed that some Trusts will offload patients in to longer corridors but that she felt that this was unsafe.

MB commented that it had long time since we had hit targets relating to discharge summaries.

JR confirmed that each CBU had its own action plan.

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

1. Recruitment – average time taken to recruit remains unchanged for October at 75.5 days against a target of 65 days.
2. Non-Contracted Pay – remains unchanged for October at 12.26%
3. 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:

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

AW commented that in relation to recruitment, the trend in notice periods is increasing.

MC confirmed that this is benchmarked against other organisations.

MC further confirmed that NHSi had made it clear that there should be a shift from Agency to Bank staff and that this would be monitored externally. MC highlighted that Medical staff were the most challenging staff group in respect of Agency spend. MC also highlighted that there was good compliance with mandatory training and that there had been an increase in the number of PDRs completed in clinical areas but there needed to be an improvement in Corporate Service.

MC also confirmed that the average cost of workers was scrutinised at FSC.

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

1. Financial Position – The cumulative deficit of £6.1m is £2.0m worse than the planned deficit of £4.1m. It was highlighted that £1.0m of the £2.0m related to the suspension of spinal services and the other £1.0m due to the under delivery of CIP and pay pressures.
2. 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.
3. Capital Programme – cumulative capital spend is £1.2m below planned capital spend of £4.5m.
4. 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.
5. Fines and Penalties – it is estimated that fines and penalties totalling £13k were incurred in October due to non-achievement of the 95% Discharge Summaries target and non-achievement of CQUIN.
6. Cost Improvement Programme Plans In Progress - £5.5m below the target of £10.5m.

The 1 additional Red indicator for October is as follows:

1. 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.

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.

The Chairman confirmed that the financial position was proving to be a difficult scenario as was a big issue across the NHS as a whole.

TA commented that the cash position was not acceptable but that the DoH support would help hopefully combined with more money from the Government.

The Chairman stated that he felt assured that the Trust had looked at everything and done more than NHSi had asked.

TA confirmed that NHSi had highlighted approximately 250 areas and that they had all been looked at. TA stated that he was assured that we had addressed everything that was in our gift.

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

	updated Single Oversight Framework: AM explained that 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 which were highlighted by AM JNE commented that there were a high number of indicators. AM stated that she felt 250 indicators was quite low. JNE advised that he felt that the report was very clear and helpful. **The Board noted the contents of the report.**
BM 17/11/117b	**(b) Nurse Staffing Report** The Chief Nurse highlighted key areas for the Board to note in the report which highlights areas where average fill rates fall below 90% of actual versus planned. **The Board noted the report.**
BM 17/11/117c	**(c) Trust Engagement Dashboard** Half year report deferred to January Board.
BM 17/11/117d	**(d) Key Issues Reports from October and November Quality Committee** The Key Issues Reports were taken as read and Margaret Bamforth, Chair of Committee commented that following training there were good RCAs but that there were still lots of open actions. KSJ explained that the introduction of Datix will support the process with an overarching action plan being fed by smaller ones. **The Board noted the report.**
BM 17/11/117e	**(e) Key Issues Report from October and November Finance and Sustainability Committee (FSC)** The Key Issues Reports were taken as read and Terry Atherton, Chair of the Finance & Sustainability Committee commented that at the November meeting the Committee has received an FSC risk report and Risk Register and were subsequently able to triangulate information. **The Board noted the report.**
BM 17/11/117f	**(f) Key Issues Report from October Audit Committee** The Key Issues Reports were taken as read and Ian Jones, Chair of the Audit Committee highlighted the following: • Low compliance with Staff Mandatory Training in DNACPR.

	• Conflict of Interest Register. Progress is being made in collecting the required data but 229 returns are awaited from a total of 563 individuals The Chairman commented that following his attendance at a roundtable meeting, it had been intimated that there 'FPP' would be looked at more closely. IJ confirmed that this was being tracked. **The Board noted the report.**
BM 17/11/117g	**(g) Key Issues report from November Charitable Funds Committee** The Key Issues Reports were taken as read and Jean Noel Ezingeard, Chair of the Charitable Funds Committee highlighted the following: • The workplan was now approved fully; • Annual accounts had been approved; • Charitable Funds were financially healthy. PMcL commented that the Trust needs to work harder to spend the money. IJ stated that the running costs were not being covered. JNE confirmed that the running costs were high compared to the funds coming in. **The Board noted the report.**
BM 17/11/117h	**(h) Key Issues Report from October Trust Operational Board** The Key Issues report was taken as read. **The Board noted the report.**
BM 17/11/118	**CQC Update Report** The Chief Nurse delivered a presentation about the recent CQC report and covered the following areas: • Acknowledge of improvements made • Outstanding Practice • Rating 2017 • Areas for improvement – Trust Must Do's • Fundamental Standards Breaches • Action plan • Governance ▪ Reporting to Board KSJ explained that the CQC assessment process had changed and that the process was

	essentially becoming harder. KSJ explained that 17 'Must Do's' had been highlighted but that many of these had been acted on within two weeks of the inspection taking place. However, in addition to these, there were approximately 200 'would like to do's'. KSJ detailed the breaches in regulation that had been highlighted and explained that a comprehensive action plan was being developed. It was also confirmed that the Trust had signed up to the 'Getting to Good' NHSi collaborative that will support the Trust and help focus on key areas such as Quality Improvement, Patient Voice and the new CQC Well Led assessment. KSJ detailed the proposed Governance structure to include a CQC steering group and the procedure for reporting to the Board was explained. AW asked if the CQC took in to account the immediate actions that took place when publishing the final report. KSJ confirmed that the CQC can only review what they see at the time of the inspection. For example, risk management was very immature at the time and is very different now. The Trust shared the future plans. KSJ confirmed that the reports would be circulated to member of the Board in full. **Action: Reports to be circulated (JC)** The Chairman advised that the Non-Executive Directors had discussed the CQC report. The Chairman added that that the second 'Requires Improvement' CQC report made it look that the Trust had regressed. The Chairman acknowledged that the Trust had over 200 areas of improvements to tackle and that we must take a step back, focus on the detail and carry on with the highlighted areas of good practice. The Chairman commented that it must not be about blaming people and the Trust must see this as an opportunity to provide the best service for patients. The Chairman confirmed that it would be looked at further in the Board session in December. KSJ further described that the Trust will address the 'Must Do's' but addressing all the other areas was the right thing to do. **The Board were in agreement and noted the presentation.**
BM 17/11/119	**Quarterly Complaints Improvement Report** The reports were taken as read and the Chief Nurse highlighted the following: • There has been a 60% reduction in the complaints backlog since April 2017, • 96% reduction in cases over 6 months old since April 2017 (there are four left) • The Trust is working with Datix to improve the functionality even further;

	• Currently 110 open complaints. KSJ emphasised that in addition to the continued reduction in the number of complaints, focus will be on the timeliness of responses. The Chairman explained that he continued to attend the Complaints Quality Assurance Group and it was proving to be successful. The Chairman also commented that that at the time of the CQC inspection, the Trust had 315 outstanding complaints with 100 over six months old. The Chairman acknowledged that there was little chance of receiving a 'Good' rating with all those complaints but that a huge amount of work had gone in to rectifying the situation and the Trust were in lot stronger position for the CQC now. AW asked if there was evidence that the number of new complaints tended to rise following a CQC report. KSJ explained that there is a natural increase around negative issues such as spinal services and car parking; however, there is no evidence that she was aware of in relation to rises following a CQC report. JNE commented that it was an impressive improvement and would like some clarification on the number of dis-satisfied complainants. KSJ explained that previously, a high number of dis-satisfied complaints were in relation to the complaint handling. MB asked if the Board would be happy for the Quality Assurance Committee (QAC) to oversee complaints and if it still needed to come to Board. The Chairman stated that he would like to attend another Complaints Assurance Group and then would like a task and finish paper recommending that complaints just report to the QAC. **The Board noted the report.**
BM 17/11/120	**Complaints and Concerns Policy** The updated Complaints and Concerns Policy was taken as read and the Chief Nurse ask that it was approved. **The Board approved the Policy.**
BM 17/11/121	**Strategic Risk Register and Board Assurance Framework (BAF)** The report was taken as read and the Chief Nurse highlighted the following: • One new risk had been added to the register which was in relation to Spinal Services; • Two other risked were currently in being scoped. These related to insufficient

	anaesthetic cover and Governance in Sexual Health. • The risk rating in respect of complaints has reduced. • 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. • 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 Chairman remarked that the report was excellent, well laid out and clear, provided a true sense of where the Trust was. KSJ highlighted that in respect of the BAF, the main risks related to staffing and finance. AW explained that specific risks were highlighted and discussed in FSC. **The Board noted the content of the report.**
BM 17/11/122	**Quarterly Mortality Report** Paper was missing from the pack. The Medical Director/Deputy Chief Executive provided a verbal update and explained that the paper had previously been discussed in QAC.
BM 17/11/123	**Freedom to Speak Up Report** The report was taken as read and it was highlighted that there had been seven new disclosures: • Patient Safety x4 • Staff Dignity at Work x1 • Fraud x1 Three of the disclosure related to one ward and a Senior Nurse had been put in to the ward to resolve the issues. KSJ thanked JH for her hard work and impact. The Chairman commented that it was a really important report and that it was relevant to our time. The Chairman commented that bullying and harassment had been discussed at the NHS Providers Conference and it was shocking how prevalent it was. MC commented that it looks like there is a cultural problem in certain areas but that there needed to be clarity on what bully and harassment was.

	JNE asked if there had been a theme that linked the three cases form the same ward. KSJ confirmed that there was and that the leadership has since changed. The Chairman added that there was a fine line between assertive management and bullying and harassment, and that we must ensure the procedures are followed. The Chief Executive commented that if people have historically not been held to account, they may not be used to it. IJ asked KSJ if she was satisfied that the whistleblowing procedure was correct and advertised sufficiently. KSJ explained that it is disseminated through flyers, posters, pull ups, team briefs, people champions. KSJ further added that more can always be done and new processes can take time to embed. The Chairman added that the re-introduction of ward/departmental visits by Non-Exec Directors would help by increasing visibility. MB agreed that the re-introduction of the visits would help. **The Board noted the report.**
BM 17/11/124	**Quarterly response to Lord Carter (def from Oct)** The report was taken as read and the following was highlighted: • 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. The Chairman asked if we should comment in a report that the increase is not racially motivated if there is no evidence to support this. JNE commented that there was no clear HR outcome MC stated that the numbers were small and The Trust has a Black Minority Ethnic (BME) focus group that is focussing on both staff and patients. The Chairman asked if the statement in the report could be re-looked at and clarified and that the Trust could not be complacent. **Action: Director of HR & OD to clarify the statement** **The Board noted the report.**

BM 17/11/125	**NHS Care Cyber Security** The report was noted and the Chairman confirmed that the request should be taken back with a business case for the Executives to agree.
BM 17/11/126	**Emergency Preparedness, Resilience and Response (EPRR) Assurance 2016/17** The report was taken as read and the Acting Chief Operating Officer highlighted the following: • The Trust has undertaken the annual self-assessment against the NHS England Emergency Preparedness, Resilience and Response (EPRR) Core Standards. Of the 59 Core Standards, the Trust is fully compliant with 57, and non-compliant in just 2 categories. This provided the Trust with a 'Substantial' compliance level. It was highlighted that improvement plans were in place for the 2 non-compliant areas. **The Board noted the report.**
BM 17/11/127	**Halton Accountable Care System** The report was taken as read and the Director of Transformation asked or comments from the Board. TA highlighted that on page 18 of the Halton Accountable Care Strategic Vision, the organisation had not been included in the Governance Structure. LG clarified that decisions would have to go to the individual Board of each organisation. MP clarified that WHH was on the One Halton ACS Board. An in depth discussion followed and the following concerns in relation to the Halton Accountable Care Strategic Vision were highlighted: • P10, para 4 – Uncomfortable with the word 'badgeless' and it is was proposed that it was replace with 'seamless' • P10, para 4 – "increased investment in the community", provided a lack of clarity where this would come from and what exactly this means. However, the principle of increasing community provision was agreed with. • P19, governance structure diagram – Uncomfortable with "single" provider partnership, there may be more than one provider partnership. Do not recall it being a single provider partnership in earlier versions. JDaC highlighted concerns in respect of digital plans and leadership. The Chairman commented that he was supportive but that aspects of the document seemed to close doors prematurely. The Chairman emphasised that the Trust wanted to be key partner going forward.

	TA advised that the Trust could currently not sign up to it The CEO added that if we could not sign up to it in its current guise, the Board need to be constructive as to what changes would enable it to do so. It was agreed that the Board were supportive of the general thrust. **Action: Director of Transformation to provide feedback on the Strategic Vision document, so that changes could be made as appropriate prior to us fully supporting the vision.** **The Board noted the report and approved the Memorandum of Understanding and the Terms of Reference for the One Halton Board.**
BM 17/11/128	**Well Led Framework 2017** The report was taken as read and the Head of Corporate Affairs following was highlighted: • The new Well-Led framework had been expanded and was more in-depth; • The status of the existing action plan based on the previous framework; The Chairman commented that the Trust should expect a CQC Well-Led inspection soon in the new financial year. **The Board noted the report.**
BM 17/11/129	**Charitable Fund Annual Report and Accounts for year ending 31st March 2017** The report and accounts were taken as read and the Board were asked to approval. PMcL clarified that it was a positive move that the Trust was dispensing the funds properly. **The Board approved the accounts.**
BM 17/11/130	**Corporate Calendar 2018 and Trust Operational Board Terms of Reference** **The updated Corporate Calendar and Trust Operational Board Terms of reference were agreed by the Board**
BM 17/11/131	**Any other business** **Update in Acting Up Arrangements notified to Board in September 2017** The report was taken as read and the Director of Community Engagement & Corporate Affairs updated the Board of the acting up arrangements for the Medical Director/Deputy CEO and Acting Medical Director. **The Board approved the amended 'acting up' arrangements.**
	Next Meeting: **Wednesday 31st January 2018, Full Trust Board Meeting, Trust Conference Room.**

We are WHH

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Warrington and Halton Hospitals NHS Foundation Trust

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NHS Warrington and Halton Hospitals NHS Foundation Trust

Warrington and Halton Hospitals NHS Foundation Trust Minutes of the Extraordinary Trust Board of Directors meeting held on Wednesday 20th December 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
Ian Jones (IJ)	Non-Executive Director / Senior Independent Director
Kimberley Salmon-Jamieson (KSJ)	Chief Nurse
Anita Wainwright (AW)	Non-Executive Director
Jean-Noel Ezingeard (JNE)	Non-Executive Director
Alex Crowe	Medical Director
In Attendance	
Lucy Gardner (LC)	Director of Transformation
Pat McLaren (PMcL)	Director of Community Engagement + Corporate Affairs
Jason DaCosta (JDaC)	Director of IM&T
Chris Evans(CE)	Designate Chief Operating Officer (Commences 1st March 2018)
John Culshaw	Head of Corporate Affairs
Apologies	
Simon Constable (SC)	Executive Medical Director + Deputy Chief Executive

Agenda Ref BM/17/11/	
	Welcome, Apologies & Declarations of Interest The Chairman opened the meeting, and welcomed those in attendance. Apologies: as above. Declarations of Interest: none declared in respect of agenda items. The Chairman welcomed Chris Evans, Designate Chief Operating Officer and thanked Jan Ross, Acting Chief Operating Officer.
BM 17/12/01	**Modification to the WHH Organisation Structure** The proposal/report was taken as read and the Chief Executive explained that the proposal had been shared with the Trust Operational Board where it was welcomed and supported. The Chief Executive further described how the modifications align with the CQC and Ward to Board principles, and with the improvement of quality. The Chief Executive explained that the modifications had no cost implications as posts were being moved from Divisional teams and placed in the new structure. TA asked if there were any cost saving opportunities. The Chief Executive commented that it was felt that the Trust was currently not in a position to reduce the amount of leadership capacity and it was not the time to look to save costs in that area.

	IJ felt that cost saving opportunities should be looked at as the wage bill for November 2017 had been £1m above plan. The Chief Executive much of those costs were associated with temporary and ad hoc staffing due to the difficulties experienced in recruiting. The Chief Executive explained that the new structure would support substantive staffing through attracting and retaining staff more easily. IJ stated that he agreed to an extent but the sum of £1m was significant and beyond what had been expected. AMcG stated that there had not been an explosion in the wage bill but the trust had not been able to achieve its budgeted position all year and had relied on reserves to prop it up. There was a deep dive taking place on pay expenditure and what was most important was clarity on accountability and responsibility for pay Cost Improvement Plans (CIPs) that had not been delivered. AMcG further highlighted that the control total this year had been harder. TA explained that it was not about hijacking the process to modify the structure but to highlight the financial issues. TA further explained that he hadn't got clarity from the Finance and Sustainability Committee about why the Trust's pay spend has increased significantly to circa £4m over budget since April 2017. Work had however started to look at why as the Trust needed to get to the underlying reason. TA confirmed that a new risk was to be proposed about the DoH loan required to pay the Trust's bills and if the Trust would be able to roll the existing loans over. The Chairman added that if the increasing staffing costs were aligned to care costs and winter costs, staffing shortages etc, it would be easy to explain. The Chairman commented that the Trust must be careful of back office management costs but on the surface it looked like the structure changes were removing management and streamlining. The Chairman added that the CQC report highlighted a lack of co-ordination and if the modification led to simplification and streamlining, it would be a positive step. IJ commented that it is important to put it in context and look at the prior year. There had been a significant uplift compared to the previous year. IJ felt that if the increase in spend was matched by an increase in the standards of care it would be positive; however, there was no evidence of this as yet. LG added that she felt that the organisation needed to grow and that strong CBU leadership would help deliver the challenged. MB explained that she felt in a similar way and it was a good way of expanding leadership capability and that the proposal made sense. KSJ commented that she felt that it was still a minimal structure as there were only two doctors and two nurses to support the Executive Team and the 'must dos' and 'should dos'

	would have to be prioritised to deliver a 'Good' CQC report. AC added that he felt that the new structure enabled appropriate prioritisation from a medical perspective and would allow tight line management. The Chairman advised that the felt that in order to address the CQC plan, the proposal was a sensible adjustment and that it was always necessary to challenge and test the money issue. The Chairman further added that we must always ask ourselves the question that if it were not for the CQC report, would we still be doing it. The Chief Executive verified that that when the CBU structure was originally put in place, it was agreed that it would be reviewed. The lines of accountability were then clarified and PMcL confirmed that triumvirates would be held to account at the Trust Operational Board (TOB) The Chief Executive further explained that there was a great deal of day to day accountability in addition to TOB. The Chairman concluded that he felt it was a good simplification of arrangements and a key enabler for operational activity. **The Board noted the proposal and agreed the modifications.**
BM 17/12/02	**Additional Working Capital Loan 2017/18** The paper was taken as read and the Director of Finance & Commercial Development clarified the Trust's current financial position: As at 30th November 2017 the difference between the year to date planned and actual control total is £4.133m. As the Trust has a larger deficit than plan, additional cash support of £4.133m is required to meet day to day working capital commitments. It was explained that if the loan application was approved, it would be drawn down in February 2018 AMcG also highlighted that if the deficit increases then the Trust will require a further working capital loan to meet financial obligations. IJ confirmed that it would be highly likely that further loan requests would have to be made in the future. AMcG explained that this as the only option for the Trust at this stage. It was clarified that thr the Trust was good at collecting debts and that it would receive £700k in winter pressure support in two instalments, December 2017 and February 2018. The Chairman highlighted that the support form NHSi was conditional that they had confidence that the Trust was doing all that it could and had assurance we were in control.

	AMcG confirmed that as the Trust had always highlighted the risks it was facing, the regulators were fully sighted and had confidence that there were no surprises. TA confirmed that the proposal had been discussed at the Finance and Sustainability Committee and that he was fully supportive. TA further highlighted that if the Trust were to move further off the financial plan than additional money would be required. JNE acknowledged that the Trust has to apply for the loan as there was currently no alternative. JNE queried if there was a case that as the suspension of Spinal Services was unforeseen and bore no relation to work elsewhere, that it should not affect STP. AMcG explained that NHSi has confirmed that it was unlikely that an allowance would be made; however, we would continue to ask. A discussion ensued about the level of premium payments the Trust were experiencing relating to spinal services and it was agreed that AMcG would contact the Director of Finance at the Walton Centre NHS Foundation Trust to discuss this. **The Board approved the proposal**
	Next Meeting: **Wednesday 31st January 2018, Full Trust Board Meeting, Trust Conference Room.**

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Warrington and Halton Hospitals NHS Foundation Trust

BOARD OF DIRECTORS ACTION LOG

AGENDA REFERENCE:	BM/18/01/04	SUBJECT:	TRUST BOARD ACTION LOG	DATE OF MEETING	31 January 2018

1. ACTIONS ON AGENDA

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

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.	
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)	**24 October 2017**	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/17/11/118	29 November 2017	CQC Update Report	Complete CQC reports to be circulated to NEDs.	Head of Corporate Affairs	ASAP	**29 November 2017**		
BM/17/09/102	27 September 2017	Learning from Deaths Policy	To have the Comms in place prior to document being published.	Director of Communications + Corporate Affairs	29 November 2017	September 2017		

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ROLLING TRACKER OF OUTSTANDING ACTIONS

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
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		7.7.2017. Deferred to Part 1 Board on 26 July 2017. 26.7.17. Deferred to Part 1 Board 25 October. 23.01.2018. Deferred to February Board	
BM/17/11/124	29November 2017	Quarterly Response to Lord Carter	Statement re: instances of BME harassment be reviewed and reworded.	**Director of HR+OD**	**ASAP**	**TBC OF COMPLETED**		
BM/17/011/127	29 November 2017	Halton Accountable Care System	Requested changes to made to the Strategic Vision documents	**Director of Transformation**		**TBC OF COMPLETED**		

RAG Key

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

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BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/17** BM/18/01/07
SUBJECT:	**Integrated Performance Dashboard**
DATE OF MEETING:	31st January 2018
ACTION REQUIRED	**For Discussion**
AUTHOR(S):	Marie Garnett – Head of Contracts and Performance
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse Alex Crowe – Medical Director (Acting) Michelle Cloney – Director of Human Resources & Organisational Development Andrea McGee - Director of Finance & Commercial Development Lucy Gardner – Director of Transformation & Acting COO
LINK TO STRATEGIC OBJECTIVES:	All
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	All
STRATEGIC CONTEXT	To provide the Trust Board with assurance in relation to performance in the following areas: • Quality • Access and Performance • Workforce • Finance Sustainability
EXECUTIVE SUMMARY (KEY ISSUES):	There are 3 Quality indicators which have moved from Green to Red in month due to missed targets around Sepsis screening for AED and Inpatients and VTE assessments. Plans are in place to improve the position of several indicators including Incidents, NICE Compliance and Complaints. The CQUIN Sepsis Antibiotic Review Indicator cannot be RAG rated this month due to a delay in the data validation process. It is anticipated that this will be resolved in the next week.

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	Access and Performance Red indicators have decreased from 8 in November to 7 in December, due to improved performance around the Cancer 62 Days Urgent and Breast Symptoms 14 Days indicators, which have both achieved target and have moved from Red to Green. The Trust has had 2 cancelled operations for non-clinical reasons where the patient did not receive a new date for their operation within 28 days of the original cancellation; this has resulted in this indicator moving from Green to Red. The number of Red Workforce indicators has decreased from 6 in November to 4 in December with improved performance around Agency Nursing Spend and reduction in length of service for Top 10 agency workers. At the end of month 9 the Trust has a financial deficit of £11.2m which is £6.8m worse than plan. This poses a risk to the Trust's forecast outturn and cash position. The forecast outturn will be addressed under a separate agenda item.	
RECOMMENDATION:	The Trust Board is asked to: **1.** Note the contents of this report. **2.** Note the amendments to the capital programme.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	
FREEDOM OF INFORMATION STATUS (FOIA):	Choose an item.	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.	

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SUBJECT	Integrated Performance Dashboard	AGENDA REF:	

1. BACKGROUND/CONTEXT

The RAG rating for all 64 indicators from April to December 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 KPIs across the following areas:

- Quality
- Access and Performance
- Workforce
- Finance Sustainability

2. KEY ELEMENTS

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

- Red - 29 in December decreased from 30 in November.
- Amber – 5 in December the same number as November.
- Green – 27 in December the same number as November.
- Not RAG rated – 3 in December increased from 2 in November

QUALITY

Quality KPIs

There are 10 Red indicators in December an increase of 2 in month. The 7 Red indicators for December which were Red in November are as follows:

- Incidents – the Trust has open incidents which are over 40 days old.
- 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.
- Safer Surgery – The Trust achieved 99.91% against a target of 100%.
- NICE Compliance – The Trust achieved 68.29% against a target of 75%, a slight increase from November's performance of 67.24%.
- Complaints – The Trust is currently behind the agreed improvement trajectory of 75 open complaints, with 95 open at the end of December. The corporate nursing and governance department has plans in place to bring this back in line. At the time of this report, there were 76 open complaints with 32 breaches over 6 months old.
- Friends & Family Test (A&E and UCC) – The Trust achieved 82% in month the same as November, against a target of 87%.

- Mixed Sex Accommodation Breaches (MSA) – there were 19 Mixed Sex Accommodation Breaches in December an increase from 13 in November. There is a national threshold of zero tolerance for this indicator. With effect from January 2018 the Department of Health has suspended fines that would normally be applied to MSA breaches; this is to take in to account winter pressures.

There are 3 additional Red indicators in December are as follows:

- VTE Assessment – The Trust achieved 91.70% against a target of 95%, a decrease from November's performance of 95% (after validation). Please note that data provided for December has not been validated as the VTE nurse is awaiting records to be coded, coding takes place within the same timeframe as this report is developed.
- Sepsis AED Screening – the Trust achieved 88% in December against a target of 90%, therefore this indicator has moved from Green to Red.
- Sepsis Inpatient Screening – the Trust achieved 86% in December against a target of 90%, therefore this indicator has moved from Green to Red.

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

- Friends & Family (Inpatient & Day Case) – the Trust achieved the 95% target in December, an improvement from November's performance of 94%.

There is 1 Quality indicator that cannot be RAG rated this month as follows:

- CQUIN Sepsis Antibiotic Review – the Trust was Green in November, however due to a delay in the data validation process the December position is not currently available.

Access and Performance

Access and Performance KPIs

There are 7 Access and Performance indicators rated Red in December compared to 8 in November, a decrease of 1 in month.

Of the 7 indicators that were Red in November, 6 remain Red in December as follows:

- A&E Waiting Times 4 hour national target – the Trust achieved 83.78% in December, a decrease from November's performance of 87.5%.
- A&E STP Trajectory – the Trust achieved 83.78% in December against the improvement trajectory of 89.96%.
- Ambulance Handovers 30>60 minutes – the Trust has seen an increase in the number of patients experiencing a delayed handover in month rising from 189 in November to 291 in December. It should be noted that up until Christmas the Trust was the best in the region, at times averaging 30 minutes.

- Ambulance Handover at 60 minutes or more – the Trust seen an increase in the number of patients experiencing a delayed handover in month rising from 78 in November to 145 in December.
- Discharge Summaries % sent within 24 hours – The Trust has achieved 83.38% in December, which is a decrease from November's performance of 88.83%. As the Trust has not achieved the quarter 3 95% target, CCG Commissioners will fine the Trust £15k.
- Cancelled operations on the day (for non-clinical reasons) – the Trust has zero tolerance to cancelled operations on the day for non-clinical reasons. There were 27 cancelled operations in December the same number as November.

There is 1 additional Red indicator for December as follows:

- Cancelled operations on the day (for non-clinical reasons) not offered a readmission date within 28 days – There were 2 cancelled operations for non-clinical reasons in December where the patient was not offered another date within 28 days. This will result in the Trust receiving a fine from CCG Commissioners for the total cost of the episode of care. Both patients have now been treated.

There are 2 Access & Performance indicators which have moved from Red to Green in December as follows:

- Breast Symptoms 14 days – the Trust achieved 93.42% (target 93%) which was an improvement from November's Performance of 81.63%, therefore this indicator has moved from Red to Green.
- Cancer 62 Days Urgent – the Trust has achieved 89.66% (target 85%) in December an improvement from November's performance of 82.5%, therefore this indicator has moved from Red to Green.

PEOPLE

Workforce KPIs

There are 4 indicators rated Red in December compared to 6 in November, a decrease of 2 in month.

The 4 indicators rated Red in December that were Red in November are:

- Sickness Absence – was 5.03% (target 4.2%) in December a slight improvement from November's position of 5.13%.
- Non-Contracted Pay – was 11.39% above budget in December.
- Agency Medical Spend – was £600k in December, above the December 2016/17 baseline of £183k.
- Agency AHP Spend – was £65k in December, above the December 2016/17 baseline £17k.

The 2 Workforce indicators that have moved from Red in November to Green in December are as follows:

- Agency Nurse Spend – was £177k in December which is below the December 2016/17 baseline of £251k.
- Average Length of Service for Top 10 Agency Workers - was 21 months in December, reduced from 22 months in November.

SUSTAINABILITY

Finance and Sustainability KPIs

There are 8 Finance and Sustainability indicators rated Red in December the same number as November.

The 8 indicators rated Red in November have remained Red in December as follows:

- Financial Position – The cumulative deficit of £11.2m is £6.8m worse than plan. As at 30th November 2017 the deficit was £4.1m worse than plan and this has increased by £2.7m in December 2017. The main reasons for the cumulative variance to plan are unclaimed STF (£2.1m), the lost income and additional costs associated with the suspension of spinal activity (£1.0m) and a shortfall against the CIP target (£3.1m).
- Cash Balance – Cash continues to be a challenge and is under daily monitoring and management. The cash balance at the end of December was £1.2m. In order to achieve the minimum cash balance and continue to meet its financial obligations additional cash support is required. The Trust has applied for a working capital loan of £4.1m to cover the variance to the control total as at 30th November 2017 but is waiting for confirmation of approval from NHSI and the Department of Health. In addition, support is required from the Trust Board to apply for an additional loan of £2.7m to cover the variance to the control total for December 2017 (this is covered under a separate agenda item). A further deterioration in the financial position over the remainder of the year will mean further cash support is required.
- Capital Programme – cumulative capital spend is £1.6m below the planned capital spend of £5.6m. The forecast outturn is £6.5m which is £0.8m below the capital plan of £7.3m. A revised programme was presented to the Finance and Sustainability Committee in January 2018. This is attached at Appendix 3.
- Better Payment Practice Code continues to underperform with year to date performance of 33% which is 62% below the national standard of 95%, this is due to the challenging cash balance.
- Use of Resource Rating – the current use of resource rating remains at 4 against a planned rating of 3.
- Fines and Penalties – it is estimated that fines and penalties totalling £17k were incurred in December due to non-achievement of the 95% Discharge Summaries quarter 3 target and potential non-achievement of CQUIN.
- Cost Improvement Programme Plans In Progress - £4.8m below the target of £10.5m.

- Cost Improvement Programme Performance To Date – impact of transformation activities at the end of December was £3.8m and £2.1m cost avoidance, £1m below month 9 CIP target of £6.9m.

The Income Statement, Statement of Financial Position and Cash Flow, as presented at the January Finance and Sustainability Committee, are attached in Appendix 4. This highlights the current challenges to the delivery of the control total of £3.7m deficit. The Trust has updated the forecast outturn to a gross deficit of £19.0m before mitigations and £16.0m after mitigations. A £16.0m deficit is £12.3m above the control total and will require a £12.3m working capital loan to maintain the minimum cash balance and meet its financial obligations. The Trust has applied for a £4.1m working capital loan based on the variance to the control total as at 30th November 2017 but is awaiting approval from NHSI and Department of Health. If the application is approved the cash will be received in February 2018. A further working capital loan of £2.7m based on the increased variance to the control total as at 31st December 2017 is required and the Board is requested to approve this application. This is presented as a separate paper.

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
- KPI Sub-Committee

5. RECOMMENDATIONS

The Trust Board is asked to:

1. Note the contents of this report.
2. Note the amendments to the capital programme.

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**												

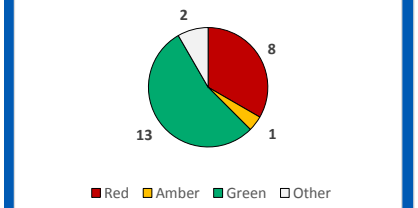
Warrington and Halton Hospitals NHS
NHS Foundation Trust

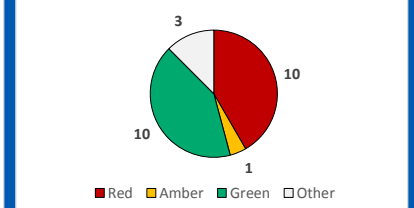
Integrated Dashboard - December 2017

Appendix 2

Key Points/Actions

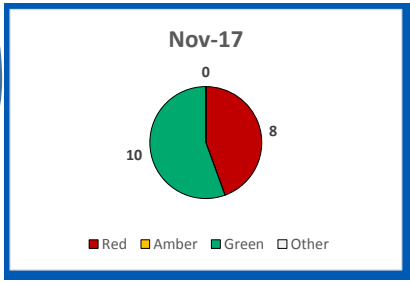
Quality Improvement

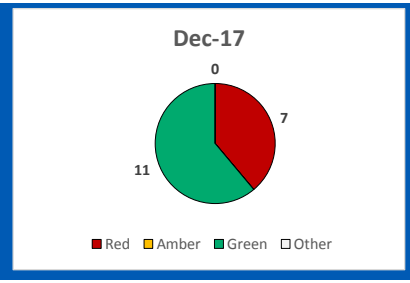




At the time of writing this report there are 654 open incidents that require review and sign off. Acute Care Services have 461 open incidents, SWC have 123, the remaining incidents are for Corporate or External organisations. Duty of Candour for Serious Incidents has improved and we can see 100% compliance across the CBU's. We have seen an improvement in C-Diff cases from 3 to 1 in month. There has been a decrease in the percentage of VTE assessments being completed and we have dropped below the 95% target to 91.70%. At the time of producing the report the Sepsis (assessment of clinical antibiotic review) data was not available for inclusion due to delays in validating the data.

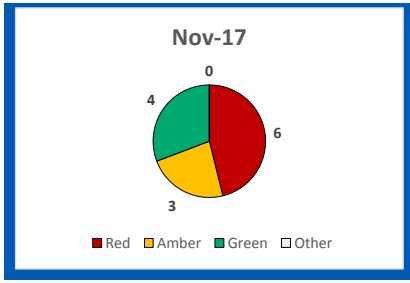
Access & Performance

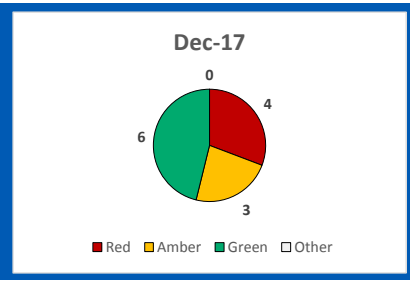




In December, 7 out of the 18 indicators are RAG rated as Red, an improvement of 1 from November. There have been improvements in performance around Cancer 14 Day Breast Symptoms and Cancer 62 Day Urgent and Screening. Work is ongoing to improve the % of discharge summaries sent within 24 hours. Due to winter pressures on A&E, the Trust has not achieved the 4 hour target or improvement trajectory. Up until Christmas, the Trust was the best in the region in terms of ambulance handover times, although due to significant demand we have not achieved this target.

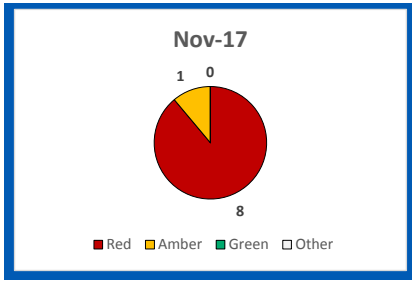
Workforce

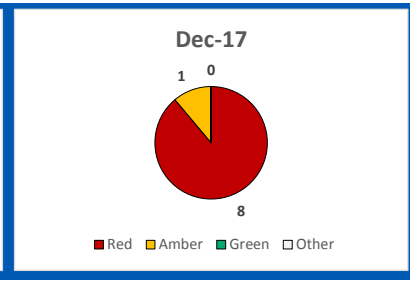




Sickness absence has increased and is now above target. Key actions are in place to address this, at both Trust and Departmental level. There is work still to be done in achieving the Return to Work Interview compliance target but this is achievable and support is in place from HR.
The Trust target for turnover was achieved in month but has increased. Work will be taking place over the next few months to produce an Attraction Strategy and a Retention Strategy. PDR Compliance has dipped in December 2017. Both clinical divisions decreased compliance rates, likely to be due to operational pressures. Corporate Services increase to over 85% compliance.
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 month, the Trust recorded a deficit of £3.4m (excluding October to December STF monies of £2.1m) which increases the year to date deficit to £11.2m, this is £6.8m worse than the planned deficit. Year to date income is £0.8m below plan, expenses are £6.4m above plan and non operating expenses are £0.4m below plan. The year to date capital spend is £4.0m which is £1.6m below the planned capital spend of £5.6m. Due to the historic and current operating position the cash balance remains low and at month end the cash balance is £1.2m which is £2.0m below the planned cash balance of £3.2m. However under the terms and conditions of the working capital loan, the Trust is required to have a cash balance equivalent to 2 operational days (which equates to £1.2m) at some point during the month and due to the timing of cash flow, this is only possible at month end. NHSI are aware of the circumstances and accept the variation in the cash balance. The year to date performance against the Better Payment Practice Code is 33% which is 62% lower than the 95% target. The Trust has recorded a Use of Resources Rating of 4 which is below the planned rating of 3.

Warrington and Halton Hospitals NHS Foundation Trust

Integrated Dashboard - December 2017

Quality Improvement - Trust Position

Description	Aggregate Position	Trend	Variation

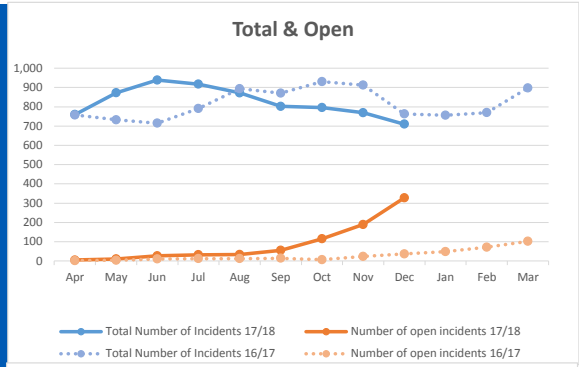
Patient Safety

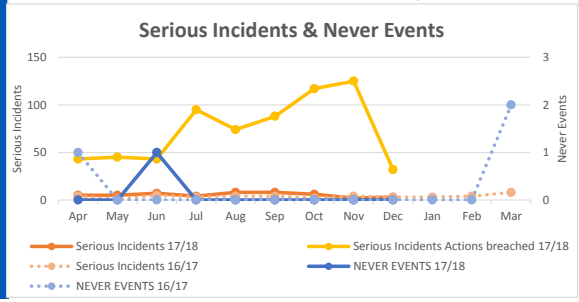
Incidents

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

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

The target for Never Events is a zero tolerance.
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).





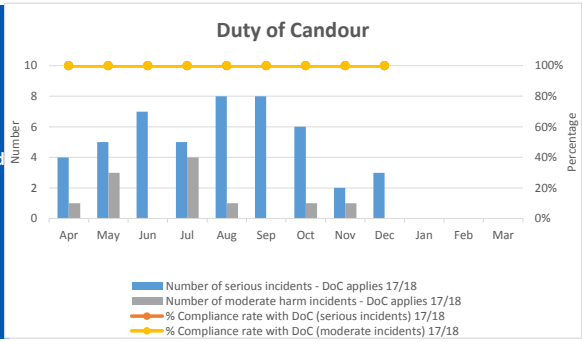
A workshop took place in November chaired by the Deputy Director of Governance to scrutinise and review all open SI actions with the services, ensuring there was a multidisciplinary review. This workshop resulted in 98 actions being closed; 97 actions remain open, of these 58 are breached.
At the time of writing this report there are 654 open incidents that require review and sign off. Acute Care Services have 461 open incidents, SWC have 123, the remaining incidents are for Corporate or External organisations. In January 2018, 2 workshops took place to review all open incidents to reduce the number open in Datix. The workshops closed a total of 240 incidents. Further workshops will be held in January and February to further reduce the backlog of open incidents and in addition communication and training will be provided to ward and dept heads on the new Datix Web system in order that staff can proactively review and close their own incidents This was chaired by the Director of Governance. 1 Never Event occurred in January on ITU where a guide wire was left in a CVP line. Immediate actions have involved contacting the agency as the doctor involved was a locum doctor; an investigation is underway.

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.

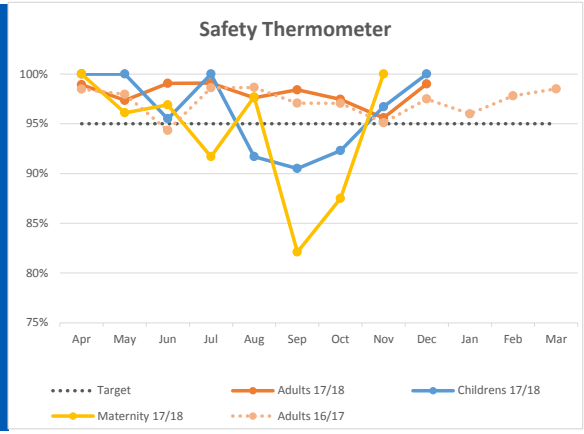
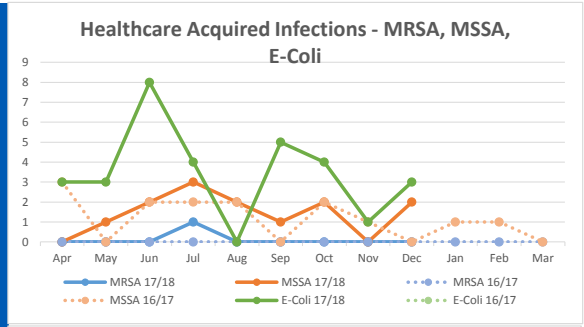
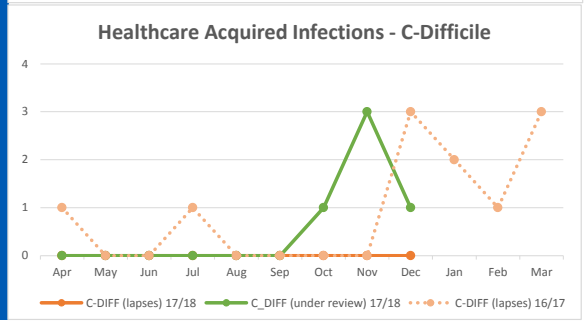


Duty of Candour remains a focus of work and improvement. From week commencing 19/6, this has been monitored at the weekly Serious Incident Meeting and weekly in a report sent to all Board members. Of the 3 Serious Incidents where Duty of Candour applied in December; 0 for Acute Care Services, 3 for Surgery and Women & Children's and 0 for Corporate Services. The Divisions now receive a breakdown by CBU of DoC performance and have been requested to review and improve compliance rates.

Warrington and Halton Hospitals NHS Foundation Trust

Integrated Dashboard - December 2017

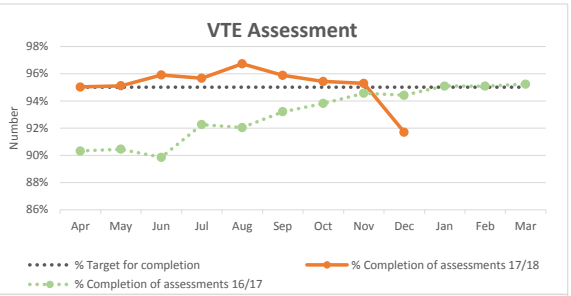
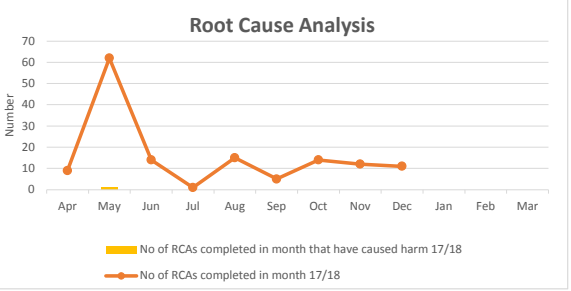
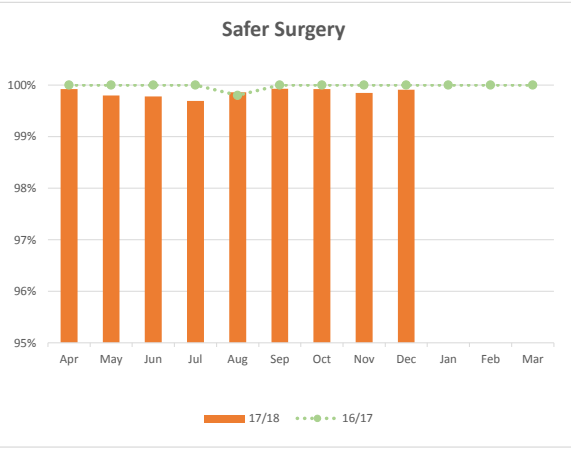
Quality Improvement - Trust Position

	Description	Aggregate Position	Trend	Variation
Safety Thermometer Red: Less than 90% Amber: 90% to 94% 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%.		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 Falls (2) UTI (1) and VTE (1). Children's services scored 100%. Maternity data for December is not available yet as it is submitted in January, this is due to external reporting times being different for maternity. The Trust has moved the Classic ST to a Maternity specific one in the last year. The sample size is small, so 1 instance of harm can have a significant impact on the percentage that is reported. In the last year, a number of different people have collected the information due to changes at Matron level. Given that the questions can be subjective, for instance "Mother felt safe at all times", changes to who asks the question will lead to variability in the response. The timing of the survey has also led to issues, the Classic ST is collected on the middle Wednesday of every month, whereas Maternity is the last Wednesday – this means that when reporting on the ST the Maternity data can be behind the schedule of the others.
Healthcare Acquired Infections MRSA Red: 1 or more Green: 0 C-Difficile Red: More than 2 Amber: 1 to 2 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.	 	Clostridium difficile – 1 hospital onset Clostridium difficile case was reported in December 2017. YTD the Trust has reported 16 hospital onset cases against the annual threshold of 27 cases. The CCG review panel will meet in March 2018 to review cases from Q3. MRSA bacteraemia – one hospital apportioned case was reported in July 2017. MSSA bacteraemia – YTD the Trust has reported 13 hospital onset cases. These are under review to identify any areas for care improvement. E. coli bacteraemia – YTD the Trust has reported 31 hospital onset cases. Partnership working is in place across the health economy. The Trust is working with community partners to progress the action plans.

Warrington and Halton Hospitals NHS Foundation Trust

Integrated Dashboard - December 2017

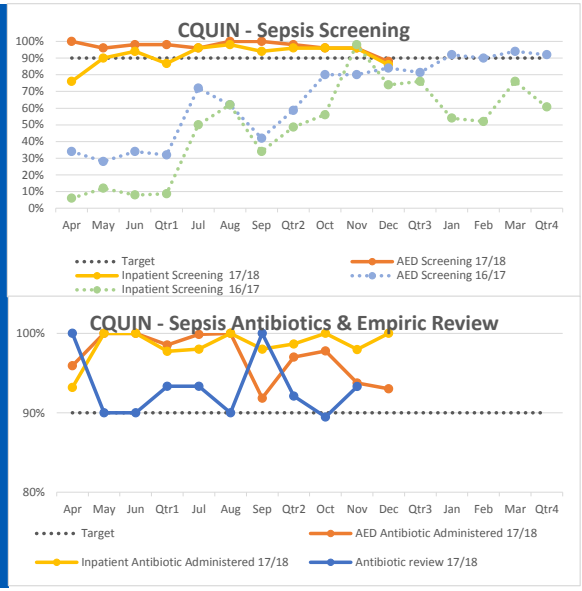
Quality Improvement - Trust Position

	Description	Aggregate Position	Trend	Variation
VTE Assessment Red: <95% Green >=95%	Venous thromboembolism (VTE) is the formation of blood clots in the vein. This data looks at the % of assessments completed in month and the incidents of preventable harm. We also look at the number of RCA's completed in relation to VTE's.	The target for completion and documentation of VTE risk assessment on admission is 95%. The Trust achieved 95.09% in January 2017, 95.08% in February 2017 and 95.23% in March 2017 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 2017 onwards. This has been communicated to Divisions.	 	The data provided for December is not yet fully complete due to the VTE nurse awaiting records to be coded. The full data will be available in the last week of January for the VTE nurse to complete her audit of assessments and an update will be provided in the January IPR. A revised RCA process has been put in place for April 2017 onwards. This was discussed at the Thrombosis Group on the 11th Sept 2017 and RCA process needs further review to minimise backlog, which currently stands at 32 RCA's. We are introducing an RCA template from King's College Hospital which provides a matrix to help determine the level of harm.
Safer Surgery Red: <100% Green: 100%	The Safe Surgery check list is monitored through OMIS BI and checked and validated via 20 case per month by Head of theatre services.	The target is to achieve 100%.		We have 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 11377, of which 1123 were for the month of December.

Warrington and Halton Hospitals NHS Foundation Trust

Integrated Dashboard - December 2017

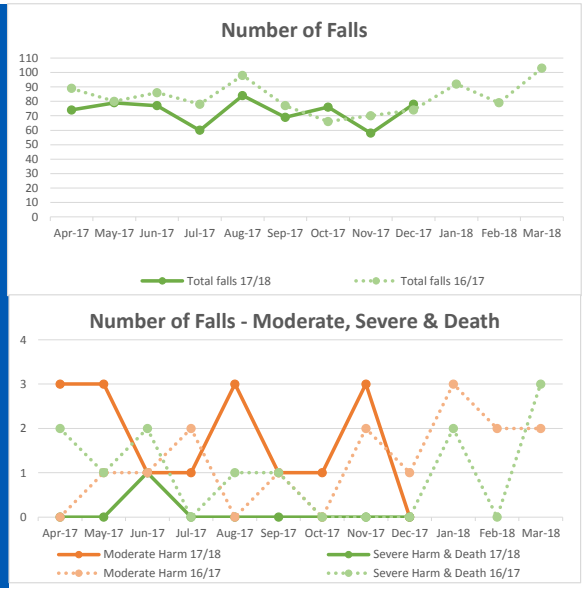
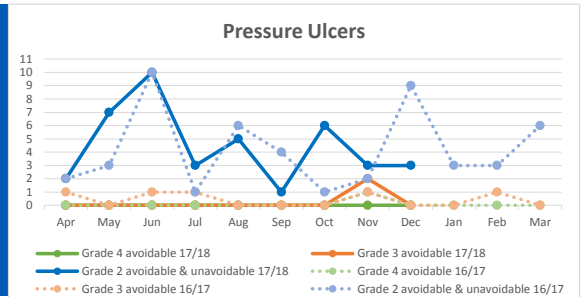
Quality Improvement - Trust Position

	Description	Aggregate Position	Trend	Variation
CQUIN - Sepsis AED Screening Red: Less than 90% Green: 90% or more CQUIN - Sepsis Inpatient Screening Red: Less than 90% Green: 90% or more CQUIN - Sepsis AED Antibiotics Administration Red: Less than 90% CQUIN - Sepsis Inpatient Antibiotics Administration Red: Less than 90% CQUIN - Sepsis Antibiotic Review	Screening of all eligible patients - acute inpatients. Screening of all eligible patients admitted to emergency areas AED. Inpatient received treatments and empiric review within three days of prescribing antibiotics. Emergency patients received treatment and empiric review within three days of prescribing the antibiotics.	The target is to achieve 90%		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 December data has not been fully validated due to delays in selecting the patients at random. However, the percentage of patients screened for sepsis in ED and in an inpatients setting both dropped below the 90% target in December, achieving 88% and 86% respectively. The Sepsis Nurses will review the data to see if there is a trend in relation to when these screenings have not occurred and will re-educate staff. Although we have not achieved in month we have still achieved the quarterly target.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - December 2017

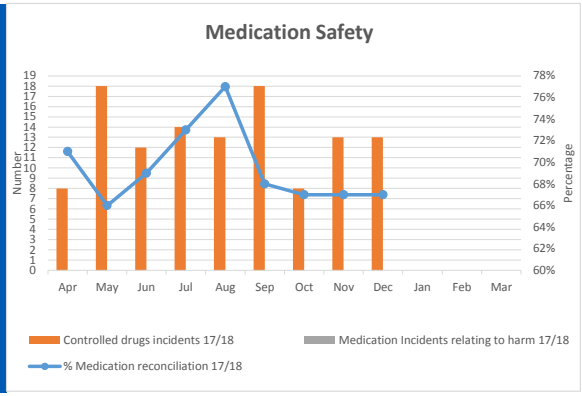
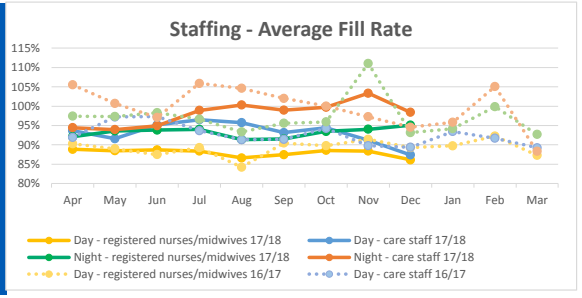
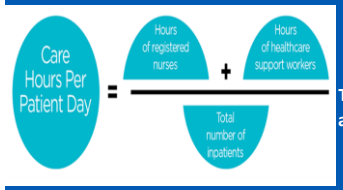
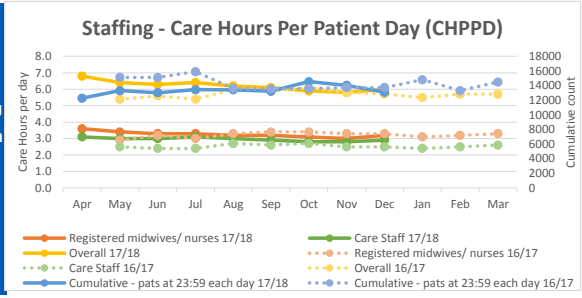
Quality Improvement - Trust Position

	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 0 moderate harm falls reported during December. The overall number of reported falls has increased from 58 to 79 in December.
Pressure Ulcers Grade 4 Red: 1 or more Grade 3 Red: More than 3 Green: 3 or less Grade 2 Red: More than 7 Green: 7	Pressure ulcers, also known as pressure sores, bedsores and decubitus ulcers, are localised damage to the skin and/or underlying tissue that usually occur over a bony prominence as a result of pressure, or pressure in combination with shear and/or friction.	Grade 4 hospital acquired (avoidable) Grade 3 hospital acquired (avoidable) Grade 2 hospital acquired (avoidable and unavoidable)		Monthly panel meetings are in place to ratify RCA's identifying whether the pressure ulcer was deemed to be avoidable or unavoidable and hospital or community acquired. Learning from these panels is disseminated via lessons learned flyers. In the January dashboard we will see the data split by avoidable and unavoidable for all gradings. Of the 3 grade 2 pressure ulcers from December all have developed in a different anatomical location and patients are on different wards.

Warrington and Halton Hospitals NHS Foundation Trust

Integrated Dashboard - December 2017

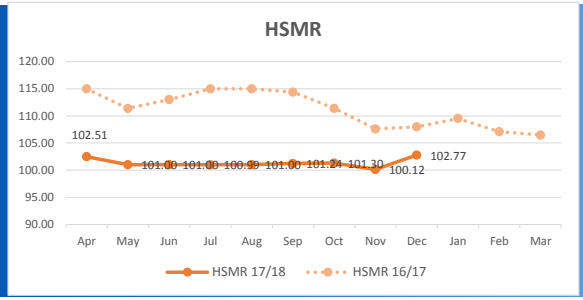
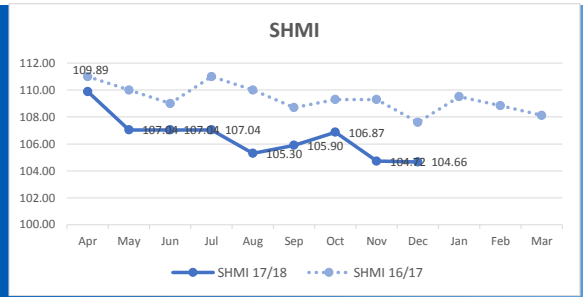
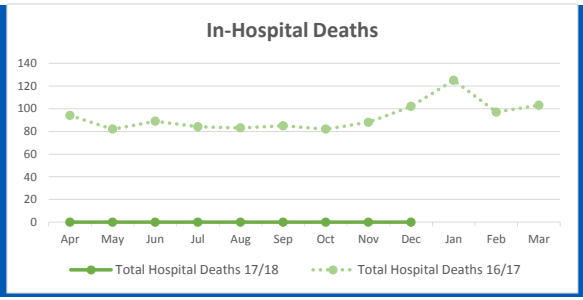
Quality Improvement - Trust Position

	Description	Aggregate Position	Trend	Variation
Medication Safety Red - any incidents of harm. Green - no incidents of harm.	Overview of the current position in relation to medication, to include; medication reconciliation, controlled drugs incidents and medication incidents relating to harm.	The target for Medication Safety is a zero tolerance for incidents of harm.		Medication reconciliation is the process of creating the most accurate list possible of all medications a patient is taking. YTD the % of patients with an electronic medicines reconciliation record is on a slight downward trend. The total number of patients requiring this in December was 1432 (excluding Paediatrics, Maternity and patients with a length of stay <1 day). Of these 1432, 960 medication reconciliations were recorded electronically; 202↑ (14%↑) occurred within 24 hours of admission (requires improvement) & 461 ↑ (48% ↑) within 48 hours of admission. There were 13 controlled drugs incidents for the month of December and no medication incidents related to harm (grade 3 or above). Most commonly reported incidents relate to diabetic, antibacterial, anticoagulant and opioid medication. Attention is being focussed on diabetic medication incidents. An overview of medicines governance in relation to controlled drug incidents and audits was presented at the December Patient Safety and Effectiveness Committee.
Staffing - Average Fill Rate Red: 0-79% Amber: 80-89% Green: 90-100%	Percentage of planned verses actual for registered and non registered staff by day and night	Target of >90%. The data produced excludes CCU, ITU and Paediatrics.		Although most areas are above the 90% target ytd and it is acknowledged that the percentage of registered nurses/midwives in the day is below the target. However, mitigation and responsive plans are in place to ensure that the safe delivery of patient care is discussed at every bed meeting and escalated as appropriate. Shift fill rates have decreased, likely due to seasonal trend. Bank incentives and escalated rates for critical areas have been put in place to improve the shift fill rate.
Staffing - Care Hours Per Patient Day (CHPPD)		The data produced excludes CCU, ITU and Paediatrics and does not have an associated target.		We continue to monitor CHPPD as part of the daily responsive plans regarding care delivery.

Warrington and Halton Hospitals NHS Foundation Trust

Integrated Dashboard - December 2017

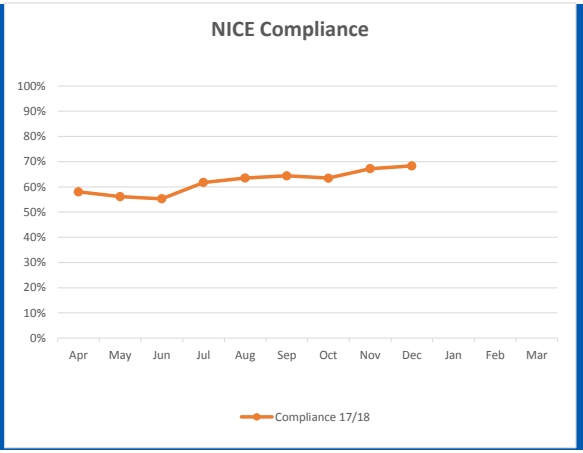
Quality Improvement - Trust Position

	Description	Aggregate Position	Trend	Variation
Mortality ratio - HSMR Red: Greater than expected Green: As or under expected	Hospital Standardised Mortality Ratio (HSMR 12 month rolling). The HSMR is a ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in- hospital deaths (multiplied by 100) for 56 specific Clinical Classification System (CCS) groups.	Target for Green would be to be within expected ranges.		For the latest 12 months Warrington's SHMI is rated green by the over-dispersed model used by NHS Digital, and also HED's stricter 'early warning' system using Poisson control limits. Latest HSMR and SHMI figures show little difference between weekend and weekday mortality for Warrington. Looking at the confidence intervals, neither weekend HSMR nor weekday HSMR is statistically significant separately. When we look at the underlying trends over the last 3 years, 12 month rolling HSMR weekend rates have reduced, although stable recently.
Mortality ratio - SHMI Red: Greater than expected Green: As or under expected	Summary Hospital-level Mortality Indicator (SHMI 12 month rolling). SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.	Target for Green would be to be within expected ranges.		Our SHMI for December is 104.66; 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.

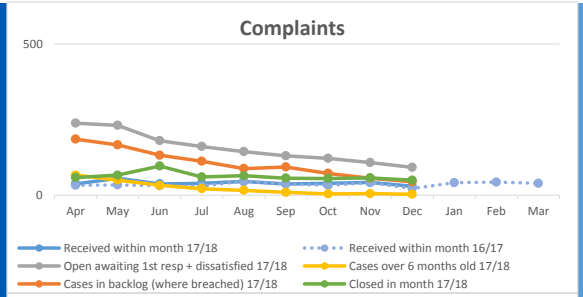
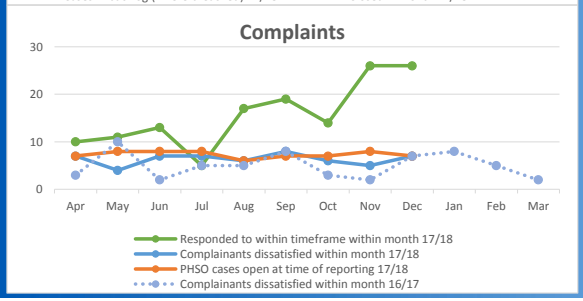
Warrington and Halton Hospitals NHS Foundation Trust

Integrated Dashboard - December 2017

Quality Improvement - Trust Position

Description	Aggregate Position	Trend	Variation
NICE Compliance Red: <75% Amber: 75% to <100% Green: 100%	The National Institute for Health and Clinical Excellence (NICE) is part of the NHS and is the independent organisation responsible for providing national guidance on treatments and care for people using the NHS in England and Wales and is recognised as being a world leader in setting standards for high quality healthcare and are the most prolific producer of clinical guidelines in the world.	The target is to achieve 100% compliance against all NICE guidance.		Compliance with NICE guidance remains a challenge although there has been a small and steady increase in compliance from April. The Medical Director has raised the issue with Clinical Directors at Medical Cabinet and this continues to be discussed at Patient Safety and Effectiveness Sub Committee. The Clinical Governance Department has identified support specifically for NICE guidance compliance and this continues to be deployed across the CBU's. Specific CBU's that are currently being supported are ABC, Specialist Medicines and Women's and Children's Health.

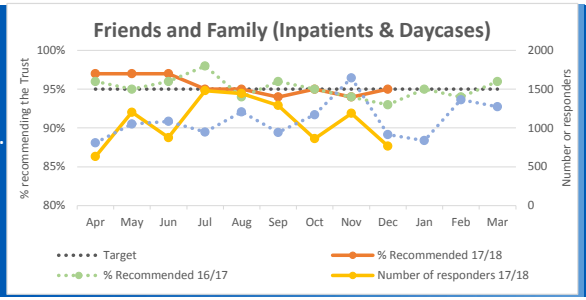
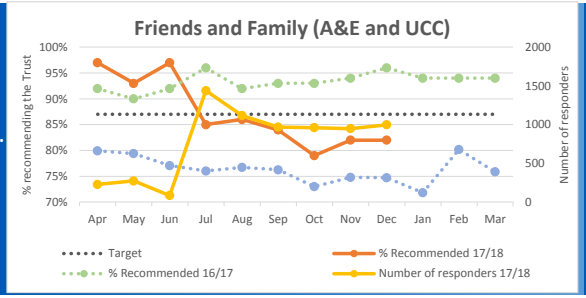
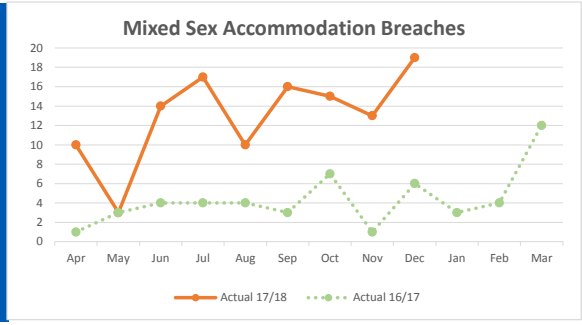
Patient Experience

Complaints	Overall review of the current complaints position, including; Number of complaints received, number of dissatisfied complaints, total number of open complaints, total number of cases over 6 months old, total number of cases in backlog where they have breached timeframes, number of cases referred to the Parliamentary and Health Service Ombudsman and the number of complaints responded to within timeframe.	Red - Trust not meeting improvement trajectories or complaints open over 6 months old. Amber - No complaints over 6 months old, Trust meeting backlog improvement targets Green - No backlog, complaints responded to within agreed timescales. Please note that the above RAG rating will be reviewed following the completion of the complaints improvement plan.	 	The 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. Weekly performance meetings with Divisions and the Chief Nurse / Director of Governance have been reinstated to monitor complaints performance and to focus areas for improvement. The Trust did not meet its target to have 75 complaints by the end of December 2017, due to operational pressures and an increase in complaints due to the Spinal suspension. The Trust has a target of having no cases that have breached their deadline by March 2018. It should be noted that there has been an increase in timeliness of responses being sent out to complainants. In December 2017 the Trust sent out 69% of all responses due in December 2017 on time. This was an increase from 42% in November 2017.

Warrington and Halton Hospitals NHS Foundation Trust

Integrated Dashboard - December 2017

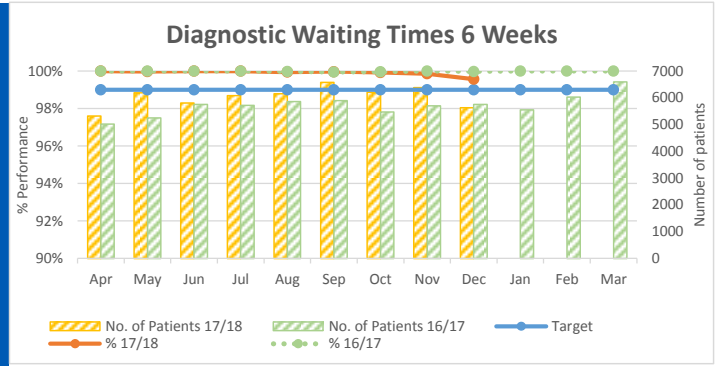
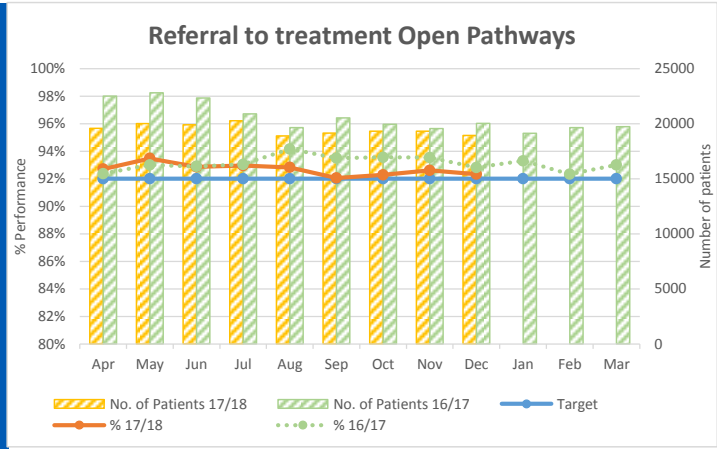
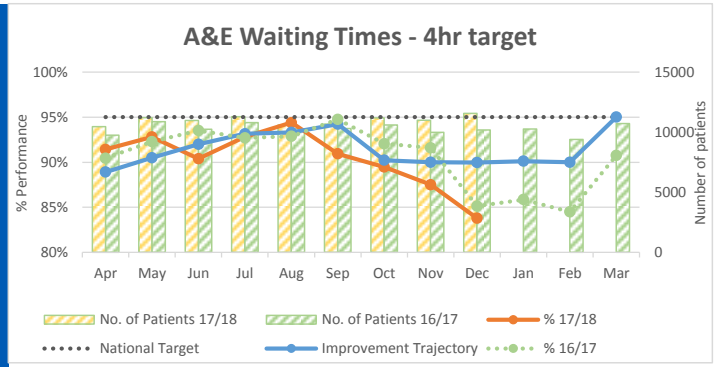
Quality Improvement - Trust Position

	Description	Aggregate Position	Trend	Variation
Friends and Family (Inpatients & Day cases) Red: Less than 95% Green: 95% or	Percentage of Inpatients and day case patients recommending the Trust. Patients are asked - How likely are you to recommend our ward to friends and family if they needed similar care or treatment?	The target set is to achieve over 95%.		We have achieved the 95% target for Inpatients and Day cases for our patients recommending the Trust. The overall number of responders has decreased compared to the previous month, from 1189 to 767 from 4291 eligible which is lower than previous months. We are currently reviewing the current paper based system utilised for Inpatient and Daycase FFT along with the introduction of weekly ward monitoring by the Head of Patient Experience to ensure consistency of returns and early escalation to CBU lead nurses and the Chief Nurse where necessary.
Friends and Family (A&E and UCC) Red: Less than 87% Green: 87% or more	Percentage of AED (Accident and Emergency Department) patients recommending the Trust : Patients are asked - How likely are you to recommend our AED to friends and family if they needed similar care or treatment?	The target set is to achieve over 87%.		The target set is to achieve over 87%. 82% of our patients recommended the Trust in December. The overall number of responders has remained relatively the same going from 950 to 999 from 5910 eligible responders. The A&E Matron is encouraging staff to promote completion of the electronic text message feedback. Additional patient information has been provided to A&E. Following interrogation of the patient feedback through the Envoy system, the main area of patient discontent is with regard to overall waiting times and time to see a Doctor.
Mixed Sex Accommodation Breaches Red: 1 or more Green: Zero	We submit data to NHS England in relation to the number of occurrences of unjustified mixing in relation to sleeping accommodation.	There is a target of zero tolerance.		MSA breaches continue originating from the Intensive Care Unit. Escalation of individual cases remains variable up to Executive level. The escalation process has been reiterated to the Lead Nurses and CBU Managers. Mini RCA's are conducted for each patient and reported in a format agreed with the CCG. Winter pressures have significantly impacted on the ability to step down patients in a timely enough manner.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - December 2017

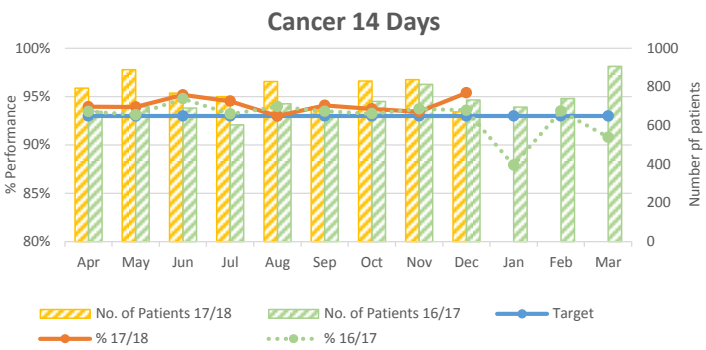
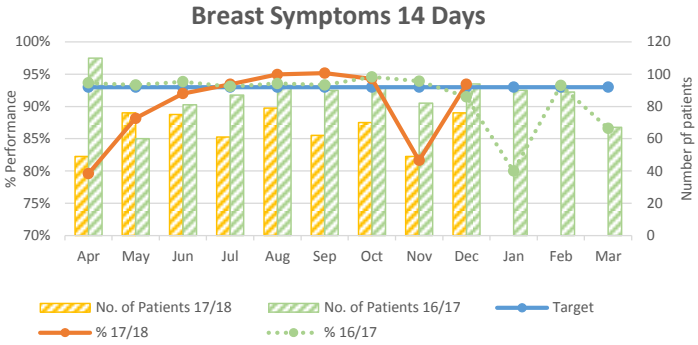
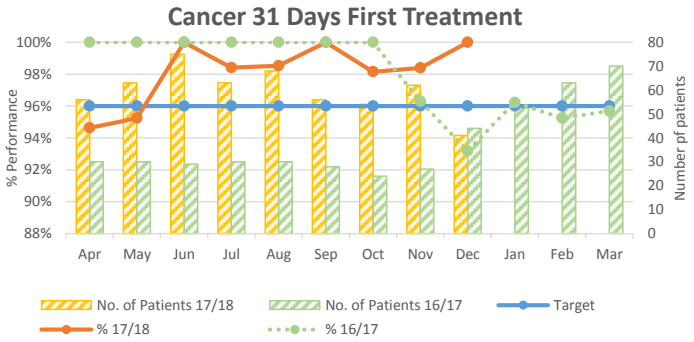
Mandatory Standards - Access & Performance - Trust Position

	Description	Aggregate Position	Trend	Variation
Diagnostic Waiting Times 6 Weeks Red: Less than 99% Green: 99% or above	All diagnostic tests need to be carried out within 6 weeks of the request for the test being made. The national target is 99% or over within 6 weeks. This metric also forms part of the Trust's Sustainability and Transformation Plan (STP) Improvement trajectory. The proposed tolerance levels applied to the improvement trajectories are also illustrated.	The national target of 99% for Diagnostic waiting times has been achieved. The Trust has also met the STP Improvement trajectory.		The Trust achieved this target for December.
Referral to treatment Open Pathways Red: Less than 92% Green: 92% or	Percentage of incomplete pathways waiting within 18 weeks. The national target is 92% This metric also forms part of the Trust's STP Improvement trajectory. The proposed tolerance levels applied to the improvement trajectories are also illustrated.	Open pathways continue to perform above the 92% target. The Trust has also met the STP improvement trajectory.		The Trust achieved this target in December. Achievement was a challenge in December and continues to be a challenge in January and February due to the elective cancellations as a result of Winter pressures and guidance from NHSI. We are planning achievement in January and February through case by case management.
RTT - Number of patients waiting 52+ weeks Green = 0, otherwise Red				
Four Hour Standard - National Target Red: Less than 95% Green: 95% or above	All patients who attend A&E should wait no more than 4 hours from arrival to admission, transfer or discharge. The national target is 95% This metric also forms part of the Trust's STP improvement trajectory. The proposed tolerance levels applied to the improvement trajectories are also illustrated.	The Trust is not achieving the 95% national 4 hour target and has not met the improvement trajectory for December 2017.		December has proven extremely difficult and the Trust achieved 83.78% against the improvement trajectory of 90%. In December our performance for type 1 activity was the best in the region, excluding specialist Trusts. Over Winter we have seen an increase in the acuity of patients attending ED. Therefore whilst the number of attendances has typically been at or slightly below expected levels, admissions have been at or above expected levels, this is in line with our peers. We cancelled a proportion of elective activity over the Christmas period to enable staff to support the non-elective demand and opened additional escalation beds in December, including 22 beds on C22 - our Winter ward, 22 beds on Daresbury and 6 additional intermediate care beds in Halton. The days delayed due to DTOC peaked in December at 1032, more than double the July position. We are working very closely with partners to address these delays.
Four Hour Standard Waiting Times - STP Trajectory Red: Less than trajectory				

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - December 2017

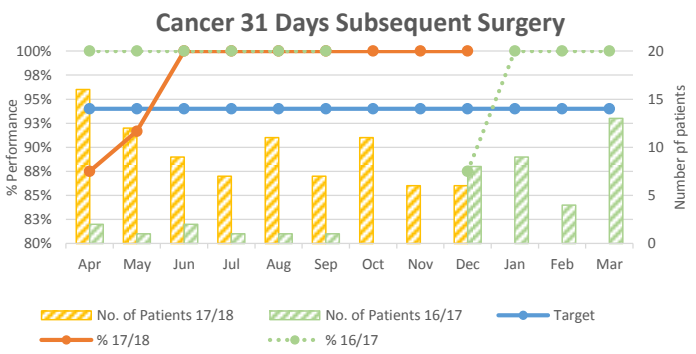
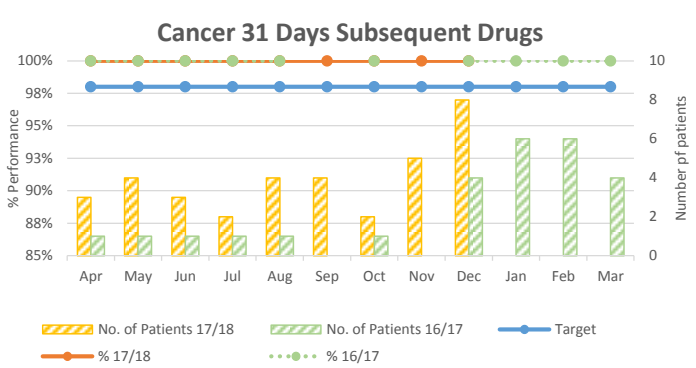
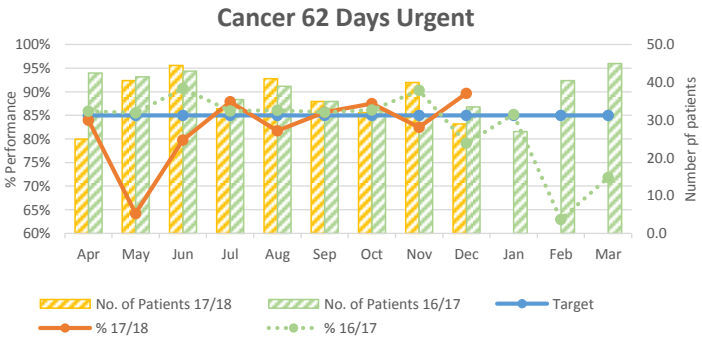
Mandatory Standards - Access & Performance - Trust Position

	Description	Aggregate Position	Trend	Variation
Cancer 14 Days Red: Less than 93% Green: 93% or above	All patients need to receive first appointment for cancer within 14 days of urgent referral. The national target is 93%. This target is measured and reported on a quarterly basis.	The Trust achieved 95.38% in December 2017.		This target has been consistently delivered.
Breast Symptoms 14 Days Red: Less than 93% Green: 93% or above	All patients need to receive first appointment for any breast symptom (except suspected cancer) within 14 days of urgent referral. The national target is 93%. This target is measured and reported on a quarterly basis.	The Trust achieved 93.4% in December 2017 and 89.78% for Q3.		We failed the Breast Symptomatic 2 week wait target in November (93%) posting 81% - We had 9 breaches in total of which 8 were patient choice. We have improved our rate of patients listed within 7 days for December and unvalidated figures indicate achievement of this target for December, with 93.4% compliance.
Cancer 31 Days First Treatment Red: Less than 96% Green: 96% or above	All patients to receive first treatment for cancer within 31 days of decision to treat. This national target is 96%. This target is measured and reported on a quarterly basis.	The Trust achieved 100% in December 2017 and 98.8% for Q3.		The Trust achieved this target.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - December 2017

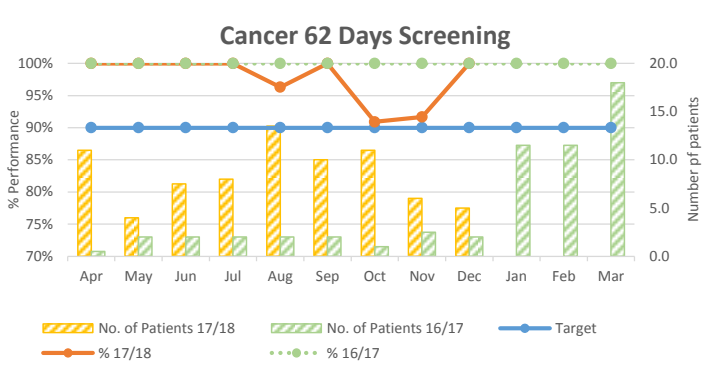
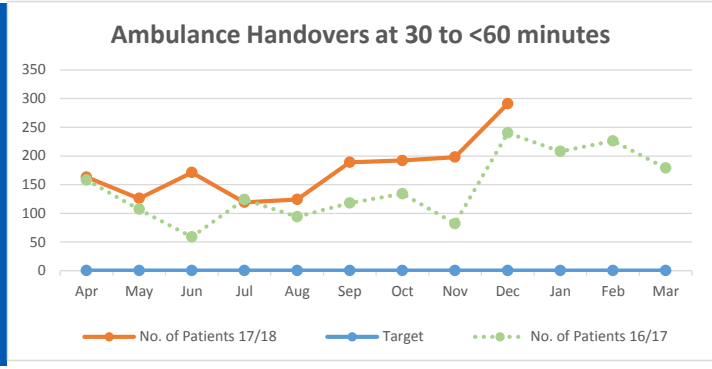
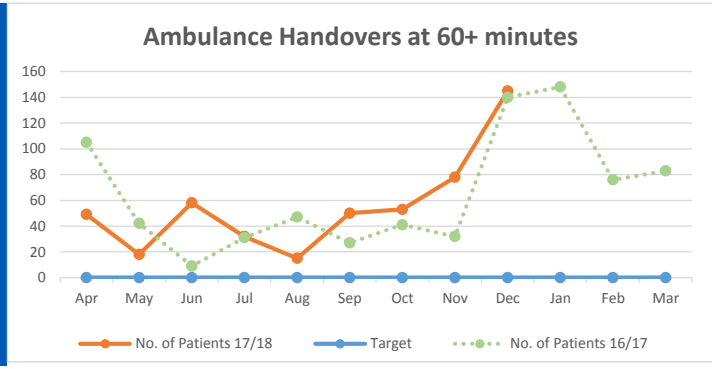
Mandatory Standards - Access & Performance - Trust Position

	Description	Aggregate Position	Trend	Variation
Cancer 31 Days Subsequent Surgery Red: Less than 94% Green: 94% or above	All patients to receive a second or subsequent treatment for cancer within 31 days of decision to treat/surgery. The national target is 94%. This target is measured and reported on a quarterly basis.	The Trust achieved 100% in December and 100% for Q3 2017.		The Trust achieved this target.
Cancer 31 Days Subsequent Drug Red: Less than 98% Green: 98% or above	All patients to receive a second or subsequent treatment for cancer within 31 days of decision to treat – anti cancer drug treatments. The national target is 98%. This target is measured and reported on a quarterly basis.	The Trust achieved 100% in December and 100% for Q3 2017.		The Trust achieved this target.
Cancer 62 Days Urgent Red: Less than 85% Green: 85% or above	All patients to receive first treatment for cancer within 62 days of urgent referral. The national target is 85%. This metric also forms part of the Trust's STP Improvement trajectory. The proposed tolerance levels applied to the improvement trajectories are also illustrated.	The Trust achieved 89.66% in December 2017 and 86.5% for Q3.		The Trust achieved this target in December and for Q3.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - December 2017

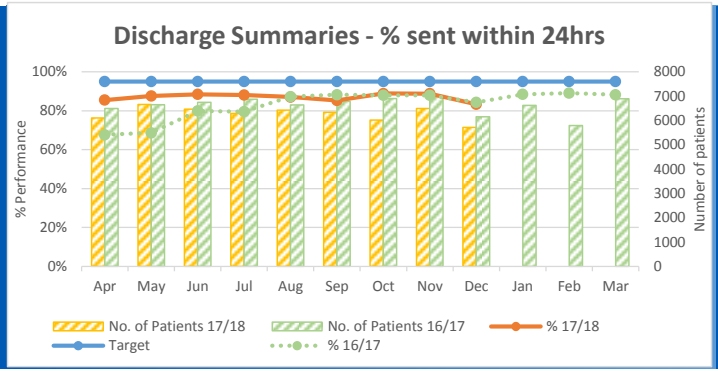
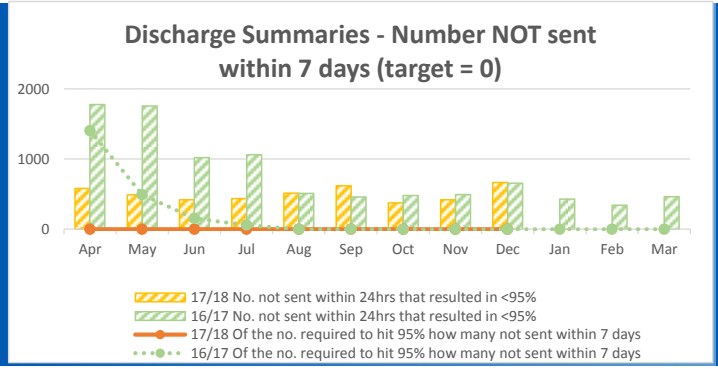
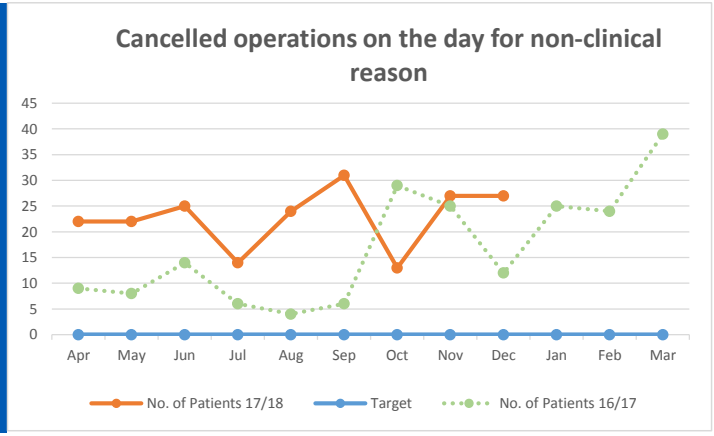
Mandatory Standards - Access & Performance - Trust Position

	Description	Aggregate Position	Trend	Variation
Cancer 62 Days Screening Red: Less than 90% Green: 90% or above	All patients must wait no more than 62 days from referral from an NHS screening service to first definitive treatment for all cancers. The national target is 90%. This target is measured and reported on a quarterly basis.	The Trust achieved 100% in December 2017 and 94.2% for Q3.		The Trust achieved this target.
Ambulance Handovers 30 to <60 minutes Red: More than 0 Green: 0	Number of ambulance handovers that took 30 to <60 minutes (based on the data record on the HAS system).	There were 291 patients where the ambulance handover was between 30 and 60 minutes in December 2017.		Ambulance handovers remain a challenge. Up until Christmas the Trust had the best performance in the region for ambulance handovers, averaging 30 minutes.
Ambulance Handovers at 60 minutes or more Red: More than 0 Green: 0	Number of ambulance handovers that took 60 minutes or more (based on the data record on the HAS system).	There were 140 patients where the ambulance handover was more 60 minutes in December 2017.		Ambulance handovers remain a challenge. Up until Christmas the Trust had the best performance in the region for ambulance handovers, averaging 30 minutes.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - December 2017

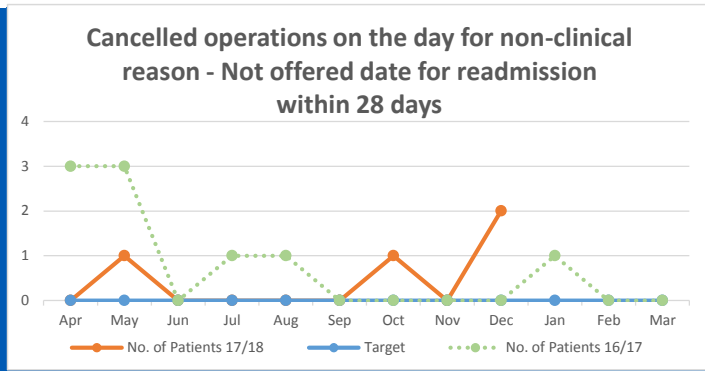
Mandatory Standards - Access & Performance - Trust Position

	Description	Aggregate Position	Trend	Variation
Discharge Summaries - % sent within 24hrs Red: Less than 95% Green: 95% or above	The Trust is required to issue and send electronically a fully contractually complaint Discharge Summary within 24 hrs of the patients discharge.	The Trust achieved 84.34% in December 2017.		The Trust has started a focussed improvement project to improve compliance with this target across all CBUs.
Discharge Summaries - Number NOT sent within 7 days Red: Above 0	If the Trust does not send 95% of discharge summaries within 24hrs, the Trust is then required to send the difference between the actual performance and the 95% required standard within 7 days of the patients discharge.	All discharge summaries were sent within 7 days in December 2017.		The Trust achieved this target.
Cancelled Operations on the day for a non-clinical reason Red: Above zero	Number of operations cancelled on the day or after admission for a non-clinical reason.	There were 27 operations cancelled due to non clinical reasons in December 2017.		There was an increase in cancelled operations on the day in December due to bed pressures.

Warrington and Halton Hospitals NHS Foundation Trust

Integrated Dashboard - December 2017

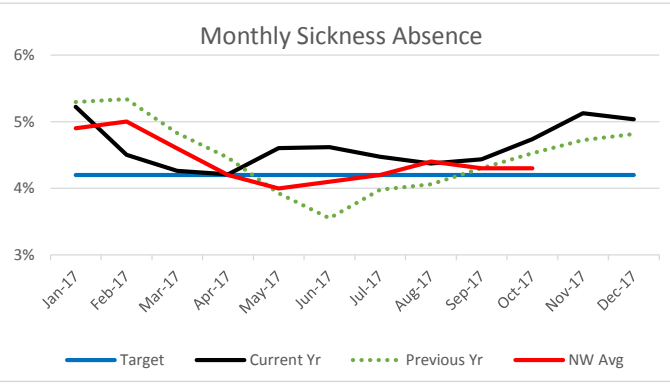
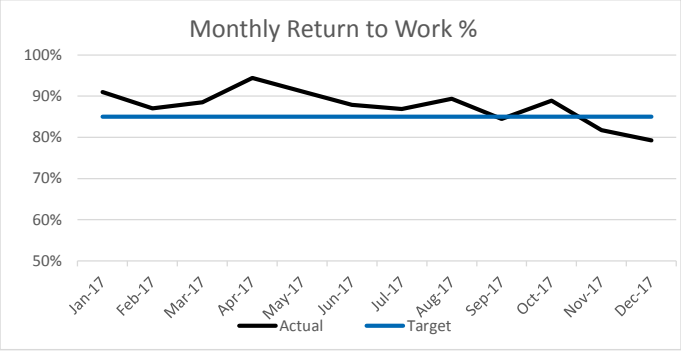
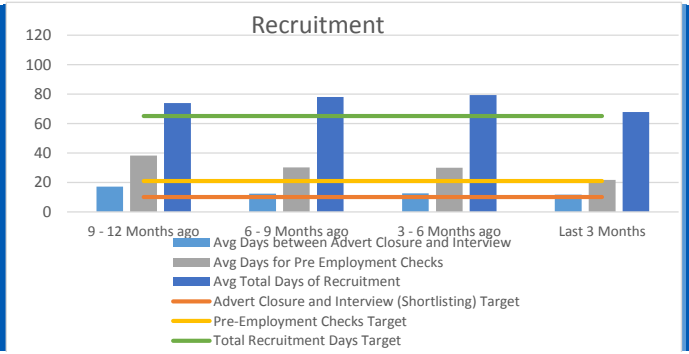
Mandatory Standards - Access & Performance - Trust Position

	Description	Aggregate Position	Trend	Variation
Cancelled Operations on the day for a non-clinical reason - Not offered a date for readmission within 28 days of the cancellation	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.	2 patients cancelled on the day did not receive their treatment within 28 days, in December.		Both patients have now received their treatment.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - December 2017

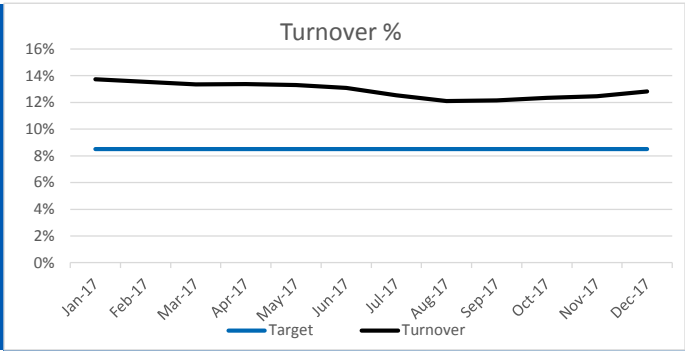
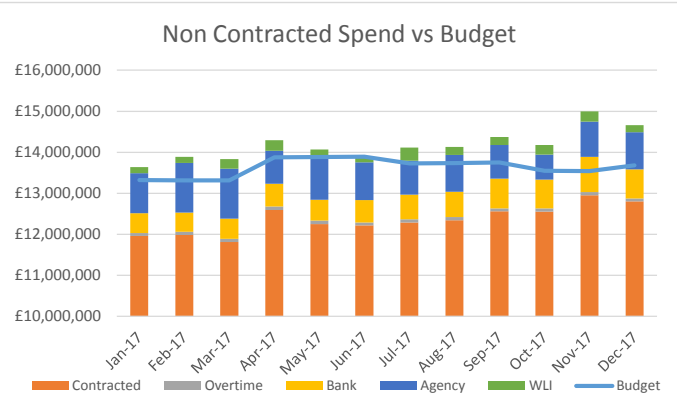
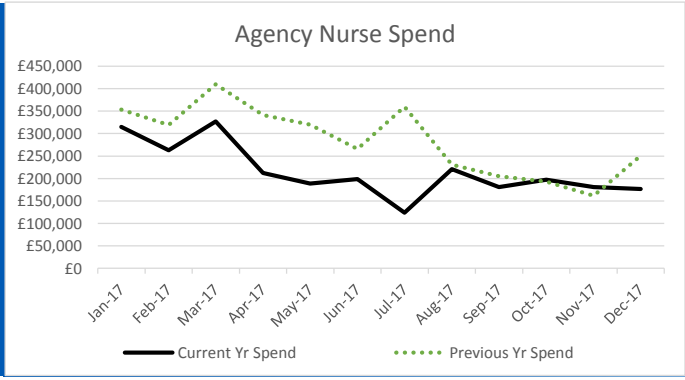
Workforce

	Description	Aggregate Position	Trend	Variation
Sickness Absence Red: Above 4.5% Amber: 4.2% to 4.5% Green: Below 4.2%	Comparing the monthly sickness absence % with the Trust Target (4.2%) previous year, and North West average	Sickness absence has increased to 5.03%, which is above target and higher than the same period last year.		Key actions to address this increase include: > a renewed focus on flu vaccinations > proposals to strengthen reporting arrangements for nursing staff > mental health first aid training to take place > bespoke actions on areas with high levels of absence
Return to Work Red: Below 75% Amber: 75% to 85% Green: Above 85%	A review of the completed monthly return to work interviews.	Return to work interviews have reduced to 79.30%, which is below target.		The RTW Interview compliance continues to decline. Whilst this is likely to be due to operational pressures, managers are reminded of the importance of conducting RTW interviews as a key tool in tackling sickness absence.
Recruitment Red: 76 days or above Amber: 66 to 76 days Green: 65 days or	A measurement of the average number of days it is taking to recruit into posts. It also shows the average number of days between the advert closing and the interview (target 10) to measure if we are taking too long to complete shortlisting and also highlights the number of days for which it takes successful candidates to complete their pre-employment checks	Average days to recruit has reduced to 67.8 in the last 3 months, only slightly above target.		Improved use of technology, streamlining and recruiting managers and forward planning will continue to improve the efficiency of our Time to Hire.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - December 2017

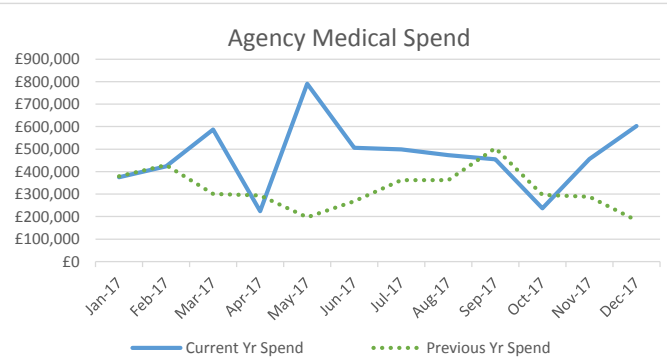
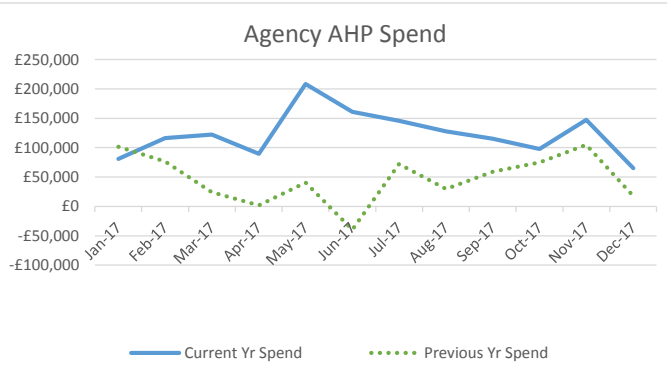
Workforce

	Description	Aggregate Position	Trend	Variation
Turnover Red: Above 15% Amber: 13% to 15% Green: Below 13%	A review of the turnover percentage over the last 12 months	Turnover has increased to 12.81%, although is still below target.		Turnover remains below target. A workshop will be held in February 2018 to share learning from the various recruitment and retention initiatives utilised across the Trust, with the intention of developing a Trust Attraction Strategy and Retention Strategy.
Non Contracted Pay Red: Greater than Budget Green: Less than Budget	A review of the Non-Contacted pay as a percentage of the overall pay bill year to date	Expenditure remains above budget, mainly due to temporary staffing costs, but has decreased slightly.		Expenditure on pay is still above budget, however this has reduced by c£500k. Total temporary staffing spend in December 2017 was c£100k less that the same month last year. The Acute Care Division remains in mandated support and is working on recovery plans for all expenditure and income. New Overtime Policy promoted to managers and staff in December 2017.
Agency Nurse Spend Red: Greater than Previous Yr Green: Less then	A review of the monthly spend on Agency Nurses	Agency nurse spend was £177k in December 2017, which is significantly lower than the same period last year.		Both substantive and bank recruitment has continued to drive down agency requirements however, bank expenditure has increased as a consequence.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - December 2017

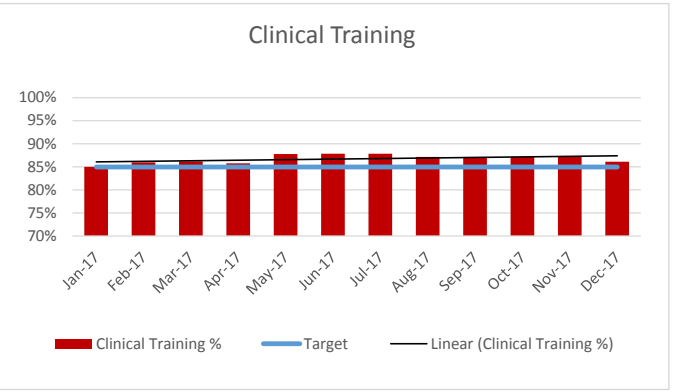
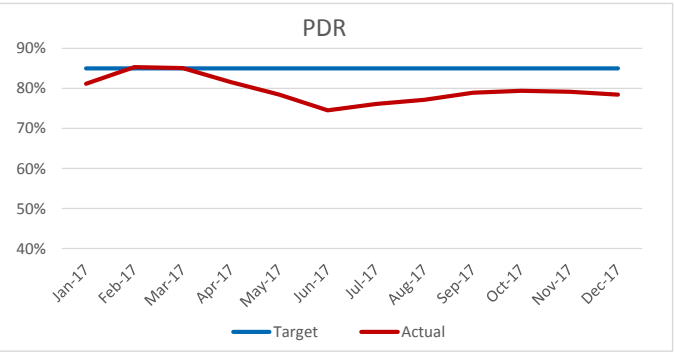
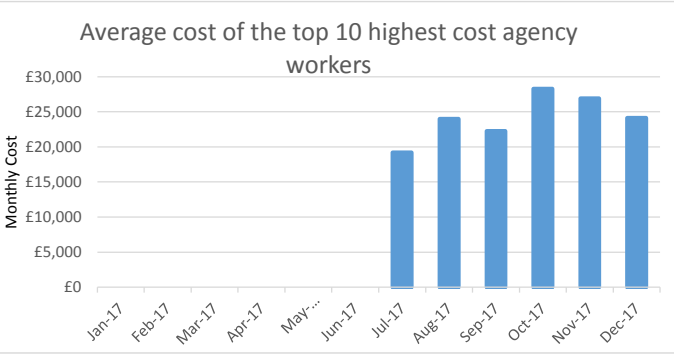
Workforce

	Description	Aggregate Position	Trend	Variation
Agency Medical Spend Red: Greater than Previous Yr Green: Less then	A review of the monthly spend on Agency Locums	Medical agency spend has increase to £602k.		The current focus on Breach Form Compliance continues. It is recognised as a key process to exerting grip and control on Medical agency spend. Another key piece of work in progress is the central medical agency team which will give greater control around medical agency usage and greater challenge to the agencies.
Agency AHP Spend Red: Greater than Previous Yr Green: Less then Previous Yr	A review of the monthly spend on AHP Locums	AHP agency spend has decreased to £65k, although is still above the same period last year.		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.
Essential Training Red: Below 70% Amber: 70% to 85% Green: Above 85%	A summary of the Essential Mandatory Training Compliance, this includes: Corporate Induction Dementia Awareness, Fire Safety Health and Safety Moving and Handling	Essential Training in December 2017 was 86%, which is above target.		The Trust is pleased to maintain the achievement of this target which has been very consistent over the last 3 months.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - December 2017

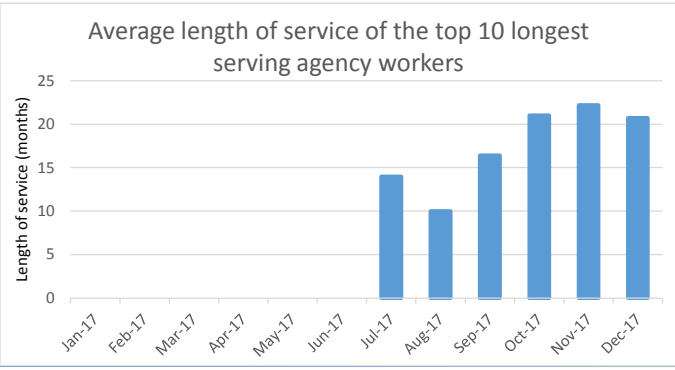
Workforce

	Description	Aggregate Position	Trend	Variation
Clinical Training Red: Below 70% Amber: 70% to 85% Green: Above 85%	A summary of the Clinical Mandatory Training Compliance, this includes: Infection Control Resus Safeguarding Procedures (Adults) - Level 1 Safeguarding Procedures (Adults) - Level 2 Safeguarding Procedures (Children) - Level 1 Safeguarding Procedures (Children) - Level 2 Safeguarding Procedures (Children) - Level 3 SEMA	The upward trend continues and the compliance rate for June is 87.87% which is above the trust target of 85%.		The Trust is pleased to maintain the achievement of this target which has been very consistent over the last 3 months.
PDR Red: Below 70% Amber: 70% to 85% Green: Above 85%	A summary of the PDR Compliance rate	PDR compliance remains below target at 74%		PDR Compliance has dipped in December 2017. Both clinical divisions decreased compliance rates, likely to be due to operational pressures. Corporate Services increase to over 85% compliance.
Average cost of the top 10 highest cost Agency Workers Red: Greater than previous month Green: Less than	Average cost of the top 10 highest cost agency workers	The average cost of the top 10 highest cost agency workers reduced to £24k in December 2017		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 Workforce meeting and to FSC monthly. Plans are in place to reduce spend in relation to each worker.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - December 2017

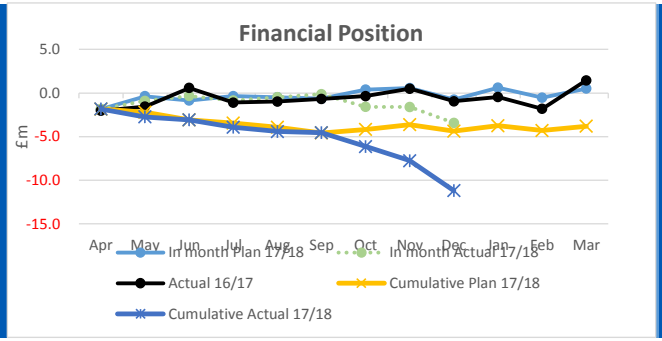
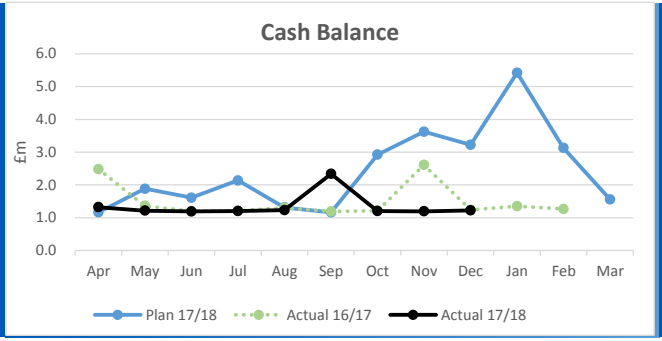
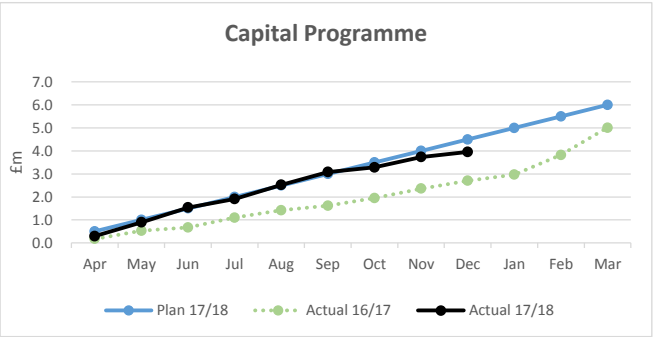
Workforce

	Description	Aggregate Position	Trend	Variation
Average length of service of the top 10 longest serving agency workers Red: Greater than previous month	**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 reduced to 21 months in December 2017**		**Of the 10 workers, 2 are within the Medical and Dental staff group, 1 is an AHP and the remaining are within the Nursing staff group.**

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - December 2017

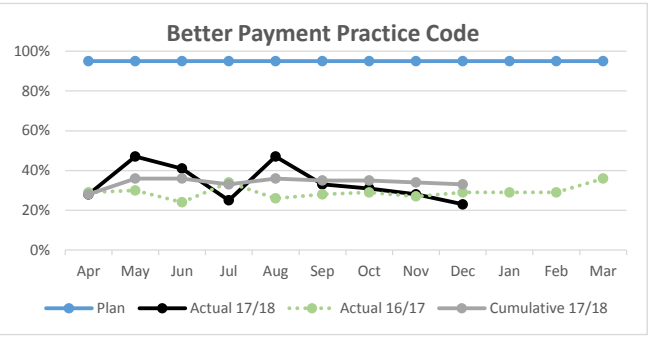
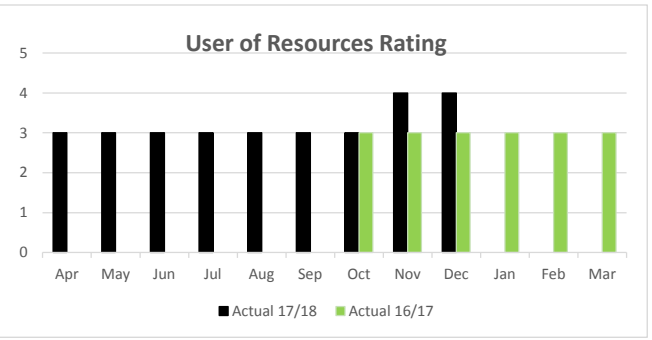
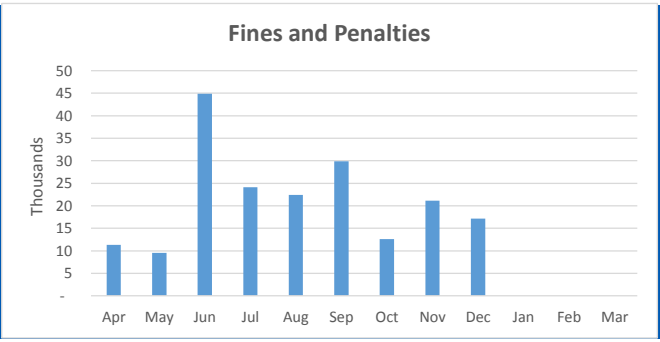
Sustainability & Mandatory Standards - Finance

	Description	Aggregate Position	Trend	Variation
Financial Position Red: Deficit Position Amber: Actual on or better than planned but still in deficit Green: Surplus	Surplus or deficit compared to plan	The actual deficit in the month is £3.4m which increases the cumulative deficit to £11.2m.		The cumulative deficit of £11.2m is £6.8m worse than plan. The Trust has updated the forecast outturn which is a gross deficit of £19.0m before mitigations and £16.0m after mitigations. A deficit of £16.0m is £12.3m worse than the £3.7m deficit control total.
Cash Balance Red: Less than 90% or below minimum cash balance per NHSI Amber: Between 90% and 100% of planned cash balance Green: On or better than plan	Cash balance at month end compared to plan (excluding cash relating to the hosting of the Sustainability and Transformation Partnership).	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 £2.0m below the planned cash balance of £3.2m but the balance of £1.2m at month end is required to comply with the terms and conditions of the working capital loan. In order to meet its financial obligations and maintain a minimum cash balance the Trust is reliant on additional working capital loans.
Capital Programme Red: Off plan <80% - >110% Amber: Off plan 80-90% or 101 - 110% Green: On plan 90%-100%	Capital expenditure compared to plan (The capital plan has been increased to £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 £4.0m.		The cumulative capital spend of £4.0m is £1.6m below the planned capital spend of £5.6m. The forecast spend for the year is £6.5m which is £0.8m below the planned spend.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - December 2017

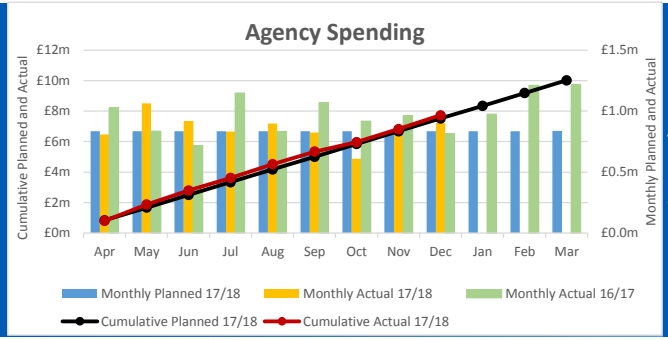
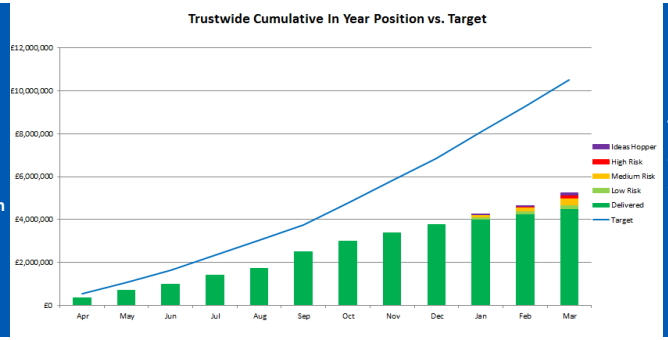
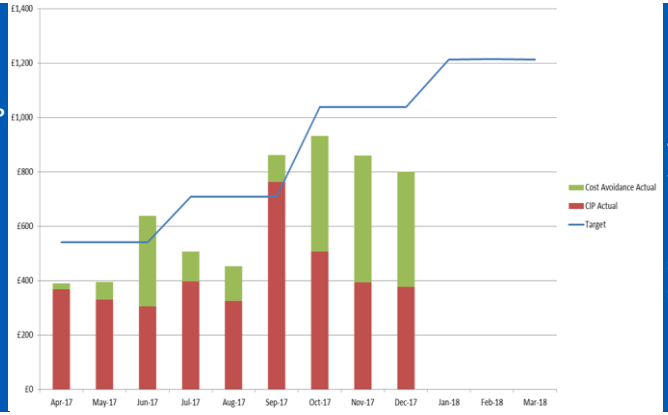
Sustainability & Mandatory Standards - Finance

	Description	Aggregate Position	Trend	Variation
Better Payment Practice Code Red: Cumulative performance below 85% Amber: Cumulative performance between 85% and 95% Green: Cumulative performance 95% or	Payment of non NHS trade invoices within 30 days of invoice date compared to target.	In month the Trust has paid 23% of suppliers within 30 days which results in a year to date performance of 33%.		The cumulative performance of 33% is 62% 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 Red: Use of Resource Rating 4 Amber: Use of Resource Rating 3 Green: Use of Resource Rating 1 and 2	Use of Resources Rating compared to plan.	The current Use of Resources Rating is 4. Capital Servicing Capacity, Liquidity, I&E margin and I&E margin (distance from financial plan) are scored at 4 whilst Agency Ceiling is scored at 2.		The current Use of Resources Rating of 4 is below the planned rating of 3.
Fines and Penalties Red: Greater than zero Green: Zero	Monthly fines and penalties	Fines and Penalties levied by the CCG as outlined in the Contract.		During December 2017, the Trust received a penalty of £5k for discharge summaries, and £12k for penalties relating to potential non delivery of CQUIN.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Integrated Dashboard - December 2017

Sustainability & Mandatory Standards - Finance

	Description	Aggregate Position	Trend	Variation
Agency Spending Red: More than 105% of ceiling Amber: Over 100% but below 105% of ceiling Green: Equal to or less than agency ceiling.	Agency spend compared to agency ceiling	The actual agency spend in the month is £0.9m which increases the cumulative spend to £7.7m.		The cumulative agency spend of £7.7m is £0.2m (3%) above the cumulative agency ceiling of £7.5m.
Cost Improvement Programme - In year performance to date Red: 0-70% Plan delivered YTD Amber: 70-90% Plan delivered YTD Green: >90% Plan delivered YTD	Cost savings delivered year to date compared to year to date plan.	CIP savings delivered in M9 are £0.4m against the M9 target of £1m, a further £0.4m was delivered in cost avoidance. The YTD M9 position for CIP is £3.8m against a YTD plan of £6.9m with a further £2.1m YTD M9 delivered in cost avoidance / income recovery.		The financial impact of transformation activities YTD M9 was £5.8m (£3.8m CIP & £2.1m cost avoidance) this is £1m below the Trust M9 CIP target of £6.9m.
Cost Improvement Programme - Plans in Progress - In Year/Recurrent Red: Forecast is less than 50% of annual target Amber: Forecast is between 50% and 90% of the annual target Green: Forecast is more than 90% of the annual target	Planned improvements in productivity and efficiency - In Year & Recurrent forecast vs £10.5m target	In Year - The best case forecast for Trust CIP schemes in year is £5.2m. Best case assumes full delivery of all schemes on the tracker including all hopper ideas. The best case forecast for recurrent CIP is around £5.7m which leaves a gap of £4.8m against the CIP target.		The best case for CIP in year is £5.2m which is still £5.2m below the CIP target. Best case cost avoidance of £3.5m will help mitigate the position but would still leave a bottom line shortfall of £1.7m.

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

Appendix 3 **FINANCE AND SUSTAINABILITY COMMITTEE**

AGENDA REFERENCE:	**FSC/**
SUBJECT:	**Finance and Procurement Report as at 31 December 2017**
DATE OF MEETING:	24 January 2018
ACTION REQUIRED	**For discussion**
AUTHOR(S):	Steve Barrow, Deputy Director of Finance
EXECUTIVE DIRECTOR	Andrea McGee, Director of Finance and Commercial Development
EXECUTIVE SUMMARY	For the period ending 31 December 2017 the key financial headlines are: • Monthly deficit of £3.4m (£2.7m worse than plan). • Year to date deficit of £11.2m (£6.8m worse than plan). • Cash balance of £1.2m • Use of Resources Rating of 4.
RECOMMENDATIONS	The Finance and Sustainability Committee is asked to: • Note the contents of the report. • Note the changes to the 2017/18 capital programme. • Approve the approach for the submission of the forecast outturn. • Note the approach for construction of the 2018/19 capital programme.
FREEDOM OF INFORMATION STATUS (FOIA):	Partial FOIA Exempt
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Section 41 – confidentiality

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

FINANCE AND PROCUREMENT REPORT AS AT 31 DECEMBER 2017

1. PURPOSE

This report sets out the financial position of the Trust as at 31 December 2017.

Resulting from feedback from the Well Led Review the report format has been updated to incorporate an expanded dashboard that includes both financial and procurement metrics and performance to provide a more focused report.

2. EXECUTIVE SUMMARY

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

With effect from 18th September 2017 the Trust took over the hosting arrangements for the Cheshire & Merseyside Sustainability and Transformation Partnership (STP). This has resulted in a £1.7m transfer of funds from Alder Hey Foundation Trust to meet future commitments. The cash balance relating to the STP is not included in this report or the finance dashboard. This is because the cash does not belong to the Trust and is excluded from the minimum cash balance requirements specified in the working capital loan terms and conditions.

Key financial indicators:

Indicator	Monthly Plan £m	Monthly Actual £m	Monthly Variance £m	YTD Plan £m	YTD Actual £m	YTD Variance £m
Operating income	19.0	17.9	(1.1)	174.7	173.9	(0.8)
Operating expenses	(19.5)	(21.1)	(1.6)	(176.3)	(182.7)	(6.4)
Operating surplus/(deficit)	(0.5)	(3.1)	(2.7)	(1.6)	(8.8)	(7.2)
Non-operating expenses	(0.3)	(0.3)	0.0	(2.8)	(2.4)	0.4
Surplus/(deficit)	(0.8)	(3.4)	(2.7)	(4.4)	(11.2)	(6.8)
Control total adjustments	0.0	0.0	0.0	0.1	0.1	0.0
Control total	(0.8)	(3.4)	(2.7)	(4.3)	(11.1)	(6.8)
Cash balance	-	-	-	3.2	1.2	(2.0)
CIP target	1.1	0.4	(0.7)	6.9	3.8	(3.1)
Capital Expenditure	(0.6)	(0.2)	4.0	(5.6)	(4.0)	1.6

Key financial headlines:

- The monthly position is a deficit of £3.4m which increases the year to date deficit to £11.2m (£6.8m worse than plan) and delivers a Use of Resources Rating score of 4. To achieve a score of 3 in February the financial position would have needed to be £3.4m better (ie maximum deficit of £7.8m) or the agency spend would have needed to be £0.2m less.
- The suspension of spinal services has significantly impacted on the financial position (£0.3m income reduction in the month and £0.8m year to date) and is a risk to the delivery of the total control. The Trust will be charged for any premium commissioners need to pay for service delivery with alternative providers plus any other costs such as legal fees. An

additional accrual of £0.2m for this expenditure has been included in the financial position. October to December STF monies (£2.1m) are not included in the financial position as the Trust has not delivered the financial plan during Quarter 3. Therefore the overall year to date impact of spinal and unclaimed STF monies equates to £3.1m.

- The annual cost savings target is £10.5m with planned savings to date of £6.9m. The actual savings delivered to date is £3.7m which is a shortfall of £3.2m (see agenda item Cost Improvement Report for further details).
- The annual capital programme has increased to £7.3m with planned spend to date of £5.6m. The actual expenditure to date is £4.0m.
- The cash balance is £1.2m which is in line with the balance required under the terms and conditions of the working capital loan agreement.
- The Better Payment Practice Code performance based on volume is 23% for the month and 33% for the year to date.
- The value of aged debt is £2.3m.
- The value of aged creditors is £14.8m.
- The Trust has secured or requested a number of working capital loans in the current year:
    - A £3.7m loan has been secured to support the 2017/18 planned deficit and to date £3.1m has been drawn down.
    - A £2.3m loan has been secured to support the payment of aged creditors which will be drawn down in January 2018.
    - A £4.1m loan has been requested to support the variance from the planned deficit as at 30th November 2018 and confirmation of the approval is awaited from NHSI and the Department of Health.
    - The Trust has received 2017/18 Q2 STF monies in December 2017 so the repayment of the working capital loan drawn down to support the delay in the receipt of the monies will be made in February 2018 (see section 4).
- The value of the 2017/18 interest associated with both the capital and working capital loans is £0.4m (see section 4).

3. 2017/18 CAPITAL PROGRAMME

The capital budget for the year including contingency is £7.3m. Emergency repairs to the kitchen roof at Warrington Hospital are required for health and safety reasons. The cost of this is covered by reducing the funding required for site lift repairs. The changes to the programme are summarised in the table below.

Table: changes to the 2017/18 capital programme.

Scheme	**Value £000**
Additional funding required	
Kitchen Roof Repair (Warrington)	41
Total	**41**
Funded by	
Lift Repairs	(72)
Total	**(72)**
Balance to contingency	31
Net impact	**0**

A revised capital programme is attached at Appendix K which shows that the contingency has reduced from the approved £0.4m at the start of the year to £0.1m.

The forecast spend for the year is £6.5m which is £0.8m below the budget of £7.3m.

4. LOANS

The operating position continues to have an adverse effect on the cash availability and therefore working capital loans are required to support liquidity.

In 2015/16 the Trust secured a working capital loan of £14.2m to cover the planned deficit. The loan term was three years and is repayable in full in 2018/19. The current and forecast operating position of the Trust means that no additional cash will be generated so the loan will not be able to be repaid on the due date. The Trust is in discussions with NHSI on the options available and it is likely that another working capital loan will be required.

In 2106/17 the Trust secured a working capital loan of £7.9m to cover the planned deficit. The loan term was three years and is repayable in full in 2019/20.

The Trust has secured a £3.7m working capital loan to support the 2017/18 planned deficit. The first instalment of £1.6m was received in April, the second instalment of £1.5m was received in September and the final instalment of £0.6m is planned for March. These loans attract a rate of 1.5%.

The Trust received 2017/18 Q1 STF monies of £1.1m in September and Q2 STF monies of £1.4m in December. The repayment of the working capital loan in support of the delay of Q2 STF monies will take place in February 2018.

The Trust has secured a working capital loan of £2.3m to support aged creditors and this will be drawn down in January 2018. This loan attracts an interest rate of 1.5%.

The deterioration in the financial position together with the variance between the annual planned control total and forecast outturn meant the Trust needed to apply for an additional loan to cover the cash gap resulting from the increased deficit. The Trust Board approved an application for a £4.1m working capital loan at the Trust Board meeting on 20th December 2017. The Trust is awaiting confirmation of the loan application from NHS Improvement and the Department of Health and if approved the monies would be received in February 2018.

The interest resulting from the working capital and capital loans are included within the financial position as a non operating expense. The outstanding loan value and 2017/18 forecast interest charges for agreed loans as at 31st December 2017 is summarised in the table below.

Table: Outstanding loan value and 2017/18 forecast interest charges (full year)

Narrative	Loan Value £k	Interest Rate	Interest Charge £k
2015/16 Capital Loan	1,440	1.78%	26
2015/16 Working Capital Loan to cover deficit	14,200	1.50%	208
2016/17 Working Capital Loan to cover deficit	7,918	1.50%	119
2016/17 Working Capital Loan to cover Q4 STF (1)	0	1.50%	12
2017/18 Working Capital Loan to cover deficit	3,657	1.50%	37
2017/18 Working Capital Loan to cover Q1 STF (2)	0	1.50%	1
2017/18 Working Capital Loan to cover Q2 STF (3)	1,406	1.50%	6
Total	**28,621**		**425**

(1) Repaid August 2017.
(2) Repaid October 2017.
(3) To be repaid February 2018.

The cumulative value of working capital loans covering the period 2015/16 to 2017/18 equates to £27.2m.

5. 2017/18 FORECAST OUTTURN

The forecast outturn will be presented under a separate agenda item.

NHSI has introduced a protocol for adverse changes to an in year forecast which includes the submission of Board Assurance Statement signed by the Chair, Chief Executive, Audit Committee Chair and the Director of Finance (attached at Appendix L).

The risk to delivery of the control total and the impact on cash has been presented and debated at each Finance and Sustainability Committee and Trust Board from month 3. The deterioration of the financial position over the last three months and the uncertainty of the mitigating actions necessary to deliver the financial plan, means there is a significant risk that the Trust will not achieve the planned deficit

The Trust has been in discussions with the NHSI Regional Team regarding the submission of the 2017/18 forecast outturn from month 3 and has kept the regulator very closely sighted on the financial risks. NHSI has advised that for the monthly monitoring return as at 31 December 2017 (submitted 16th January 2018) the Trust does not change the forecast from the current control total. This is due to the number of significant issues that will have an impact on the forecast. These issues need to be resolved as far as possible by the submission date of 15 February 2018 to provide a robust assessment of the forecast year end position. Given the current variance from plan and issues set out below it is recommended that the Trust will submit a revised forecast at month 10 that will include an assessment of the deliverability of the risks and mitigating actions.

Issues that remain unresolved that will have a significant impact on the forecast and actual outturn position include:

- Cost of additional winter activity and receipt of winter monies.
- Payment of all activity in full from commissioners (including sepsis coding and agreement of non elective marginal rate)
- Cancellation of elective activity to deal with winter pressures.
- Impact of cessation of spinal activity and additional costs.
- Impact of additional cost reduction schemes.

In order to comply with NHSI reporting requirements and protocol the forecast outturn discussed under a separate agenda item will form the basis of the month 10 forecast outturn submission which will be presented to Trust Board on 31 January 2018.

6. CHESHIRE AND MERSEYSIDE FINANCIAL POSITION

The current financial position across the Cheshire and Merseyside economy is also extremely challenging and based on the latest available information the variance to plan at month 8 and the forecast outturn is summarised in the table below:

Narrative	Month 8 Surplus/(Deficit) £m	Forecast Outturn Surplus/(Deficit) £m
Plan	(50.4)	(52.9)
Actual	(121.9)	(73.9)
Variance	**(71.5)**	**(21.0)**

Further analysis by both commissioning and provider organisations is detailed in Appendix M.

7. 2018/19 CAPITAL PROGRAMME

The exercise to construct and recommend the 2018/19 capital programme to the Finance and Sustainability Committee is led by the Capital Planning Group. The operating performance of the Trust means that capital resources are extremely limited so it is important that the capital planning process is robust and transparent so that funding is allocated to those capital schemes scoring highest in terms of priority.

There are a number of schemes that are allocated funding and not subject to the assessment, these include:

- Schemes pre-approved in 2017/18 and carried forward to 2018/19
- Schemes approved by the Board
- Schemes mandated by statute / legislation

The approach adopted for all other schemes involved the completion of a prioritisation template that allocated a weighted score across a range of factors, namely:

- Recommended by statute / legislation
- Clinical and non clinical safety
- Business continuity, growth and invest to save

- Quality
- Experience

The value of the schemes resulting from the exercise total £17.9m as summarised in the table below:

Narrative	**£m**
Schemes pre-approved in 2017/18	1.6
Schemes approved by the Board	0.3
Schemes mandated by statute / legislation	1.3
Sub total	**3.2**
Estates schemes	4.2
IM&T schemes	4.1
Medical Equipment schemes	6.3
Total	**17.6**

The 2018/19 capital budget including the funding for schemes carried forward from 2017/18 is circa £7.0m so there is only £3.8m available to fund those schemes subject to the prioritisation exercise which currently total £14.6m.

The next Capital Planning Group is scheduled for 26th January 2018 and at this meeting members will review and recommend those schemes to be funded which will be presented to the February Finance and Sustainability Committee and Trust Board for approval.

It is important that all schemes not funded are subject to a risk assessment exercise by scheme leads to ensure that all risks are managed and mitigated.

8. CONCLUSION

The year to date deficit is £11.2m (£6.8m behind plan), of which £2.1m relates to potential non achievement of STF and £1.0m relates to the spinal suspension. Under achievement of CIP year to date is £3.1m. Given the deterioration from plan, NHSI has recommended that the Trust formally updates the forecast outturn position at month 10.

9. RECOMMENDATION

The Finance and Sustainability Committee is asked to:

- Note the contents of the report.
- Note the changes to the 2017/18 capital programme.
- Approve the approach for the submission of the forecast outturn.
- Note the approach for construction of the 2018/19 capital programme.

Andrea McGee
Director of Finance & Commercial Development

Warrington & Halton Hospitals NHS Foundation Trust

Income Statement, Activity Summary and Use of Resources Ratings as at 31st December 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	2,519	2,595	76	27,133	25,413	-1,721
Elective Excess Bed Days	12	6	-6	117	111	-6
Non Elective Spells	5,342	4,845	-497	44,609	45,638	1,029
Non Elective Excess Bed Days	198	148	-50	1,650	1,449	-201
Outpatient Attendances	2,344	2,432	88	25,247	24,769	-479
Accident & Emergency Attendances	1,046	1,113	67	9,830	9,888	58
Other Activity	5,237	4,957	-280	47,186	48,355	1,169
Sub total	**16,697**	**16,096**	**-601**	**155,772**	**155,622**	**-150**
Non NHS Clinical Income						
Private Patients	9	7	-2	81	91	10
Other non protected	107	104	-3	963	824	-139
Sub total	**116**	**111**	**-5**	**1,044**	**915**	**-129**
Other Operating Income						
Training & Education	641	640	-1	5,769	5,769	0
Donations and Grants	0	0	0	0	32	32
Sustainability & Transformation Fund	703	0	-703	4,569	2,460	-2,109
Miscellaneous Income	848	1,104	256	7,509	9,085	1,576
Sub total	**2,192**	**1,745**	**-447**	**17,847**	**17,346**	**-501**
Total Operating Income	**19,005**	**17,951**	**-1,054**	**174,663**	**173,883**	**-780**
Operating Expenses						
Employee Benefit Expenses	-13,679	-14,657	-978	-123,631	-128,699	-5,068
Drugs	-1,438	-1,342	96	-12,984	-12,440	544
Clinical Supplies and Services	-1,500	-1,919	-419	-13,830	-15,391	-1,561
Non Clinical Supplies	-2,375	-2,742	-367	-21,674	-22,068	-394
Depreciation and Amortisation	-463	-442	21	-4,167	-4,068	99
Restructuring Costs	0	0	0	0	-39	-39
Total Operating Expenses	**-19,455**	**-21,103**	**-1,647**	**-176,286**	**-182,705**	**-6,419**
Operating Surplus / (Deficit)	**-450**	**-3,151**	**-2,701**	**-1,624**	**-8,822**	**-7,199**
Non Operating Income and Expenses						
Profit / (Loss) on disposal of assets	0	0	0	0	0	0
Interest Income	2	6	4	18	17	-1
Interest Expenses	-37	-52	-15	-316	-365	-49
PDC Dividends	-273	-223	50	-2,456	-2,005	451
Impairments	0	0	0	0	0	0
Total Non Operating Income and Expenses	**-308**	**-269**	**39**	**-2,754**	**-2,353**	**401**
Surplus / (Deficit)	**-758**	**-3,420**	**-2,662**	**-4,378**	**-11,175**	**-6,798**
Depreciation on Donated and Granted Assets	12	13	1	108	111	3
Control Total	**-746**	**-3,408**	**-2,662**	**-4,270**	**-11,064**	**-6,794**
Activity Summary	**Planned**	**Actual**	**Variance**	**Planned**	**Actual**	**Variance**
Elective Spells	2,661	2,684	23	29,853	26,731	-3,122
Elective Excess Bed Days	55	23	-32	550	450	-100
Non Elective Spells	3,540	2,834	-706	29,565	27,542	-2,023
Non Elective Excess Bed Days	944	596	-348	7,887	5,953	-1,934
Outpatient Attendances	22,808	22,905	97	245,657	237,860	-7,797
Accident & Emergency Attendances	8,459	9,329	870	79,523	85,712	6,189
Use of Resources Ratings	**Planned Metric**	**Actual Metric**	**Variance Metric**	**Planned Metric**	**Actual Metric**	**Variance Metric**
Metrics						
Capital Servicing Capacity (Times)				0.91	-0.63	-1.54
Liquidity Ratio (Days)				-50.4	-46.2	4.2
I&E Margin (%)				-2.44%	-6.36%	-3.92%
Variance from control total (%)				0.00%	-3.92%	-3.92%
Agency Ceiling (%)				0.00%	2.75%	2.75%
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	4	3
Agency Ceiling (%)				1	2	1
Use of Resources Rating				**3**	**4**	**0**

Warrington and Halton Hospitals NHS Foundation Trust

Cash Flow Statement For 2017/18

	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Forecast	Forecast	Forecast	Annual
	April £000's	May £000's	June £000's	July £000's	August £000's	September £000's	October £000's	November £000's	December £000's	January £000's	February £000's	March £000's	Position £000's
CASH FLOW FROM OPERATING ACTIVITES													
Operating Surplus/(deficit)	**(1,535)**	**(586)**	**(30)**	**(551)**	**(424)**	**106**	**(1,304)**	**(1,346)**	**(3,151)**	**929**	**(237)**	**8,006**	**(123)**
Non-cash income and expense	463	463	381	475	445	447	487	465	442	462	462	560	5,552
Operating cash flows before movement in working capital	**(1,072)**	**(123)**	**351**	**(76)**	**21**	**553**	**(817)**	**(881)**	**(2,709)**	**1,391**	**225**	**8,566**	**5,429**
(Increase)/decrease in working capital	1,911	657	306	497	1,495	1,002	961	1,855	2,321	3,118	(2,047)	(6,732)	**5,344**
Net cash generated from/(used in) operations	**839**	**534**	**657**	**421**	**1,516**	**1,555**	**144**	**974**	**(388)**	**4,509**	**(1,822)**	**1,834**	**10,773**
CASH FLOW FROM INVESTING ACTIVITIES													
Interest received	1	2	1	1	2	1	1	2	6	2	4	3	**26**
Purchase of property, plant and equipment and investment property	(291)	(604)	(645)	(368)	(623)	(552)	(206)	(446)	(218)	(463)	(463)	(2,121)	**(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)**	**(444)**	**(212)**	**(461)**	**(459)**	**(2,118)**	**(6,974)**
CASH FLOW FROM FINANCING ACTIVITIES													
Public dividend capital received	-	-	-	-	166	183	68	109	229	80	80	85	**1,000**
Public dividend capital repaid	-	-	-	-	-	-	-	-	-	-	-	-	**-**
Loans from DH - received	1,603	-	-	-	1,054	1,503	-	1,046	360	-	-	551	**6,117**
Loans from DH - repaid	(2,000)	-	-	-	(2,053)	-	(1,054)	-	-	(1,406)	(53)	-	**(6,566)**
Other loans received	-	-	-	-	-	-	-	-	-	-	-	-	**-**
Other loan repaid	-	-	-	-	-	-	-	-	-	-	-	-	**-**
Other capital receipts	-	-	-	-	-	-	-	-	-	-	-	-	**-**
Capital element of finance lease rental payments	-	-	-	-	-	(172)	(29)	(47)	-	-	-	-	**(248)**
Interest paid	(30)	(33)	(36)	(37)	(36)	(30)	(45)	(41)	(48)	(31)	(33)	(31)	**(431)**
Interest elements of finance leases	(3)	(4)	(3)	(2)	(3)	(3)	(3)	(3)	(4)	(4)	(4)	(6)	**(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)**	**1,064**	**537**	**(1,361)**	**(10)**	**(1,289)**	**(3,445)**
Increase/(decrease) in cash and cash equivalents	**119**	**(105)**	**(26)**	**15**	**23**	**1,111**	**(1,137)**	**1,594**	**(63)**	**2,687**	**(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	2,795	2,732	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**	**2,795**	**2,732**	**5,419**	**3,128**	**1,555**	**1,555**
Memorandum line:													
Less STF Cash								**(1,601)**	**(1,509)**				
Trust Cash Balance								**1,194**	**1,223**				
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	2,795	2,732	5,419	3,128	1,555	**1,555**
Variance	**160**	**(666)**	**(420)**	**(931)**	**(86)**	**1,178**	**(1,723)**	**(825)**	**(487)**	**-**	**-**	**-**	**-**

Warrington and Halton Hospitals NHS Foundation Trust

Statement of Financial Position as at 31st December 2017

Narrative	Audited Position as at 31/03/17 £000	Actual Position as at 30/11/17 £000	Actual Position as at 31/12/17 £000	Monthly Movement £000	Forecast Position as at 31/03/18 £000
NON-CURRENT ASSETS					
Intangible Assets	2,308	2,501	2,537	36	1,047
Property, Plant and Equipment	117,890	117,804	117,543	(261)	124,091
Trade and Other Receivables, non-current	991	878	900	22	1,205
Total Non-Current Assets	**121,189**	**121,183**	**120,980**	**(203)**	**126,343**
CURRENT ASSETS					
Inventories	3,437	3,410	3,428	18	3,312
Trade and Other Receivables, current	13,163	11,741	8,812	(2,929)	8,398
Cash and Cash Equivalents	1,201	2,795	2,732	(63)	1,555
Total Current Assets	**17,801**	**17,946**	**14,972**	**(2,974)**	**13,265**
Total Assets	**138,990**	**139,129**	**135,952**	**(3,177)**	**139,608**
CURRENT LIABILITIES					
Trade and Other Payables	(16,405)	(23,657)	(24,012)	(355)	(22,824)
Other Liabilities	(4,070)	(4,428)	(3,684)	744	(3,880)
Borrowings, current	(454)	(13,751)	(14,111)	(360)	(14,491)
Provisions	(279)	(238)	(273)	(35)	(256)
Total Current Liabilities	**(21,208)**	**(42,074)**	**(42,080)**	**(6)**	**(41,451)**
TOTAL ASSETS LESS CURRENT LIABILITIES	**117,782**	**97,055**	**93,872**	**(3,183)**	**98,157**
NON-CURRENT LIABILITIES					
Borrowings, non-current	(28,152)	(14,705)	(14,707)	(2)	(13,562)
Provisions	(1,377)	(1,329)	(1,335)	(6)	(1,198)
Total Non Current Liabilities	**(29,529)**	**(16,034)**	**(16,042)**	**(8)**	**(14,760)**
TOTAL ASSETS EMPLOYED	**88,253**	**81,021**	**77,830**	**(3,191)**	**83,397**
TAXPAYERS' EQUITY					
Public dividend capital	87,742	88,268	88,497	229	88,742
Income and expenditure reserve	(21,967)	(29,725)	(33,145)	(3,420)	(27,823)
Revaluation Reserve	22,478	22,478	22,478	0	22,478
TOTAL TAXPAYERS' EQUITY	**88,253**	**81,021**	**77,830**	**(3,191)**	**83,397**

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NHS Warrington and Halton Hospitals NHS Foundation Trust

BOARD OF DIRECTORS CHAIR'S KEY ISSUES REPORT

AGENDA REFERENCE:	BM 18 01 07 b i	COMMITTEE OR GROUP:	Quality Assurance Committee	DATE OF MEETING	31st January 2018

Date of Meeting	5th December 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
	Matters Arising / Action Log QC/17/11/227 – Controlled Drugs	Update that work commenced regarding a deep dive of controlled drug incidents, which will report to December PSESC	**Committee agreed it should be brought to the Q&A Committee in January and if necessary the Trust Board**	**Q&A Committee Jan 2018**
	Serious Incidents Monthly Report	KSJ highlighted key points within the report for the Committee to note since the previous report: • In November 2017 the Trust has identified and reported 2 serious incidents for investigation. Both were reported within the 48 hour timeframe of them being identified; • As at 27/11/2017 the Trust has 25 serious incident investigations open and 4 have an agreed extension; • Falls incidents account for the highest number of SI investigations since April 2016, but there have been no	**It was noted that the Committee was not assured in relation to staffing levels.**	**Q&A Committee Jan 2018**

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		falls related to SIs reported since August - 27th November; • A review of SIs investigations within A3 will be undertaken; • Specialist Medicine and Urgent and Emergency Care account for the highest number of SI investigations over this period which was to be expected. • Duty of Candour for SI investigations is being closely monitored and further training will be delivered; • The Coroner has requested an update of actions by 8th January 2018, related to a concluded inquest involving an SI investigation and patient fall. This will be provided by Acute Services; and • The Incident Reporting & Investigation Policy including Serious Incident Framework & Duty of Candour has now been approved.		
	Patient Safety + Clinical Effectiveness Committee	AC reviewed his report and the following were amongst the issues escalated to the Committee: • Issues were identified as part of the Quality Dashboard relating to VTE reporting and RCA. Deputy Director of Integrated Governance & Quality is meeting with the VTE Leads in November to clarify the approach to identifying patient cohorts and undertaking RCAs • Risk Update report - identified a new risk scoring 16 related to the voluntary suspension of Spinal Services. Assurance was sought around the scoring on the risk	**It was noted that the Committee was not assured in relation to staffing levels.**	**Q&A Committee Jan 2018**

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		related to: ➢ Administration of blood – it was noted that the audit related to transfusion training was about to complete. ➢ Compliance with VTE policy and procedures. ➢ Failure to prevent harm to patients, caused by lack of timely and quality discharge Review required of paediatrics urgent and emergency care due to escalated staffing issues - Committee were advised by the Associate Director of Nursing Acute Care Services that the Consultant Nurse for A&E has developed a paediatric integration plan to address this and it would be forwarded following the meeting.		
	Health & Safety Sub-Committee	KSJ reviewed her report escalating several items to the committee. The following items was noted as providing a lack of assurance: • A sharps report was presented to the group to give a position statement on the management of sharps. It was noted that current processes are not being followed throughout both Divisions. The Safer Sharps Group was reinstated in August 17 but the attendance at the meeting is poor. There is not representative from either Division. • A comprehensive report was presented around medical devices. This highlighted gaps in training of equipment and not knowing if staff are competent in	**The report was noted along with lack of assurance in relation to sharps and medical devices.**	**Q&A Committee Jan 2018**

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		using the equipment. The Trust has in place a system which could potentially be set up as a competency based training programme. The Medical Device Officer is going to be piloting this system across Maternity throughout November 17. • A further concern related to medical devices was that Ward Managers, Nursing Staff invite Reps to the Department to trial devices and then the devices are purchased without going through the Procurement Procedure.		
	Quality Dashboard	Overviews were provided from Surgery and Woman & Children and Acute Care. Several areas were highlighted and discussed; however, a lack of assurance was noted in relation to the following: • Nice Compliance - NICE guidance is monitored through all governance processes and supported by Divisional Governance managers, Governance Leads and Clinical Effectiveness team. NICE compliance is being reported through CBU and Divisional meetings with an action plan for all CBUs. • Mixed Sex Accommodation - There is an ongoing piece of work with the Patient Flow team to develop a robust escalation process. Level 1 patients are discussed at every Bed Meeting and through e-mail alerts to the relevant teams, plans made wherever possible for timely discharge. When this is not possible it is escalated.	**The report was noted along with lack of assurance in relation to NICE, dementia and mixed sex accommodation.**	**Q&A Committee Jan 2018**

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		• Dementia Screening - There has been a recognised drop in Dementia screening in October. This drop was recognised and there is now an alert from Cognitive Assessment Team sent to Matrons of the area, to address any inpatients and outpatients who have not been screened.		
	Information Governance & Corporate Records	KF provided an overview and highlighted the following: • Data Protection Officer for GDPR compliance needs to be identified. This has been referred to the Trust Board. • Potential gaps in compliance for IG assurance audit 2017/18 are IT system audit capability evidence and completion of assessments against NICE guidelines 12&13. This has been escalated to Deputy Chief Nurse with a view to Patient Experience Lead completing when appointed. KF confirmed that actions following CQC were being picked up in the IM&T steering group and that training requirements for GDPR would help with satisfying the requirements.	**The Committee noted the report and it was agreed for KF to bring IM&T Action plan to the next meeting.**	**Q&A Committee Jan 2018**

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BOARD OF DIRECTORS CHAIR'S KEY ISSUES REPORT

AGENDA REFERENCE:	BM 18 01 07 b ii	COMMITTEE OR GROUP:	Quality Assurance Committee	DATE OF MEETING	31st January 2018

Date of Meeting	9 January 2018
Name of Meeting + Chair	Quality Assurance Committee Chaired by Margaret Bamforth
Was the meeting quorate?	Yes

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/ mandate to receiving body	Follow up/ Review date
	QC/18/01/05 Serious Incidents Report	Current review being undertaken in relation to perioperative deaths, which will feedback into the Patient Safety Meeting and will also be shared externally. Reviewing the last three years of perioperative deaths which accounts for approximately 50 deaths.	**Review will feedback through Patient Safety and Clinical Effectiveness**	**PSCEC April 2018**
	QC/18/01/07 Patient Safety and Clinical Effectiveness Sub Committee High Level Briefing	Escalation routes were noted in relation to Still Birth & Pathology and the continuing need for assurance relating to both areas. Still Birth concerns will be taken to Patient Safety Committee Group in January 2018 and Pathology are to produce a key issues report and action plan to be presented to the March 2018 Patient Safety Committee.	**Concerns relating to both to be review in future PSCECs**	**Still Births – Jan PSCEC Pathology – March PSCEC**

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	QC/18/01/09 Complaints Quality Assurance Group High Level Briefing	Items escalated to the committee were as follows: • Target of 75 open complaints • 92 open complaints (as at time of writing paper) • 86 as of today with 22 over 100 days old. Levels of complaints are improving but the target was not achieved due to increased numbers of complaints, operational pressures in some areas and also some vacancies in senior posts.	**An update on the position to be reviewed in Quality Assurance Committee in March 2018**	**QA Committee March 2018**
	QC/18/01/11 Safeguarding Action Plan Update	Significant progress was noted in relation to actions for the Safeguarding Action Plan. There were 43 actions to address but now there only remain 3 outstanding actions.	**Safeguarding Committee will review the full plan and raise any issues to this committee as appropriate.**	**QA Committee March 2018**
	QC/18/01/12 Quality Dashboard	It was noted that surgery have a high number of incidents open, issues in relation to patient falls may now be readdressed as C22 has moved on to what was A4 and there is now a better route for patients. It was also noted that the Trust in the process of recruiting a Dementia Consultant and the acute team are working closely with the Infection Control team to minimise spread of infection. Current situation of full capacity in the hospital was discussed along with IMPACT 5 week (Monday 8th January – Friday 12th January 2018). It was also highlighted that there is a safety thermometer and a governance weekly report being provided	**The report was noted along with a request for the weekly Governance Report to be shared with NEDs.**	**QA Committee March 2018**

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		by UM. MB notes that appropriate processes appear to be in place accordingly with assurance given to the hospital acting safely whilst at full capacity. Request from MB for the governance weekly report to be shared with the NED's weekly report.		
	QC/18/01/13 Terms of Reference for Final Approval	Updated terms of Reference were reviewed which included revisions in committee reporting and the inclusion of the opportunity for the committee to request and oversee "deep dive reviews" into particular areas.	**Amendments requested to required attendees**	**QA Committee March 2018**

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/18/01/07 d**	
SUBJECT:	**Key Issues Report from the Finance and Sustainability Committee held 19 December 2017**	
DATE OF MEETING:	31 January 2018	
ACTION REQUIRED	**For Assurance**	
AUTHOR(S):	Terry Atherton, Committee Chair	
DIRECTOR SPONSOR:		
LINK TO STRATEGIC OBJECTIVES:	All	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	BAF1.1: CQC Compliance for Quality	
	BAF1.2: Health & Safety	
	BAF2.2: Nurse Staffing	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	
EXECUTIVE SUMMARY (KEY ISSUES):	This report provides a high level summary of business at the December meeting.	
RECOMMENDATION:		
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	

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KEY ISSUES REPORT
FINANCE AND SUSTAINABILITY COMMITTEE

Date of meeting:	19 December 2017
Standing Agenda Items	The Meeting was quorate. The Minutes of the November F&SC were approved. The Deputy Director of HR & OD supported by the Deputy Chief Executive, Medical Director and Director of Nursing presented the Pay Assurance Dashboard. Discussed the Chief Executive sign off of agency greater than £120 ph and it had been noted that a lot of charges where £119 ph so the Trust has decided to set an internal limit of £110ph requiring Chief Executive sign off. The Trust is above the agency ceiling and the main areas of concern are Specialist Medicine and Emergency and Urgent Care. Director of Nursing noted that NHSP nurse shift rates fall this time of year and we are likely to see an increase in agency. The pay spend review meeting continues to look at overtime controls and on call. The committee reviewed pay expenditure and requested further analysis to the increase seen over the last two months considering activity levels and escalation beds for triangulation. It was also suggested that the dashboard was reviewed to give greater focus on all pay expenditure not just agency and locums. The Director of Transformation presented a Month 8 CIP summary showing that the Trust delivered CIP schemes to the value of £0.4m against a plan of £1.0m. YTD CIP actuals are £3.4m against the YTD target of £5.8m. At the end of November 2017 the Trust has delivered recurrent CIP schemes with a full year effect of £2.3m with a further £1.1m of income recovery schemes likely to convert to recurrent benefit. This totals £3.4m of recurrent benefit delivered against a M8 plan of £5.8m. The recurrent nature of CIP will impact on the Trust's ability to deliver plan in the next financial year. The Director of Transformation undated the Committee on the pieces of ork currently underway including review of Paediatrics, COPD Halton, Cardiology and Spinal. It was also noted that some 2017/18 schemes are currently high risk and are being reviewed such as specialist medicine ward, coding, procurement and estates. In Month 8, the Trust incurred a deficit of £1.6m against a planned surplus of £0.6m taking the ytd deficit to £7.7m against a planned loss of £3.5m. The significant deterioration relates to spinal service, STF assumptions and pay expenditure. Pay for Month 8 was £1.5m above plan; ytd £4.1m above plan. The use of resources rating has deteriorated from a score of 3 to 4. In November the Board supported the request for a £2.3m loan to pay creditors and the Trust is awaiting approval from NHSI. The cash balance at the end of November was £1.2m and the better payment practice code performance remains significantly below target.

	F&SC received a presentation around income, expenditure, the financial forecast and likely impact on cash and the potential need for an additional loan. Staffing was discussed at length and is clearly an issue that requires further exploration, given the impact on expenditure as well as patient safety and experience. Winter Planning and associated funding was discussed and further work is required to understand the impact on the financial forecast. Following the review of the revised forecast the Committee support the request to the Board to apply for a further loan to support the deficit. The Corporate Performance Report for Month 8 was presented. In terms of the 4 hour performance, the Trust failed November with DTOC and medically fit patients impacting on performance. RTT and Diagnostic targets continue to be met. We continue to be on track to deliver cancer indicators, with the exception of 62 day target which has seen an improvement. Along with the Winter Pressures Funding it was noted that NHSE has confirmed they will und GPs in GP Streaming over winter. Head of Corporate Affairs presented the risk report. It was felt that there should be a sustainability risk linked to the ability to get further loans and the level of the debt the Trust is facing. The Committee also received an update on the Performance Assurance Framework paper. Finishing with a review of the Committee with comments from all attendee as to whether the Committee had covered all areas of discussion fully. Closing with thanks to Jan Ross for her support, wishing her well in her new role and wishing everyone a Merry Christmas. The following items were identified for escalation to Trust Board:- • The further deterioration in November of financial performance against plan. • The significant adverse movement in the pay bill against forecast. • The need for an addition to the risk register around the whole aspect of loans required to cover the Trust losses and to mitigate elements of creditor pressure.

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AGENDA REFERENCE:	**BM/18/01/08**
SUBJECT:	Spinal Surgery Service Suspension
DATE OF MEETING:	31st January 2018
ACTION REQUIRED	**For discussion**
AUTHOR(S):	Professor Simon Constable, Deputy Chief Executive and Executive Medical Director
EXECUTIVE DIRECTOR	Professor Simon Constable, Deputy Chief Executive and Executive Medical Director
EXECUTIVE SUMMARY	Spinal surgery services at the Trust have been temporarily suspended as a precautionary measure on the grounds of patient safety following the identification of four, apparently un-related, Serious Incidents. This report updates the current position pending receipt of a report by the Royal College of Surgeons Invited Review Mechanism.
RECOMMENDATIONS	The Trust Board is asked to note the contents of this report.
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full
FOIA EXEMPTIONS APPLIED: (if relevant)	None

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NHS Warrington and Halton Hospitals NHS Foundation Trust

1. BACKGROUND/CONTEXT

1.1 The suspension of spinal surgery was initiated *voluntaril*y by the Trust following an Executive Safety Review Panel on 22nd September 2017 with immediate effect. This Executive Safety Review Panel consisted of Mel Pickup (Chief Executive), Professor Simon Constable (Deputy Chief Executive and Executive Medical Director), Dr Alex Crowe (Deputy Medical Director), Mr Mark Halliwell (Chief of Service, Surgery and Women's and Children's Health), Jan Ross (Acting Chief Operating Officer) and Ursula Martin (Deputy Director of Integrated Governance).

1.2 The Panel reviewed in overview four Serious Incidents (two patients with post-operative nerve damage and two postoperative patient deaths) in spinal surgery patients over a six month period in the context of broader governance data, including complaints, incidents and claims. The incidents involved different surgeons, different indications/pathologies, different procedures and complications. This was also an incident profile that was unusual for the spinal service. Serious Incident Investigations had already been instigated, alongside at least one external opinion per case. Where indicated, HM Coroner has been kept fully appraised.

2. ROYAL COLLEGE OF SURGEONS REVIEW

2.1 The Royal College of Surgeons visited the Trust on Thursday 2nd and Friday 3rd November 2017 to undertake a review of the spinal surgery service. This is part of the RCS Invited Review Mechanism. This review had originally been arranged following the Trust's voluntary suspension of a specialised commissioning complex spinal surgery in July 2017 (a relatively small number of procedures).

2.2 Following the review The Royal College of Surgeons Review Team has issued a letter detailing the interim findings and recommendations to the Trust (copied to NHS Warrington CCG and NHS England Specialised Commissioning). Essentially, this confirms the position of the service suspension.

2.3 It is now anticipated that the full report, following the site inspection and extensive document review, will be received by the Trust in February/March 2018.

3. TRANSFER AND HANDOVER OF CARE OF PATIENTS

3.1 The Trust started inter-provider transfers for inpatients during the week ending 15th October 2017 and outpatients during the week ending 29th October 2017. All new patients have been offered the independent choice of accredited alternative provider.

3.2 The care of the majority of patients has been handed over to The Walton Centre NHS Foundation Trust who have been establishing additional capacity to take on this work. The financial impact of this is being assessed.

3.3 The Trust is participating in a Cheshire and Merseyside Spinal Service Meeting led by Professor Tim Briggs' Getting it Right First Time Team and Mr Mike Hutton, a consultant spinal surgeon. This is being undertaken at Halton Hospital on February 6th 2018 and will be attended by the Chief Executive and Deputy Chief Executive and Executive Medical Director, alongside counterparts from The Royal Liverpool and Broadgreen University Hospitals NHS Trust, Aintree University Hospital NHS Foundation Trust, Alder Hey Hospital NHS Foundation Trust as well as the Walton Centre NHS Foundation Trust. WHHFT had our GIRFT review of spinal surgery services in June 2017. It is important to note that no patient safety concerns were raised through the GIRFT review.

4. SERIOUS INCIDENTS

4.1 The four index serious incident reviews, all with Trust-commissioned external consultant opinions in addition to patient-specific reviews by the RCS expert reviewer are nearing completion. Questions arising from stakeholders during the finalisation of the reports has resulted in amendments and addenda. Each Serious Incident Investigation Report is being considered as a dossier with all external reviews appended. These are being shared with all stakeholders, including families, in full. A series of meetings with families and the Deputy Chief Executive and Executive Medical Director, and Chief Nurse where appropriate, has been arranged.

4.2 The Trust has also initiated a wider peri-operative mortality review over a three year period to provide assurance that there should be no broader concerns regarding peri-operative care. Two further post-operative deaths in patients who have undergone spinal surgery have been identified as part of this review – one in 2016 (a male patient who had a stroke and who died on our stroke unit) and one in 2015 (a female patient who had a post-operative myocardial infarction). These are being investigated further as serious incidents, with external reviews commissioned.

4.3 Following completion of each Serious Incident Review, the Deputy Chief Executive and Executive Medical Director has established a Decision Making Group under the Trust Managing Concerns Policy encompassing *Maintaining High Professional Standards*. This will consider whether there are/should be fitness-to-practice concerns regarding the conduct or capability of any individual medical practitioner warranting further action. An external experienced Medical Director has also been commissioned as a 'critical friend' to give further independent opinion, in addition to communication and sharing of information with the Trust GMC Employer Liaison Advisor and our NCAS Advisor.

4.4 Complaints regarding spinal surgery cases that have been received since the service suspension are being referred for external specialist review where appropriate.

5. RECOMMENDATIONS

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

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/16/** BM/18/01/09	
SUBJECT:	**Progress on Carter Report Recommendations**	
DATE OF MEETING:	31st January 2018	
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 Board of Directors 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 some of the key targets and performance indicators and making steady progress on the remaining recommendations.	
RECOMMENDATION:	The Board of Directors is requested to note the contents of the report.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

PROGRESS ON THE CARTER REPORT RECOMMENDATIONS

1. PURPOSE

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

2. BACKGROUND

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

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

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

Table: The breakdown of the £5 billion savings:

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

3. Progress

This paper is the quarterly update report for quarter 3 (Appendix 1). The quarter 2 update report was presented to the Trust Board on 29th November 2017 and this was the first report to be presented in the agreed new format.

3. Conclusion

The Trust has embraced the recommendations and already complies with some of the key targets and performance indicators and is making progress on those applicable to the organisation.

It is important to recognise that NHS Improvement considers progress and implementation of the Lord Carter recommendations as mandatory and compliance is a key feature of future governance standards as indicated in the *Single Oversight Framework*.

5. RECOMMENDATION

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

Andrea McGee
Director of Finance and Commercial Development
24th January 2018

Appendix 1 - PROGRESS AGAINST LORD CARTER RECOMMENDATIONS

Key

- Complete
- On track for completion
- Progress off track - plans in place to get back on track
- Progress significantly off track
- 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. **Lead Director:** Director of Human Resources & Organisational Development					
Development and approval of people strategy and dashboard.	• The people strategy and dashboard has been developed. • The dashboard is reviewed monthly and any areas of concern are addressed			Trust Board, TOB, Workforce Committee	Complete
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.		• 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.		• 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.		• Implementation of factual references. • Time to hire reporting regionally. • Values based recruitment. • Regionally agreed TUPE guidelines.	Workforce Committee	Ongoing

	• Key actions to date include streamlining of notice periods for new starters, agreed honorary contract process and streamlining of mandatory training across the region.				
Staff Opinion Survey	• The Staff Opinion Survey (SOS) closed in December 2017. The Trust response rate was 46% compared to 38% in the 2016 survey. Results are expected in late February early March.		• 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/ Workforce Committee	Rolling Programme
Reduction in the high rates of bullying and harassment with a sustained campaign led personally by each trust Chief Executive	• Bullying and harassment is a key element of the Staff Opinion Survey and is measured by a number of metrics. • In the 2016 staff survey, the Trust scored either average or better than average for all metrics related to Bullying and Harassment, compared with other Trusts nationally. • 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.		• The results from the 2017 SOS will be due in February / March 2018. • Any issues relating to Bullying and Harassment will be presented to Workforce Committee, TOB and Trust Board in March/April 2018 along with key actions to address. • Promotion of the Freedom to Speak Up Guardian is on-going	Workforce Committee	Ongoing Monitoring
Ensure Staff have regular performance reviews	• The number of staff with a valid PDR is 78.4% (December 2017) against a target of 85%. • 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.		• A review of the whole PDR process will take place in March/April 2018, with a particular focus on engaging staff with the PDR and condensing timescales to avoid winter pressures.	Trust Board/TOB Workforce Committee	Ongoing Monitoring – March / April
Improving Sickness Absence	• Sickness absence was 5.03% in December 2018 • An audit has been completed on compliance with the Trust Attendance Management Policy and a number of recommendations are being implemented.		• Key actions to address this increase include: a renewed focus on flu vaccinations > proposals to strengthen reporting arrangements for nursing staff > mental health first aid training to take place > bespoke actions on areas with high levels of absence	Trust Board/TOB Workforce Committee	Ongoing Monitoring

Restructure of HR Directorate	• Restructure of HR Department • HR restructure is complete and key posts in the Senior Management Team have been recruited to.			Trust Board/ Workforce Committee	Completed

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. **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. • 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 CBU Level. • Data is submitted monthly to NHS(I) via the Trust Performance team.	Trust Board / Trust Operational Board	Ongoing Monitoring
Electronic roster and safe care module – All trusts using an e-rostering system, with the following practices being implemented: • Publishing rosters six weeks in advance, submitted to NHS Improvement • Formal process to tackle areas that require improvement and developing associated cultural change and communication plans • 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. • The corporate nursing team has taken over management of the e-roster team. • The e-roster team is now co-located within the patient flow team in a centralised location. • Operational capacity and demand meetings are attended by the e-roster team to ensure staffing is matched to operational demand, along with ensuring staff are deployed to areas of high acuity in conjunction with the Matron and Lead Nurse.		• E-Roster and Safe Care module to be fully implemented. • The Interface between e-roster and NHS(P) is in progress to allow more timely booking of temporary staff.	Trust Board	Ongoing development and daily monitoring with senior nurse oversight.

Consultant job planning - improving analysis of consultant job plans and better collaboration within and between specialist teams	• 2017/18 Job planning underway. • 2nd Job Planning round with Allocate inc. specialty and associate specialists. • 61% of job plans completed for 2017/18. • 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 to one of four medical budgets. A meeting has been arranged meeting to discuss further. • An updated draft job plan was circulated to the medical cabinet in September for comments and consistency. • A draft updated job planning policy has been completed and has been submitted to JLNC for approval.		• Job planning progress is monitored on a weekly basis. • The Deputy Medical Director is sending out the report on a weekly basis to Clinical Directors. • An updated draft job plan was circulated to the medical cabinet in September for comments and consistency. • Proposed 2 sign offs for 2018/19 and 2019/20: by CBU Managers/Clinical Directors (1st sign off) and again by Consistency Panel (2nd sign off). The timeline for this job planning round is to be discussed at Executive Team meeting.	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. **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, nominated 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 – outline business case was approved by the Trust board in October 2017, NHS Digital approved the business case in principle in November 2017. • A Project Board has been established with terms of reference and schedule of meetings. • A draft project plan has been developed.		• Finalise project plan. • EPMA pilot to commence on CDU on 5th March 2018.	Trust Board/IM&T Committee	Project Initiation
Ensuing that coding of medicines are accurately recorded.	• The JAC Pharmacy system was upgraded to enable use of DM+D codes in July 2017. • Pharmacy drug files were updated where possible with DM+D codes in August 2017. • Review of and improvement of quality of data sets submitted to NHS England, CCGs & PHE completed in September 2017.		• Work is required to improve data quality to ensure data fields show accurate and complete data. Improvements made, further meetings scheduled to review outstanding data gaps. • Meeting scheduled to review PHE SACT data. • Blueteq drop in presentation day to be held on 22/1/2018 to demonstrate the system and inform clinicians about the contractual requirements to get prior approval for the patient pathway before commencing treatment and the review process – commencing 1st April 2018.	IM&T Committee	Ongoing Work Programme

			• Implementation of Blueteq for PbR excluded indications funded by the CCGs as required by the commissioners.		
80% of trusts' pharmacist resource utilised for direct medicines optimisation activities, medicines governance and safety remits.	• The Trust is achieving the recommendation for pharmacists. • The Trust is aiming to increase time that pharmacy assistants and technicians spend on ward / with inpatients.		• A training program is in place to upskill pharmacy technicians on medicines reconciliation, optimisation and administration. • 3 wards now have a pharmacy technician administering medicines to patients. A plan in place to increase this to six. • A business case in development to support the medicines optimisation agenda.	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. **Lead Directors:** Chief Operating Officer & Director of Transformation					
Establishment of a shared pathology across the local economy.	• NHSI has proposed 29 Pathology Networks across the country, with Cheshire & Merseyside being "North 4". An STP wide Pathology Board has been created with a Clinical Director and Pathology Manager from each of the Trusts in the region. The first meeting was held on 21st November 2017. • 3 main working groups have been established (Blood Sciences, Microbiology & Cellular Pathology). The Pathology Manager for WHH is leading on the Cellular Pathology workgroup.		• Working groups to develop transformation proposals to rationalise pathology services across the STP.	Strategic Development and Delivery Committee	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.	• A Pathology Quality Assurance Dashboard (PQAD) has been developed.		• PQAD implemented in "shadow" form from November 2016. • Monthly data submitted from April 2017.	Strategic Development and Delivery Committee	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. **Lead Directors:** Director of Finance & Commercial Development					
Provide data to NHSi for the NHS purchasing price index benchmarking tool (PPIB). 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.			Finance & Sustainability Committee	Rolling Programme
Procurement and Transformation Plan 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.		• A paper to Trust Board will be written requesting the Board to note the contents of the plan. • Further discussions to be held with the Director of Finance and Commercial Development regarding a nominated Director.	Finance & Sustainability Committee	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 and 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. • Briefing setting out principles for Scan4Safety to be prepared for the Trust board for approval.	Trust Board/ Scan4Safety Project Board	Project Implementation

NHS Standards of Procurement – 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.	Finance & Sustainability Committee	Project Implementation – Expected Completion June 2018
Benchmarking	• The Trust is currently ranked 46/136 Trusts – placing the Trust in the middle of upper quartile. • Data has been submitted for 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 & Sustainability Committee.	Finance & Sustainability Committee	Ongoing
Trust focusing on the measurement of Key procurement metrics and being responsible for driving compliance to the following targets by September 2017: • 80% addressable spend transaction volume on catalogue • 90% addressable spend transaction volume with a purchase order • 90% addressable spend by value under contract.	• 92% of addressable spend transaction volume on catalogue. • 97% of addressable spend transaction volume is covered by a purchase order. • 82% of addressable spend by value under contract.		• **Addressable Spend Transaction Volume** Even though the target has been achieved this continues to be monitored on a monthly basis. For spend that is not transacted via a PO suppliers are placed on a 100% PO rule i.e. if they do not have an order number their invoice will be rejected. • **Addressable Spend under Contact** 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. This is inclusive of waivers that have been processed so that these can also be actioned in accordance with Trust SFIs and reduce the number of waivers.	Finance & Sustainability Committee	Ongoing Monitoring

Requirement	Progress/Performance	RAG	Actions to improve position/Actions for the next quarter	Assurance	Status/ Expected Completion
Recommendation 6 - All trusts estates and facilities departments should operate at or above the benchmarks for the operational management of their estates and facilities functions by April 2017 (as set by NHS Improvement by April 2016); with all trusts (where appropriate) having a plan to operate with a maximum of 35% of nonclinical floor space and 2.5% of unoccupied or under-used space by April 2017 and delivering this benchmark by April 2020, so that estates and facilities resources are used in a cost effective manner. **Lead Director:** Chief Operating Officer					
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 immediate options for delivering savings by rationalising part of the estate. Phase 2 is to explore the potential for external and/or better utilised 'on site' accommodation for current service provision and phase 3 is to explore opportunities for wider STP collaborative initiatives.		• Delivery of Phase 1 which is being monitored through Strategic Development and Delivery Committee.	Estates and Facilities sub-Committee/ Strategic Development and Delivery 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,	• Estates have accessed funding from Carbon Energy Fund (CEF) replacing 4000 halogen bulbs with more cost effective LED.		• Associate Director of Estates and Facilities is meeting with the finance lead to understand how a further funding application is made.	Estates and Facilities sub-Committee	Project Implementation – expected completion July 2018
Estates and facilities costs embedded into trusts' patient costing and service line reporting systems.	• Estates and Facilities costs are incorporated into PLICS system. Quarterly service lines reports are provided to CBUs by the income team. The costing teams use the estates system, MICAD, to export floor area and can allocate energy/facilities costs based on m2.		• Associate Director of Estates and Facilities to liaise with finance to review outputs.	Estates and Facilities sub-Committee	Ongoing Monitoring
Model Hospital & Effectiveness of Estates	• The Trust continues to review the effectiveness of its estate and monitors cost efficiency metrics to ensure it provides value for money and take actions for any deviation from the benchmark values. When the 2016/17 Model Hospital metrics are available an update will be provided.		• 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	Ongoing Monitoring

			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 2015/16 data.	Workstream	
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.	• 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 by rationalising the estate. Better use of under-utilised estate will hopefully result a reduction in the size of the estate overall.	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. **Lead Directors:** Chief Operating Officer and Director of Transformation					
NHSI Data Collection	• The Trust's corporate and administration functions current costs are 7.7% of income based on planned income. • The Trust will collaborate with other organisations where appropriate to provide services in a more streamlined way maximizing opportunities to procure and work at scale, reduce waste and support the delivery of clinical services, facilitating change where required. • 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. • 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.		• The IT workstream is planning to hold a meeting in the next quarter to collectively review benchmarking data and agree next steps. • Finalise action plans and milestones for communications and legal services workstreams during Q4.	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 M9. 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 best case CIP delivery across all corporate services stands at just over £1.66m in year (@ M09). Recurrent best case CIP delivery stands at £0.935m which includes £0.2m potential savings linked to estates transformation (high risk). • 2018/19 CIP targets will be set across the organisation linked to key strategic	ICIC	Rolling Programme

			projects and an expectation of delivery of financial improvement from those projects. Corporate functions will therefore be allocated an amount of Pay CIP target for next year and subsequent years linked specifically to the challenge to get A&C costs down to 6% of income by 2020.		
Corporate Services A&C Review	• Following ICIC in December, a named Trust Lead (Acting Deputy Chief Operating Officer) appointed to lead on the Admin & Clerical review together with Director of IM&T as Executive Lead.		• Meeting arranged with Executive and Trust Lead and Senior Transformation Manager to agree principles of review and discuss timeframes of IM&T improvements to support changes.	ICIC	Ongoing

Requirement	Progress/Performance	RAG	Actions to improve position/Actions for the next quarter	Assurance	Status/ Expected Completion
Recommendation 8 - NHS Improvement and NHS England should establish joint clinical governance by April 2016 to set standards of best practice for all specialties, which will analyse and produce assessments of clinical variation, so that unwarranted variation is reduced, quality outcomes improve, the performance of specialist medical teams is assessed according to how well they meet the needs of patients and efficiency and productivity increase along the entire care pathway. **Lead 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. • New theatre scheduling process launched in November designed to provide improved visibility and forward planning around utilising theatre and anaesthetic capacity. • Shortfalls in anaesthetic capacity have proved to be a bottleneck in terms of ensuring efficient use of theatre capacity. A business case has recently been approved for additional capacity and work ongoing to ensure available capacity is utilised as effectively as possible.		• New list planning process is set to be launched imminently with the aim of formally introducing expected list timings into the discussion to ensure all scheduled lists are planned to run at or close to maximum operating time available. • Capacity and Demand work for Outpatients commenced in December with the aim of understanding the exact clinic requirements for each specialty to deliver their activity plans and then ensuring we have robust monitoring systems in place to track delivery.	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. • The Trust has its own internal Flow board which focuses on 9 key work streams to support improvements in flow. • Red 2 Green patient data is now collected on all wards through daily board rounds and a process to share the data around patient delays with partner organisations is now in place with partner organisations expected to		• Frailty workstream – strategy document ratified by Board sub-committees in November and Frailty Assessment Unit capital works are scheduled to be completed by the end of January. • Significant work progressed via the Trust's Impact 5 event (w/c 8th Jan 2018) to bring key individuals from LA and CCG together with Trust colleagues to identify issues and agree short, medium and long term solutions. Progress against these will	A&E Delivery Board Flow Board	Ongoing

	respond with actions in place to reduce the delays.		be monitored through the Trust's internal patient flow board.		
Specialty level reviews across local delivery system.	• The Trust is participating in a series of specialty level reviews across the Local Delivery System (LDS). • Agree and implement plans to reduce variation within pathways across the LDS. • Initial specialty reviews have now been held in urology, trauma & orthopaedics and ophthalmology. • A programme of workshops across priority specialties has been agreed, led by the LDS Director of Service Redesign.		• The 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. • 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. **Lead Director:** Director of Information Management & Technology					
Electronic Patient Record	• The Trust implemented Lorenzo EPR in December 2015. • The Trust continues to optimise Lorenzo functionality to ensure that it meets with developing business and clinical needs.		• The Trust will continue to review and analyse the use of Lorenzo to ensure that we are receiving the maximum benefits.	IM&T Sub-Committee/ Trust Board	Project Implementation – expected completion – Plan up to 2020 on track.
Electronic Document Management System	• A business case for an Electronic Document Management System has been developed. It is anticipated that the full business case will be approved by the end of March 2018.		• The Trust will tender for EDMS system; once this has been completed a full implementation plan will be developed with the successful bidder.	IM&T Sub-Committee	Project Implementation – expected completion – Full Business Case to be approved end March 2018
e-Prescribing	• Electronic prescribing and medicines administration (EPMA) Business case and PID signed off by Trust Board and NHS Digital – outline business case was approved by the Trust board in October 2017, NHS Digital approved the business case in principle in November 2017.		• The Trust will tender for e-prescribing system; once this has been completed a full implementation plan will be developed with the successful bidder.	IM&T Sub-Committee	Project Implementation – Trust Full Business Case approved deployment on track March 2018.
Structured clinical notes			• An implementation plan is currently in development for the Outpatient department.	IM&T Sub-Committee	Project Implementation

Requirement	Progress/Performance	RAG	Actions to improve position/Actions for the next quarter	Assurance	Status/ Expected Completion
Recommendation 10 - DH, NHS England and NHS Improvement, working with local government representatives, to provide a strategy for trusts to ensure that patient care is focussed equally upon their recovery and how they can leave acute hospitals beds, or transfer to a suitable step down facility as soon as their clinical needs allow so they are cared for in the appropriate setting for themselves, their families and their carers. **Lead Director:** Not Applicable					
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. **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. • Pathway Integration and efficiency through the local health economy will be digitally enabled through the use of Care Record, risk stratification and patients accessing personal health records.				
Recommendation 12 - NHS Improvement should develop the Model Hospital and the underlying metrics, to identify what good looks like, so that there is one source of data, benchmarks and good practice. **Lead 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. • The key metrics include Clinical Service Lines (Emergency, General Surgery,		Ongoing Monitoring

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

We are WHH

Warrington and Halton Hospitals NHS
NHS Foundation Trust

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/18/01/10**	
SUBJECT:	**2017/18 Forecast Outturn**	
DATE OF MEETING:	**31st January 2018**	
ACTION REQUIRED	**For Decision**	
AUTHOR(S):	Steve Barrow, Deputy Director of Finance	
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	
	BAF3.2: Monitor Undertakings: Corporate Governance & Financial Management	
STRATEGIC CONTEXT	This paper sets out the updated 2017/18 forecast outturn to use as the basis for the Month 10 monitoring returns to be submitted to NHSI on 15 February 2018.	
EXECUTIVE SUMMARY (KEY ISSUES):	The 2017/18 forecast outturn with mitigating actions is a deficit of £15.8m deficit, a variance from plan of £12.1m.	
RECOMMENDATION:	The Board of Directors is requested to approve the change to forecast outturn for the Month 10 monitoring returns to be submitted to NHSI on 15 February 2018 and respond "confirmed" to all declarations on the Board Assurance Statement.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

We are WHH

Warrington and Halton Hospitals NHS
NHS Foundation Trust

1. PURPOSE

This report sets out the revised 2017/18 forecast outturn to be reported to NHSI within the Month 10 monitoring returns due for submission on 15 February 2018.

2. KEY ELEMENTS

The financial position as at 31 December 2017 is a deficit of £11.2m which is £6.8m above the planned deficit of £4.4m.

Using the financial position as at 31 December 2017 a forecast outturn has been prepared which shows that the gross deficit before potential mitigations is £19.0m (£15.4m variance to the annual control total). This was presented to the Finance and Sustainability Committee on 24 January 2017 and is summarised in the table below.

Table: 2017/18 forecast outturn before mitigations:

Income Statement	**Budget £000**	**Actual £000**	**Variance £000**
Operating Income			
NHS Clinical Income	207,873	207,096	-777
Non NHS Clinical Income	1,390	1,220	-170
Other Operating Income	17,774	19,478	1,704
Sustainability and Transformation Fund	7,029	2,460	-4,569
Total Operating Income	**234,066**	**230,254**	**-3,812**
Operating Expenses			
Employee Benefit Expenses	-164,359	-173,989	-9,630
Non Pay	-69,830	-72,354	-2,525
Total Operating Expenses	**-234,189**	**-246,344**	**-12,155**
Operating Surplus / (Deficit)	**-124**	**-16,090**	**-15,967**
Non Operating Income and Expenses	-3,675	-3,089	585
Surplus / (Deficit)	**-3,798**	**-19,179**	**-15,381**
Depreciation on Donated and Granted Assets	141	149	8
Control Total	**-3,657**	**-19,031**	**-15,373**

The key drivers for the variance are summarised in the table below. Winter costs and elective activity income reduction due to winter, spinal suspension and unclaimed Sustainability and Transformation Funds (as the Trust has not delivered the quarter 3 financial target and is forecasting non delivery at quarter 4) account for £9.6m of the variance.

Table: Key drivers of variance to plan:

Driver	£m
CIP shortfall	5.3
Pay (including bank and agency but excluding CIP and winter)	3.3
Spinal income and cost	2.3
Winter plan additional costs	2.1
Reduced elective income due to winter directive	0.6
Fines and Penalties	0.4
Sub total	**14.0**
Non achievement of STF	4.6
Total	**18.6**
Other (including PDC dividends and Income over performance)	(3.2)
Net Variance to plan	**15.4**

The Trust has considered a number of mitigating actions that could assist in reducing the gross deficit as much as possible and has RAG rated the achievability as summarised in the table below:

Table: RAG rated mitigations

							Red	Amber	Green
Mitigating Actions					**£m**		**£m**	**£m**	**£m**
Receipt of STF Monies (Q3 and Q4)					4.6		4.6		
Deliver additional CIP	Low risk (2 months at £0.1m per month)				0.2			0.2	
	Medium risk (2 months at £0.1 per month				0.2		0.2		
	High risk (Balance to achieve £10.5m target)				4.9		4.9		
Winter Monies	Tranche 1				0.7		0.7		
	Tranche 2				1.1			1.1	
Restart spinal activity (2 months at £0.3m per month)					0.6		0.6		
Ward Closure (2 wards x 2 months)					0.4		0.4		
Additional Activity (500 spells x £1000)					0.5		0.5		
Vacancy freeze (2 months x £0.1m per month)					0.5		0.5		
Reduction of clinical supplies expenditure (2 months at £0.05m per month)					0.1			0.1	
Reduction of clinical supplies expenditure (2 months at £0.1m per month)					0.2		0.2		
Reduction of non clinical supplies expenditure (2 months at £0.05m per month)					0.1				0.1
Reduction of non clinical supplies expenditure (2 months at £0.1m per month)					0.2			0.2	
Reduction of non clinical supplies expenditure (2 months at £0.1m per month)					0.2		0.2		
Review of balance sheet / technical adjustments (inc historic early retirement cases)					0.3			0.3	
Reversal of annual leave accrual					0.3				0.3
Business cases approved					0.4			0.4	
Stop agency	Medical (2 months at £0.5m per month)				1.0		1.0		
	Nursing (2 months at £0.2m per month)				0.4		0.4		
	STT (2 months at £0.1m per month)				0.2		0.2		
	A&C (2 months at £0.05m per month)				0.1			0.1	
Revenue to capital transfer for IM&T and Estates					0.1			0.1	
Cost audit of energy and telecomms expenditure					0.1			0.1	
Total					**17.4**		**14.4**	**2.6**	**0.4**

In summary this shows that Green and Amber rated schemes equate to £3.0m which if achieved would result in an improvement to the financial position and a deficit after mitigations of £16.0m (£12.3m variance to the annual control total).

Narrative	**£m**
Gross Deficit	(19.0)
Mitigating actions	3.0
Revised deficit	**(16.0)**
Control total	(3.7)
Variance to control total	**(12.3)**

This position was presented to the Finance and Sustainability Committee on 24 January 2018.

Since the Finance and Sustainability Committee further work has been undertaken which has identified a further improvement of £0.2m. This reduces the deficit to £15.8m (£12.1m variance to control total). The main improvement is the assumption that the Trust receives winter funds from NHSI of £1.1m in line with the agreed plan to open additional capacity. Of the £12.1m variance to control total £8.5m relates to unfunded winter costs, reduced elective income relating to the winter directive, the impact of the spinal suspension and unclaimed STF.

3. GOVERNANCE

The risk to the delivery of the control total and the impact on cash has been presented to and debated at the Finance and Sustainability Committee and Trust Board meetings from Month 3. In addition the Trust's regulator, NHS Improvement (NHSI) has been very closely sighted on these financial risks and has provided support to the cash position via support for loans.

There are a number of issues to be resolved that will impact upon the year-end financial position, including cost and income relating to winter (£1.8m winter funding unconfirmed and requirement to reduce elective work during winter), impact of spinal suspension, and year-end income agreement with commissioners (currently £4m difference in forecast). These issues are being addressed with NHSI and commissioners urgently. In addition further mitigations are being explored to reduce the financial risk. Any variance from plan impacts on the Trust cash position. A deficit of £15.8m will require loans to the same value, which including existing revenue loans increases revenue debt to £40.2m of which £14.2m is repayable in May 2018. NHSI is aware of this and at this stage it is anticipated that this will need to be replaced by a further loan.

NHSI has introduced a protocol for adverse changes to an in year forecast which includes the submission of a Board Assurance Statement. This requires the Board to declare "confirmed" or "not confirmed" to a series of finance and governance statements. Signatures are required by the Chair, Chief Executive, Audit Committee Chair and the Director of Finance.

The Board Assurance Statement is attached at Appendix A.

4. RECOMMENDATIONS

The Board of Directors is requested to approve the change to forecast out turn for the Month 10 monitoring returns to be submitted to NHSI on 15 February 2018 and respond “confirmed” to all declarations on the Board Assurance Statement.

We are WHH

Warrington and Halton Hospitals NHS
NHS Foundation Trust

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/18/01/11**	
SUBJECT:	**Additional Working Capital Loan 2017/18**	
DATE OF MEETING:	**31st January 2018**	
ACTION REQUIRED	**For Decision**	
AUTHOR(S):	Karen Spencer, Head of Financial Services	
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	
	BAF3.2: Monitor Undertakings: Corporate Governance & Financial Management	
STRATEGIC CONTEXT	This paper seeks approval for the Trust to apply for a working capital loan of £2.661m to support the Trust's cash position.	
EXECUTIVE SUMMARY (KEY ISSUES):	The Trust has an approved working capital loan of £3.657m in place for 2017/18 to support the planned control total deficit of £3.657m. As at 31st December 2017 the difference between the year to date planned and actual control total is £6.794m. To date the Board has approved an application for a loan of £4.133m so this paper seeks to gain approval for an additional working capital loan of £2.661m.	
RECOMMENDATION:	The Board of Directors is requested to approve the application for a working capital loan of £2.661m.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

We are WHH

Warrington and Halton Hospitals NHS
NHS Foundation Trust

1. PURPOSE

This paper seeks approval for the Trust to apply for a £2.661m working capital loan to support the Trust's cash position. The value of the working capital loan is based on the difference between the Trust's planned deficit control and actual control total for period ending 31st December 2017.

2. KEY ELEMENTS

The Trust agreed a 2017/18 deficit control total of £3.657m and has an agreed working capital loan facility for this value. To date £3.106m has been drawn down with the balance of £0.551m to be drawn in March 2018.

As at 31st December 2017 the difference between the planned control total (£4.270m deficit) and the actual control total (£11.064m deficit) is £6.794m. As the Trust has a larger deficit than plan additional cash support is required to meet day to day working capital commitments. An application for a £4.133m working capital loan has already been approved by the Board. This paper seeks to gain approval for an additional working capital loan of £2.661m. If the loan application is approved the loan will be drawn down in March 2018.

Additional working capital requirements for 2017/18 will be supported by an Uncommitted Single Currency Interim Revenue Support Facility (ISUCL) agreement with an interest rate of 1.5% per annum.

The loans secured by the Trust as at 31st December 2017 together with the loans secured and applied for in January 2018 are summarised in the table below.

Table: Outstanding loan values

Narrative	**Loan Value £k**
2015/16 Capital Loan	1,440
2015/16 Working Capital Loan to cover deficit	14,200
2016/17 Working Capital Loan to cover deficit	7,918
2016/17 Working Capital Loan to cover Q4 STF (1)	0
2017/18 Working Capital Loan to cover planned deficit	3,657
2017/18 Working Capital Loan to cover Q1 STF (2)	0
2017/18 Working Capital Loan to cover Q2 STF (3)	1,406
2017/18 Working Capital Loan to cover Aged Creditors (4)	2,300
2017/18 Working Capital Loan to cover variance to control total as at 30th November 2017 (5)	4,133
2017/18 Working Capital Loan to cover variance to control total as at 31st December 2017	2,661
Total	**37,715**

(1) Repaid August 2017.
(2) Repaid October 2017.
(3) To be repaid February 2018.
(4) Received in January 2018.
(5) Awaiting approval from NHS Improvement and Department of Health.

The cumulative value of working capital loans covering the period 2015/16 to 2017/18 equates to £36.3m. This will reduce to £34.9m after repayment of working capital loan to cover the Q2 STF monies in February 2018.

The Trust has been in discussions with NHSI regarding the 2017/18 forecast outturn and NHSI has advised that a revised forecast outturn is submitted as part of the Month 10 reporting cycle (due on 15th February 2018). The deficit before any mitigating actions is £19.0m (£15.3m variance from control total) and £16.0m after mitigating actions (£12.3m variance from control total). Therefore a £16.0m deficit will require additional working capital loans totalling £5.5m to support the cash position turn and enable the Trust to meet its financial obligations.

3. RECOMMENDATIONS

The Board of Directors is requested to:

(a) approve the terms of, and the transactions contemplated by, the Finance Documents to which it is a party and resolving that it execute the Finance Documents to which it is a party;

(b) authorise the Chief Executive Officer to execute the Finance Documents relating to uncommitted interim revenue support loans to the value of £2.661m to which it is a party on its behalf; and

(c) authorise the Director of Finance and Commercial Development, on its behalf, to despatch all documents and notices (including, if relevant, any Utilisation Request) to be signed and/or despatched by it under or in connection with the Finance Documents up to which it is a party.

(d) confirm the Borrower's undertaking to comply with the Additional Terms and Conditions.

The above is in accordance with the Trust's Scheme of Reservation and Delegation and Schedule 1 of an Uncommitted Single Currency Interim Revenue Support Facility (ISUCL) agreement.

We are WHH

Warrington and Halton Hospitals NHS
NHS Foundation Trust

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/18/01/12**	
SUBJECT:	**Safe Staffing Assurance Report**	
DATE OF MEETING:	31st January 2018	
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 November and December 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 November and December Trust wide staffing data was analysed and cross referenced for validation by Divisional Matrons and Divisional Associate Director of Nurses.

Appendix 1 & 3 identifies the fill rates for staff across the Trust with Care Hours Per Patient Day (CHPPD) for November and December 2017 respectively. The table also triangulates this information by illustrating the harms reported within each area.

Appendix 2 & 4 identifies the mitigating actions taken in November and December respectively in areas where the actual numbers of registered nurses and health care support staff were below 90% of the planned numbers of staff. This report demonstrates the monthly CHPPD per ward across the Trust and provides assurance of the divisional actions taken to provide adequate staffing levels on a day to day / shift by shift basis.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

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

Monthly Safe Staffing Report – November 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	930	697.5	460	100.0%	65.9%	0	0	0	0	-	-				
SWC	Ward A5	1713.5	1479.5	1260	1134	86.3%	90.0%	1035	989	690	690	95.6%	100.0%				
SWC	Ward A6	1725	1374.25	1258	1213.25	79.7%	96.4%	1035	989	690	805	95.6%	116.7%				
SWC	Ward C22	1276	1017.75	1127	1046.5	79.8%	92.9%	805	793.5	690	931.5	98.6%	135.0%				
SWC	Ward B4	789	777.5	510	477.5	98.5%	93.6%	253	243.5	253.08	241	96.2%	95.2%				
SWC	Ward A9	1725	1363	1380	1528.5	79.0%	110.8%	1035	1012	1104	1081	97.8%	97.9%				1
SWC	Ward B1	1541	1458.5	943	926.5	94.6%	98.3%	736	736	690	690	100.0%	100.0%				
SWC	Ward B11	1925.2	1875.2	764.2	764.2	97.4%	100.0%	1596	1606.8	0	0	100.7%	-				
SWC	NCU	1725	1493	345	276	86.6%	80.0%	1725	1432	345	287.5	83.0%	83.3%				
SWC	Ward C20	932	837	690	699	89.8%	101.3%	581.4	581.4	0	299	100.0%	-				
SWC	Ward C23	1380	1228	690	562	89.0%	81.4%	690	690	690	598	100.0%	86.7%				
SWC	Delivery Suite	2415	2135	345	320	88.4%	92.8%	2415	2211	345	345	91.6%	100.0%				
ACS	Ward A1	2250	1762.5	1500	1500	78.3%	100.0%	1890	1470	630	630	77.8%	100.0%				
ACS	Ward A2	1380	1134.5	1452.5	1360.9	82.2%	93.7%	1035	1023.5	690	828	98.9%	120.0%	1	1		1
ACS	Ward A3	1069.5	961.5	1380	1406.5	89.9%	101.9%	724.5	745.5	713	1023	102.9%	143.5%				
ACS	Ward A4	1515	1281	1552.5	1324.5	84.6%	85.3%	1035	839.5	1035	1334	81.1%	128.9%				
ACS	Ward A8	1725	1452.5	2024	1873	84.2%	92.5%	1036	977.5	1725	1690.5	94.4%	98.0%				
ACS	Ward B12	1035	1026	2254	1961.75	99.1%	87.0%	690	688	1403	1403	99.7%	100.0%	1			
ACS	Ward B14	1380	1231.5	1380	1353	89.2%	98.0%	690	690	690	690	100.0%	100.0%				
ACS	Ward B18	1380	1174.5	1372.5	1294.92	85.1%	94.3%	1035	839.5	1035	1012	81.1%	97.8%				
ACS	Ward A7	1725	1403	1725	1515	81.3%	87.8%	1391.5	1276.5	1380	1184.5	91.7%	85.8%				
ACS	Ward C21	1035	1035	1081	918	100.0%	84.9%	690	690	1081	977.5	100.0%	90.4%				1
ACS	CCU	1380	1271	371.5	262.5	92.1%	70.7%	1035	1023.5	0	0	98.9%	-				
ACS	ICU	4830	4709.25	1035	615.25	97.5%	59.4%	4830	4772.5	690	379.5	98.8%	55.0%				

Appendix 2

NOVEMBER 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	65.9	0	0	SAU closed overnight therefore zero hours return – no staff additional required
Ward A5	86.3%	90.0%	95.6%	116.7%	Ongoing recruitment as per Trust rolling programme, to fill vacancies.
Ward A6	79.7%	96.4%	95.6%	116.7%	Ongoing recruitment as per Trust rolling programme, to fill vacancies.
Ward C22	79.8%	92.9%	98.6%	135.0%	Ward C22 moved to Ward A4 22nd November 2017. Recruitment to vacancies and moving staff within Division to support the operational teams and additional beds.
Ward A9	79.0%	110.8%	97.8%	97.9%	Short term sickness has resulted in reduction in trained staff. Staff moved from other areas and ward supported with additional HCA's to support.
NCU	86.6%	80.0%	83.0%	83.3%	Unit managed with temporary NHSP staff during times of increased activity.
Ward C20	89.8%	101.3%	100.0%	-	Ongoing recruitment as per Trust rolling programme, to fill vacant positions.
Ward A1 - AMU	78.3%	100.0%	77.8%	100.0%	2 x long term RN F/T sickness, 2 x RN F/T short term sickness, 5 x RN vacancy, matron review daily, senior nursing team reviewed daily. NHSP and Agency staffing to support vacancy and sickness. Ward beds numbers to 33 for the month of November 2017.
Ward A2	82.2%	93.7%	98.9%	120.0%	Ward manager working clinically to support staff. Discharge nurse based on ward Mon-Fri to support the discharges
Ward A3 Opal	89.9%	101.9%	102.9%	143.5%	Ward moved on the 3/11/17 with a reduction in beds from 34 to 24 beds on Ward B19. Ward beds decreased to 24 throughout November 17 ahead of move. Enhanced care required in month, ward manager working clinically to support RN vacancy and sickness in month. Staffing supported by NHSP and agency. Ward risk assessed daily by senior nurse team to ensure safety.

Ward A4	84.6%	85.3%	81.1%	128.9%	Ward manager working clinically to support. AP working on the ward. Patients on the ward are medically fit.
Ward A8	76.3%	90.6%	94.4%	98.0%	Matron on ward for month of November to support due to vacant ward manager position. Ward has pharmacy Techs to support with medications and support the staff.
Ward B12 (Forget-me-not)	99.1%	87.0%	99.7%	100.0%	Ward has risk assessment in place as increase in need for enhanced care in month. Enhanced care requirements are supported by pool and temporary staffing. Ward risk assessed daily by lead nurse and matron to ensure safety.
Ward B14	89.2%	98.0%	100.0%	100.0%	Sickness and staff vacancies in month. Ward manager supported ward clinically, Ward revised daily by senior team to ensure safety.
Ward B18	85.1%	94.3%	81.1%	97.8%	Increase in sickness in month of November, managed in line with policy, ward manager working clinically to support. Daily staffing reviews by senior staff and staff moved to support.
Ward A7	81.3%	87.8%	91.7%	85.8%	Recruitment process for the Band 7 and 6 post underway. Enhanced Care and support for 1:1 needs supported by NHSP and agency.
Ward C21	100.0%	84.9%	100.0%	90.4%	LT sickness is currently high on the ward, being managed appropriately. Enhance Care requirements in month, and the ward has cohorted patients when appropriate and utilised NHSP and agency support.
Coronary Care Unit	92.1%	70.7%	98.9%	-	Staff transferred staff from A7 to CCU to support vacancies. Further support from NHSP and agency staffing.
Intensive Care Unit	97.5%	59.4%	98.8%	55.0%	Recruitment to Nursing and HCA establishment has taken place with a number of staff currently completing their supernumerary status. Unit occupancy 87% for November. Temporary staffing utilised to maintain safe nurse: patient ratios.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

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

Monthly Safe Staffing Report – December 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	930	697.5	373.5	100.0%	53.5%	0	0	0	0	-	-				
SWC	Ward A5	1771	1479.5	1302	1134	83.5%	87.1%	1069.5	989	713	690	92.5%	96.8%				1
SWC	Ward A6	1725	1419.25	1302	1205	82.3%	92.5%	1069.5	1046.5	713	701.5	97.8%	98.4%				
SWC	Ward C22	1667.5	1098	1312	1066	65.8%	81.3%	1069.5	839.5	713	1035	78.5%	145.2%				
SWC	Ward B4	754.5	743	491	474	98.5%	96.5%	241.58	239.5	241.5	241.5	99.1%	100.0%				
SWC	Ward A9	1782.5	1432	1426	1619	80.3%	113.5%	1069.5	1069.5	1104	1046.5	100.0%	94.8%				1
SWC	Ward B1	1483.5	1125.5	1069.5	688.5	75.9%	64.4%	529	517.5	529	483	97.8%	91.3%				
SWC	Ward B11	1931.3	1909.87	805.7	825.7	98.9%	102.5%	1649.2	1703.2	0	0	103.3%	-				
SWC	NCU	1782.5	1618.5	356.5	207	90.8%	58.1%	1782.5	1495.2	356.5	264.5	83.9%	74.2%				
SWC	Ward C20	932	837	690	699	89.8%	101.3%	581.4	581.4	0	299	100.0%	-				
SWC	Ward C23	1426	1263.1	713	515	88.6%	72.2%	713	713	713	575	100.0%	80.6%				
SWC	Delivery Suite	2495.5	2219.5	356.5	356.5	88.9%	100.0%	2495.5	2898.5	356.5	356.5	116.1%	100.0%				
ACS	Ward A1	1937.5	1237.5	1550	1550	63.9%	100.0%	1953	1512	651	651	77.4%	100.0%				
ACS	Ward A2	1426	1094.5	1513.4	1423	76.8%	94.0%	1069.5	1000.5	713	862.5	93.5%	121.0%				
ACS	Ward A3	1523	1193	1782.5	1705	78.3%	95.7%	1069.5	1012	1426	1426	94.6%	100.0%				
ACS	Ward A4	1725	1350	2024	1637	78.3%	80.9%	1035	1023.5	1725	1621.5	98.9%	94.0%				1
ACS	Ward A8	1069.5	1054.5	2495.5	2102.5	98.6%	84.3%	713	713	1782.5	1656	100.0%	92.9%				
ACS	Ward B12	1426	1228.5	1426	1449	86.2%	101.6%	713	713	713	713	100.0%	100.0%				
ACS	Ward B14	1426	1228.5	1426	1219	86.2%	85.5%	1069.5	839.5	1069.5	1115.5	78.5%	104.3%				
ACS	Ward B18	1782.5	1523.5	1932	1695.5	85.5%	87.8%	1426	1311	1564	1403	91.9%	89.7%				
ACS	Ward A7	1069.5	1046.5	1115.5	977.5	97.8%	87.6%	724.5	713	1081	989	98.4%	91.5%				
ACS	Ward C21	1426	1339	356.5	234.5	93.9%	65.8%	1069.5	1065	0	0	99.6%	-				
ACS	CCU	4991	4766.75	1069.5	626.75	95.5%	58.6%	4991	4726.5	713	483	94.7%	67.7%				
ACS	ICU	930	930	697.5	373.5	100.0%	53.5%	0	0	0	0	-	-				

Appendix 2

DECEMBER 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%	53.5%	-	-	SAU is closed overnight .CSW sickness is being managed as per policy.
Ward A5	83.5%	87.1%	92.5%	96.8%	Ward at full capacity supporting winter pressures taking beds up to 33. . 2 staff currently on maternity leave. Staffing reviewed daily by the matron and lead nurse.
Ward A6	82.3%	92.5%	97.8%	98.4%	ST Sickness and 1.6wte staff on maternity leave. Additional staffing provided by NHSP and agency, 2 registered nurses due to commence on the ward in March 2018.
Ward A4	65.8%	81.3%	78.5%	145.2%	Ward C22 has moved to Ward A4 and has increased bed base from 21 to 32. Additionally to support winter the ward has now increased to 34 beds. Staffing is reviewed daily and staff are moved from other areas to support. NHSP and agency staffing accessed to further support the ward to ensure adequate staffing levels.
Ward A9	80.3%	113.5%	100.0%	94.8%	Currently 2 RN vacancies and 2 trained staff on maternity leave 1 F/T- long term sickness. Vacancies out to advert. Ward staffing reviewed daily, with additional staffing accessed from NHSP and agency.
Ward 1 - CMTC	75.9%	64.4%	97.8%	91.3%	Ward closed over bank holidays. Staff supporting the Warrington site during the closure. Staffing reviewed daily, against activity to ensure sufficient staffing levels are in place.
Neonatal Unit	90.8%	58.1%	83.9%	74.2%	Unit managed with temporary NHSP staff during times of increased activity.
Ward C20	89.8%	101.3%	100.0%	-	Ward escalated throughout the month of December. Additional HCA to support escalation provided by the nurse pool or NHSP. 2 new Preceptor nurses have commenced on the ward and are being supported on

					day shifts.
Ward A1 - AMU	63.9%	100.0%	77.4%	100.0%	LT sickness and 4RN vacancies on the ward. Staffing reviewed daily and staff moved from other areas to support the ward. NHSP and agency utilised to support with covering the vacancies.
Ward A2 Admission	76.8%	94.0%	93.5%	121.0%	Ward Manager working clinically to support. Matron support with staffing and daily senior nurse review to provide cover where needed.
Ward A3 Opal	78.3%	95.7%	94.6%	100.0%	Ward Manager working clinically to support. Daily review by the senior nursing team, staff moved and NHSP and agency accessed to support when required.
Ward A8	98.6%	84.3%	100.0%	92.9%	Matron based on ward during the week to support providing senior leadership until the ward manager commences. Daily review of staffing levels by the senior nursing team.
Ward B12 (Forget-me-not)	86.2%	101.6%	100.0%	100.0%	Ward risk assessed regularly to ensure additional enhanced care staff needs are met. Additional staffing accessed from the nurse pool and NHSP.
Ward B14	86.2%	85.5%	78.5%	104.3%	Additional HCA requested on each shift due to nurse vacancies. Dependency of the stroke patients has been high so further support has been provided. Daily senior review of staffing in place.
Ward B18	85.5%	87.8%	91.9%	89.7%	Sickness being managed by ward manager in line with the policy. Pool HCA requested to support enhanced care needs ensuring patients are observed to maintain safety. Daily staffing review in place by the senior nursing team.
Ward A7	97.8%	87.6%	98.4%	91.5%	Recruitment underway for the additional staffing requirements on the ward. Band 5 secondment from CCU to support and staff moved from other areas. Senior nurse daily review of staffing in place. NHSP and agency accessed to support the ward, and Enhanced Care needs.
Ward C21	93.9%	65.8%	99.6%	-	LT sickness currently being managed. Band 6 supporting management duties. Additional staff accessed from NHSP and agency, particular when enhance care is required on the ward.
CCU	95.5%	58.6%	94.7%	67.7%	Maternity leave of RN x 2 wte, 1.6 wte HCA vacancies. Staffing reviewed daily by the senior nursing team.
ICU	98.6%	84.3%	100.0%	92.9%	Recruitment process underway to

					support band 5 vacancies. (2.96 wte) RN Long-Term Sickness remains high and is being managed in line with policy. Unit Occupancy 90% for December. Staffing review daily against occupancy levels and additional support accessed from NHSP and agency when required in order to maintain safe nurse: patient ratios.

We are WHH

Warrington and Halton Hospitals NHS
NHS Foundation Trust

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/18/01/13**	
SUBJECT:	Safe Staffing Report – 6 monthly review	
DATE OF MEETING:	31st January 2018	
ACTION REQUIRED	To discuss, note the contents and actions outlined within the report.	
AUTHOR(S):	John Goodenough – Deputy Chief Nurse	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse Choose an item.	
LINK TO STRATEGIC OBJECTIVES:	SO2: To have a committed, skilled and highly engaged workforce who feel valued, supported and developed and who work togther to care for our patients	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	BAF2.2: Nurse Staffing	
	BAF2.5: Right People, Right Skills in Workforce	
	BAF2.1: Engage Staff, Adopt New Working, New Systems	
STRATEGIC CONTEXT		
EXECUTIVE SUMMARY (KEY ISSUES):	This paper forms the six monthly review of nurse staffing in line with the commitment requested by the National Quality Board. The report was scheduled and available for the November Board of Directors and requested to be presented in January 2018. • The report represents the review of a two week sample of census data recorded within the SafeCare acuity and dependency system in October 2017. The data shows a deficit of 36.78 wte RN's and in the previous 6 monthly Board Staffing Report reported a deficit of 80.83 WTE. This was following the first run of acuity measurement using the SNCT. • Nursing Recruitment and Retention Strategy continues to be delivered and a review of the strategy is planned • Work is in the final phases of the establishment review and a business case is to follow.	
RECOMMENDATION:	It is recommended that the Board of Directors are asked to receive this paper, which highlights the 6 monthly nurse / midwifery staffing review and note the actions taken and planned to ensure safe staffing.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	

We are WHH

Warrington and Halton Hospitals NHS
NHS Foundation Trust

FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None

Contents

1.0 Introduction

This paper was available to be presented to the November 2017 Board of Directors and was requested to be presented at the January 2018 Board of Directors and forms the six monthly review of nurse staffing in line with the commitment requested by the National Quality Board (NQB) (2013) document, 'How to ensure the right people, with the right skills are in the right place at the right time', in response to the Francis Enquiry (2013). This guidance has been refreshed, broadened and re issued in July 2016 to cover all staff and to include the need to focus on safe, sustainable and productive staffing (National Quality Board 'Supporting NHS Providers to deliver the right staff, with the right skills, in the right place at the right time – safe and sustainable staffing July 2016'.

The following report is presented as an expectation of the NQB guidance and represents the outcome of reviewing the acuity and dependency data recorded in the Safe Care system for two weeks in October 2017 at WHH.

All Ward Sisters / Charge Nurses, Matrons, Lead Nurses and Divisional Associate Directors of Nursing participate in the acuity and dependency review process.

2.0 National context and expectations of the National Quality Board

Boards of organisations are ultimately responsible for the quality of care they provide, and for the outcomes they achieve. It is well documented that nursing, midwifery and care staff capacity impacts on the ability to deliver a quality experience to our patients and that this has an effect on patient outcomes. Multiple studies have linked low staffing levels to poorer patient experience and outcomes along with increased mortality rates.

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

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

3.0 Workforce information - Warrington and Halton Hospitals (WHH) Current Position

Chart 1 below shows the total number of budgeted nursing and midwifery staff in post by month since April 2017.

Chart 1

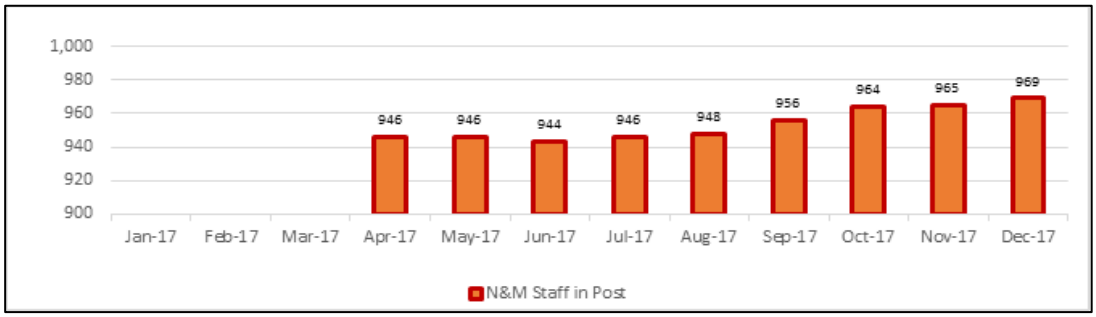


Chart 2 identifies the number of band 5 vacancies based on the funded establishments against the number of staff in post. Band 5 nursing vacancies reduced from 148.7 FTE in 2016 to 62 FTE in October 2017; there has been a subsequent small rise in November & December. It should be noted that whilst we are celebrating some success in managing to recruit this number of qualified nurses in a competitive market, we must be cognisant that the lead in time for some of the staff to commence in post reaches into 2018 and 2019 and continuing attrition rates must also be considered.

Chart 2

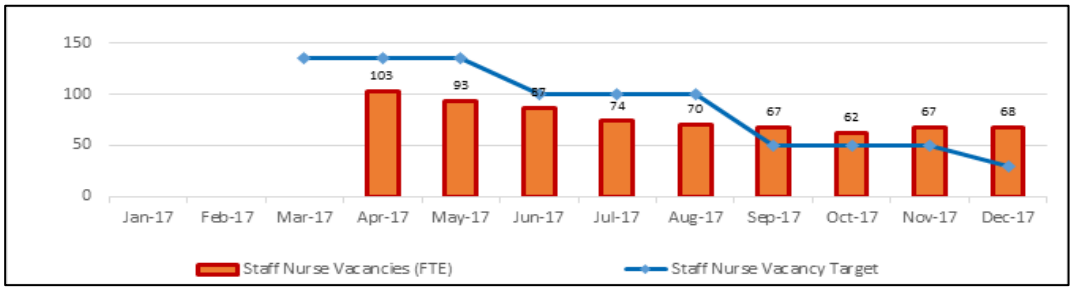


Chart 3 shows nursing and midwifery turnover which in 2016 was 14.64%; this has steadily improved and in October 2017 the amber target of threshold of 12% was achieved and remains below in December.

Chart 3

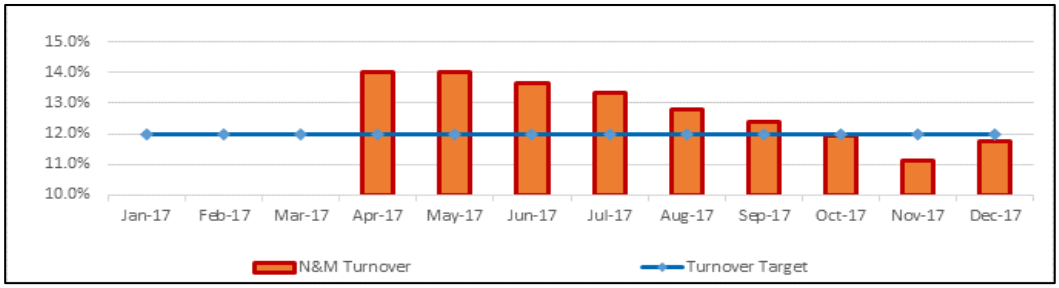
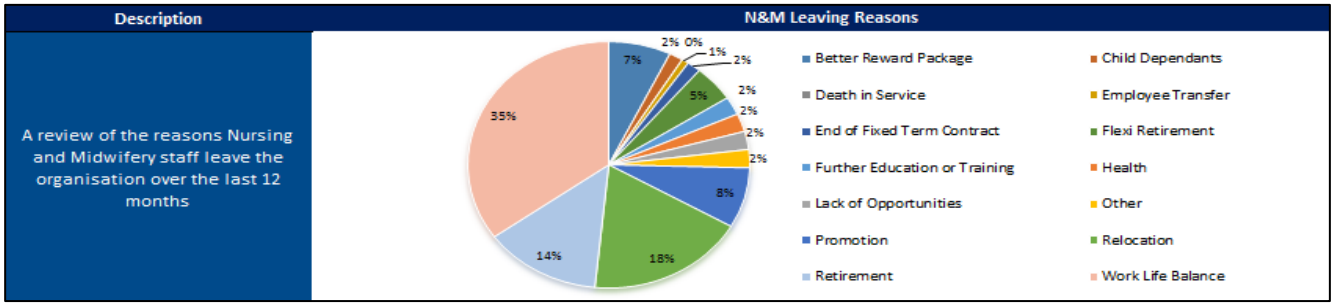


Chart 4 identifies the nursing and midwifery reasons for leaving the Trust. It should be noted that this is for only band 5 staff.

Chart 4



The Nursing Recruitment and Retention Strategy continues to be delivered with actions closely monitored by the Chief Nurse and review of the Strategy is planned for 2018. An increased focus on retention and the development of RNs once in post will be considered.

The Nursing Associate national pilot continues with 10 WHH Nursing Associates undergoing training, with completion of the programme in January 2018. It should be noted that this type of post will not replace the requirement of registered nurses rather complement the skill mix with early indications showing positives results for patient care and nursing workforce.

4.0 SafeCare System

The Trust operationally utilises the SafeCare module within the Allocate E-Rostering system to collect acuity and dependency data twice daily for all wards. This data has previously been manually collated under the name of the Safer Nursing Care Tool (SNCT) for a two week period twice a year. Recording the data on a twice daily basis means that accurate information is available in real time to enable our workforce to flex to meet the acuity of the patient group within that area.

The E-Rostering team have physically moved to a central location close to the Patient Flow Office, in order to take part and provide accurate acuity data to the three times daily staffing meetings held by senior nursing and operational staff.

4.1 SafeCare Census Results

It should be noted that the SNCT tool does not differentiate between qualified and unqualified staff staffing hours and as such requires a very good understanding of the patient groups and nursing requirements. Professional judgment is also an important and essential factor to be considered when making decisions about staffing establishments.

Evidence suggests that a minimum of four census acuity runs take place across both winter and summer periods to identify any seasonal variation and to accurately understand the patient acuity fluctuations and staffing requirements.

The tool also requires that between census periods there are no significant changes in ward environment or patient case mix as both of these factors impact on the validity of the census information.

Operationally this can often be difficult to support for some wards and can be factored into overall evaluation commentary.
Overall the SafeCare results show that there is an approximate shortfall of 36.78 WTE nurses for the wards, based upon the acuity and dependency of the patient group over the two week sampling period (16th to 29th October 2017).

As shown in Table 1 below, it is clear that variance in the data has improved since the previous Safecare result following targeted training for ward staff; however anomalies remain; an example of which shows AMU with an over establishment of almost 25 WTE which is clearly anomalous in nature. Further training and support will be provided to AMU and wards as appropriate.

As such the data should be used with caution, triangulated with other safety, experience and quality metrics alongside professional judgement before changes to establishments are made.

An output from the SafeCare live system is shown at **Appendix 1** for reference.

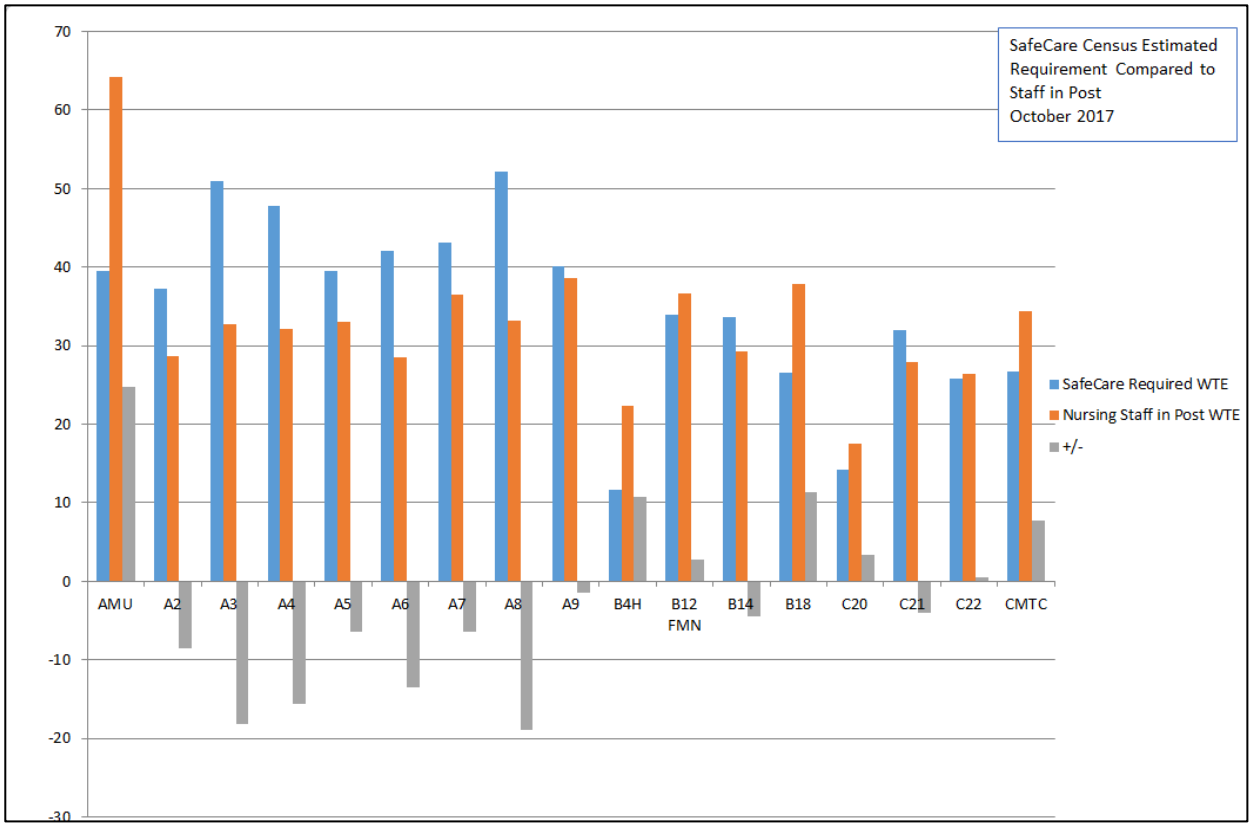
Table 1

Ward	SafeCare Required WTE Nurses vs Nurses in Post*		
	SafeCare Required WTE	Nursing Staff in Post WTE	+/-
AMU	39.5	64.29	24.79
A2	37.32	28.72	-8.60
A3	50.89	32.7	-18.19
A4	47.85	32.15	-15.70
A5	39.48	33.07	-6.41
A6	42.07	28.53	-13.54
A7	43.06	36.55	-6.51
A8	52.11	33.12	-18.99
A9	40.11	38.58	-1.53
B4H	11.67	22.35	10.68
B12 FMN	33.92	36.65	2.73
B14	33.71	29.26	-4.45
B18	26.55	37.89	11.34
C20	14.18	17.56	3.38
C21	32.05	27.98	-4.07
C22	25.81	26.35	0.54
CMTC	26.71	34.46	7.75
	596.99	560.21	-36.78

* Nurses in post information taken from e-rostering system

Chart 5 below shows a comparison of staff in post against the SafeCare data output in WTE.

Chart 5



5.0 Monthly Staffing Return

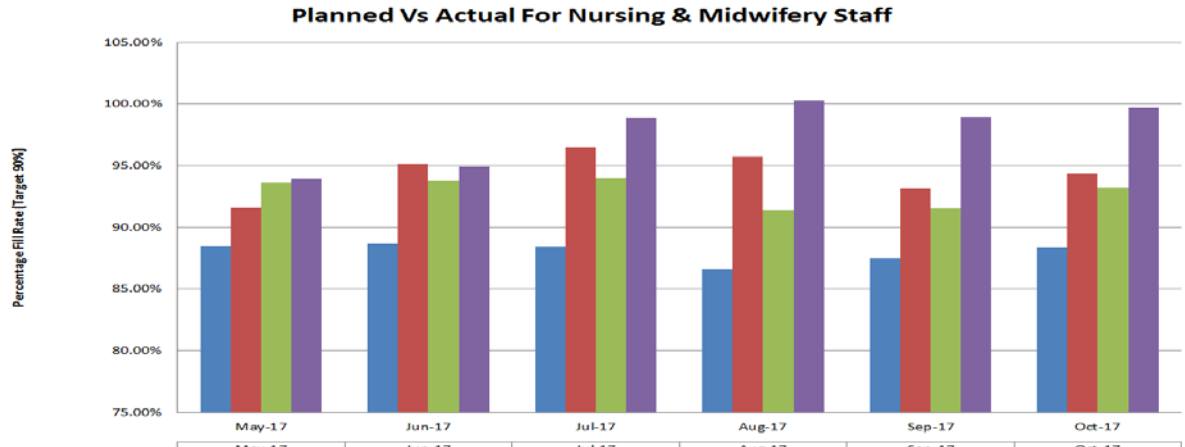
Nursing and Midwifery staffing data is published on a daily basis at entrances to WHH wards along with submission of data on a monthly basis through the Unify system to NHSE, in addition to publication on the Trusts website and reporting to the Board of Directors. A review of the 'ward staffing boards' will take place in 2018 to support patient understanding of ward staffing areas.

The following chart (6) shows a summary position of the last 6 monthly returns to NHSE. Planned versus actual staff on duty per day is described as a "Fill Rate" with achievement of the 90% standard for RN fill rates for night duty.

Although the 90% standard has not been constantly achieved during the day time there have been mitigating actions taken with senior nurse escalation, and an increase in health care support worker fill rates to support the ward teams. Matrons and Lead Nurses support the Ward Managers with ward risk assessments and staffing plans to ensure safety is maintained.

Chart 6 illustrates Planned versus Actual Staff on Duty- as per the monthly staffing return.

Chart 6



	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
Qualified Day Fill Rate	88.49%	88.70%	88.42%	86.63%	87.48%	88.36%
CSW Day Fill Rate	91.59%	95.16%	96.48%	95.76%	93.14%	94.34%
RN Night Fill Rate	93.61%	93.82%	94.00%	91.39%	91.51%	93.22%
CSW Night Fill Rate	93.94%	94.93%	98.90%	100.30%	98.97%	99.69%

Work is currently ongoing to consider and benchmark the overall qualified and health care support worker fill rates with other hospitals.

5.1 Ward Manager Supervisory time

There is significant variability in the allocation and usage of supervisory (also known as Management) time for Ward Managers on WHH wards. It is clear however that a significant amount of supervisory time which has been allocated in the E Rostering system as management time is being spent by the Ward Managers on the ward caring for patients in order to adequately manage patient acuity due to staffing issues that can be related to sickness/maternity and the requirements for ward establishment reviews. An audit is to be undertaken on ward manager supervisory time so we can better understand the ward managers who are not able to perform some of their duties and ward manager roles.

6.0 Women and Children

6.1 Paediatrics

Nurse staffing levels for Paediatrics are based on RCN standards from the document Defining Staffing Levels for Children and Young People's Services: RCN Standards for Clinical Professionals and Service Managers (July 2013). This supports assessing acuity with numbers of staff on shift patient acuity and dependency needs. The adapted acuity tool commenced use in June of this year. Acuity against staffing is monitored at 3 different time points through a 24 hr period on B10, B11 and PAU, these being 0700, 1400 and 2100. Data collated during the first 2 weeks of October showed a shortfall of acuity against staffing on 1st (am -0.1wte, pm -4.9wte and night -4.3wte), 3rd (am -0.3wte), 4th (am -0.4wte and night -1.1wte), 5th (am -0.5wte), 12th (night -0.5wte), 13th (am -0.2wte), 14th pm -0.2wte and night -0.8wte).

To ensure safe quality care delivery in the paediatric department staff were moved flexibly from one area to another within the speciality and temporary staff utilised where there was a shortfall. A business plan for paediatric staffing is currently underway and a review of paediatric urgent care has recently been completed. The Lead Nurse for Paediatrics oversees the current staffing model to ensure safety is maintained whilst the review is underway.

6.2 Neonatal Unit (NNU)

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

BAPM staffing recommendations are assessed at two points of a 24 hour period on the Badgernet system for the NNU at Warrington. This system is used across the whole of the region for all NNU's. Acuity against BAPM standards using the Badgernet system was assessed over a 14 day period 1st October 2017- 15th October 2017. There was one occasion when staffing was below recommended standards and temporary staffing was utilised to cover this period. Temporary staffing is utilised to ensure BPAM compliance and the new lead for Paediatrics is undertaking a review of the ward staffing in early 2018.

6.3 Midwifery Workforce Position

Staffing levels are based on assessment of clinical risk and the needs of the women and their babies during labour, delivery and the immediate postnatal period. A minimum staffing ratio of 1:1 care for women in established labour has been recommended in Safer Childbirth 2007 and is further supported by NICE, 2015. A two week snapshot of staffing levels to meet acuity was performed between the 1st to the 15th October 2017.

The Birthrate Plus Acuity Tool provides staff with a framework to assess the demands within the Labour Ward and the number of staff needed. Using a classification system based upon clinical indicators during labour, birth and the immediate postnatal period the tool is able to record the fluctuating workload and can give an early indication when demand is greater that staffing available.

The two week snapshot has provided limited data and a longer reporting period would be more useful to show trends in activity and acuity. It should be noted that The Royal College of Midwives (RCM) recommend a target of 85% staffing levels to meet acuity with clear protocols for escalation.

It should be noted that WHH Midwives work flexibly between different areas of the Maternity service to ensure each setting is safe. The previous Birthrate Plus assessment was performed in 2015, and considered the whole of the woman's childbirth journey and covered all settings. This assessment gave a ratio of 1:29 (midwife: births). Birthrate Plus will be repeated in early 2018.

7.0 Additional Safe Staffing Considerations

7.1 Establishment Uplift

There is a requirement for an agreed level of contingency for planned and unplanned leave, within the nursing establishments, (this may also referred to as headroom or uplift). This uplift should include time for annual leave in line with Agenda for Change, study leave, sickness and any other absences that are within Trust Human Resource policies. Local factors must be considered when calculating the percentage allowances in an agreed uplift. Factors to be included currently within the organisation are long service entitlements in annual leave and alignment with Trust sickness / absence targets along with both mandatory and specific training leave for development. The requirement for this will be greater if there is a higher proportion of part time staff. Cognisance should be taken of the Mid Staffordshire Inquiry Report recommendation regarding the supervisory time for Ward Manager roles in order for them to be visible, role models and mentors for patients and staff whilst monitoring and reporting performance throughout their clinical areas.

It is important that the level of uplift is realistic and reviewed at least annually. Currently work is underway with the finance team to understand the WHH position against peer organisations in more detail to ensure alignment and parity, particularly with regard to the management of maternity leave which currently does not align with the uplift in establishment. At present WHH is both a national and local outlier in regards 'uplift' based at 20% with national recommendations between 22.5 – 25%.

7.2 Review of Ward Establishments

The Transformation Team and Deputy Chief Nurse have been working to identify areas of opportunity to redesign current workforce models to ensure alignment of the acuity of WHH patients with the skill mix needed to deliver the care that our patients need.

Appendix 2 shows the draft outline proposals for Ward A4 which has been populated with data extracted from various trust systems in order to redesign and create a new contemporary workforce proposal for the ward. A full and comprehensive risk assessment of the any new proposed staffing models aligned to the mitigations for changes and outcomes measures are essential before implementation.

The draft report aims to describe the current staffing situation relating to the bed capacity and patient acuity. It then moves on to describe what changes might be required to a) the bed capacity, b) the patient type, c) the staffing model and funded establishment, d) the skill mix or e) the function of the ward in future in order to ensure it operates as clinically and financially effectively as possible and also ensuring that we are able to staff it appropriately both now and in the future.

The Chief Nurse has requested that the review of ward establishments is undertaken at pace across all WHH wards especially in respect of the CQC "Must Do's" associated with staffing.

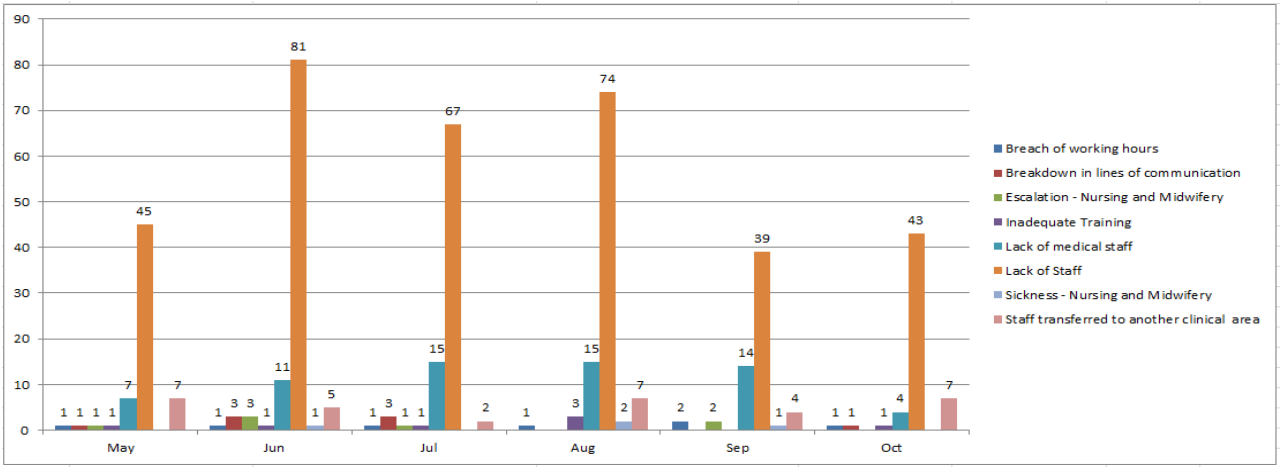
7.3 Reported Staffing Incidents

In order to ensure effective triangulation of data the following information was gathered from the Trusts Datix system to understand staff reporting rationales under the heading of staffing incidents.

Lack of staff, sickness and staff transfers are highlighted as the largest reason for completing a Datix within this criterion. This does not distinguish between members of the multi-disciplinary team however from initial analysis the predominant reason is due to lack of either Registered Nurse (RN) or Care Support Worker (CSW)

Chart 7

Number of staffing incidents from May 2017 to October 17.



7.4 Red Flags -NICE Requirements

From the "Safe staffing for nursing in adult inpatient wards in acute hospitals" Nice guidance, published July 2014, there is a recommendation that Trusts have a mechanism to capture 'red flag' events.

Red flag events can be defined as events that prompt immediate response by the registered nurse in charge of the ward on a given shift to ensure there is sufficient staff to meet the needs of patients on the ward. These events can be created and documented in the E Rostering Safe Care system in real time, and a rollout is being taken forward. It should be noted however that red flag type events are raised as part of the staffing element of the regular patient flow capacity meetings by Ward Managers, Matrons and Lead Nurses where actions to mitigate are implemented. Please see **Appendix 3** for further information

7.5 Use of temporary staffing

NHS Professionals (NHSP) is the preferred supplier of temporary staffing to the Trust. During periods of high demand NHSP have been unable to meet the demand which has resulted in the use of agency staff as per table 2 below.

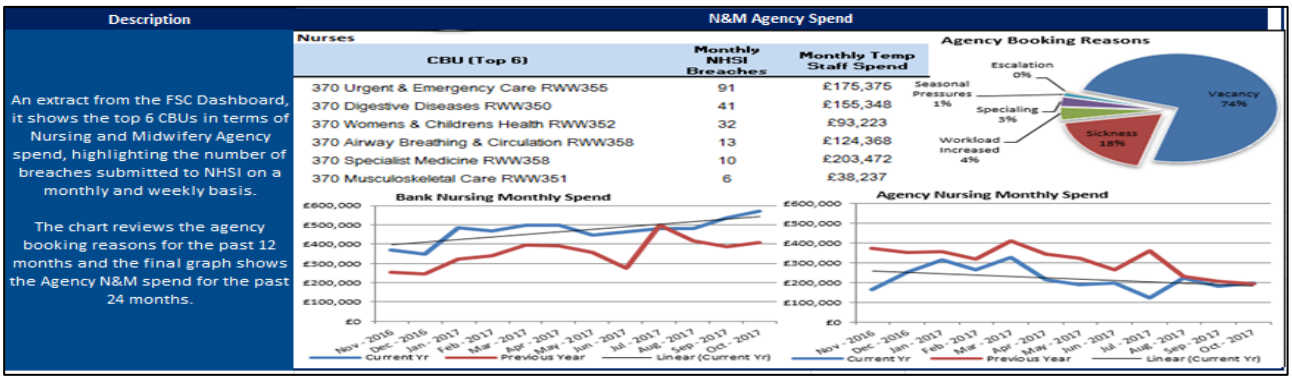
Table 2 Identifies Bank and Agency demand and fill rates over the last 6 months.

Directorate	Shifts Filled NHSP	Shifts Filled Agency	Unfilled Shifts	Demand	Overall Fill
AIRWAY BREATHING & CIRCUL	2046	324	1229	3599	65.85%
DIAGNOSTICS	336	57	197	590	66.61%
DIGESTIVE DISEASES	2103	1528	913	4544	79.91%
DISCHARGE/PATIENT FLOW	28	0	1	29	96.55%
MUSCULOSKELETAL CARE	668	151	525	1344	60.94%
OUTPATIENTS	64	0	20	84	76.19%
SPECIALIST MEDICINE	4378	515	2900	7793	62.79%
SPECIALIST SURGERY	32	0	17	49	65.31%
URGENT & EMERGENCY CARE	2102	978	1169	4249	72.49%
WOMEN'S & CHILDREN'S HEALTH	1515	377	456	2348	80.58%
Totals	11541	3367	6459	21367	69.77%

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

Chart 8 below shows reduction in usage of agency nursing staff with a reducing trend; however our aim continues to be to reduce our reliance on the temporary workforce overall.

Chart 8



8.0 Overall conclusions

The report represents the review of a two week sample of census data recorded within the SafeCare acuity and dependency system in October 2017 which overall shows a deficit of 36.78 WTE; in the previous report this deficit was significantly higher. The Executive Team received a high level presentation related to the review of ward establishment in November 2017 mainly related to the Division of Medicine and finalisation of this work, linked in with the contemporary workforce redesign is aimed for the end of December 2017.

Targeted training has been undertaken with ward staff to reduce inconsistency and variation in the assessment of acuity of our patients. This will continue in order that we can fully utilise the SafeCare system and have reliable and consistent staffing data. Senior staff review ward staffing on a three times daily basis with escalation of any areas of concern where actual staffing numbers do not meet those planned.

Furthermore the ongoing Nursing Recruitment and Retention Strategy continues to be delivered at pace, a review will be taken in 2018 and work is underway to ensure that the supervisory time afforded to Ward Managers that becomes direct care is recorded as such within SafeCare. Consistent recording and escalation of Red Flag events will become fully established in January 2018.

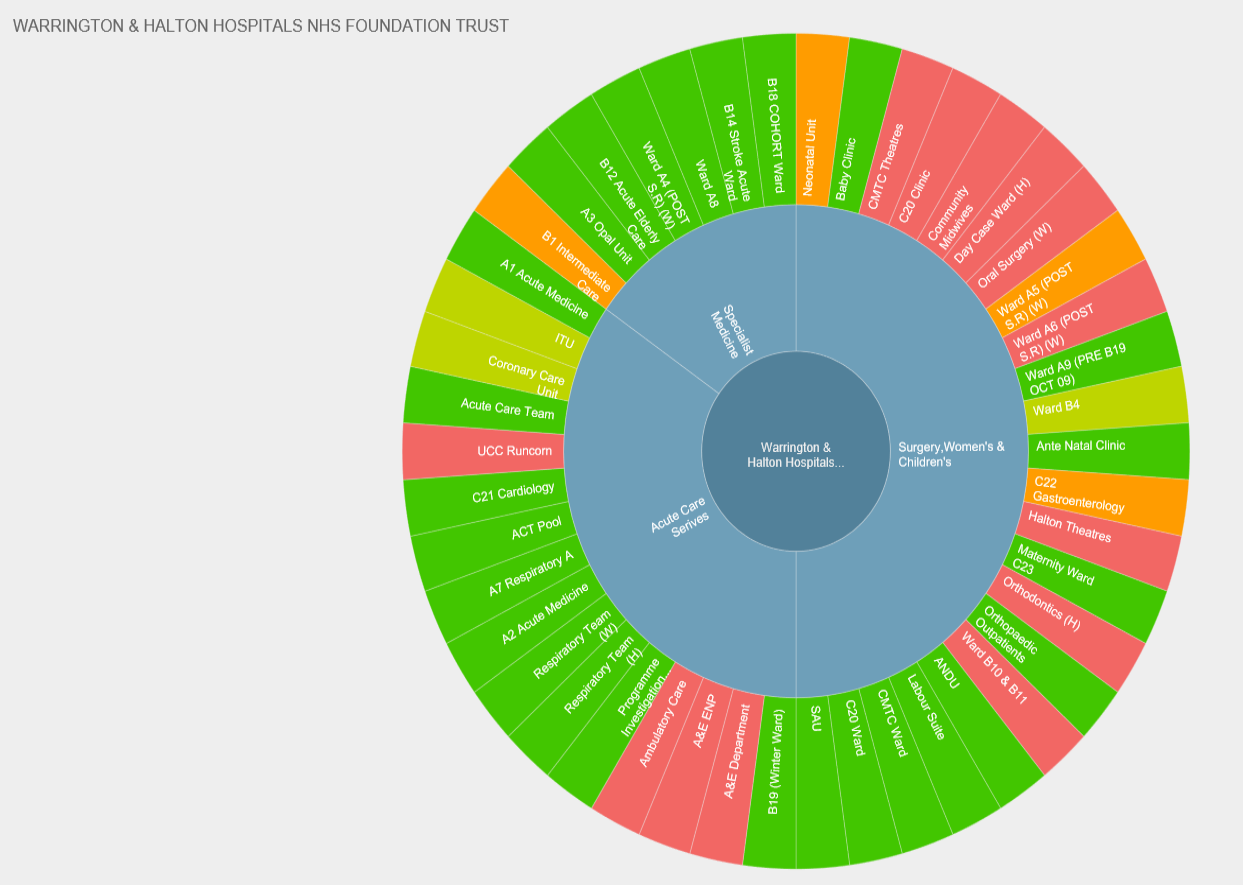
Daily shift checks by the Senior Nursing team along with real time escalation is in place to ensure safe, high quality care continues to be delivered to WHH patients.

9.0 Recommendations

It is recommended that the Board of Directors are asked to receive this paper, which highlights the 6 monthly nurse / midwifery staffing review and note the actions taken and planned to ensure safe staffing.

Appendix 1

Allocate Safe Care "live" output



The above chart is an example of the live report that can, with one click, provide detailed information about staff and patients on all of our wards. Wards highlighted in 'Red' have either got a potential challenge (insufficient staff to provide adequate care) or have no submitted the required patient information.

This is reviewed with senior nurses on a three times daily staffing meeting that occur before patient flow meetings. Areas of concern are addressed and risks to patients and staff are minimised as a result.

Appendix 2

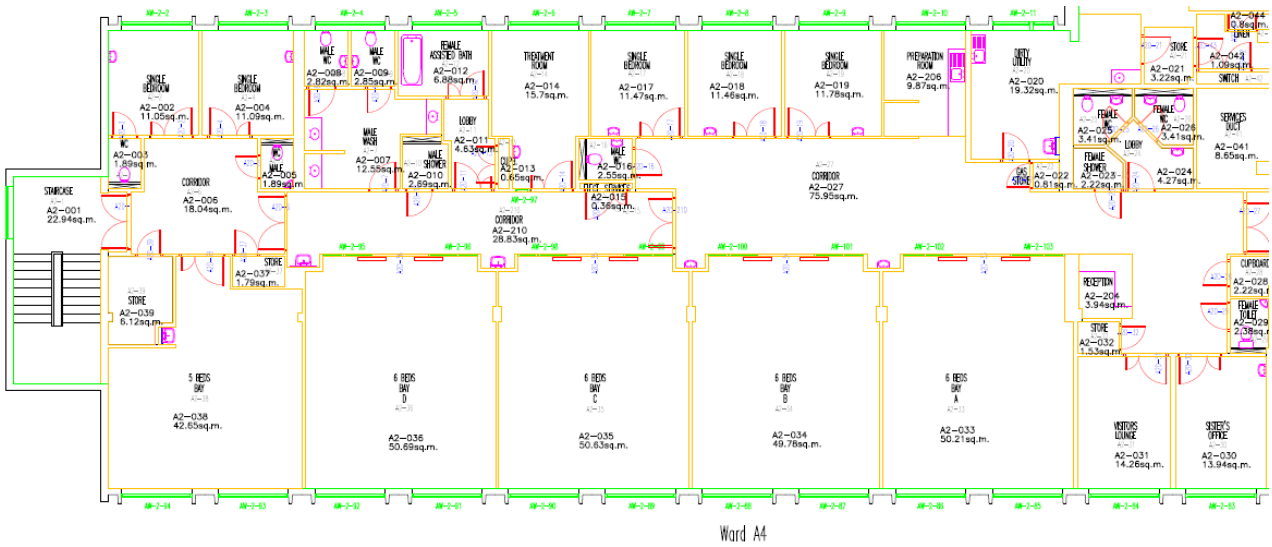
Ward A4

October 2017

1. Description of Ward in Current Form

A4 is located on the first floor of Appleton Wing.
It is managed within the Specialist Medicine CBU as part of the Acute Care Services Division.
The Ward Manager is Fiona Flack, reporting up through Grace Delaney-Segar (Matron) and Deb Hatton (Lead Nurse).

The ward is open 24/7/365 and has 34 physical beds across 5 bays and 5 side rooms (see ward floor plan below), however, the ward is currently only commissioned and therefore funded/established to open 24 beds routinely meaning that the other 10 beds are escalation beds only.
For the vast majority of the last 12 months, the 10 escalated beds have been open and in use by the Trust which has created some significant staffing challenges for the ward. The ward activity data to illustrate the bed demand is shown below in section 2 and the staffing situation is illustrated in section 4 below.

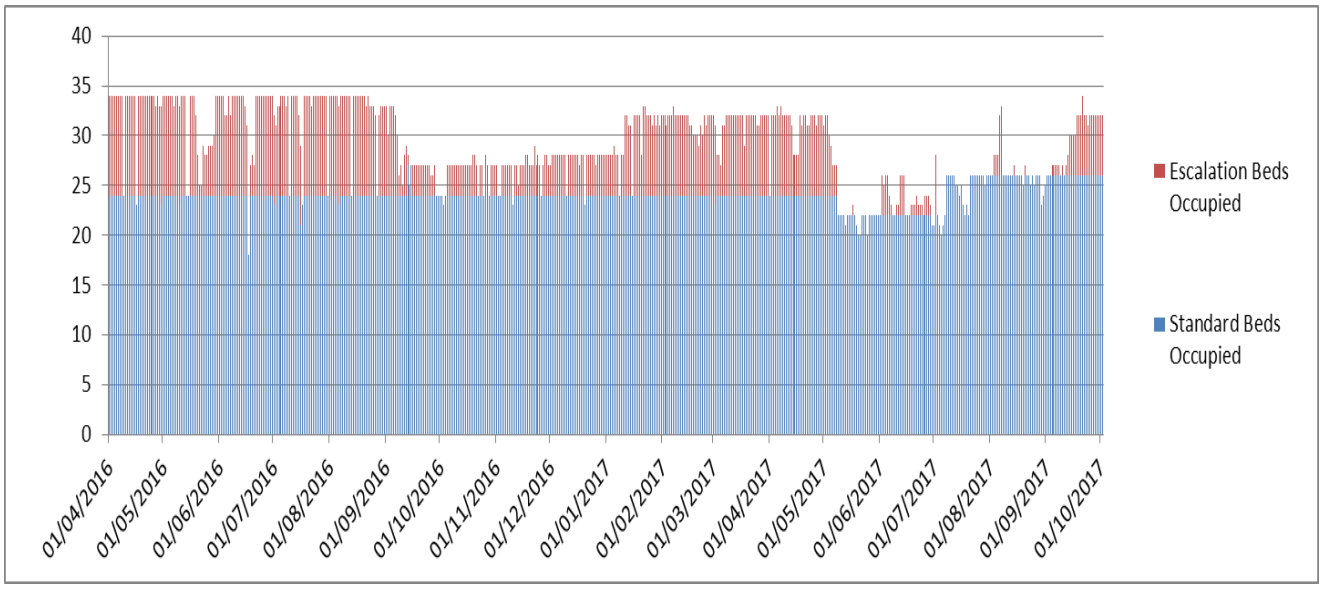


Ward Floor Plan – Ward A4

Some history on this ward is helpful in terms of understanding the commissioned bed base. Ward A4 was historically a 34 bed surgical ward containing SAU and a bed base for surgical inpatients. Following a prolonged period where the ward regularly accommodated a high number of medical outliers, the decision was made to physically relocate the SAU elsewhere and convert the ward to a medical ward. Once the funding for the SAU had been stripped out, the remaining staffing budget was only sufficient to safely staff 24 beds, hence this is what the establishment for A4 is based on. The ward is medically overseen by a GP covering 5 sessions per week

2. Activity Profile of Ward

32 beds in use between January and May 2017 then reduced then 32 beds in use again from mid-September. All of the patients are medically optimised and awaiting transfer to either their own home or an alternative care setting



3. Current Funded Establishment

A4 is currently funded for 25.98 wte staff as per the table below:

Band	WTE		
	Rostered	Other	Total
7	0.20	0.80	1.00
6	2.00	0.00	2.00
5	10.68	0.00	10.68
Total qualified	12.88	0.80	13.68
2	10.30	0.00	10.30
Ward Clerk A&C Band 2	0.00	1.00	1.00
House Keeper HCA Band 3	0.00	1.00	1.00
Totals	**23.18**	**2.80**	**25.98**

The funded establishment is based upon staffing **24** beds with the off duty numbers below:

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Long Day	3+2	3+2	3+2	3+2	3+2	3+2	3+2
Night	2+2	2+2	2+2	2+2	2+2	2+2	2+2

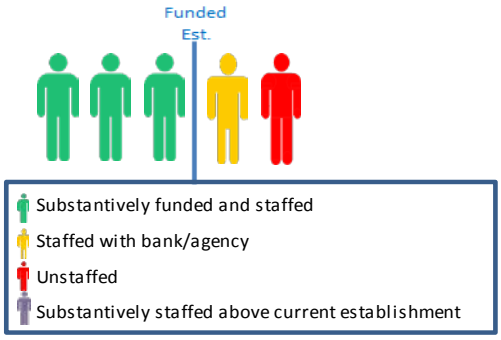
The current funded establishment includes headroom of 20% broken down as follows:
15.7% Annual leave and bank holiday cover
3.1% Sickness cover
1.2% Study leave cover

4. Current Workforce Situation

The following analysis of the current staffing situation on the ward reflects a bed demand of 34 beds. Note: the current funded establishment is only based upon 24 beds.

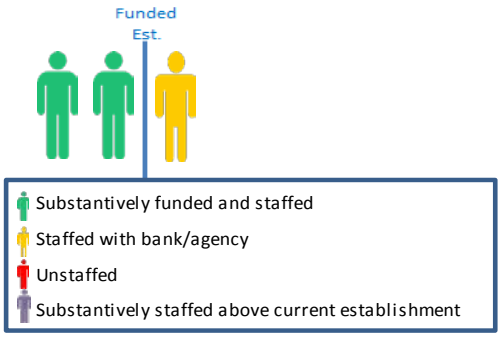
Ward A4 - Day Shift

Bed Numbers	34
RGNs required per day shift	5
RGN:Patient ratio	*6.8 : 1*

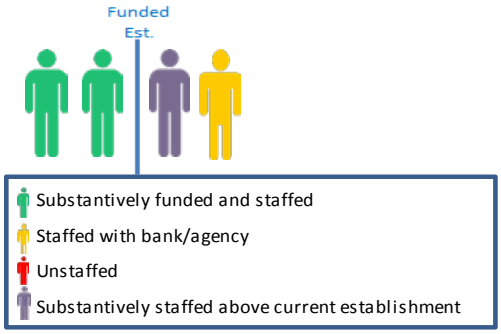


Ward A4 - Night Shift

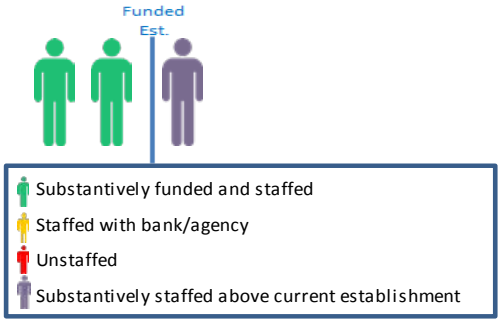
Bed Numbers	34
RGNs required per night shift	3
RGN:Patient ratio	*11.3 : 1*



HCAs required per day shift	4



HCAs required per night shift	3



The above analysis does not take into consideration any factors that would mean substantively employed staff were not available for work such as sickness, annual leave or maternity leave.

These factors are analysed below:
Sickness levels on Ward A4 over the last 12 months have averaged 8.09% although it should be noted that sickness has significantly reduced since February 2017 (average dropped to 5.33%).

	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Grand Total
370 ACS SM Ward A4 - 535169	13.01%	9.29%	13.21%	13.44%	10.81%	5.80%	4.25%	7.44%	4.23%	2.32%	6.41%	6.84%	8.09%

Maternity leave – Ward A4 has had no staff on maternity leave during the current financial year.

In addition, there were a significant number of shifts requested by this ward for specialing (enhanced care) purposes, averaging almost 1 shift per day during the first 6 months of the year.

Ward A4 NHSP Shift Requests for reason: Specialing - April to September 2017							
	April	**May**	**June**	**July**	**August**	**September**	**Grand Total**
Qualified		2					2
Unqualified	44	13	19	36	1	15	128
Grand Total	***44***	***15***	***19***	***36***	***1***	***15***	***130***

5. Current Quality/Safety Indications

Pressure Ulcers – Since April 2016, Ward A4 has recorded 3 grade 2 and 1 grade 3 pressure ulcers.

Complaints – Ward A4 has received 2 formal complaints between January and September 2017. Both complaints related to the admissions, discharge and transfer processes on the ward.

6. Summary

Changes to Ward Function/Form
New bed base?
Different cohort of patients?
Different location?

Changes to Funded Establishment
Review staffing model
Impact on ratios?
Cost
Wrap around discharge support?
Enhanced pharmacy support?
Enhanced therapy support?

Recruitment Requirement to Deliver
Needs to link to current staff in post (+ new recruits)

Other Considerations
Need for robust, documented and widely communicated criteria for admission
Target LOS for patients and ability to monitor against this.

Appendix 3

Red Flag Events

The following are recognised as Red Flag events:

- Unplanned omission in providing patient medications.
- Delay of more than 30 minutes in providing pain relief.
- Patient vital signs not assessed or recorded as outlined in the care plan.
- Delay or omission of regular checks on patients to ensure that their fundamental care needs are met as outlined in the care plan. Carrying out these checks is often referred to as 'intentional rounding' and covers aspects of care such as:
- Pain: asking patients to describe their level of pain level using the local pain assessment tool.
- Personal needs: such as scheduling patient visits to the toilet or bathroom to avoid risk of falls and providing hydration.
- Placement: making sure that the items a patient needs are within easy reach.
- Positioning: making sure that the patient is comfortable and the risk of pressure ulcers is assessed and minimised.
- A shortfall of more than 8 hours or 25% (whichever is reached first) of registered nurse time available compared with the actual requirement for the shift. For example, if a shift requires 40 hours of registered nurse time, a red flag event would occur if less than 32 hours of registered nurse time is available for that shift. If a shift requires 15 hours of registered nurse time, a red flag event would occur if 11 hours or less of registered nurse time is available for that shift (which is the loss of more than 25% of the required registered nurse time).
- Less than 2 registered nurses present on a ward during any shift.

Red Flags are currently inconsistently recorded in the SafeCare system; however we plan to re-energise and repeat ward level training in Spring 2018 ensuring that appropriate recording takes place.

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BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/18/01/14**
SUBJECT:	**Engagement Dashboard M9 and Half Year Report 2017-18**
DATE OF MEETING:	Choose an item. 31st January 2018
ACTION REQUIRED	**For Assurance**
AUTHOR(S):	Pat McLaren
EXECUTIVE DIRECTOR SPONSOR:	Pat McLaren, Director of Community Engagement Choose an item.
LINK TO STRATEGIC OBJECTIVES:	All
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	BAF2.4: Engaging & Involving Workforce
	Choose an item.
	Choose an item.
STRATEGIC CONTEXT	The Trust is required to engage with its patients, public, staff and partners and many other stakeholders as set out in the Foundation Trust's membership and engagement strategy.
EXECUTIVE SUMMARY (KEY ISSUES):	The 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. Key items to note: a. Positive and neutral media coverage outweighs negative, but issues in October 2017 relating to Suspension of Spinal Surgery has affected overall balance b. The Warrington Guardian continues to be the main publisher of WHH news with online reporting being the dominant medium 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) 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 e. Website engagement has risen steadily in year with 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)

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

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.

M9 Engagement Dashboard

Media dashboard: Overall media activity was down in month due to festive season and there was some negative media around A&E waiting times, the CQC report and suspension of spinal surgery. This was well balanced with significant positive reporting around Xmas and New Year activities at the hospitals.

Social Media: Twitter – we continue to grow our Twitter followers at a steady pace each month. Top Tweet was about our Head of Midwifery receiving her MBE.

Facebook: As expected for December there was a significant increase in activity and engagement across FB, with reach almost doubling and engagement and activity up by a third on normal rates.

Website whh.nhs.uk
A new website has been commissioned and engagement and involvement of staff, patients and public is underway. Expected 'go live' by 1st April 2018.

Staff Engagement
Staff Engagement with Team Brief continues to be challenging, however this has been augmented by the Brief in Brief distributed to all wards and departments by our new People Champions (60+ engaged so far).

Patient Engagement
Our new Patient Experience survey mechanism allows us to collate FFT feedback by interactive voice message, paper or text message depending on patient preference.
Response rates are significantly higher than previous paper only

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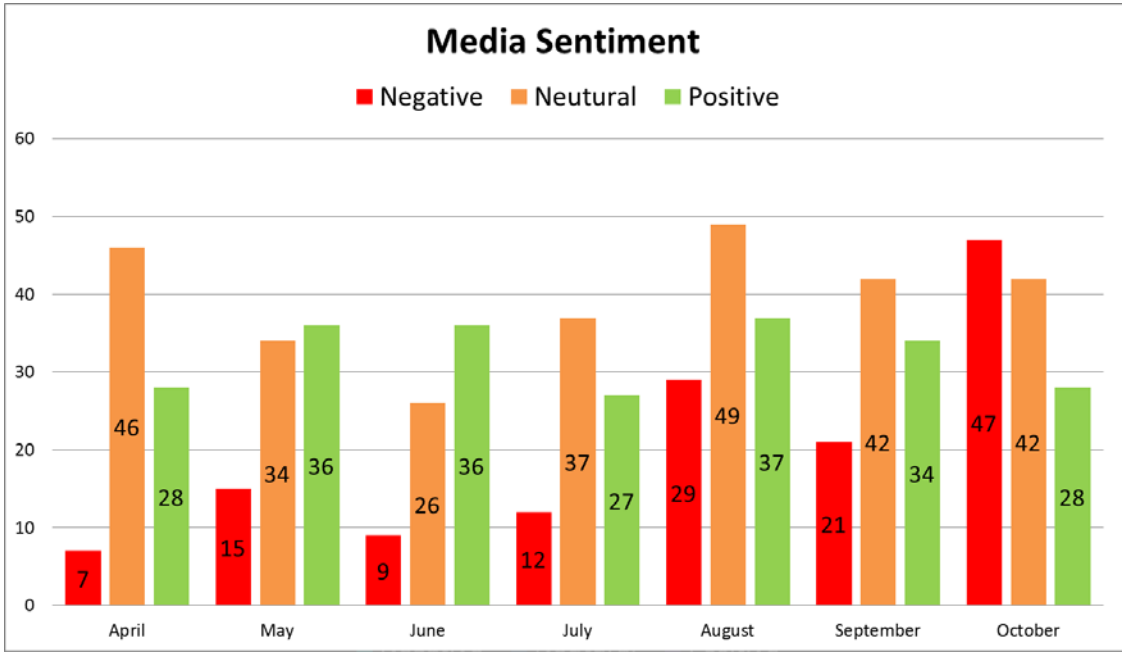
	systems and also provide richer experiential data. The data is also accessible in real-time enabling swift intervention. In December response rates were 1% lower than the previous month however recommendation rates remained steady at circa 95%.	
RECOMMENDATION:	The Board is asked to note the half year Engagement Report and the M9 Engagement Dashboard	
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	

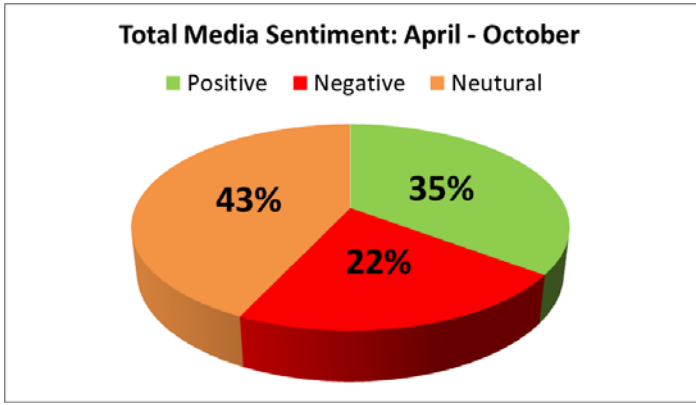
Warrington and Halton NHS Foundation Trust

Trust Engagement Dashboard

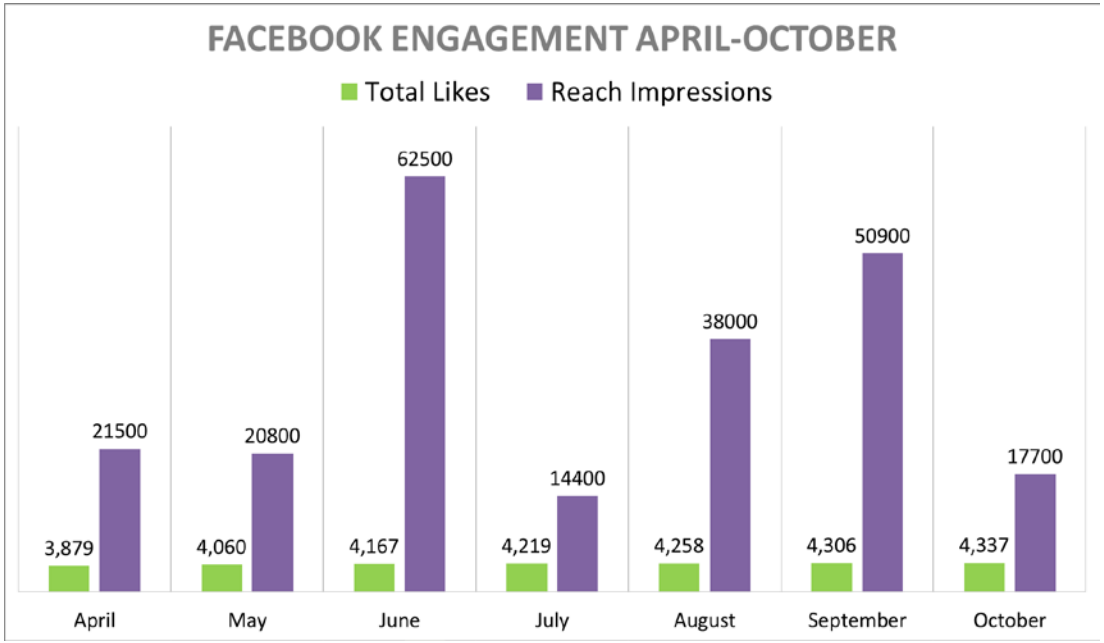
April 2017 – October 2017

Media Sentiment: April – October 2017





Social Networking: facebook



Warrington and Halton Hospitals NHS Foundation Trust

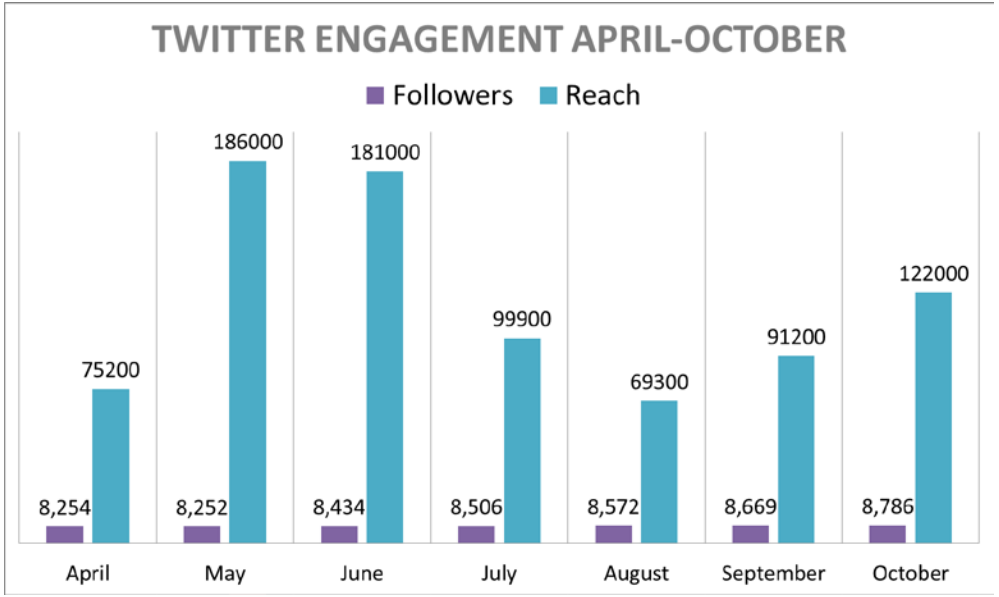
@WarringtonAndHaltonHospitalsNhsFoundationTrust

Total posts since April 2017: 188

Social Networking: twitter

Warrington&Halto...
@WHHNHS

Tweets	Following	Followers
4,982	242	8,786



Total tweets since April 2017: 572

Top mention earned 1,057 engagements

Jeremy Hunt
@Jeremy_Hunt · Oct 16

Who says 100% is impossible? Not @WHHNHS where they have achieved 100% screening of A & E patients for sepsis. Where Warrington leads...

55 57 114

Website Dashboard: April – October 2017

Device Category	Sessions	% New Sessions
	178,881 % of Total: 100.00% (178,881)	63.59% Avg for View: 63.57% (0.02%)
1. mobile	**97,671** (54.60%)	58.86%
2. desktop	**57,257** (32.01%)	73.40%
3. tablet	**23,953** (13.39%)	59.39%

Mobile Device Info	Sessions	% New Sessions
	121,624 % of Total: 67.99% (178,881)	58.97% Avg for View: 63.57% (-7.24%)
1. Apple iPhone	**54,157** (44.53%)	58.30%
2. Apple iPad	**16,482** (13.55%)	60.76%
3. Samsung SM-G920F Galaxy S6	**4,122** (3.39%)	55.56%
4. Samsung SM-G930F Galaxy S7	**3,782** (3.11%)	58.96%
5. Samsung SM-G935F Galaxy S7 Edge	**3,617** (2.97%)	57.76%
6. (not set)	**3,525** (2.90%)	60.62%
7. Samsung SM-G925F Galaxy S6 Edge	**1,726** (1.42%)	52.55%
8. Samsung SM-G900F Galaxy S5	**1,341** (1.10%)	57.42%
9. Microsoft Windows RT Tablet Windows RT Tablet	**1,140** (0.94%)	34.65%
10. Samsung SM-G950F Galaxy S8	**997** (0.82%)	56.97%

We are WHH and together we make a difference

Warrington and Halton Hospitals NHS

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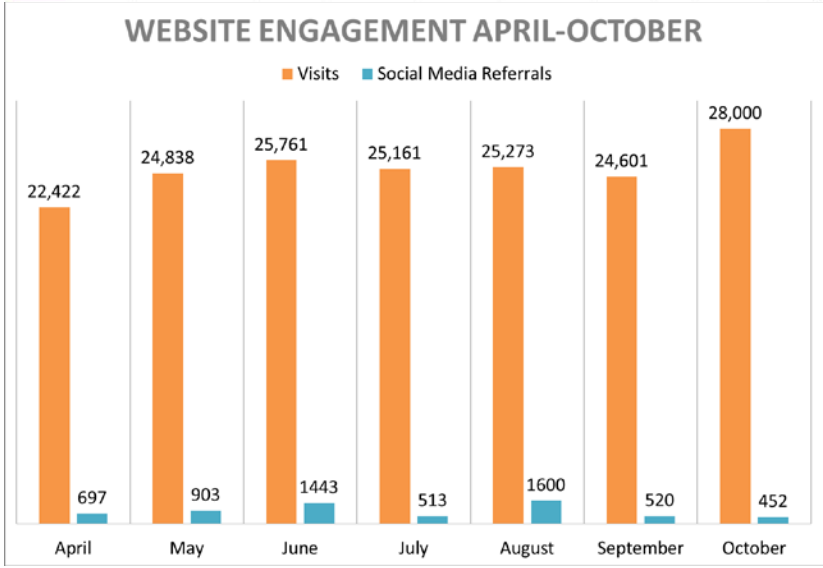
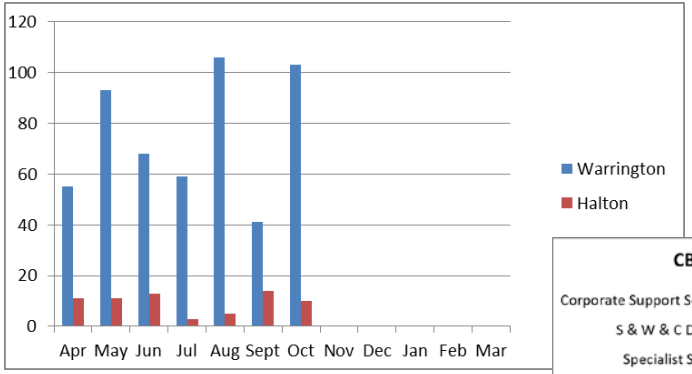


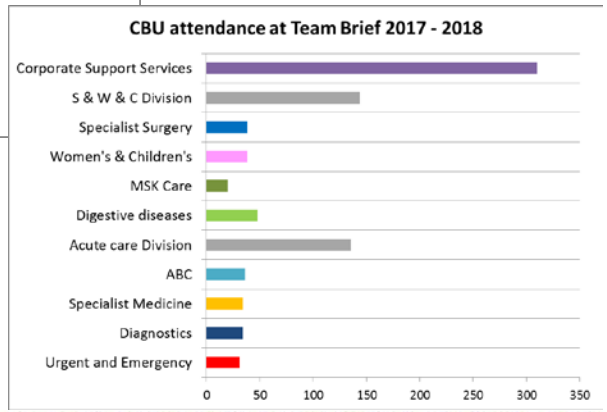
Total users since April 119,413, Total sessions 178,881, Average time 1.34 minutes

Staff Engagement: April – October 2017

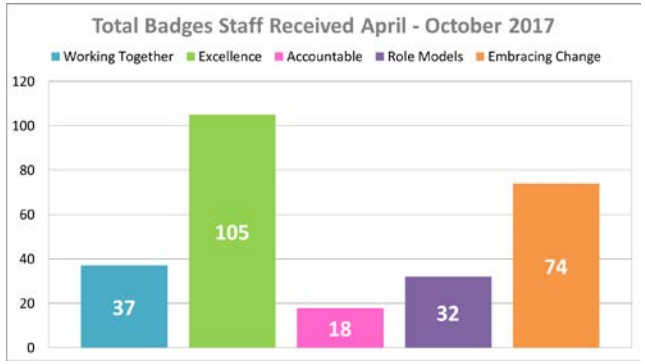
Team Brief Attendances

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





Working Together Excellence Accountable Role Model Embracing Change



Patient Engagement/ Experience: April – October 2017

Average Rating by NHS Choices

3.5 Average rating at Warrington

Last month: 3.5

5 Average rating at Halton

Last month: 5

4.5 Average rating at CMTC

Last month: 5

Care Opinion What's your story?

"could not have received better treatment..."

"A most pleasant experiance"

"Speedy XRay"

"Thankyou for your help"

"Excellent level of care."

"I can't fault my experience today."

"Well satisfiedwith service"

"Very caring endoscopy dept."

iWantGreatCare

The trusted site for healthcare reviews

Friendly and caring staff

The staff at all levels were true professionals

All staff friendly and understanding to my needs

Could not of had better and quicker treatment.

A very pleasant experience with caring staff

healthwatch

Warrington Hospital

Feedback Rating

Based on 334 reviews

Halton Hospital

Feedback Rating

Based on 66 reviews

CMTC

Feedback Rating

Based on 9 reviews

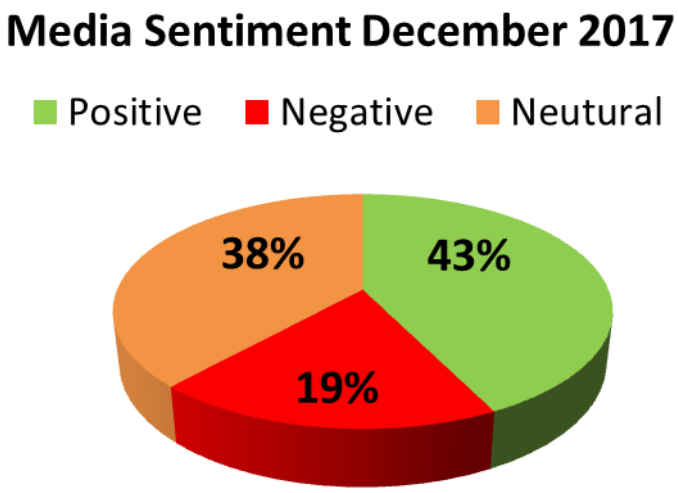
Warrington and Halton NHS Foundation Trust

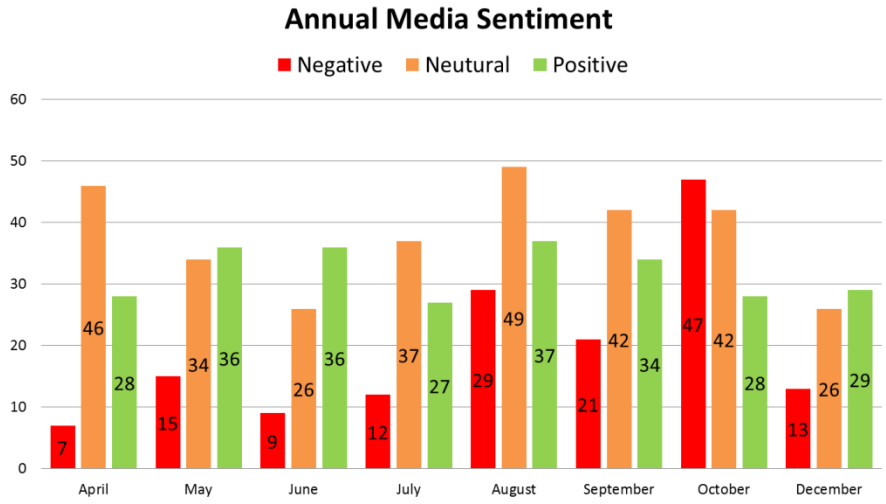
Trust Engagement Dashboard

Month 9 December 2017

Media Sentiment December 2017

Total Media Coverage = 68 Reports





Date	Headline	Sentiment	Reach	Publication
31-Dec-2017	Our picks of the best pictures of 2017: October to December	Positive	38,769	Warrington Guardian
30-Dec-2017	New Year Honours list in full - All the people being honoured for services to Britain in 2018	Positive	18,581,776	Mirror.co.uk
27-Dec-2017	PICTURES: Meet the Christmas Day babies born at Warrington Hospital	Positive	38,769	Warrington Guardian (eClips Web)
25-Dec-2017	Warrington Wolves players visit children spending Christmas in Warrington Hospital	Positive	38,769	Warrington Guardian
24-Dec-2017	St Barnabas' Church of England Primary School pupils sing Christmas carols for Warrington Hospital patients	Positive	38,769	Warrington Guardian
24-Dec-2017	Hospital Christmas dinner menus revealed - this is what patients are eating on Christmas Day	Positive	1,246,162	Liverpool Echo (eClips Web)
24-Dec-2017	Meet the 11-year-old girl who has made it her mission to 'spread kindness every Christmas'	Positive	38,769	Warrington Guardian (eClips Web)
14-Dec-2017	Warrington Hospital A&E doctor to retire after more than 40 years working in NHS	Positive	38,769	Warrington Guardian (eClips Web)
12-Dec-2017	Celebratory NHS exhibition at Warrington Museum & Art Gallery needs your help	Positive	4,626	Artinliverpool.com
11-Dec-2017	Former superstar wrestler conquers Italian Stallion Challenge in memory of his brother	Positive	13,253	Runcorn and Widnes World
4-Dec-2017	Mark Bostock from Callands died at Warrington Hospital after spending time on the intensive care unit	Positive	13,253	Runcorn and Widnes World
Date	**Headline**	**Sentiment**	**Reach**	**Publication**
30-Dec-2017	Residents urged to avoid Warrington Hospital's A&E departments with patients facing 'very long waits'	Negative	13,253	Runcorn and Widnes World
28-Dec-2017	Mum fears she could choke at any time as she waits for surgery on her neck	Negative	1,246,162	Liverpool Echo (eClips Web)
17-Dec-2017	Patients urged to use other services as A&E is at 'full capacity'	Negative	38,769	Warrington Guardian
15-Dec-2017	Spinal surgery to remain suspended at Warrington Hospital	Negative	38,769	Warrington Guardian (eClips Web)
13-Dec-2017	'More needs to be done' to bring Warrington Hospital up to standard - Warrington North MP Helen Jones	Negative	38,769	Warrington Guardian
7-Dec-2017	Tolls on the Mersey Crossings Next Share this debate 05 December 2017	Negative	37,230	Hansard Online - Parliament
7-Dec-2017	Campaigner says law change could help families who suffer agony of a stillborn child	Negative	38,769	Warrington Guardian (eClips Web)

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Warrington Guardian

25th December 2017

Warrington Wolves players visit children spending Christmas in Warrington Hospital

Bundles of joy delivered on Christmas Day

Top Sources

Results

0%

Warrington Guardian (eClips Web)
38.33%

Warrington Guardian
31.67%

Runcorn and Widnes World
8.33%

Mirror.co.uk
3.33%

InsideHalton.com (Metroland Media Group)
3.33%

Runcorn and Widnes World (eClips Web)
3.33%

30th December 2017

NEW YEAR'S HONOURS: Cllr Ian Marks, Dr Tracey Cooper and Norman Banner awarded MBEs by the Queen

24th December 2017

Meet 11-year-old Freya Allen, who has made it her mission to 'spread kindness every Christmas'

24th December 2017

St Barnabas' Church of England Primary School pupils sing Christmas carols for Warrington Hospital patients

Warrington&HaltonNHS @WHHNHS · Dec 18

Santa's helpers on the Xmas chocolate night round @WHHNHS #TeamWHHXmas @Mel_Pickup pic.twitter.com/MJbcUqjtlU

Warrington Hospital Maternity Unit Like Page

Published by Gina Coldrick [?] · 17 November 2017 ·

A big thank you from some of #teamneonatal for your support today. It was lovely to see you all #worldprematurityday

Top Tweet earned 15.5K impressions

Congratulations to our Head of Midwifery, Dr Tracey Cooper on being awarded MBE for her contribution to Midwifery in the Queen's New Year's Honours #proud pic.twitter.com/V2ue7EcAME

40 69 322

Twitter

8,987 Followers (Last month: 8,893)

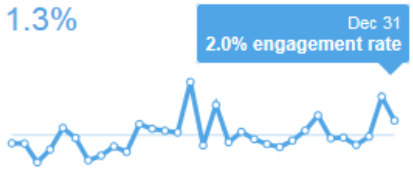
99 WHH Tweets (Last month: 72)

227K Reach (Last month: 249K)

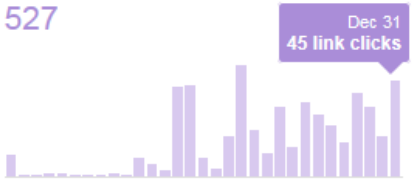
Engagements

Showing 31 days with daily frequency

Engagement rate **1.3%**

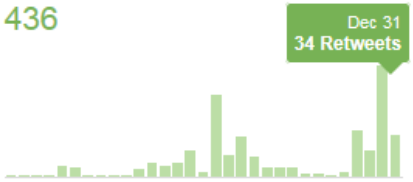


Link clicks **527**



On average, you earned **17 link clicks** per day

Retweets **436**



On average, you earned **14 Retweets** per day

Likes **911**

On average, you earned **29 likes** per day

Actions on Page
6 December – 2 January

34
Total actions on Page ▲278%

Page Likes
6 December – 2 January

91
Page likes ▲30%

Post engagements
6 December – 2 January

31,239
Post engagement ▲36%

Page Views
6 December – 2 January

3,452
Total Page views ▲34%

Reach
6 December – 2 January

51,730
People reached ▲96%

Warrington Hospital Maternity Unit Like Page

Published by Gina Coldrick [?] · 27 December 2017 at 18:50 ·

Meet our Christmas Day babies in Warrington Guardian this week. It was a busy day with 8 babies - 4 boys and 4 girls.

PICTURES: Meet the Christmas Day babies born at Warrington Hospital

MIDWIVES at Warrington Hospital delivered the perfect present to eight families on Christmas Day.

WARRINGTONGUARDIAN.CO.UK

27/12/2017 07:00		Our Tiny Stars Early Loss support group will meet again in January. Here
25/12/2017 12:28		Merry Christmas from the day staff in Labour Ward today. Wishing everyone
25/12/2017 08:05		Timeline Photos
24/12/2017 09:34		Merry Christmas Eve from C23!
21/12/2017 16:27		Need advice? Pop along tonight to our weekly clinic between 5-7.30pm The
20/12/2017 10:41		Need Breastfeeding Support this Christmas? Follow the link for our
19/12/2017 12:11		A big thank you to the West Lancashire Freemasons for their Christmas
19/12/2017 11:48		Our Children's Ward need chocolate selection boxes for the children this
19/12/2017 07:00		Come along this evening.

Facebook

5,900 Total Likes (Last month: 4380)

33 WHH Posts (Last month: 30)

4.7K Reach (impressions) (Last month: 3.8K)

Website Dashboard

Users
16,318

Pageviews
50,154

Pages / Session
2.27

Website

WHH
22063
Visits
Last month: 5995

651
Social Media Referrals
Last month: 311

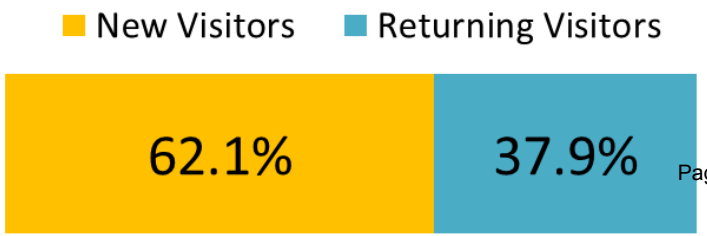
1min 33s
Length of average time
Last month: 1.285

We are WHH and together we make a difference

Home | About us | Patients & visitors | Services | Work at WHH | Contact us | Train at WHH | Charity | GPs | Volunteer

Device Category	Sessions	% New Sessions
	22,063 % of Total: 100.00% (22,063)	62.05% Avg for View: 62.03% (0.04%)
1. mobile	12,668 (57.42%)	58.60%
2. desktop	6,417 (29.08%)	71.56%
3. tablet	2,978 (13.50%)	56.28%

Mobile Device Info	Sessions	% New Sessions
	15,646 % of Total: 70.92% (22,063)	58.16% Avg for View: 62.03% (-6.24%)
1. Apple iPhone	7,344 (46.94%)	57.83%
2. Apple iPad	2,014 (12.87%)	57.10%
3. Samsung SM-G930F Galaxy S7	486 (3.11%)	61.11%
4. (not set)	478 (3.06%)	65.69%
5. Samsung SM-G935F Galaxy S7 Edge	457 (2.92%)	52.74%
6. Samsung SM-G950F Galaxy S8	398 (2.54%)	58.04%
7. Samsung SM-G920F Galaxy S6	342 (2.19%)	54.09%
8. Microsoft Windows RT Tablet	220 (1.41%)	39.09%
9. Samsung SM-A520F Galaxy A5 (2017)	178 (1.14%)	58.43%
10. Samsung SM-G925F Galaxy S6 Edge	134 (0.86%)	49.25%

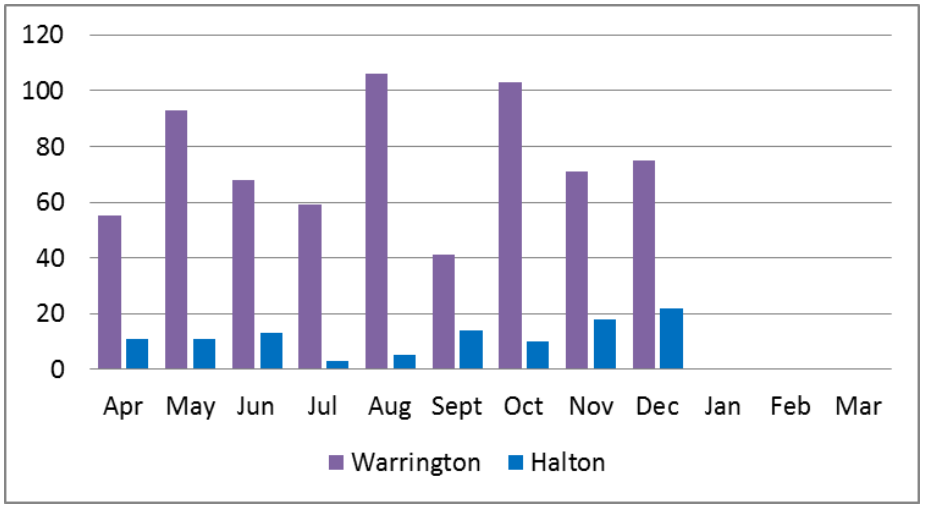


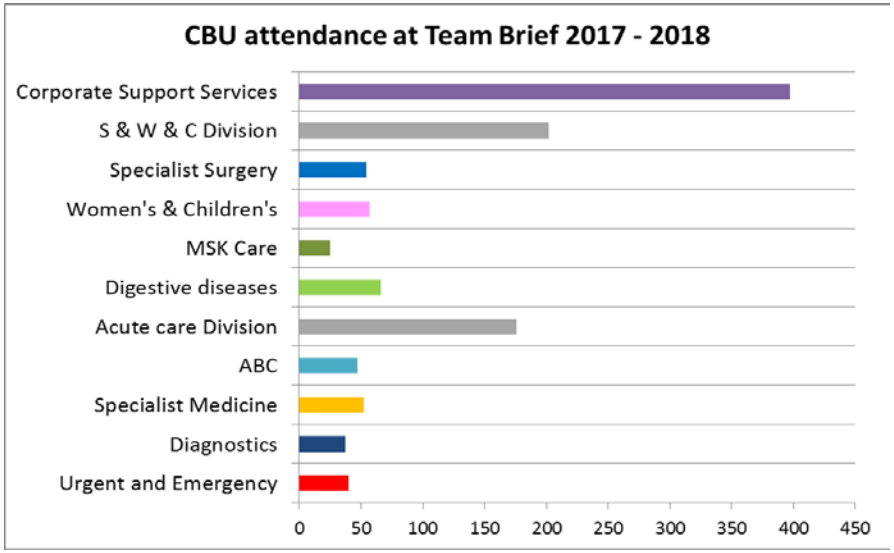
Staff Engagement

We are WHH

Team Brief Attendances

Staff engagement with Team Brief, delivered at two sites on two separate days following Board each month, remains challenging this year. Additional programmes are being implemented to drive this engagement including the appointment of our People Champions. Team Brief is a proven large, multi-site organisation engagement tool.





Patient Engagement/Experience December 2017

Average Rating by NHS Choices

3.5
Average rating at Warrington
Last month: 3.5

5
Average rating at Halton
Last month: 5

4.5
Average rating at CMTC
Last month: 5

12%
Response Rate

Patient Experiences

Positive: 90.35%
Negative: 5.50%
Ratings

Question 1	Ratings Received
IVM	1933
Paper Survey	848
SMS	2306
Totals	**5087**

Question 2	Comments Received
IVM	1547
Paper Survey	653
SMS	1764
Totals	**3964**

Top 10 Themes

	+ Positive		− Negative	
1.	Staff attitude	1972	Waiting time	138
2.	Implementation of care	1428	Staff attitude	132
3.	Environment	673	Environment	98
4.	Waiting time	641	Implementation of care	89
5.	Communication	502	Communication	76
6.	Patient Mood/Feeling	387	Patient Mood/Feeling	64
7.	Clinical Treatment	343	Clinical Treatment	63
8.	Admission	336	Admission	45
9.	Staffing levels	73	Staffing levels	19
10.	Catering	37	Catering	9

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healthwatch

Warrington Hospital

Feedback Rating

Based on 336 reviews

Halton Hospital

Feedback Rating

Based on 71 reviews

CMTC

Feedback Rating

Based on 9 reviews

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NHS Warrington and Halton Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/18/01/15**	
SUBJECT:	**Board Assurance Framework and Strategic Risk Register**	
DATE OF MEETING:	31 January 2018	
ACTION REQUIRED	**Review, Discuss and approve**	
AUTHOR(S):	John Culshaw, Head of Corporate Affairs	
EXECUTIVE DIRECTOR SPONSOR:	Pat McLaren, Director of Community Engagement	
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 are key updates to strategic risks. Notable existing risk updates are given, with any impact of risk scores. 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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NHS Warrington and Halton Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

SUBJECT	Board Assurance Framework	AGENDA REF:	BM/18/01/15

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 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.	Medical staffing updates in Acute Care Division • Approval for 7 Trust grades across the Acute Care division (3 appointed) , with a business case for additional 3 (Dec 17) • 3 speciality Drs recruited in acute care Division in past 6 months (Dec 17) A Medical Staffing Group has been convened – the remit will be widened to look at wider staffing issues e.g. education, trainees etc.	No impact on risk rating
Failure to deliver national and local performance targets will impact on patient care, reputation and financial position.	The Trust reported a Never Event in January 2018 which incurs a £10,000 financial penalty. Based on the latest reconciliation figures relating to M7, the Trust incurred sanctions relating to performance to the sum of £18,282.	No impact on risk rating
Failure to provide a spinal service for the local population, caused by	A weekly meeting is in place and looks at the following issues:	No impact on risk rating

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

Strategic Risk	Update since last Risk review	Impact of update on risk rating
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.	- External review - Serious Incidents and Complaints - HR issues - Contractual Issues - Finance issues - Communications The Medical Director and Deputy Director of Governance are meeting with the families/patients as appropriate of those who have been involved in Serious Incidents within the Trust. There has been a further Serious Incident declared regarding a death following on from a spinal procedure in October 2016.	
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.	ICE fully operational to report all results	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.	The first reported Serious Incident (SI) fall for four months was reported in January. The Falls Action plan continues to be implemented and the impact of staffing assessed on a regular basis. The financial impact associated with falls is great, the average cost of a no harm fall is approximately £2,600 for people over the age of 65 and for a severe harm fall £14,100.	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:

- 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 will be rolled out on 1st February 2018 and training has been taking place since 14th December 2017.

- The first meeting of the CQC Getting to Good Steering Group will meet on 8th February 2018. On review of the approved action plan, it is likely that new risks will emerge that require elevating to the Board.

3 RECOMMENDATIONS

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

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

Appendix 1- Strategic Risk Register

Risk	Residual Risk Rating (Impact x Likelihood) March 2017	Residual Risk Rating (Impact x Likelihood) April 2017	Residual Risk Rating (Impact x Likelihood) May 2017	Residual Risk Rating (Impact x Likelihood) June 2017	Residual Risk Rating (Impact x Likelihood) July 2017	Score at last review 21/09/17	Score at last review 14/11/17	Score at last review 17/01/18
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)	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)	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)	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)	16 (4x4)
Failure to provide adequate and timely	20 (5x4)	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

Risk	Residual Risk Rating (Impact x Likelihood) March 2017	Residual Risk Rating (Impact x Likelihood) April 2017	Residual Risk Rating (Impact x Likelihood) May 2017	Residual Risk Rating (Impact x Likelihood) June 2017	Residual Risk Rating (Impact x Likelihood) July 2017	Score at last review 21/09/17	Score at last review 14/11/17	Score at last review 17/01/18
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.								
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)	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	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

Risk	Residual Risk Rating (Impact x Likelihood) March 2017	Residual Risk Rating (Impact x Likelihood) April 2017	Residual Risk Rating (Impact x Likelihood) May 2017	Residual Risk Rating (Impact x Likelihood) June 2017	Residual Risk Rating (Impact x Likelihood) July 2017	Score at last review 21/09/17	Score at last review 14/11/17	Score at last review 17/01/18
decision making due to lack of quality data.								
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)	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)	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)	15 (5x3)
Lack of assurance regarding complaints handling within the Trust, caused by ineffective systems and processes, resulting in a poor experience for complainants, the Trust not meeting statutory and contractual complaints targets and not having effective systems in place to learn lessons from complaints	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	12 (3x4)	12 (3x4)

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

Risk	Residual Risk Rating (Impact x Likelihood) March 2017	Residual Risk Rating (Impact x Likelihood) April 2017	Residual Risk Rating (Impact x Likelihood) May 2017	Residual Risk Rating (Impact x Likelihood) June 2017	Residual Risk Rating (Impact x Likelihood) July 2017	Score at last review 21/09/17	Score at last review 14/11/17	Score at last review 17/01/18
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)	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)	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)	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	N/A	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

Risk	Residual Risk Rating (Impact x Likelihood) March 2017	Residual Risk Rating (Impact x Likelihood) April 2017	Residual Risk Rating (Impact x Likelihood) May 2017	Residual Risk Rating (Impact x Likelihood) June 2017	Residual Risk Rating (Impact x Likelihood) July 2017	Score at last review 21/09/17	Score at last review 14/11/17	Score at last review 17/01/18
in some areas, resulting in the risk of patients not receiving the appropriate, preventative treatment for VTE in hospital.								
Clinical variation, caused by lack of systems/process or failure of systems/to follow process leading to lack of evidence based practice, potential patient harm and reputational impact.	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)
Failure to successfully engage the Workforce, causing the potential for a negative working environment and the consequential loss of discretionary effort and productivity, or loss of talented colleagues to other organisations, which would impact patient care, staff morale and delivery of the Trust's strategic objectives	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	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)	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	12 (4x3)	12 (4x3)	12 (4x3)	12 (3x4)	12 (3x4)	12 (4x3)	12 (4x3)	12 (4x3)

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

Risk	Residual Risk Rating (Impact x Likelihood) March 2017	Residual Risk Rating (Impact x Likelihood) April 2017	Residual Risk Rating (Impact x Likelihood) May 2017	Residual Risk Rating (Impact x Likelihood) June 2017	Residual Risk Rating (Impact x Likelihood) July 2017	Score at last review 21/09/17	Score at last review 14/11/17	Score at last review 17/01/18
regulatory requirements								

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

Trust Board

DATES 2018-2019

All meetings to be held in the Trust Conference Room

Date of Meeting	Agenda Settings	Deadline For Receipt of Papers	Papers Due Out
2018			
Wednesday 31st January	Wednesday 10th January	Monday 22nd January	**Wednesday 24th January**
Wednesday 28th March	Wednesday 7th March	Monday 19th March	**Wednesday 21st March**
Thursday 24th May *(Year End)*	Friday 11th May **DATE TBC**	Wednesday 16th May **DATE TBC**	Friday 18th May **DATE TBC**
Wednesday 25th July	Wednesday 4th July	Monday 16th July	**Wednesday 18th July**
Wednesday 26th September	Wednesday 5th September	Monday 17th September	**Wednesday 19th September**
Wednesday 28th November	Wednesday 7th November	Monday 19th November	**Wednesday 21st November**
2019			
Wednesday 30th January	Wednesday 9th January	Monday 21st January	**Wednesday 23rd January**
Wednesday 27th March	Wednesday 6th March	Monday 18th March	**Wednesday 20th March**