We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

WHH Board of Directors Meeting Part 1

Wednesday 28 MARCH 2018
9.30am-12.00pm
Trust Conference Room

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

P U R D A H

Warrington and Halton Hospital NHS Foundation Trust

Agenda for a meeting of the Board of Directors held in Public (Part 1).

Wednesday 28 March 2018 **9.30am-12.00pm**

Trust Conference Room, Warrington Hospital

REF BM/18	ITEM	PRESENTER	PURPOSE	TIME	
BM/18/03/	**PATIENT STORY**	**Trish Richardson Patient Experience Manager**		**9.30**	**Verbal**
BM/18/03/17	**Welcome, Apologies & Declarations of Interest**	**Steve McGuirk, Chairman**	**N/A**	**9.35**	**Verbal**
BM/18/03/18	Minutes of the previous meeting held 31 January 2018 and 28 February 2018 **PG 3 + 16**	**Steve McGuirk, Chairman**	**Decision**	**9.37**	**Enc**
BM/18/03/19	**Actions & Matters Arising PG 19**	**Steve McGuirk, Chairman**	**Assurance**	**9.40**	**Enc**

Quality People Sustainability

BM/18/03/20	**(Integrated Performance Dashboard M10 and Key Assurance Committee Reports PG 21**	**All Executive Directors**	**Assurance**	**9.45**	**Enc**
(a)	**Quality Dashboard inc Key Issues reports**	**Alex Crowe Medical Director Kimberley Salmon-Jamieson Chief Nurse**			
(b)	• **Key issues report Quality Assurance Committee (06.03.2018) PG 61**	**Margaret Bamforth, Cttee Chair**			
(c)	**Sustainability Dashboard inc Key Issues Reports**	**Andrea McGee DoF+Commercial Development**			
(d)	• **Finance and Sustainability Committee (24.01.2018 and 21.02.2018) PG 67 + 71**	**Terry Atherton, Cttee Chair**			
(e)	• **Audit Committee (22.02.2018) PG 76**	**Ian Jones, Cttee Chair**			
(f)	**People Dashboard inc Key Issues Reports PG 81**	**Michelle Cloney Director of HR&OD**			

Quality

BM/18/03/21	**Quarterly Mortality Review Report PG 104**	**Simon Constable Deputy Chief Executive/ Executive Medical Director**	**Assurance**	**10.15**	**Enc**
BM/18/03/22	**Learning from Experience Summary Q3 Report PG 118**	**Kimberley Salmon-Jamieson Chief Nurse**	**Assurance**	**10.25**	**Enc**
BM/18/03/23	**CQC Update PG 148**	**Kimberley Salmon-Jamieson Chief Nurse**	**Assurance**	**10.35**	**Enc**

Sustainability

BM/18/03/24	**Working Capital Loan PG 155**	**Andrea McGee Director of Finance + Commercial Development**	**Assurance**	**10.45**	**Enc**

BM/18/03/25	NHS Staff Opinion Survey PG 159	Michelle Cloney Director of HR&OD	Assurance	10.55	Enc
BM/18/03/26	Nurse Staffing Report PG 172	Kimberley Salmon-Jamieson Chief Nurse	Assurance	11.05	Enc
BM/18/03/27	Freedom to Speak up – Guardian Report PG 180	Kimberley Salmon-Jamieson Chief Nurse	Assurance	11.15	Enc
BM/18/03/28	Guardian of Safeworking Q3 report PG 184	Mark Tighe Guardian	Assurance	11.25	Enc

GOVERNANCE					
BM/18/03/29	Strategic Risk Register + BAF PG 197 - Quarterly Risk Register and BAF report - Monthly Strategic Risk update	Director of Community Engagement & Corporate Affairs	Assurance	11.35	Enc
BM/18/03/30	TOR + Annual Cycle of Business for ratification: (i) Trust Board PG 214 (ii) Audit Committee PG 226 (iii) Quality Assurance Committee PG 217	Director of Community Engagement & Corporate Affairs	Approval	11.45	Enc
BM/18/03/31	Council of Governors (a) Reappointment of the Trust Chair PG 237 (b) Amendments to the Trust Constitution (voting required) PG 241	Director of Community Engagement & Corporate Affairs	Assurance	11.50	Enc
	Close			11.55	
	Date of next meeting: Year End 24 May 2018				

Warrington and Halton Hospitals NHS Foundation Trust Minutes of the Board of Directors meeting held in Public (Part 1) on Wednesday 31 January 2018 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
Simon Constable (SC)	Executive Medical Director + Deputy Chief Executive
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 (AC)	Medical Director
In Attendance	
Lucy Gardner (LC)	Director of Transformation
Pat McLaren (PMcL)	Director of Community Engagement + Corporate Affairs
John Culshaw (JC)	Head of Corporate Affairs
Norman Holding	Lead Governor
Alison Kinross	Public Governor
Anne Robinson	Public Governor
	Representatives from Ramsey Health Care
Dr Ravi Badge	
Apologies	
Jason DaCosta (JDaC)	Director of IM&T

Agenda Ref BM/18/01/ 01	
BM/18/01/ 01	**Staff Story – Partnership with King Edward Memorial Hospital Mumbai and Recruitment Initiative** The Chairman welcomed Dr Ravi Badge who briefed the Board following a recent visit to Mumbai as part of a Trust recruitment initiative to recruit overseas Doctors, with Dr Alex Crowe. They shared key learning, options available which include Medical Training Initiative (MTI), working collaboratively with MCh Wrightington/Edge Hill and proposed next steps for the Trust to take which will help resolve the current recruitment and retention difficulties experienced by the Trust for Dr and Consultant recruitment. Cost of locums had been analysed, future options discussed and it was agreed to explore the recruitment of overseas Junior Doctors through MCh Programme run by Wrightington. This will enable in-house surgical rotation. The Chairman thanked Dr Badge and Alex Crowe for sharing the findings of their visit and asked if the plan is to secure these Doctors this year. AC advised 300 Doctors had been interviewed, 125 selected with 26 organisations involved in the process. WHH are in a good position to support and gaps identified in rota in different specialties, T&O) (6) and Acute

	Medicine (5) in the first instance with an anticipated commencement date of July/August 2018, with support from HR colleagues. IJ asked if a cohort had been identified to come to WHH, if an embedding period will impact on the 2 year duration of the placement and if a 'return' rate to India had been determined. AC reassured the Board that the Doctors want to complete this training, the return to India was minimal. RB asked MP if it was possible for C&M CEOs to request support through local MPs of the Home Office to expedite these visa applications. MP was pleased to advise that colleagues from HEE had attended a recent C&M CEO meeting where a consultation document had been shared for workforce planning which would see an NHS workforce strategy. The STP HRD is to lead on this for C&M to formulate a regional robust response across C&M which will include support for Visa applications. **The Board to receive a progress report in October/November.**
BM 18/01/02	**Welcome, Apologies & Declarations of Interest** The Chairman opened the meeting, and welcomed those in attendance. Apologies: as above. Declarations of Interest: J N Ezingeard with respect to BM/18/01/01 as Deputy Vice Chancellor of Manchester Metropolitan University with responsibility for under and post graduate education. No other declarations respect of agenda items.
BM 18/01/03	**Minutes of the meeting held 29 November 2017 and 20 December 2017** 29 November 2017, Pg 9 SOF. Indicator number to read 64. Pg 12 BM/17/11/119 Quarterly Complaints Report 5th para to read.. KSJ explained that there has been an increase in complaints around some external communication: spinal services and car parking; however, there is no evidence that KSJ was aware of in relation to rises in complaints associated with the Trusts receipt of the CQC report. 29 November 2017 Pg 15 BM 17/11/127 Halton Accountable Care System Action to read The Director of Transformation shared an overview of the development of the Trust Strategy and a draft Strategy Delivery dashboard. It was agreed that a dashboard/exception report would be provided regularly to board with the opportunity to "deep dive" into specific programmes as required. With these amendments, the minutes of November and December 2017 were agreed as an accurate record of proceedings.
BM 18/01/04	**Actions and Matters Arising** BM/17/11/24 Lord Cater. **Action closed**. Report received at today's meeting. BM/17/11/127 Halton Accountable Care System. Requested changes had been submitted to both Accountable Care Organisations. **Action Closed** Matters Arising.

	BM/17/11/111 Guardian of Safe Working Quarterly Report. MB asked if the Lead Employer for trainee Doctors had been resolved. MP explained this had been raised at a recent CEO meeting and a specialist Risk Review Group is to be established to explore options. The preference is for one Lead Employer for the whole of the North West. Once agreed, a competitive tender process would commence before a contract could be awarded. HEE have secured continuation of funding to March 2019.
BM 18/01/05	**Chief Executives Report** The Chief Executive updated the Board on matters that had occurred or progressed since the previous Board meeting: - Over the last 2 months the Trust had been dominated by operational issues which had required all Executives to be more operational than usual due to unprecedented demand in Urgent and Emergency Care. MP shared with the Board the systems the Trust set up to help during this time which included a 'Gold Command' centre at Warrington to manage flow of patients through the hospital during this time. Demand on capacity was exacerbated due to complexities and acuity of some patients. Delays in discharge of patients into the community and home also experienced due to delayed packages of care. - The Trust had also ran 'IMPACT 5' w/c 8 January 2018 in collaboration with stakeholders and partners to assist in the management of patient flow, identifying patients to be discharged as well as information gathering. Where capacity was not available in the community, patients remained in hospital. At one point 75 additional patients were admitted in the absence of any alternative setting for treatment. - MP and Board colleagues recognised the phenomenal response of clinical and non-clinical colleagues during this busy time, especially the response to the 'Helping Hands' initiative. - MP advised the Board that she had written the commissioners to meet as a matter of urgency to discuss how the commissioning of services that are urgently required can be progressed. Under instruction from the DoH and NHSE, the Trust had cancelled its elective programme. This will be reinstated from 1 February, however beds still need to be available to minimise further cancellation of planned operations. - MP also updated the Board on recent progress relating to the Accountable Care Organisations (ACO). In Warrington, plans are being progressed to establish an ACO Warrington Together, with representation across all health providers, to address demand and capacity issues across health, community and social care. - In Halton, plans for a partnership approach had been discussed with the Board in December. - Warrington Together had received a draft strategy business case for a new of working. MP confirmed that A Davies, the Chief Officer at Warrington CCG has been nominated as Place representative for Warrington and will report directly to Andrew Gibson, STP Chair who is leading on the Place plans for Cheshire and Merseyside. There are 9 themes in total and WHH will service 2 of these. The Senior Change Team has representation from WHH.
BM 18/01/06	**Chairmans Report** The Chairman concurred with CEO sentiments regarding the excellent response and work of staff during the recent period of demand on capacity.

	- The Chairman briefed the Board on developments of Warrington Together. The first meeting of the Chair's sub-set of Warrington Together had met last week with colleagues from a wide range of stakeholders and partners where there was a degree of commitment to integrated working albeit concerns regarding associated financial implications to support this new way of working as there was no 'new' money identified for social care. All partners recognised the need for all organisations to recognise each organisations individual legal responsibilities during any decision making.
BM 18/01/0 *(a)*	**Integrated Performance Dashboard M9** The report was taken as read and each Director highlighted key areas for the Board to note <u>Quality Dashboard</u> The Chief Nurse highlighted areas to note **relating to the Quality KPIs:** 3 Quality indicators have moved from Green to Red in month: - (1) Sepsis AED screening, 88% achieved in December against a target of 90%. (2) Sepsis Inpatient screening, 86% achieved in December against a target of 90% December. (3) VTE 91.70% achieved against a target of 95%, a decrease from November of 95%. Data had yet to be validated for December. Review of themes underway with regards reduction of target since last month - Plans are in place to improve a number of indicators, including Incidents, NICE Compliance and Complaints. - <u>NICE compliance</u> – 68.39% achieved against target of 75% which is a slight increase from November position of 7.24%. Steady improvement noted from April 2017. AC and SC have raised through the Medical Cabinet and this continues to be monitored through PSCE. Support from the Clinical Governance Department continues across CBUs. - <u>Incidents</u> – further work taken place to close down outstanding actions for incidents. A workshop in November resulted in 98 actions being closed down, 97 remain open, of these 58 have breached. 240 closed down in a workshop in January and further workshop in February planned. 654 remain open requiring review and sign off. - <u>Complaints</u> – 95 open complaints at the end of December, the Trust improvement trajectory of 75 open complaints by the end of December not met. KSJ reassured the Board that the Governance team is working to resolve and obtain responses from colleagues to allow responses to complainants to be finalised, albeit delays experienced due to winter pressures for some responses. A plan is in place to be back on plan by the end of March. - KSJ reassured the Board that a recent workshop to look at the number of incidents had enabled 200 to be removed with further work to reduce this number - Upward trend in outstanding actions not being closed down due to staff becoming familiar with the new Datix process systems and now being able to close down incidences. Training is being rolled out to support staff. - 1 Never Event reported in January on ITU, involving a locum member of staff. KSJ reassured the Board that agreed actions are in place to mitigate further events. - <u>HCAI</u> indicator will remain Red for the remainder of the year as the Trust reported 1 case of MRSA in July 2017 against a national threshold of zero tolerance. - Safer Surgery, 99.91% achieved against a target of 100%, on review this is slightly higher

	than last month. - CQUIN – SEPSIS Antibiotic Review, Green reported in November but unable to provide a report for December due to a delay in the validation of data. - Falls and Pressure Ulcers both moved to Green. Pockets of inconsistency on some wards noted and shared learning is taking place on all wards regarding assessments and use of Kits. - F&F Inpatient indicator moved from Red to Green achieving 95% in December. - F&F A&E and UCC – 82% patients recommended WHH in December against trajectory of 87%, number of responders similar at 70%. A dip seen in recommendations partially due to the number of patients completing the F&F test, these themes are being analysed to improve recommendations. - MRSA Breaches – remain challenging around critical care - step down in 24 hours. The Medical Director highlighted areas to note:- - AC reassured the Board that NICE Compliance performance is being monitored through the Patient Safety and Clinical Effectiveness Committee (PSCE) and 1:1 discussions are being held with NICE leads in order to progress. - VTE – moved to Red in December, achieving 91.70% against a 95% target. AC informed the Board that there are some IT matters to be resolved with DXC relating to retrieval of data through Lorenzo meaning that data is being validated manually. The Director of IM&T is exploring alternative options and if this can be supported through E-Outcomes. The VTE Task and Finish Group will monitor progress to ensure performance is back on track either through electronic or manual validation. A new template is also being developed for VTE which has been adapted from Kings College. - In relation to safer surgery and checklists, MB challenged that performance had dipped and asked if and where exceptions are been reviewed to identify where checks were not been carried out. SC advised this data is available for speciality level and this data will be included in next months IPR.
(b)	Key Issues Report – Quality and Assurance Committee 5 December 2017 and 9 January 2018 The Key Issues Reports were taken as read and Margaret Bamforth, Chair of Committee highlighted: - Medical Devices training – is part of the MIAA Internal Audit Plan to monitor performance. - Safeguarding Plan – this will be aligned with the CQC Action Plan. - SMcG requested an update from MP on progress against the CQC Action Plan from the Monthly CQC Steering Group.
(c)	Sustainability Dashboard The Director of Finance + Commercial Development highlighted areas to note: - At the end of month 9, the Trust had a financial deficit of £11.2m, which is £6.8m off plan YTD. This has increased by £2.7m in December. This poses significant risk to the Trust's forecast outturn and cash position which had been debated at length at the Finance + Sustainability Committee (FSC) on 24 January when the CEO, Chairman and NED

colleagues joined the meeting to be part of those discussions. The FSC continue to scrutinise all aspects of spend on a monthly basis, as delegated by the Board, escalating any matters of concern to the Board.

- Key drivers for this cumulative variance to plan are unclaimed STF (£2.1m), loss of income and activity associated with suspension of spinal activity (£1.0m) and a CIP shortfall against target (£3.1m)
- Cash - continues to be a key challenge and is monitored on a daily basis.
- Capital – cumulative spend £1.6m below planned capital spend of £5.6m. Minor changes had been made to the capital plan which had been reviewed by the FSC.
- AM reassured the Board that the financial challenges have been discussed with NHSI since month 3, who remain fully supportive of the measures and actions the Trust have in place to meet these pressures.

CIP

The Director of Transformation highlighted the following for the Board to note:

- YTD behind £3.8m at month 9 and £2.1m cost avoidance, £1m below month 9 CIP target of £6.9m.
- LG noted, following meetings with each CBU that some improvements have been noted.
- As Chair of the FSC, TA informed colleagues that the FSC on 24 January had discussed the necessity to seek further working capital loan (WCL) support to manage creditor and debtor payment. They were joined by the CEO, Chairman and other NED colleagues where these and other financial pressures were robustly discussed. Pay was discussed at length and the 2017-18 forecast to NHSI which had assumed a reduction in pay which had not been achieved. TA reiterated that on behalf of the Board, the FSC continues to interrogate and review all components of pay spend through monthly reports from the Pay Spend Review Group.
- There were concerns regarding continued reliance on DoH to fund Trust deficits and the cumulative value of WCLs covering 2015-16 to 2017-18 of £27.2m.
- TA commented that it is important that the Trust can demonstrate systems and controls of pay and other spend are as robust as possible with continued reporting across FSC and the Audit Committee. PMcL reassured the Board that all appointments at 8C above will be reported to the Audit Committee to provide an additional level of scrutiny.
- To reflect the current financial position, the FSC proposed and recommended an additional risk to the Risk Register which will be discussed later in this meeting.

- In reply to questions asked regarding NHSI view to the current financial situation and their support, AM reassured the Board that there is open, continued and transparent dialogue and reporting with NHSI both through individual meetings and the PRM meetings. NHSI are clear on the current financial risk faced. They have not raised any major concerns and support the systems in place and actions being taken by the Trust to meet the financial challenges. NHSI recommendation is to retain the current position. The Trust is working with NHSI, NHSE and commissioners to establish a clear structure for collaborative working across the system. Despite the support of the NHSI, there are concerns regarding 'Going Concern' issue which will be the focus of the Trust External Auditors and will become an emphasis of matter with the Annual Report.
- JNE asked AM if the Trust was doing all it could in the current situation as management of

	cash position previously had contributed to the current position. TA reassured that some areas had been identified where some inconsistencies in seeking approval for expenditure had been identified and had not followed due process despite there being systems in place. Systems are now in place for a deeper level of control and are escalated to the CEO. - SC acknowledged that there needs to be continued tighter control on pay but this needs to be considered alongside the bigger problem of increased demand on capacity due to escalated beds and not being able to discharge medically fit patients to the correct care setting, together with recruitment to difficult to recruit to posts. As such agency spend is needed to meet these demands but SC reassured the Board that the initiatives discussed earlier in the Mumbai presentation will support this.
(d)	<u>Key Issues Report – Finance and Sustainability Assurance Committee 19 December 2017</u> The report was taken as read and key elements of this report had been discussed at length in the Finance and Sustainability item.
(e)	<u>People Dashboard</u> The Director of HR and Organisational Development highlighted areas to note: - <u>Sickness absence</u> - 5.03% in December against a target of 4.2% which is slightly higher than the same period last year. Work to identify where staff are being moved around dependent on acuity. An additional centralised reporting structure for staff to report into for absence as a mechanism for early intervention, will help provide checks and balances with further support for ward managers to manage absences. Completion of RTW will remain with line managers. In addition the Health & Wellbeing Team have been working on the delivery of the national flu vaccination campaign and to date 82.5% of front line staff have been vaccinated. Further vaccinations were given in January with a noted inclusion of staff who had previously refused. The final submission for flu vaccination rates is expected on 28 February 2018. - AW supported this early intervention, reiterating the importance of timely completion of RTW and asked if this is being done. MC reassured the Board that an audit had been undertaken for the Workforce Committee with an action plan to identify gaps. RTW is happening but there are some delays electronically submitting the RTW after it has completed manually. HRBPs are supporting this piece of work. The Chairman commented that since the governance review the profile of the QPS 'people' agenda was not as evident to the Non Executives as had been previously and that this may be an area for future review. - MC was pleased to report that a Mental Health First Aider Programme, endorsed by HEE, had been launched across the Trust to work with staff who have been absent with stress and mental health issues. This will reduce waiting times for Occupational Health. - Non-contracted pay spend 11.39% above budget in December. Collaborative discussions across STP to develop a regional bank with workshops for HRDs and Nurses to understand requirements and share information. This is being led by HEE and the local lead is Countess of Chester HRD. - Agency Medical spend £600k in December and agency AHP spend £65k in December. - Two Workforce indicators had moved from Red to Green in December, agency Nurse

	spend £177k in December is below the December 2016-17 baseline of £251k. - Average length of service for Top10 agency workers was 21 months in December reduced from22 months in November. - MC reassured the Board that all spend elements will be reported to the FSC for scrutiny, including nurse spend and that Top 10 agency workers continue to be monitored. Access and Performance The Director of Transformation highlighted key points for the Board to note: - Red indicators had decreased to 7 in December, from 8 in November due to improved performance around Cancer 62 days and urgent breast symptoms 14 day indicators. Cancelled operations - indicator had moved from Green to Red due to 2 cancelled ops for non-clinical reasons where a date was not issued with 28 days of the cancellation. Patients have both now received treatment. - A&E waiting times 4 hours – 83.78% achieved in December, a decrease from November of 87.5% however the Trust were the best in the region for December. - A&E STP trajectory – 83.78% achieved against a trajectory of 89.6%. January trajectory will not be achieved which will impact on plans for February and March. - Ambulance Handovers - delayed handover in month from 189 to 291 in December however the Trust was the best in region up to Christmas, averaging 30 minutes and is continuing to take diverts in December and January. - RTT - all indicators Green. CMTC had been closed to support recent challenges and reopened on 29 January. 60 patients will be treated by the end of this month. - **The Board noted the report.**
BM 18/01/08	**Spinal Services Update** The Deputy CEO/Executive Medical Director provided a update for the Board to note, highlighting the following: - The final report had been delayed and is now expected February/March 2018. - SC and MP had attended C&M Spinal Services meeting to discuss further service provision across C&M. • **The Board noted the update and will continue to receive monthly reports.**
BM 18/01/09	**Quarterly Reponse to Lord Carter** The report was taken as read and the Director of Finance + Commercial Development asked the Board to note progress and compliance against the Carter Report targets and performance indicators. • **The Board noted the report and progress against compliance**
BM/18/01/10	**Forecast Outturn Position** The Director of Financial and Commercial Development highlighted key areas for the Board to note, which had also been discussed earlier in the meeting: - 2017-18 forecast outturn with mitigating actions is a deficit of £15.8m, a variance of £12.1m from plan. - Financial position at the end of December is a deficit of £11.2m which is £6.8m above planned deficit of £4.4m. - A forecast outturn has been prepared which indicates the gross deficit before potential mitigations is £19.0m (£15.4m variance to the annual control total). This was presented

	to the FSC on 24 January 2018 to seek their approval and support the recommendation to change the forecast outturn. - AM explained there are a number of key drivers contributing to the variance, including pay bill, including agency spend, in excess of plan (£3.3m), CIP shortfall (£5.3m) winter plan additional costs (£2.1m), reduced elective income due to winter £0.6m) spinal income (£2.3m) and non achievement of STF (£4.6m) as the Trust has not delivered Q3 financial target and is forecasting non delivery at Q4. Quarter 3 and 4 of STF funding is back-loaded this year and only £2.4m of £7m achieved. The Trust at the request of NHSI to provide additional winter capacity had presented a case to NHSI for £1.1m which was supported, however there is no guarantee at this time that this will be awarded to the Trust as it is being linked to performance delivery target. - The Board were asked to note the mitigating actions in place to reduce the gross deficit which had been RAG rated on their achievability. If the savings within the Green and Amber schemes were achieved this equates to £3.0m which would result in an improvement to the financial position to £16.0m deficit (£12.3m variance to annual control total). - AM advised the Board that since discussion at the FSC on 24 January, who had supported the change to its Forecast Outturn, further work had been undertaken which had identified a further improvement of £0.2m, reducing the deficit to £15.8m (£12.1m variance to annual control total). - NHSI had recommended the Trust change its Forecast Outturn at Month 10, to be submitted February 2018 due to the number of significant variables in the forecast. As further savings could be identified before 15 February, the Board supported the delay in signing by the Chairman, CEO, DoF and Audit Committee Chair of the Board Assurance Statement until nearer the deadline. • **The Board approved the change to forecast outturn for Month 10 monitoring returns to be submitted to NHSE and responded "confirmed" to all declarations on the Board Assurance statement.**
BM/18/01/11	**Additional Working Capital Loan (WCL)** The Director of Financial and Commercial Development highlighted key points for the Board to note: - The Trust agreed a 2017-18 deficit control total of£3.657m and has an agreed WCL facility for this value. To date £3.016m has been drawn down with the balance of £0.551m to be drawn in March 2018. - As the Trust has a larger deficit than plan, additional cash support is required to meet day to day capital commitments. An application for a £4.133m WCL has already been approved by the Board. - Based on Month 9 position, the Board is asked to support and approve a further loan of £2.661m to support the Trust's cash position in line with the month 9 variance from plan which has been discussed at length today and at the FSC on 24 January. - Based on the historic deficit position and current forecast, the Trust is likely to exit this financial year with approx. £40m outstanding loans, of which £14.2m payable in 2018. NHSI is aware of this issue and latest advice is that a further loan will be necessary in 2018.

	• **The Board noted the report and approved the application for a Working Capital Loan of £2.661m.**
BM 18/01/12	**Nurse Safe Staffing Report** The Chief Nurse highlighted key points for the Board to note where average fill rates fall below 90% of actual versus planned, of particular note: - Amber and Red ratings are associated with the differences in ward establishment and when additional capacity is required with a correlation where staff have stepped in to assist, especially in times of increased demand on capacity. • **The Board noted the report**
BM 18/01/11	**Nurse Staffing Bi-Annual Report** The Chief Nurse highlighted key points for the Board in this 6 monthly report: to note: - The Board were asked to note the data in Charts 1 and 2 which indicates (1) an increase in budgeted nurses due to an increase in vacancies and (2) reduction in Band 5 nursing vacancies from 148.7 FTE in 2016 to 62 FTE in October 2017, albeit a small rise had been noted in November and December. The Board were asked to note this with caution due to the lead in time for some staff to commence in post. - The SafeCare model within Allocate E-Rostering is used to collect acuity and dependency data twice daily for all wards ensuring accurate information is available. This enables greater ability for the workforce to flex to meet the acuity of patients within specific areas. - The Safecare results identified an approximate shortfall of 36.78 WTE nurses for wards based on acuity and dependency of patient groups over the two week sampling period. - Variance in data has improved, however anomalies remain, AMU data indicated an over establishment of almost 25 WTE. Further training will be available for AMU and wards as appropriate. - A number ward managers are working in a clinical capacity on shifts which is impacting across all areas, working as Band 5 clinical nurses, with support from Matrons to undertake ward risk assessment and staff plans to ensure safety is maintained. - There is a variability in allocation and usage of supervisory time for Ward Managers and an audit on supervisory time is to be undertaken to identify Ward Managers who are not able to perform some of their duties. - Nurse staffing level for Paediatrics is based on RCN standards. The acuity tool used commenced in June. To ensure safe quality care in Paediatrics, staff were moved flexibly from one area to another within speciality and temporary staff utilised where there was a shortfall. A business case for Paediatric ward staffing has been partially approved by the Executive team. MB asked for an update regarding paediatric staffing are working across A11 and A&E. KSJ advised that Paediatrics have not yet fully integrated into ED due to winter presssures although plans are in place to support this happening. - CBUs to review all ward establishments and present to Executives for review. - MP added that there are 2 components that need to be considered (1) establishment discrepancy what there is currently and what is needed and (2) uplift due to annual leave / absence /training. - AW asked if the 20% uplift is a national requirement. KSJ commented this is suggested national guidance from CQC and AM added a rebasing exercise will look at a number of

	factors including uplift, annual leave, training etc. - From a HR perspective, MC added that a review of ward establishment is ongoing but due to on-going winter pressures it had been difficult for clinical staff to support this work, however work is progressing with ward managers. Workshops will be updated to support ward and project managers with an identified AHP to look at different ways of working. This will be monitored through Workforce and Quality Assurance Committees to redesign ways of working. - There was one occasion identified when staffing was below recommended standards for Neonatal Unit and temporary staffing was to cover this period. A review of ward staffing is to commence in early 2018. - Midwifery colleagues continue to work flexibility between different areas of the Maternity service and Birthrate Plus will be repeated in early 2018. **The Board noted the report and the actions taken and planned to ensure safe staffing.**
BM 18/01/14	**Trust Engagement Dashboard M9 and Half Year Report** The Director of Community Engagement and Corporate Affairs heighted the following for the Board to note: - Positive and neutral media coverage outweighed negative coverage relating to the suspension of Spinal Services. - Facebook 'likes' remain static but slight increase noted when stories are shared. - Twitter followers increasing and the Top Tweet referred to the Trust Head of Midwifery receiving her MBE. - Website engagement risen steadily and it is anticipated that the newly commissioned mobile enabled website will result in further increased web site engagement. This is due to go live by 1 April 2018. - The Board will receive a full year dashboard to July Board **The Board noted the report and asked for its congratulations to be noted and extended to the Head of Midwifery on her MBE.**
BM 18/01/14	**Bi-Monthly Strategic Risk Update** The Head of Corporate Affairs highlighted the following for the Board to note: - Datix web risk management system to go live from 1 February 218. - Approve the addition of a new risk related to Financial Sustainability as - ***(a) Failure to sustain financial viability, caused by internal and external factors, leading to potential impact to patient safety, staff morale and enforcement/regulatory action being taken.*** - ***(b) Failure to deliver the financial position and a surplus places doubt over the future sustainability of the Trust. There is a risk that current and future loans cannot be repaid and this puts into question if the Trust is a going concern.*** • **The Board noted the updates within the report.** • **The Board approved the addition of the Financial Sustainability risk to the Risk Register.**
BM 18/01/15	**One Halton** The Director of Transformation provided an update on progress since the December meeting: - MOU, ToR and Vision to be approved and signed by Board in February/March. - Provider Alliance and ACS Governance in place and had been discussed at the last ACO Board. Bridgewater CHFT expressed an interest to lead on Provider Alliance, WHH

	expressed an desire to be involved and are attending a meeting on 2 February. - LG reassured the Board that a full public consultation with all partners, stakeholders will take place before any decision is made to options to be explored. Currently 3 options are part of early proposals and all are being explored. - The Board will continue to be appraised of further discussions
BM 18/01/16	**Any Other Business** MP asked colleagues to provide comments to support the submission for the 360 survey for Halton and Warrington CCGs. St Helens had been submitted.
	Next Meeting: **Full Trust Board Wednesday 28 March 2018, Full Trust Board Meeting, Trust Conference Room.**

Warrington and Halton Hospitals NHS Foundation Trust
Minutes of the
Trust Board of Directors meeting held on Wednesday 28th February 2018
Lecture Theatre, Halton Hospital

Present	
Steve McGuirk (SMcG)	Chairman
Terry Atherton (TA)	Non-Executive Director
Mel Pickup (MP)	Chief Executive
Simon Constable (SC)	Executive Medical Director + Deputy 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
Chris Evans(CE)	Chief Operating Officer
In Attendance	
Lucy Gardner (LC)	Director of Transformation
Pat McLaren (PMcL)	Director of Community Engagement + Corporate Affairs
Jason DaCosta (JDaC)	Director of IM&T
John Culshaw	Head of Corporate Affairs

Agenda Ref	
	Welcome, Apologies & Declarations of Interest The Chairman opened a short meeting for the Board to receive important updates on Trust matters, and welcomed those in attendance. The Chairman welcomed Chris Evans, Chief Operating Officer
	Spinal Services Update The Deputy Chief Executive & Executive Medical Director provided the Board with an update on the Trust's Spinal Services. It was explained that the Trust had received the final RCS report and a meeting had been held with Commissioners to commence the checking of factual accuracy. The RCS report is currently embargoed with limited circulation because of concerns about data protection and patient confidentiality. An overview of the report's main findings were highlighted and it was explained that a plan was being progressed for Stakeholder communications. Furthermore, it was confirmed that the aim would be to share the final document with the Board in March 2018. As discussion was held about the future of a Spinal Service at the Trust and the possible guise any service would take.

	It was confirmed that the Executive Medical Director, Medical Director, Chief Nurse and Director of Integrated Governance & Quality had met regularly to discuss the serious incidents. The Chief Nurse confirmed that the CQC was meeting at a CQC Management Review Meeting (to be held at the end of March) to decide next steps (including if any potential regulatory action should be taken). They were looking at potential systematic failure. **The Board noted the update**
	Financial Forecast – Update to 2017/18 plan The Director of Finance and Commercial Development provided an update on the 2017/18 financial plan. The financial position is a deficit of £13.9m which is £10.2m variance from the planned deficit of £3.6m. Moreover, the Trust will be required to repay loans to the value of £14.2m in May. The Trust applied for adjustment to the mitigated forecast outturn to £16.8m deficit (a variance from plan of £13.1m), which was supported by the Trust Board in January and approved by Chairs action. The Director of Finance and Commercial Development advised that the Trust will need to apply for loans on a monthly basis as the DoH can only provide loans on need on the current financial position rather than based on a forecast outturn. NHSI remain fully sighted on the Trust financial plans and position. It was explained that the £16.8m forecast outturn is reliant on delivery of mitigating actions and does contain elements of risk that may have an adverse impact on the final position. The following risks were highlighted: • Cost of additional winter activity. • Non receipt of winter monies. • Further reductions in activity to support operational pressures during the winter period. • Payment of all activity in full from commissioners (including sepsis coding and agreement of non-elective marginal rate). • Impact of mitigating actions and additional cost reduction schemes. A discussion was held in relation to the 2018/19 plan and the difficulties in meeting the plan were noted. It was explained that the Trust must submit the plan by the end of April 2018. The Director of Finance and Commercial Development explained that the Trust had voluntarily signed up to a 'Lite' Capped Expenditure Process (CEP Lite). The main headlines of the process were highlighted as follows: • A CEP has been mandated across parts of the healthcare system that face challenges

	to delivering financial sustainability. • C&M STP has designed a CEP 'Lite' process based on national guidance. • The Trust has not been mandated to adopt this process but has volunteered with Warrington and Halton CCGs. The three organisations have met to consider adoption of the 'Lite' process and discussed an approach to methodology and framework to work together as detailed within the paper. • A joint framework will allow for greater transparency on the organisations financial plans and operational challenges, joint ownership of the challenge to reduce expenditure and additional savings identified and achieved. • Each organisation is presenting this approach to their respective Finance Committees for support. **The Board noted the contents of the report**
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. This paper sought the approval for the Trust to apply for a £3.462m 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 January 2018. It was confirmed that the cumulative value of working capital loans covering the period 1st April 2015 to 31st January 2018 equates to £39.7m. This will reduce to £38.3m after repayment of working capital loan to cover the Q2 STF monies in March 2018. **The Board approved the proposal**

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

BOARD OF

DIRECTORS ACTION LOG

AGENDA REFERENCE:	BM/18/03/XXX	SUBJECT:	TRUST BOARD ACTION LOG	DATE OF MEETING	28 March 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

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 + CA	On-Going		24.5.17. This process has commenced. 20.9.17. Shared at Annual Members meeting in September. 31.1.2018. awaiting outcome of Chester University application to become a Medical School on 7 March 2018. Anticipated GMC approval	

							September 2019 following GMC visit in September 2018,.	
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 + CA	28 February 2018		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/18/01/01	31 January 2018	Partnership with King Edward Memorial Hospital Mumbai	Update Report to November Trust Board	**Medical Director**	28 November 2018			
BM/18/01/05	31 January 2018	CEO Update, Warrington Together	Draft Strategy to be presented to March Trust Board	**Director of Transformation**	28 March 2018			
BM/18/01/07	31 January 2018	IPR Dashboard	Safer Surgery/check list – exceptions at speciality level to be included in next months IPR.	**Medical Director**	28 February 2018			
BM/18/01/07	31 January 2018	IPR Dashboard	Progress report from MP on progress against the CQC Action Plan from the Monthly CQC Steering Group	**CEO**	28 February 2018			
BM/18/01/14	31 January2018	Engagement Dashboard	**Full Year Dashboard to July Trust Board**	**Director of COmms + CA**	25 July 2018			

RAG Key

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

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Warrington and Halton Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/17** BM 18/03/20 ~~BM 18/03/22~~
SUBJECT:	**Integrated Performance Dashboard**
DATE OF MEETING:	28th March 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 Chris Evans - Chief Operating Officer
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):	**Quality** The number of Red indicators has improved from 12 to 10 in month. There was 1 medication safety incident which resulted in harm; a 72 hour review has been completed. **Access & Performance** The 4 hour A&E Target and Ambulance Handover indicators continue to be a challenge with winter pressures compounding the situation. The Cancer 31 day first treatment and Cancer 62 day urgent targets moved from Green to Red due to 3 internal breaches, Root Cause Analysis has been undertaken for these

	instances. Due to bed pressures, there was a rise of Cancelled Operations for non-clinical reasons in month. All patients were offered readmission within 28 days. **Workforce** There has been an improvement in Sickness Absence rates, however this indicator remains Red and key actions are in place to address. The Trust has seen a decrease in agency spend for Nurses and AHPs from the 2016/17 baseline, however Medical agency spend has increased due to substantive vacancies. **Finance** The Trust has a deficit of £15.9m at the end of month 11, which is a variance of £11.7m from the control total. The Trust is forecasting a year end deficit of £16.8m.	
RECOMMENDATION:	The Trust Board is asked to: **1.** Note the contents of this report.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	
FREEDOM OF INFORMATION STATUS (FOIA):	Choose an item.	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.	

SUBJECT	Integrated Performance Dashboard	AGENDA REF:	BM 18 03 22

1. BACKGROUND/CONTEXT

The RAG rating for all 64 indicators from April to February 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 - 30 in February decreased from 31 in January.
- Amber – 5 in February decreased from 7 in January.
- Green – 22 in February decreased from 24 in January.
- Not RAG rated – 7 in February increased from 2 in January.

Quality

Quality KPIs

There are 10 Red indicators in February, a decrease of 2 in month.

The 10 indicators which were Red in January and remain Red in February are as follows:

- Incidents – the Trust has 166 open incidents which are over 40 days old.
- Safety Thermometer – The Trust achieved 96.91% for Adults, 93.8% for Children and 73.7% for Maternity against a 95% target.
- 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.
- VTE Assessment – The Trust achieved 92.34% (target 95%) in February, a decrease from January's performance of 94.75%.
- Total Falls & Harm Levels – There was 1 incident of harm resulting from a fall in month. There has been a decrease in the number of reported falls from 94 in January to 86 in February.
- Medication Safety – in February, there was 1 incident which resulted in harm, a 72 hour review has taken place.

- NICE Compliance – The Trust achieved 66.7% (target 100%), a decrease from January's performance of 72.2%.
- Complaints – Due to the impact of Winter Pressures, the Trust is currently behind the agreed improvement trajectory of having no complaints which have breached the deadline by the end of March 2018 with 92 open complaints at the end of February and 34 cases in the backlog which are over 6 months old.
- Friends & Family Test (A&E and UCC) – The Trust achieved 82% in February, (target 87%) a decrease from January's performance of 85%.
- Mixed Sex Accommodation Breaches (MSA) – there were 10 Mixed Sex Accommodation Breaches in February, an increase from 7 in January. There is a national threshold of zero tolerance for this indicator.

There are 2 indicators which have moved from Red to Green in month as follows:

- Friends & Family – Inpatient & Daycase – the Trust achieved 95% (target 95%) in February an improvement from January's performance of 90%.
- Safer Surgery – the Trust achieved 100% in month an improvement from January's performance of 99.8%.

There are 5 Quality indicators relating to the Sepsis CQUIN that cannot be RAG rated this month.

Access and Performance

Access and Performance KPIs

There are 8 Access and Performance indicators rated Red in February (the same number as January) as follows:

The 6 indicators which were Red in January and remain Red in February are as follows:

- A&E Waiting Times 4 hour national target – the Trust achieved 83.8% in February (target 95%), a decrease from January's performance of 85.8%.
- A&E STP Trajectory – the Trust achieved 83.8% in February against the improvement trajectory of 84.5%.
- Ambulance Handovers 30>60 minutes – the Trust has seen a decrease in the number of patients experiencing a delayed handover in month from 228 in January to 165 in February.
- Ambulance Handover at 60 minutes or more – the Trust seen a decrease in the number of patients experiencing a delayed handover in month from 78 in January to 68 in February.
- Discharge Summaries % sent within 24 hours – The Trust has achieved 83.7% in February (target 95%), which is a decrease from January's performance of 88.23%.
- 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 30 cancelled operations in February, an increase from 26 in January.

There are 2 additional Red indicators for February as follows:

- Cancer 31 Days First Treatment – the Trust has achieved 93.2% in February (target 96%), a decrease from January's performance of 98.5%.
- Cancer 62 Days Urgent - the Trust has achieved 78.87% in February (target 85%), a decrease from January's performance of 87.5%.

Performance for both indicators relates to the same 3 internal breaches and Root Cause Analysis has been undertaken.

There are 2 indicators which have moved from Red to Green in February as follows:

- Cancer 14 Days Wait – the Trust has achieved 93.34% (target 93%) in February an improvement from January's performance of 92.31%.
- Cancelled operations on the day (for non-clinical reasons) not offered a readmission date within 28 days – There were no patients in February where an operation was cancelled for non-clinical reasons and not rebooked within 28 days.

PEOPLE

Workforce KPIs

There are 4 indicators rated Red in February decreased from 5 in January.

The 3 indicators which were Red in January and remain Red in February are as follows:

- Sickness Absence – 4.82% (target below 4.2%) in February an improvement from January's position of 5.57%.
- Non-Contracted Pay – 12.78% above budget in February compared to 12.77% in January.
- Agency Medical Spend – £0.462m in February, above the February 2016/17 baseline of £0.423m

There is 1 additional indicator rated Red in February as follows:

- Average Cost of Top 10 Agency Workers - £23,284 in February, increased from £18,085 in January.

There are 2 indicators which have moved from Red to Green in February as follows:

- Average Length of Service for Top 10 Agency Workers - was 22 months in February, decreased from 23 months in January.
- Agency AHP Spend – was £96,000 in February which is below the February 2016/17 baseline of £0.116m.

SUSTAINABILITY

Finance and Sustainability KPIs

There are 8 Finance and Sustainability indicators rated Red in February, an increase of 2 in month.

The 6 indicators which were Red in January and remain Red in February are as follows:

- Financial Position – the cumulative deficit of £15.9m is £11.7m worse than the planned deficit of £4.2m. The main reasons for the cumulative variance to plan is unclaimed STF (£3.7m), the lost income and additional costs associated with the suspension of spinal activity (£1.6m) and a shortfall against the CIP target (£4.7m).
- Cash Balance – Cash continues to be a challenge and is under daily monitoring and management. The cash balance at month end was £1.2m. Loans have been requested this year to support the deficit and the payment of creditors. Approved loans this year are £12.7m. A loan of £4.1m was requested and received for the month 10 (January) deficit. The deficit loan support in month 11 (February) was £2.6m. The Trust board supported all applications for loans to cover the deficit. A further loan will be required to support the deficit position in March 2018.
- Capital Programme – the cumulative capital spend of £5.2m which is £1.5m below the planned capital spend of £6.7m. The forecast outturn is £7.0m which is £0.5m below the capital plan of £7.5m. Several schemes will be carried forward into 2018/19.
- Better Payment Practice Code continues to underperform with year to date performance of 30% which is 65% 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 – the estimated value of fines and penalties levied by commissioners is £116,786.

There are 2 additional indicators which have moved from Amber to Red in February as follows:

- Cost Improvement Programme Plans In Progress - £5.3m below the target of £10.5m.
- Cost Improvement Programme Performance To Date – impact of transformation activities at the end of February was £4.6m CIP, £4.7m below month 11 CIP target of £9.3m.

The Income, Activity Summary and Use of Resource Rating Statement, as presented at the March Finance and Sustainability Committee, are attached in Appendix 3. The Trust has updated the forecast outturn to a mitigated deficit of £16.8m which is £13.1m above the control total. Loans will continue to be required to maintain the minimum cash balance and meet financial obligations. It is anticipated that the Trust will have loans outstanding

at the end of this year of £41m. The Trust is working with Commissioners on a shared plan to improve sustainability of the next 3 years using CEP lite (Capped Expenditure Process) as a framework.

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.

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												

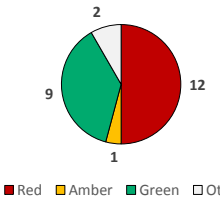
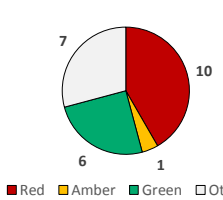
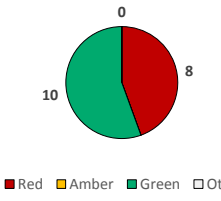
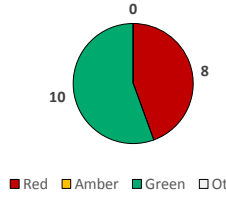
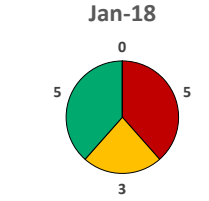
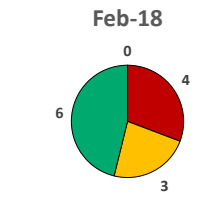
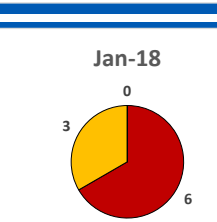
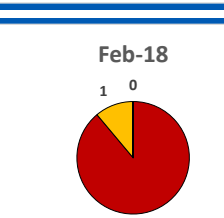
Appendix 1 – KPI RAG Rating April 2017 – March 2018

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 - February 2018

Appendix 2

	Jan-18	Feb-18	Key Points/Actions
Quality Improvement			At the time of writing this report there are 609 open incidents that require review and sign off. Clinical Services have 569 incidents. The remaining incidents are for Corporate or External organisations. Duty of Candour for Serious Incidents remains at 100% compliance across the CBU's. There has been a decrease in the percentage achieved for the Maternity element of the safety thermometer. Reported HCAI's has decreased across all areas. Medication reconciliation has remained at 78% for the second consecutive month. The Trust has dropped below the 95% target for the third consecutive month. At the time of writing this report, the Sepsis data is not currently available. We have achieved 95% for FFT in relation to inpatients but have dropped to 82% for A&E where the target is set is to achieve over 87%. However, it is positive to note that the response rate increased from 15.7% to 17.1% as 972 patients responded to the survey from a total of 5677 eligible responders.
Access & Performance			In February 2018, 10 out of the 18 indicators are RAG rated as Green. RTT and Diagnostic performance continues to be positive with standards being achieved. Due to continuing pressures within A&E, the Trust has not achieved the 4 hour target or improvement trajectory, although remains a lead performer regionally in this area as well as in terms of ambulance handover times. The Trust has not achieved the 31 or 62 day cancer target due to internal breaches, which are subject to further validation.
Workforce			Sickness absence has reduced in month but is still above target. There are key actions are in place to address sickness, which are a combination of managing attendance closely (such as the proposed increased reporting arrangements for nursing staff) and supportive measures (such as the role out of Mental Health First Aider training). Return to work interview compliance remains very low. This is due to the fact that interviews are not recorded in real time and the Allocate system shuts down at month end. In addition, the current pressures mean that it is likely that return to work interviews are not always taking place. However not all of the non-compliant areas are clinical / ward based and there is opportunity to improve. Recruitment processes have improved significantly and time to hire is now well below target. Turnover remains below target. PDR Compliance has continued to reduce. A project to review the PDR process has been launched and will be reported through the Workforce Committee in April 2018. Expenditure on pay is still above budget but has reduced in month. Key actions to address all pay spend include the Central Medical Agency Team, WHH Medical Bank and Workforce Redesign. These projects report to the Finance and Sustainability Committee via Premium Pay Spend Review Group and / or the Workforce Committee.
Finance			In month, the Trust recorded a deficit of £2.0m, increasing the year to date deficit to £15.9m, which is £11.7m worse than the planned deficit. Year to date income is £1.3m below plan, expenses are £11.1m above plan and non operating expenses are £0.7m below plan. The year to date capital spend is £5.2m which is £1.5m below the planned capital spend of £6.7m. 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 £1.9m below the planned cash balance of £3.1m. 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 a point during the month and due to the timing of cashflow 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 30% which is 65% lower than the 95% target. The Trust has recorded a Use of Resources Rating

Quality Improvement - Trust Position

Description	Aggregate Position	Trend	Variation

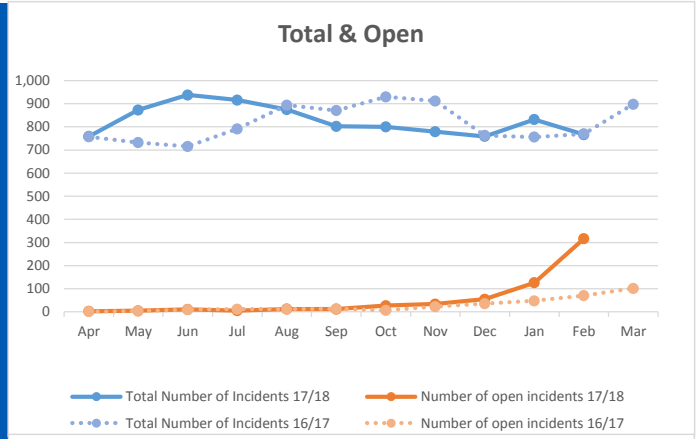
Patient Safety

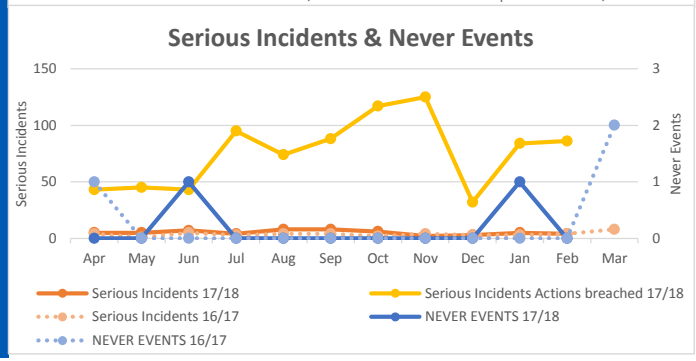
Incidents

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).





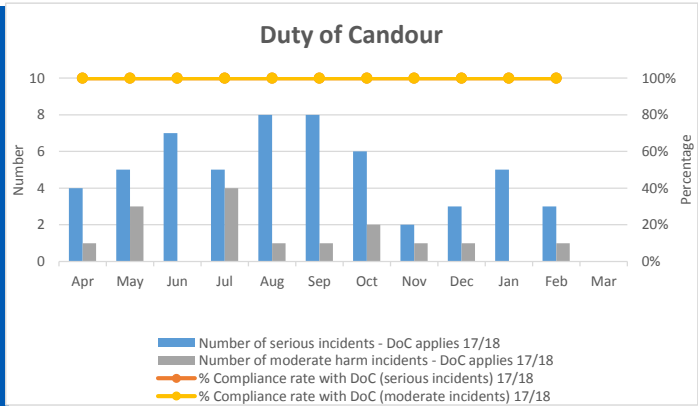
At the time of writing this report, there are 609 open incidents that require review and sign off. 569 relate to CBUs with the remaining incidents for Corporate or External Organisations. There has been a 40% reduction in open incidents since January 2018. Further workshops are planned for March/April to review the incident backlog and reports are being issued to CBUs and specialities regarding their open incidents, to ensure further focus. A 2018/19 Quality Priority has been agreed to increase the profile of incident reporting in the Trust, to further implement the Trust Lessons Learned Framework.

Duty of Candour

Red: <100%
Green: 100%

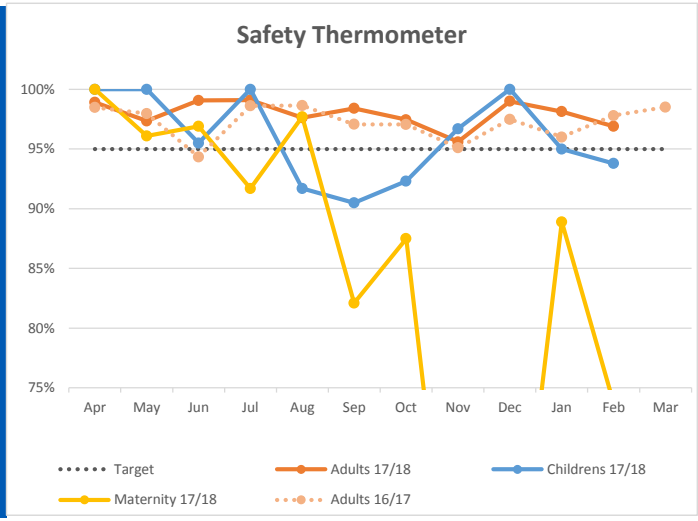
Every healthcare professional must be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress. Duty of Candour is where we contact the patient or their family to advise of the incident; this has to be done within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

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



The Trust can report 100% compliance for completion of Duty of Candour for those incidents determined to be moderate/serious. There has been a review of training for Duty of Candour in February and a new training programme is being rolled out from April 2018. This will ensure all staff are aware of their legal/professional and contractual duties regarding Duty of Candour, and also ensuring that meaningful conversations are being had with patients and/or families.

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 is small in number of Pressure Ulcers (3)Falls (2) UTI (2) and VTE (5). Children's services scored 93.8%, a small number having incomplete EWS at the time of the census. Maternity data low score due to 1 urine infection, 4 PPH of more than 100mls & 3 babies transferred to NNU. The CQC Insight Report has given us some comparison data and identified our ward areas with highest level of harm. This is being addressed at Patient Safety & Effectiveness Sub Committee, to monitor improvements required.

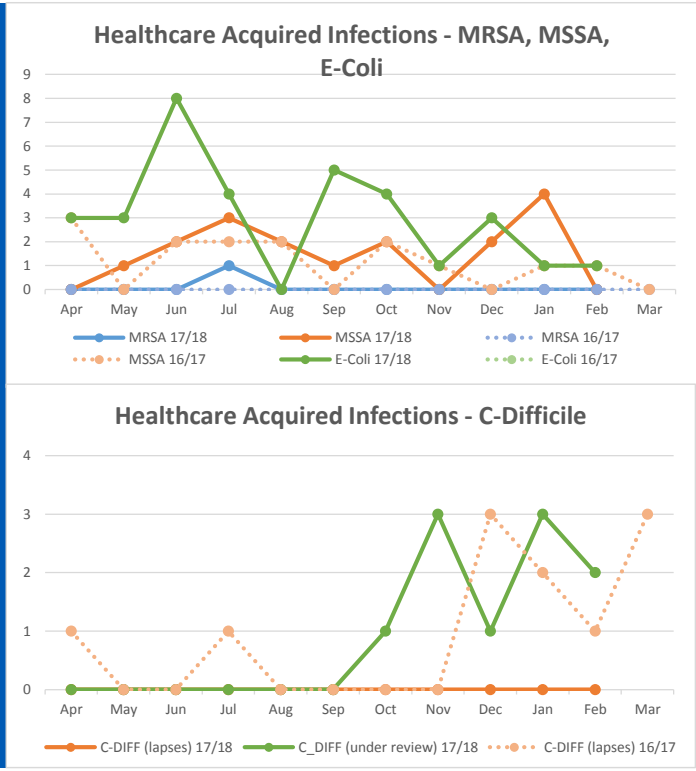
Quality Improvement - Trust Position

Healthcare Acquired Infections

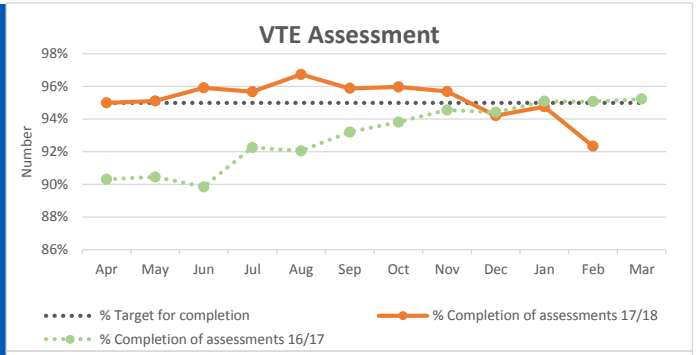
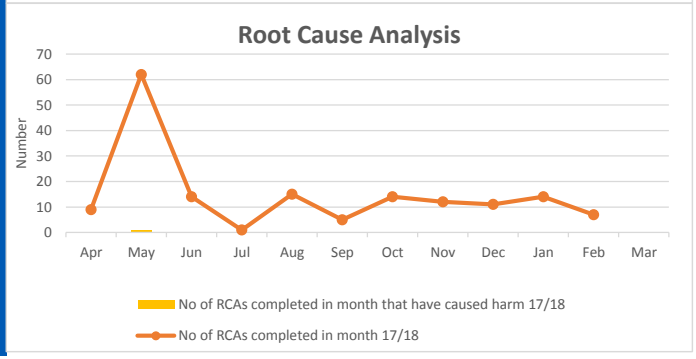
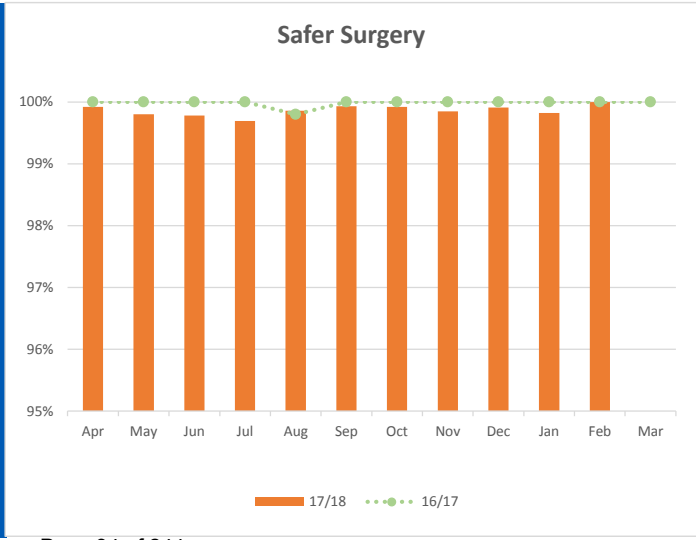
MRSA
Red: 1 or more

Green: 0

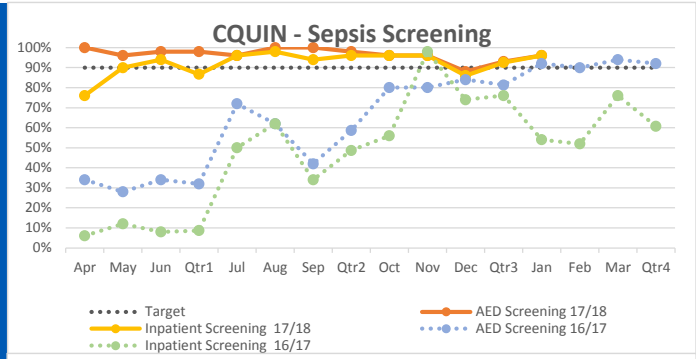
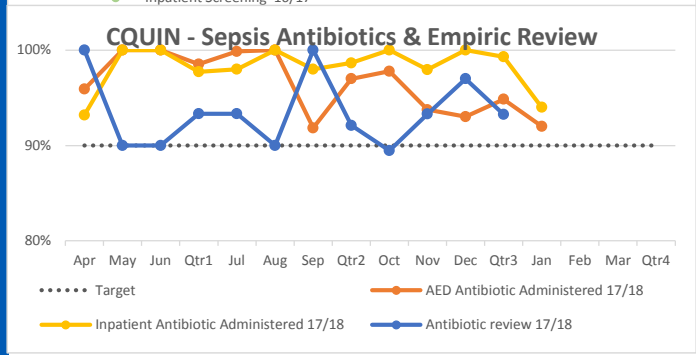
C-Difficile
Red: More than 2
Amber: 1 to 2
Green: 0

Description	Aggregate Position	Trend	Variation
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 – 2 hospital onset Clostridium difficile cases were reported in February 2018. YTD the Trust has reported 21 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 17 hospital onset cases. These are under review to identify any areas for care improvement. E. coli bacteraemia – YTD the Trust has reported 33 hospital onset cases. Partnership working is in place across the health economy. The Trust is working with community partners to progress the action plans.

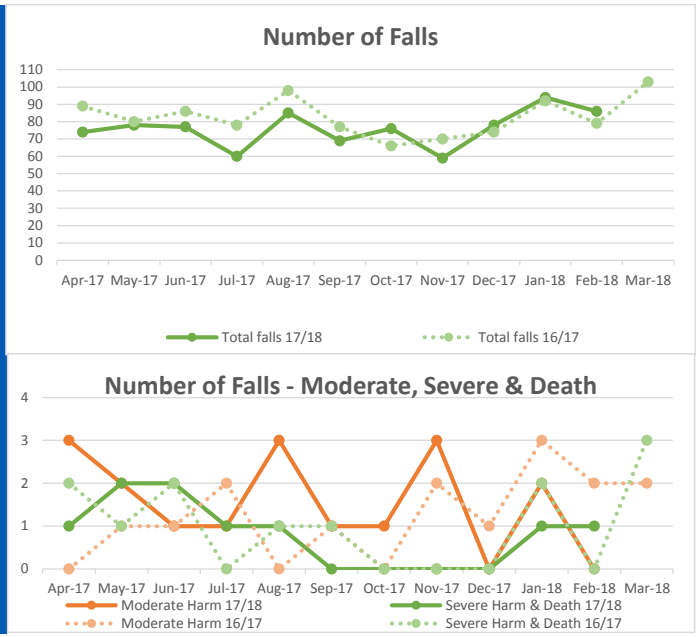
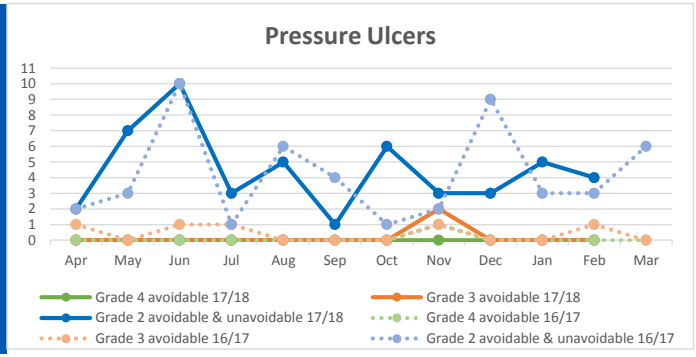
Quality Improvement - Trust Position

	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.	 	A discussion regarding VTE performance was held at March Patient Safety & Effectiveness Sub Committee and it was asked that the Associate Medical Director and Associate Nurse Director for Safety undertake a review and bring an improvement plan back to the Sub Committee. VTE Performance The position for February is still being validated at the time of writing this report. External auditors Grant Thornton are conducting a data quality review of VTE, as this was selected as a local indictor for review as part of the Quality Account monitoring. VTE RCA April 17 -January 18 – 14 RCAs outstanding to be completed. February – Additional 20 RCAs identified- currently being reviewed.
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. In the month of February 100% of check lists were reviewed and the overall score was 100% compliant. In addition during the month of February, the Head of Theatre Services also completed 38 safe surgery observations. This will be reported on in the March 2018 safe surgery audit.

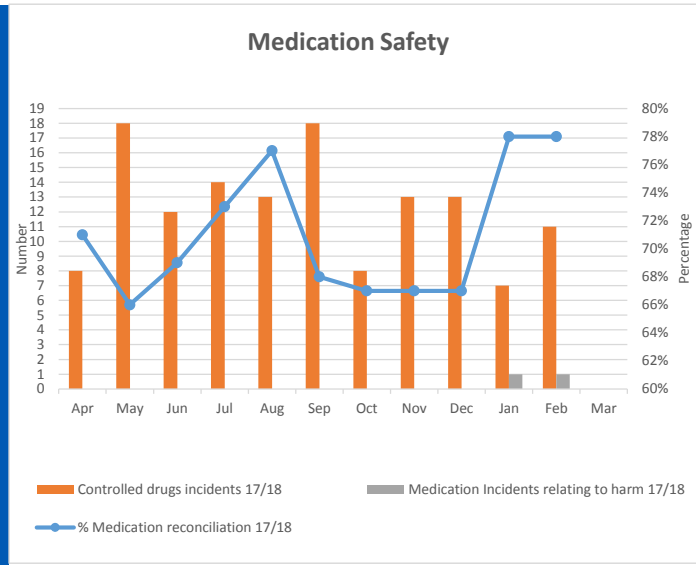
Quality Improvement - Trust Position

	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%	 	At the time of writing this report, the January and February data has not been fully validated due to delays in selecting the patients at random for the assessment of the clinical antibiotic review. However, we can report that all other areas of the CQUIN have scored over the required 90% for the month of January but we are still awaiting February data.

Quality Improvement - Trust Position

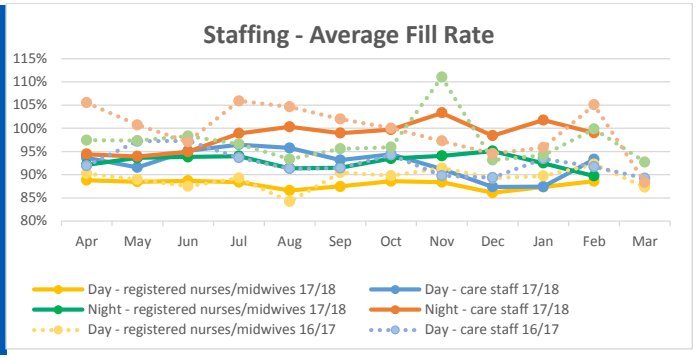
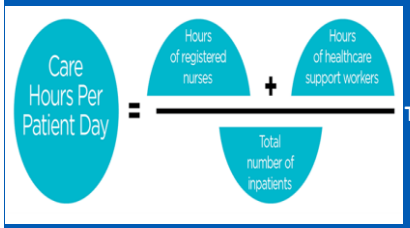
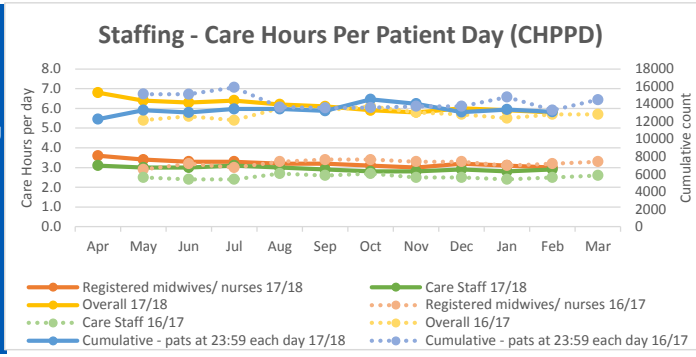
	Description	Aggregate Position	Trend	Variation
Total number of Falls & harm levels	Total number of falls per month and their relevant harm levels.	10% reduction in falls in 2017/18 using 2016/17 data as a baseline.		There has been 1 severe harm fall reported during February. The overall number of reported falls has decreased from 94 to 86 since January. The indictor still remains red as we are not achieving 10% reduction in month; year to date in comparison to 16/17, we have achieved a 6% reduction in falls overall.
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 RCAs 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 February we reported 4 grade 2 pressure ulcers; 3 to heel and 1 to sacrum. 1 occurred on Ward A1, 1 on Ward A5, 1 on Ward B18 and 1 on Ward C21. Of the 4 reported pressure ulcers 3 were avoidable, and one is awaiting completion of an RCA.

Quality Improvement - Trust Position

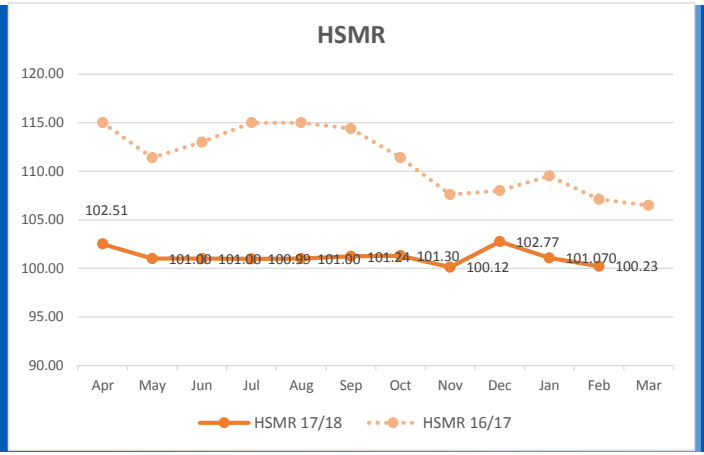
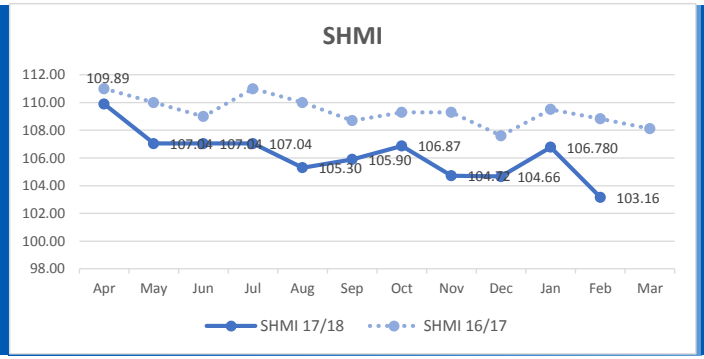
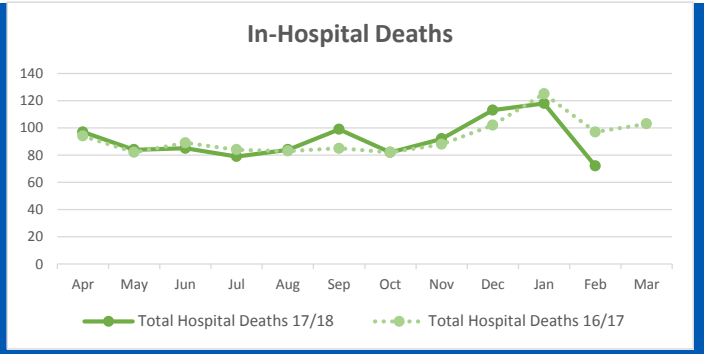
Description	Aggregate Position	Trend	Variation
Overview of the current position in relation to medication, to include; medication reconciliation, controlled drugs incidents and medication incidents relating to harm.	The target for Medication Safety is a zero tolerance for incidents of harm.		YTD the % of patients with an electronic medicines reconciliation record is on an upward trend. The total number of patients requiring this in February was 1397 (excluding Paediatrics, Maternity and patients with a length of stay <1 day). Of these 1397, 1085 medication reconciliations were recorded electronically; 348 (25%↔) occurred within 24 hours of admission (requires improvement) & 667 (48% ↑) within 48 hours of admission. There were 11 controlled drugs incidents for the month of February and 1 medication incident related to harm (grade 3 or above). A 72 hour review has been completed. Most commonly reported incidents relate to diabetic, antibacterial, anticoagulant and opioid medication. Attention is being focussed on diabetic medication incidents and the use of EPMA to improve medication safety in these areas.

Medication Safety
Red - any incidents of harm.
Green - no incidents of harm.

Quality Improvement - Trust Position

	Description	Aggregate Position	Trend	Variation
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, 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.

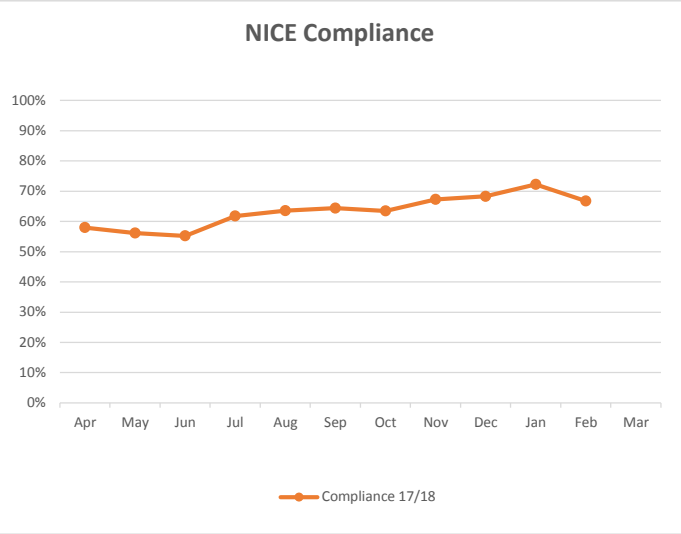
Quality Improvement - Trust Position

	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.		HSMR has been rated as "Green" and falls into the "As expected" range. Discharges included in the HSMR for the latest month of data (November 2017) are less than a third of those recorded for October 2017, so care should be taken in interpreting results relating to this month. It is anticipated that this will change next month as coding is more complete. Weekend / weekday mortality is not an issue for Warrington. Comorbidity levels have stabilised at a lower level than other peers and work is underway with Lorenzo to make the recording of patient's comorbidities a lot easier and carry through to each encounter to ensure correct coding.
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.		SHMI has been rated as "Green" and fall into the "As expected" range. Our SHMI has fallen to 103.16 which is the lowest it has been for some considerable time.
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 Standard Judgment Reviews (SJRs) are being tracked through Mortality Review Group, reporting to Patient Safety & Effectiveness Sub Committee. The Trust will be reporting avoidable mortality in the Quality Accounts, which are currently being prepared. Any review conducted where they may be potentially avoidable mortality, is reported as a Serious Incident and subject to a full Root Cause Analysis before avoidability is confirmed.

Quality Improvement - Trust Position

NICE Compliance

Red: <75%
Amber: 75% to <100%
Green: 100%

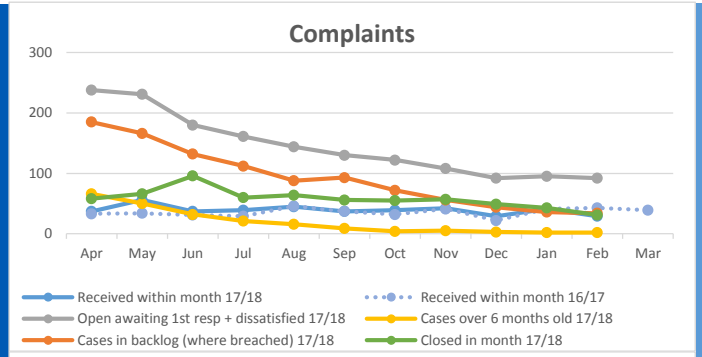
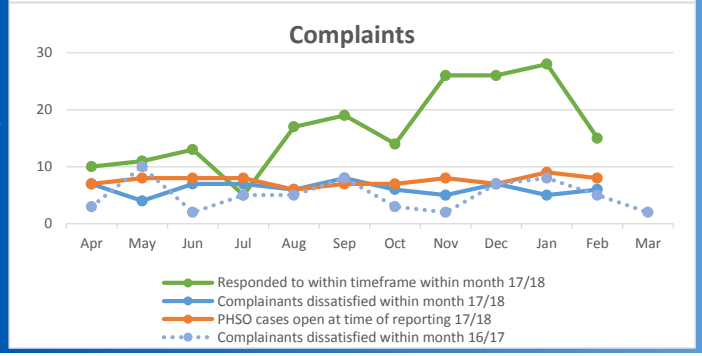
Description	Aggregate Position	Trend	Variation
The National Institute for Health and Clinical Excellence (NICE) is part of the NHS and is the independent organisation responsible for providing national guidance on treatments and care for people using the NHS in England and Wales and is recognised as 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.		The Trust position regarding compliance with NICE guidance remains a focus for improvement. The newly appointed Associate Medical Director of Effectiveness will be supporting Clinical Directors to ensure improvement plans are in place. Although there are 43 guidance marked as outstanding, 27 of those are still within the 90 day assessment period and we are confident that our compliance will have been assessed by the required deadline. The 16 outstanding are mainly within ABC and Women's & Child Health CBUs.

Quality Improvement - Trust Position

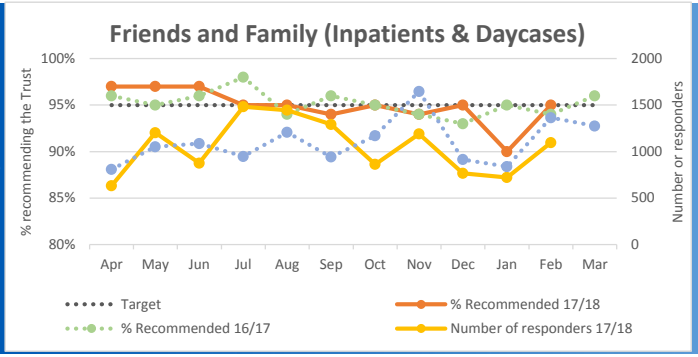
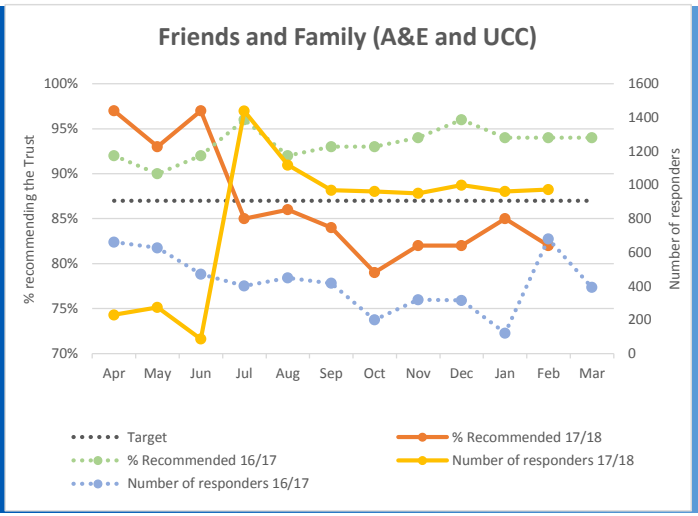
Description	Aggregate Position	Trend	Variation

Patient Experience

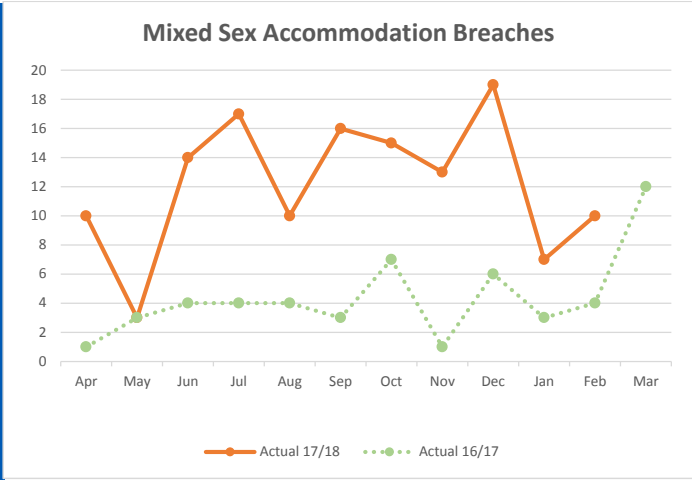
Complaints

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 Trust has a target of having no cases that have breached their deadline by March 2018. It was reported to Quality Assurance Committee that, whilst this will continue to be a priority, operational pressures has significantly impacted on this target, due to capacity of staff to undertake complaints investigations that are within backlog. Despite this, responsiveness of complaints has improved overall. Timeliness in responding to complaints continues to improve. The Trust responded to 69% of complaints on time in the month of December 2017 an increase from 26% in April 2017. At the time of writing this report, we have 1 complaint rated red. The Trust received more complaints in January 2018, although comparable numbers to January 2017. This is linked to Winter Pressures.

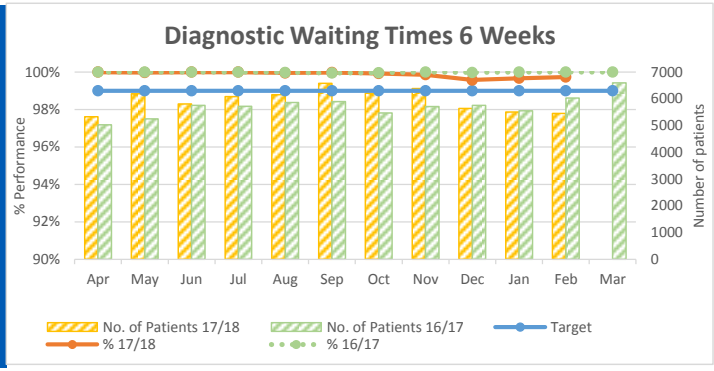
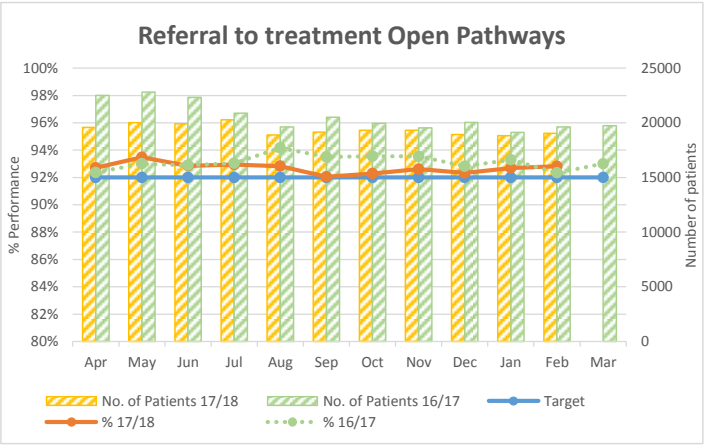
Quality Improvement - Trust Position

	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 this month. The overall response rate has increased from 16% to 27.5%. The Head of Patient Experience has been reviewing the FFT process in the Trust, to ensure there is consistency in reporting and exploring our ability to maximise the information acquired. The themes that were reported highlighted that the staff were caring, reassuring and attentive, with positive attitudes.
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%, in February, 82% of our patients recommended the Trust. The response rate increased from 15.7% to 17.1% as 972 patients responded to the survey from a total of 5677 eligible responders. The Head of Patient Experience is working with the matron of A&E to ensure patients are not excluded from surveys due to inaccurate or missing demographic details. Front desk staff are being reminded to always verify contact details to ensure that patients can be followed up and therefore, the Trust could potentially see an increase in the amount of responses to the surveys. Waiting times featured in the negative themes, and although there were some less than positive comments about staff attitude, this was more than outweighed by praise for friendly, amazing and helpful staff.

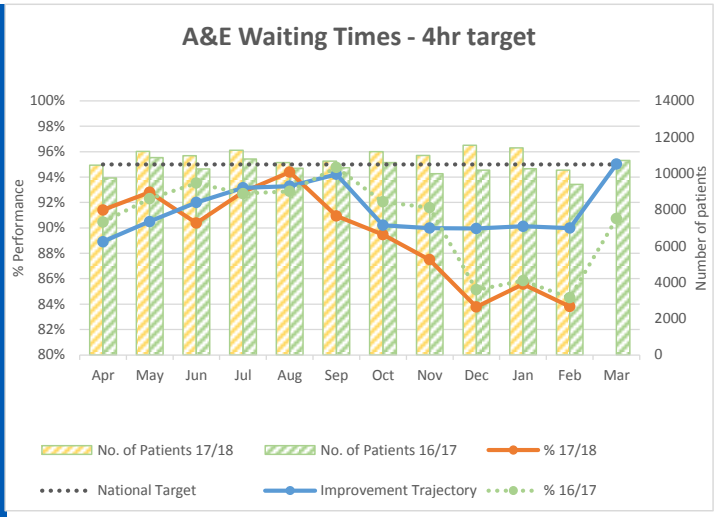
Quality Improvement - Trust Position

	Description	Aggregate Position	Trend	Variation
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 totalled 10 for February 2018, which is an increase from 7 in January 2018. This is remains an improvement on the number of breaches that occurred in Q3 17/18 and there has been recognised pressures which have impacted on the ability to step down patients from Intensive Care Unit and Coronary Care Unit. The Trust acknowledges the need to undertake further work to improve this and as a results has reviewed the escalation process, in order to move patients as soon as they are deemed medically fit. MSA Breaches continues to be high priority and as such is discussed at each bed briefing meeting. Mini RCAs continue to be completed and sent to the CCG for all MSA breaches, to look at learning and action required.

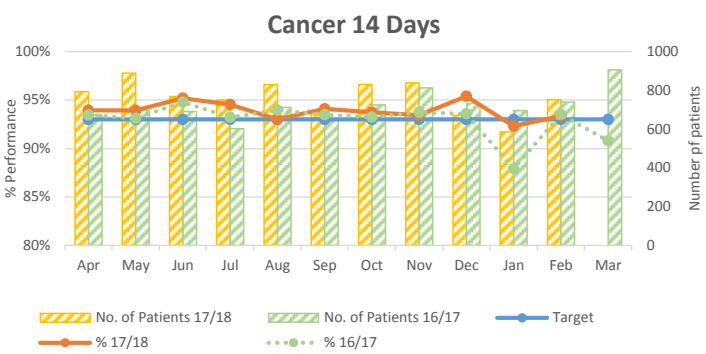
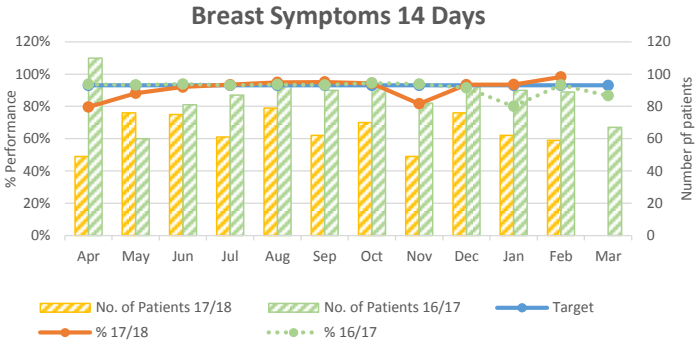
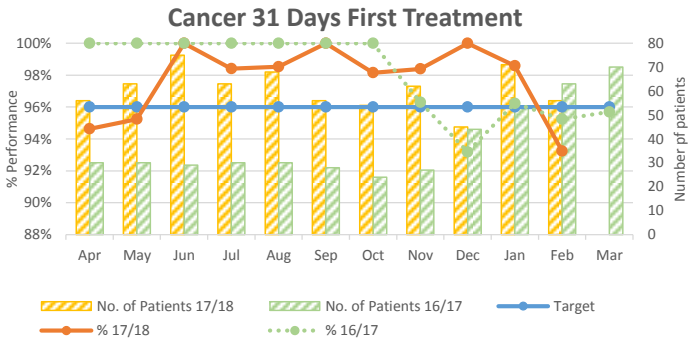
Mandatory Standards - Access & Performance - Trust Position

	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 Trust achieved 99.73% in month.		The Trust achieved this target for February 2018.
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.	The Trust achieved 92.82% in month.		The Trust achieved this target in February. Achievement was a challenge in January and February due to reduction in the elective programme as a result of Winter pressures and guidance from NHSI. An early warning process which highlights areas of pressure has been developed, which is discussed at the RTT meeting with the relevant CBU managers so early action can be taken to support performance.
RTT - Number of patients waiting 52+ weeks Green = 0, otherwise Red				

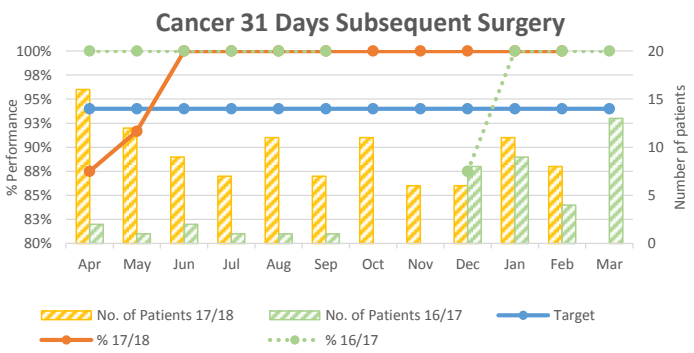
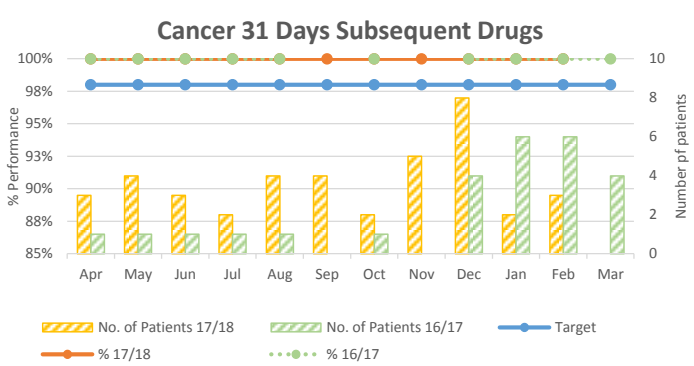
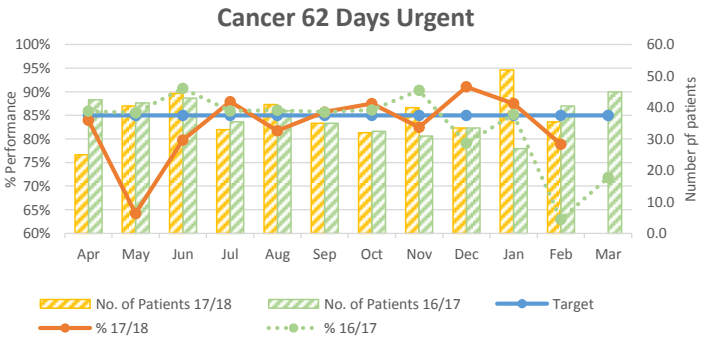
Mandatory Standards - Access & Performance - Trust Position

	Description	Aggregate Position	Trend	Variation
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 achieved 83.81% in month,		Q4 remains a significant challenge with deterioration in the 4 hour performance seen both regionally and nationally. The validated February performance is 83.51% against the improvement trajectory of 90%. The winter period has been the most challenging to date with an increase in the acuity of patients attending ED. Whilst we have not seen an increase in attendances, non-elective admissions have been above expected levels, which is consistent with our peers within Cheshire & Mersey. We have continued to reduce the elective programme, focusing on urgent and cancer cases to maximise capacity to support the non-elective demand. Ambulatory Emergency Care Unit (AEC) has been regularly utilised as a 16-bedded escalation area, in addition to our planned escalation beds on C22, Daresbury and additional intermediate care beds in Halton. The number of medically fit peaked in February 2018 at 183, supporting the level of escalation capacity in the Trust. There have been a number of system and regional meetings and we continue to work with both partners in the LA and CCG to address these delays.
Four Hour Standard Waiting Times - STP Trajectory Red: Less than trajectory				

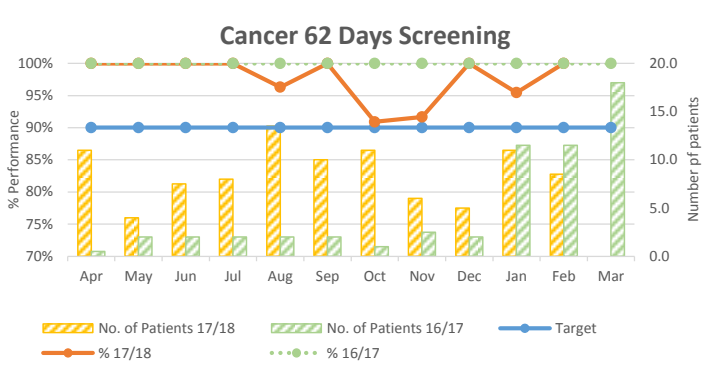
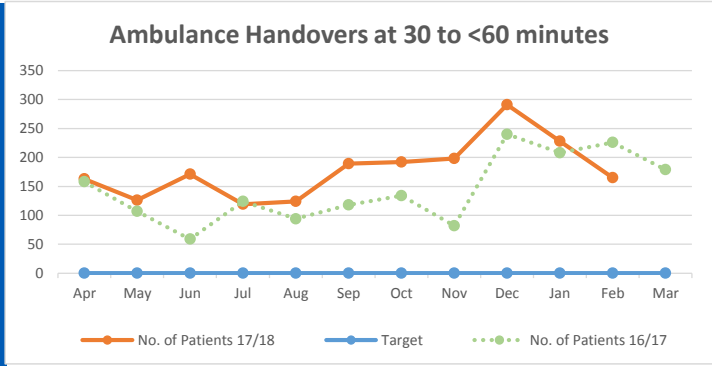
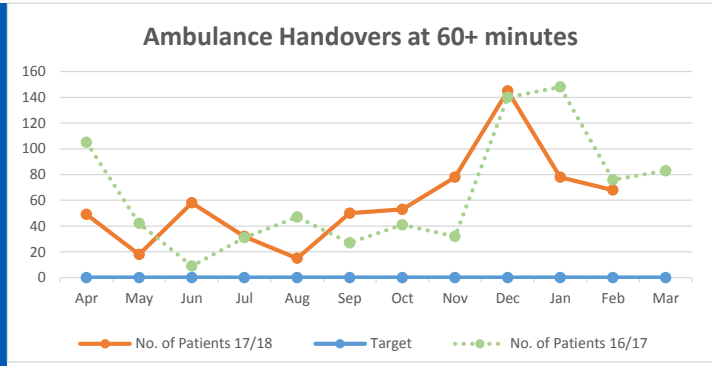
Mandatory Standards - Access & Performance - Trust Position

	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 93.34% in February 2018.		The Trust achieved this target for February 2018.
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 98.31% in February 2018.		The Trust achieved this target in January and February 2018.
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 93.24% in February 2018.		The Trust did not achieve this target in February 2018 due to 3 internal breaches. Reasons for these included, clinical urgency taking priority, no HDU capacity and a non-cancer pathway which only became apparent post treatment. RCA's have been undertaken to prevent reoccurrence. This is an unvalidated position due to understanding the regional position.

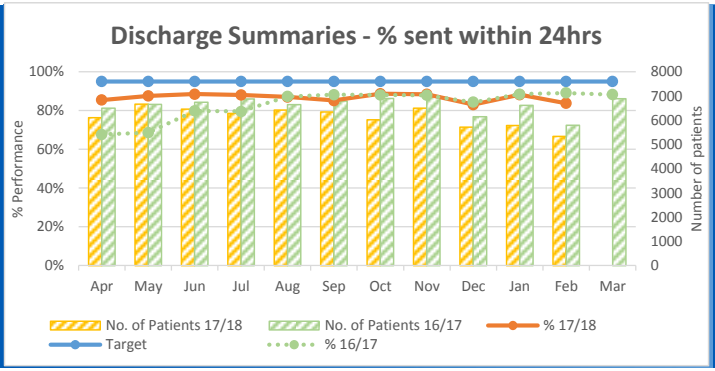
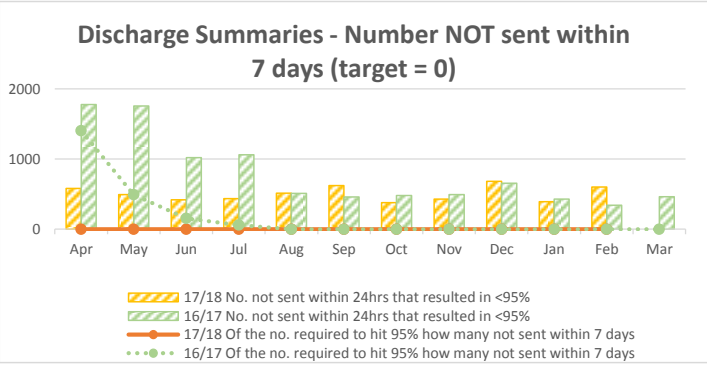
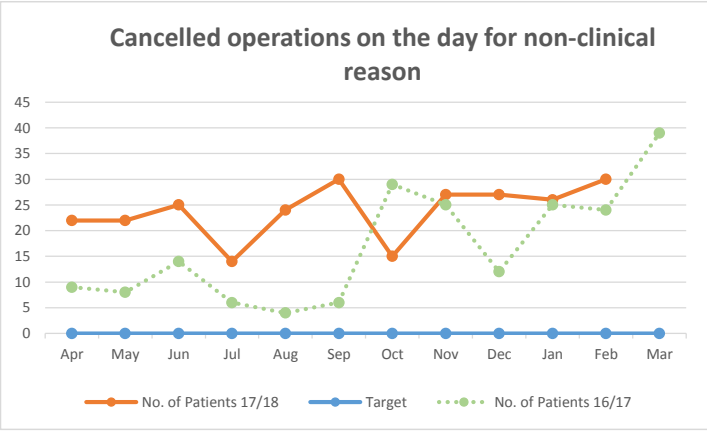
Mandatory Standards - Access & Performance - Trust Position

	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 February 2018.		The Trust achieved this target in February 2018.
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 February 2018.		The Trust achieved this target in February 2018.
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 78.87% in February 2018.		The Trust achieved this target in January but did not meet the standard in February 2018. This was due to 3 internal breaches, clinical urgency taking priority, no HDU capacity and a complex pathway. RCA's have been undertaken to prevent reoccurrence. This is an unvalidated position due to understanding the regional position.

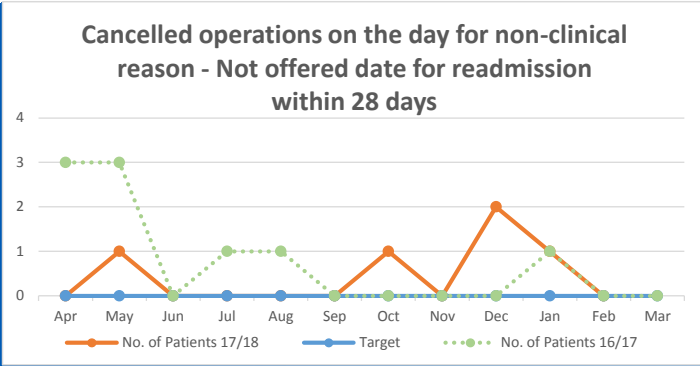
Mandatory Standards - Access & Performance - Trust Position

	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 February 2018.		The Trust achieved this target in February 2018.
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 165 patients where the ambulance handover was between 30 and 60 minutes in February 2018.		Ambulance handovers remain a challenge. We continue to be one of the best performers 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 68 patients where the ambulance handover was more 60 minutes in February 2018		Ambulance handovers remain a challenge. We continue to be one of the best performers in the region for ambulance handovers, averaging 30 minutes.

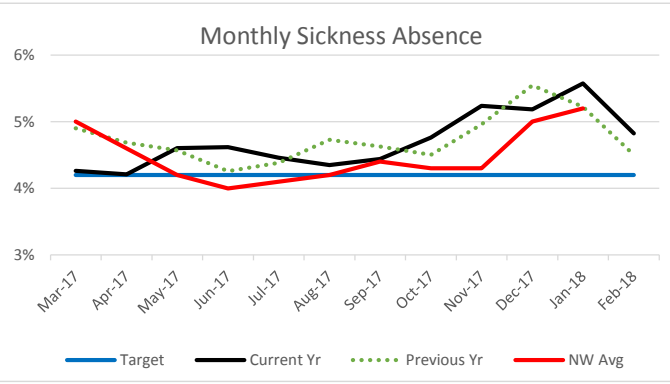
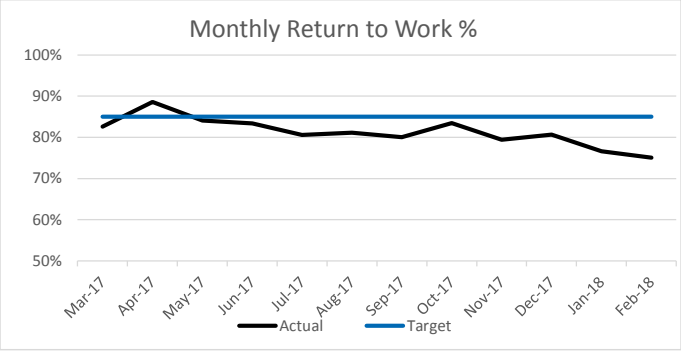
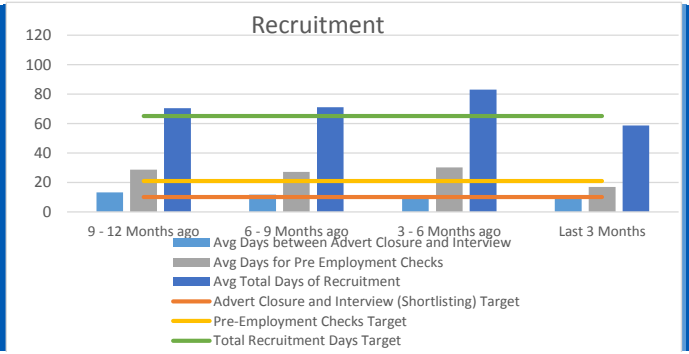
Mandatory Standards - Access & Performance - Trust Position

	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 83.75% in February 2018.		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 February 2018.		The Trust achieved this target in February 2018.
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 30 operations cancelled due to non clinical reasons in February 2018.		There was an increase in cancelled operations on the day in February 2018 due to bed pressures.

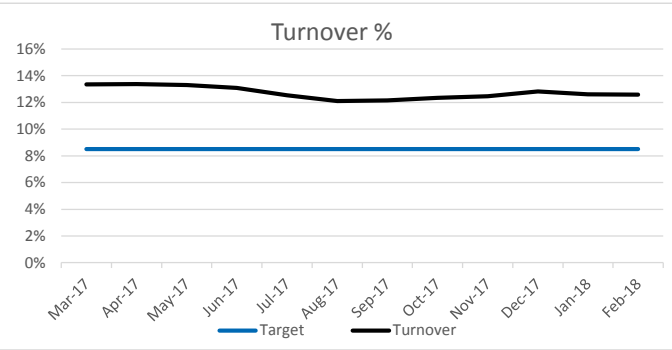
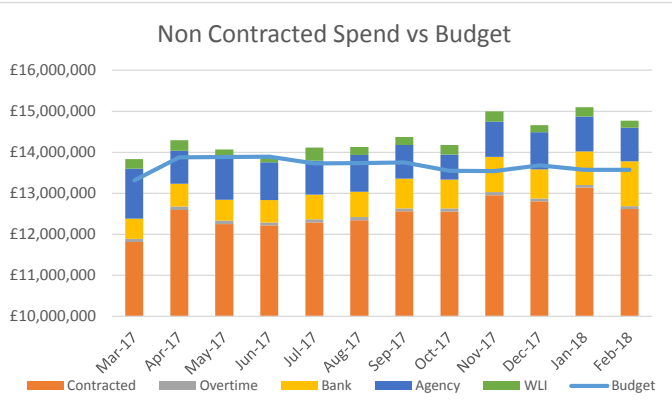
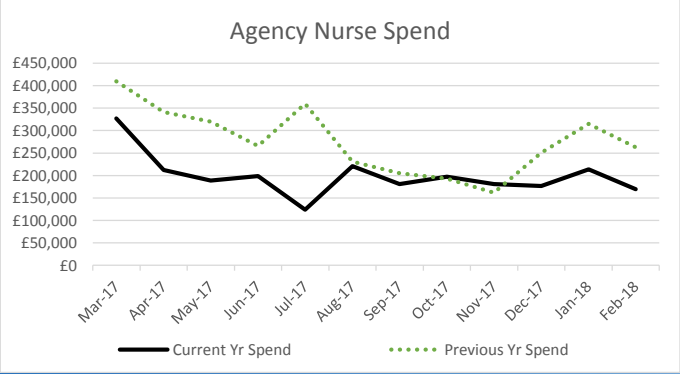
Mandatory Standards - Access & Performance - Trust Position

	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.	All patients cancelled on the day received their treatment within 28 days, in February.		The Trust achieved this target in February 2018.

Workforce

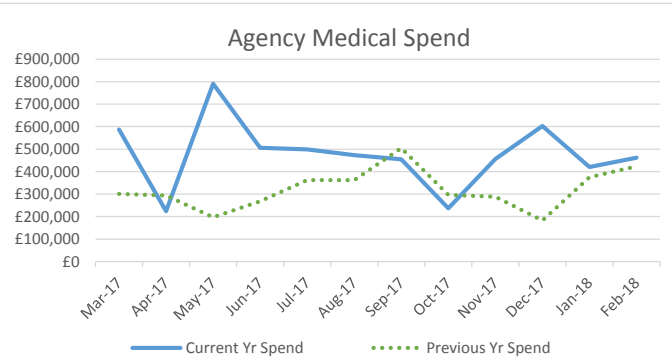
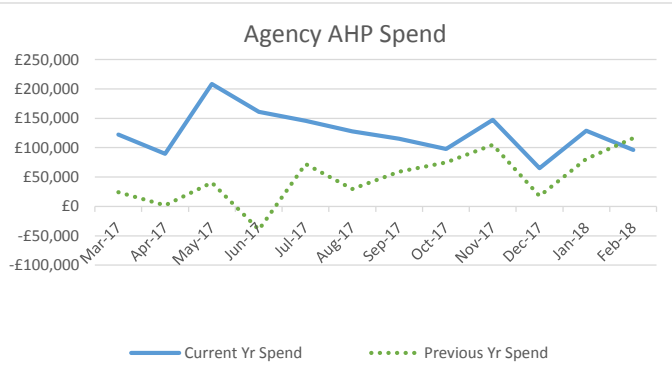
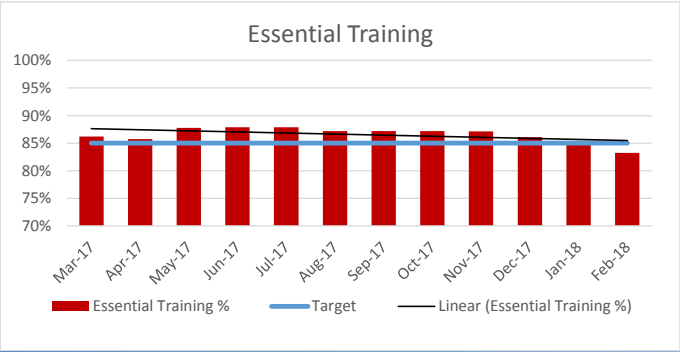
	Description	Aggregate Position	Trend	Variation
Sickness Absence Red: Above 4.5% Amber: 4.2% to 4.5% Green: Below 4.2%	Comparing the monthly sickness absence % with the Trust Target (4.2%) previous year, and North West average	Sickness absence has decreased to 4.82%, which is above target and higher than the same period last year.		Attendance at work has improved in February 2018, although is still above target at 4.82%. Key actions to address this include: > strengthened 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 75.06%, 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. The timeliness of recording RTW Interviews is particularly important, due to the fact that the Allocate system will not allow input after month end.
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 58.7 in the last 3 months, which is below target		Improved use of technology, Streamlining and recruiting managers forward planning will continue to improve the efficiency of our Time to Hire.

Workforce

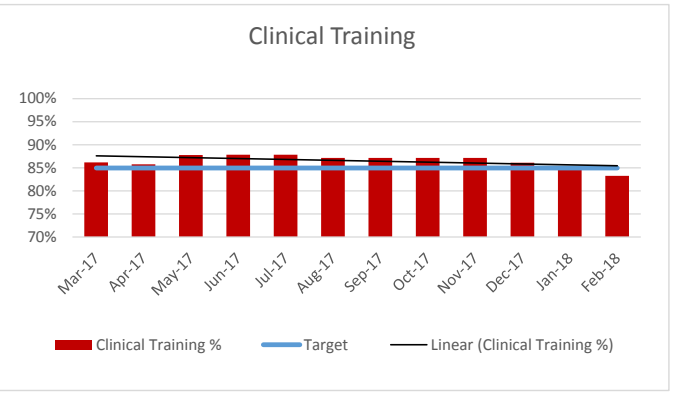
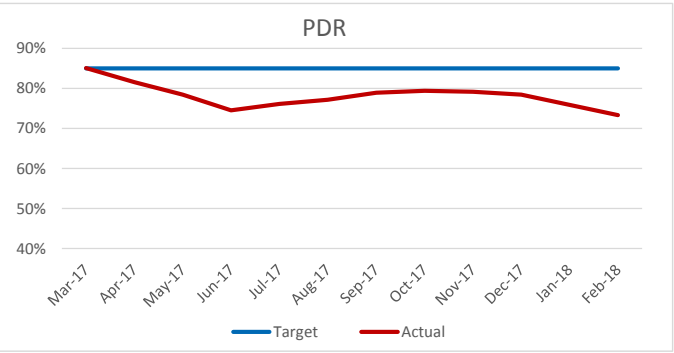
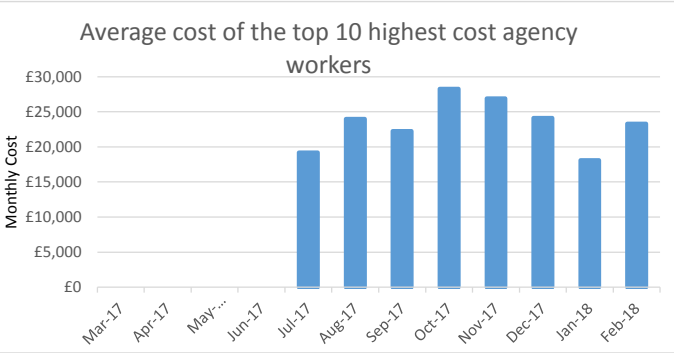
	Description	Aggregate Position	Trend	Variation
Turnover Red: Above 15% Amber: 13% to 15% Green: Below 13%	A review of the turnover percentage over the last 12 months	Turnover remains below target at 12.58%		Turnover remains below target. A workshop will be held in March 2018 to share learning from the 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 but has reduced in month. There has been an increase in Bank spend in February 2018. This relates mainly to the Nursing and Midwifery staff group (linked to escalated beds) and correlates with an increase in bank hours worked from 9626 in January 2018 to 12075 in February 2018. Key actions to address all pay spend include the Central Medical Agency Team, WHH Medical Bank and Workforce Redesign. This projects report to the Finance and Sustainability Committee via Premium Pay Spend Review Group and / or the Workforce Committee.
Agency Nurse Spend Red: Greater than Previous Yr Green: Less then	A review of the monthly spend on Agency Nurses	Agency nurse spend was £169k in February 2018, which is significantly lower than the same period last year.		Both substantive and bank recruitment has continued to drive down agency requirement but bank expenditure has increased as a consequence.

Integrated Dashboard - February 2018

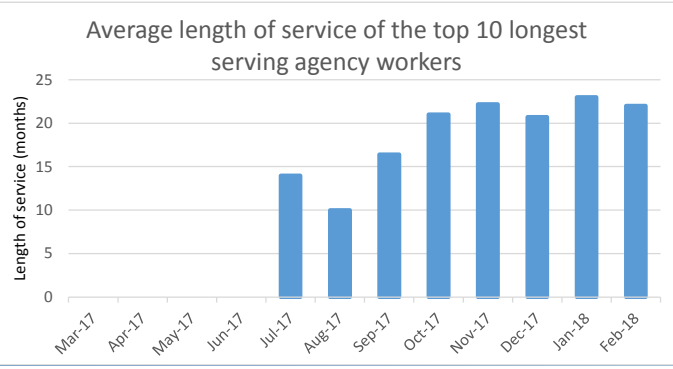
Workforce

	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 increased slightly in month to £462k.		Medical agency spend has increased slightly in month to £462k and the most commonly occurring reason for agency bookings were vacancies. Specialist Medicine and Urgent and Emergency Care were the CBUs with the highest agency spend at £121k and £123k respectively.
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 £96k.		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 February 2018 was 85.26%, 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.

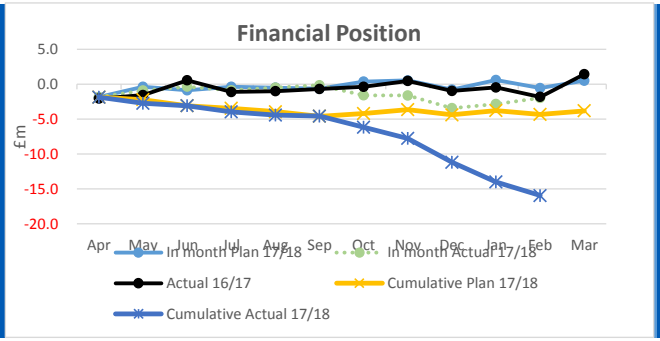
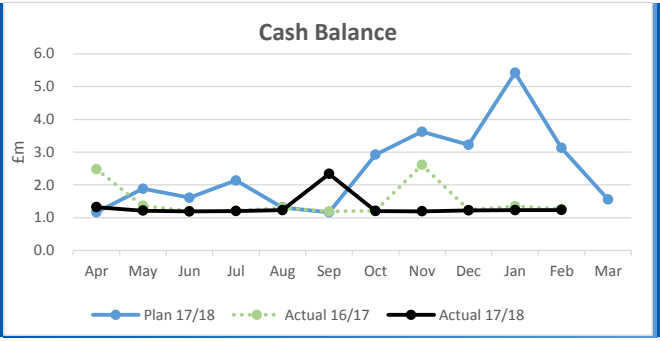
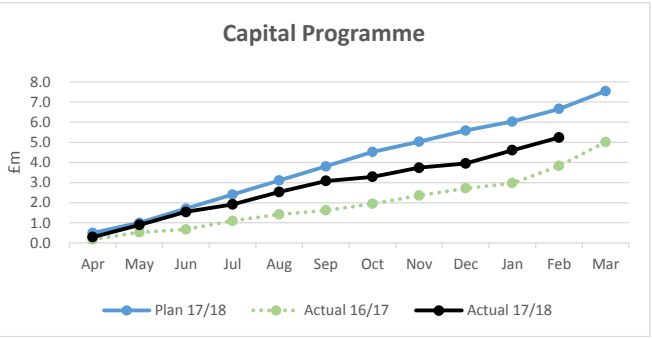
Workforce

	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 downward trend since November continues and for the first time since April the Trust target is not being achieved. The status has therefore changed from Green to Amber. February was 83.3% compared with January at 85%. This is due to the cancellation of training in January and low attendance in February, both due to the operational pressures.
PDR Red: Below 70% Amber: 70% to 85% Green: Above 85%	A summary of the PDR Compliance rate	PDR compliance remains below target at 73%		PDR Compliance has continued to reduce. All CBUs are below target. The following CBUs are rates as 'Red': > Musculoskeletal Care (65%) > Women's and Children's Health (62%) > Urgent and Emergency Care (62%) Corporate Services compliance rates remained stable but below target at 84%. A project to review the PDR process has been launched and will be reported through the Workforce Committee in April 2018
Average cost of the top 10 highest cost Agency Workers Red: Greater than previous month Green: Less than	Monthly costs for the top 10 highest cost Agency Workers	The average cost of the top 12 highest cost agency workers was £23k in February 2018.		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.

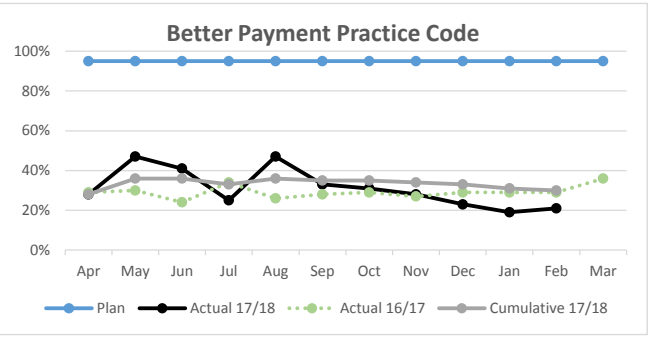
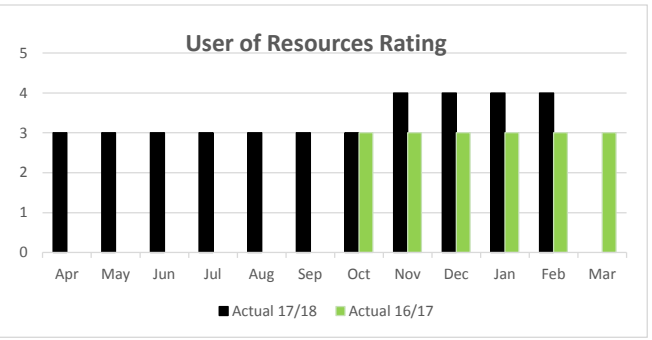
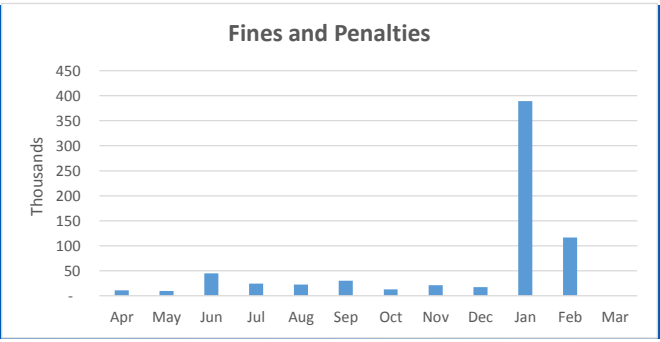
Workforce

	Description	Aggregate Position	Trend	Variation
Average length of service of the top 10 longest serving agency workers Red: Greater than previous month	**The 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 was 22 months in February 2018.**		**Of the 10 workers, 3 are within the Medical and Dental staff group, 5 are within the Nursing staff group and 2 are AHPs.**

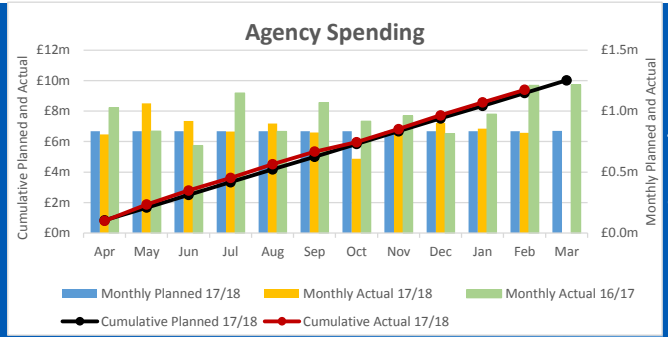
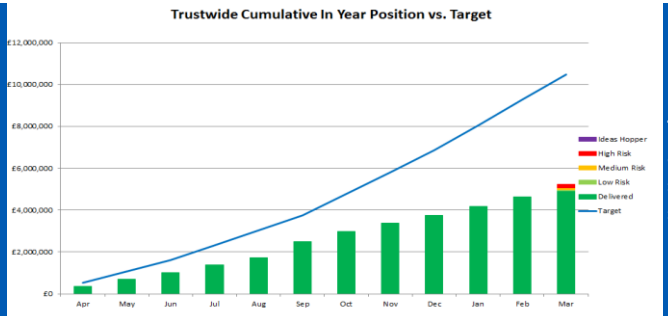
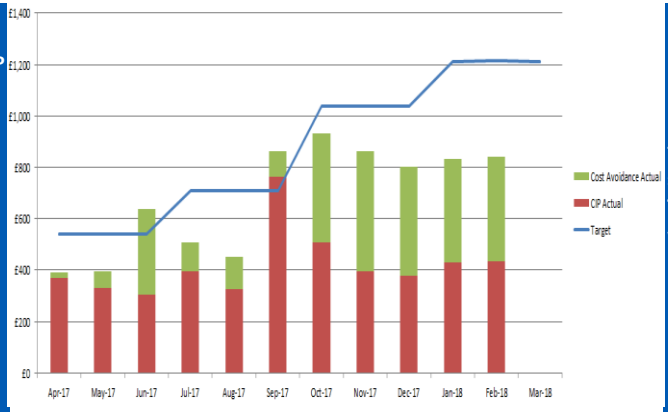
Sustainability & Mandatory Standards - Finance

	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 £2.0m which increases the cumulative deficit to £15.9m.		The cumulative deficit of £15.9m is £11.7m worse than plan.
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 £1.9m below the planned cash balance of £3.1m but the balance of £1.2m at month end is required to comply with the terms and conditions of the working capital loan.
Capital Programme Red: Off plan <80% - >110% Amber: Off plan 80-90% or 101 - 110% Green: On plan 90%-100%	Capital expenditure compared to plan (The capital plan has been increased to £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 £0.6m which increases the cumulative capital spend to £5.2m.		The cumulative capital spend of £5.2m is £1.5m below the planned capital spend of £6.7m but several schemes are to be carried forward to 2018/19.

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 21% of suppliers within 30 days which results in a year to date performance of 30%.		The cumulative performance of 30% is 65% 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.		For month 11, the Trust is anticipating £116,786 based on mixed sex accommodation breaches, discharge summaries, costs relating to the transfer of spinal services and non achievement of CQUIN targets.

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 £0.8m which increases the cumulative spend to £9.4m.		The cumulative agency spend of £9.4m is £0.2m (2%) above the cumulative agency ceiling of £9.2m.
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 M11 are £0.4m against the M11 target of £1.2m.		The financial impact of transformation activities YTD M11 was £4.6m this is £4.7m below the Trust M11 CIP target of £9.3m.
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 worst case forecast for CIP in year is around £5m. Worst case assumes the risk adjusted value of all schemes on the tracker and excludes all hopper ideas. Recurrent - The best & worst case forecast for recurrent CIP is around £3.3m which leaves a gap of £7.1m against the CIP target.		The worst case current in year forecast for Trust CIP schemes is £5m which is £5.5m below the CIP target of £10.5m. The best case for CIP in year is £5.2m which is still £5.2m below the CIP target.

Warrington & Halton Hospitals NHS Foundation Trust

Income Statement, Activity Summary and Use of Resources Ratings as at 28th February 2018

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	2,763	2,727	-35	33,016	30,489	-2,526
Elective Excess Bed Days	12	7	-5	141	118	-23
Non Elective Spells	4,717	4,060	-657	54,414	54,403	-12
Non Elective Excess Bed Days	175	65	-110	2,013	1,593	-420
Outpatient Attendances	2,631	2,673	42	30,879	30,335	-544
Accident & Emergency Attendances	1,027	1,038	11	11,913	12,150	237
Other Activity	5,304	6,742	1,438	57,813	60,957	3,144
Sub total	**16,628**	**17,312**	**684**	**190,190**	**190,046**	**-144**
Non NHS Clinical Income						
Private Patients	8	6	-2	98	106	8
Other non protected	107	136	29	1,177	1,017	-160
Sub total	**115**	**143**	**28**	**1,275**	**1,123**	**-152**
Other Operating Income						
Training & Education	641	742	101	7,051	7,152	101
Donations and Grants	0	0	0	0	32	32
Sustainability & Transformation Fund	820	0	-820	6,209	2,460	-3,749
Miscellaneous Income	857	1,375	518	9,223	11,803	2,581
Sub total	**2,318**	**2,117**	**-201**	**22,483**	**21,448**	**-1,035**
Total Operating Income	**19,061**	**19,572**	**511**	**213,948**	**212,616**	**-1,331**
Operating Expenses						
Employee Benefit Expenses	-13,573	-14,768	-1,196	-150,771	-158,563	-7,792
Drugs	-1,434	-1,445	-11	-15,852	-15,497	355
Clinical Supplies and Services	-1,479	-1,832	-353	-16,788	-19,082	-2,293
Non Clinical Supplies	-2,350	-2,941	-591	-26,376	-27,787	-1,411
Depreciation and Amortisation	-462	-461	1	-5,091	-4,987	104
Restructuring Costs	0	0	0	0	-39	-39
Total Operating Expenses	**-19,298**	**-21,448**	**-2,150**	**-214,878**	**-225,955**	**-11,077**
Operating Surplus / (Deficit)	**-237**	**-1,876**	**-1,639**	**-930**	**-13,338**	**-12,408**
Non Operating Income and Expenses						
Profit / (Loss) on disposal of assets	0	0	0	0	-4	-4
Interest Income	3	5	2	23	26	3
Interest Expenses	-37	-41	-4	-388	-457	-69
PDC Dividends	-273	-48	225	-3,002	-2,176	826
Impairments	0	0	0	0	0	0
Total Non Operating Income and Expenses	**-307**	**-85**	**222**	**-3,367**	**-2,611**	**756**
Surplus / (Deficit)	**-544**	**-1,961**	**-1,417**	**-4,297**	**-15,949**	**-11,652**
Less Donations & Grants Income	0	0	0	0	-32	-32
Less Depreciation on Donated & Granted Assets	11	16	5	130	142	12
Control Total	**-533**	**-1,945**	**-1,413**	**-4,167**	**-15,839**	**-11,671**

Activity Summary	Planned	Actual	Variance	Planned	Actual	Variance
Elective Spells	3,031	3,285	254	36,369	32,822	-3,547
Elective Excess Bed Days	56	30	-26	667	484	-183
Non Elective Spells	3,126	2,404	-722	36,063	32,800	-3,263
Non Elective Excess Bed Days	834	276	-558	9,621	6,559	-3,062
Outpatient Attendances	25,604	25,008	-596	300,454	290,336	-10,118
Accident & Emergency Attendances	8,306	8,252	-54	96,375	103,211	6,836

Use of Resources Ratings	Planned Metric	Actual Metric	Variance Metric	Planned Metric	Actual Metric	Variance Metric
Metrics						
Capital Servicing Capacity (Times)				1.20	-1.02	-2.21
Liquidity Ratio (Days)				-50.5	-44.1	6.4
I&E Margin (%)				-1.95%	-7.45%	-5.50%
Variance from control total (%)				0.00%	-5.50%	-5.50%
Agency Ceiling (%)				0.00%	2.32%	2.32%
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**	**1**

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

BOARD OF DIRECTORS CHAIR'S KEY ISSUES REPORT

AGENDA REFERENCE:	BM 18 03 20 (b)	COMMITTEE OR GROUP:	Quality Assurance Committee	DATE OF MEETING	28th March 2018

Date of Meeting	6 March 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
QAC/18 03 19 i	**Action Log**	• Spinal Surgery – Draft report has been received as is being reviewed for factual accuracy. The Trust has been asked to complete a review to look for internal and external themes. • Safeguarding Action Plan – The action plan is monitored through PSCE and many of the actions align with the CQC recommendations	**Review of themes relating to spinal surgery to report to QAC in May 2018** **Safeguarding Action plan to be reported on at QAC in May 2018**	**QAC May 2018**
QAC/18/03/22	**Getting to Good Steering Group**	• Assurance was provided that capital funding in the 2018/19 programme is aligned to the 'must & should do' CQC actions. • Confirmation was provided that each of the services graded as RI have been assigned an Exec lead and will be monitored through Exec meetings and the G2GM2O steering group.	**The Committee reviewed, discussed and noted the report.** **The Committee to continue to receive high level briefings with any points for escalation to the other Committees and Trust Board through the Chairs Log.**	**QAC May 2018**

QAC/18/03/23	**SI Lessons Audit of action plans April-June 2017**	• The audit recommended that improvements are required in the management of action plans to ensure that the evidence can be demonstrated. Assurance was provided that the setting of actions has significantly improved since Q1 • 86% of the actions set had been implemented • It was confirmed that an Exec Panel now sign off all Sis and Senior Managers sign off complaints.	**The Committee reviewed, discussed and noted the report.**	
QAC/18/03/24	**DIPC Infection Control Quarter 3 Report**	• Update provided on cases of CDiff, MRSA, E-Coli, VRE & Influenza • An external review of the service has been commissioned and will be reported to PSCE and QAC	**The Committee reviewed and noted the report.**	**QAC May 2018**
QAC/18/03/25	**Learning From Experience Report Q3**	The new style report was provided the Committee highlighting: • The number of open incidents has increased with an improvement plan in place to reduce numbers. • An increase in the number of verbal abuse cases. Security and Health and Safety Teams are supporting delivery of an action plan to provide support training to staff • Action is underway to address the number of open medication safety incidents. Progress will be monitored through PSCE, and weekly meetings with the Medication Officer.	**The Committee reviewed, discussed and noted the report and supported the recommendations within the report.**	**QAC July 2018**

		• 15 SIs concluded in this period with learning identified and shared with staff. • MDT process raised in a number of incidents. MIAA audit concluded limited assurance in MDT processes. This will be monitored through PSCE for assurance. • 100% compliance reported in Duty of Candour • Timeliness in responding to complaints continues to improve, reaching 69% in December 2017 against 26% in April 2017. • PALS response time significantly improved with a 55% improvement, from 20 days to 9 days in Quarter. • New Medicolegal group established to analyse claims profile and how improvements can be implemented.		
QAC/18/03/26	**Nurse Staffing Establishment Business Case**	It has confirmed that the business case had been reviewed and supported at the Executive Team Meeting. The business case highlighted the follow: • Current funded establishment included in the review is 886.66 WTE • Following modelling, it is recommended this be increased to 980.32 WTE which equates to an additional 93 WTE (20 RGN and 71 health care support workers) • actual uplift requirement based on data from ESR is over 28%, the paper recommends uplift is increased to 23% • Additional funding required budget is circa £3m in April 2018. This is £420k over what is currently being spent	**The Committee reviewed, discussed the business case and strongly endorsed it and recommended approval to the FSC and Trust Board from a quality perspective.**	

QAC/18/03/28	**Patient Safety and Clinical Effectiveness Sub Committee High Level Briefings**	• Positive news noted in relation to SEPSIS achieving trajectory in the midst of winter pressures.	**The Committee noted the report**	
QAC/18/03/29	**Mortality Review Quarterly Report**	The following was highlighted to the Committee: • Cancer – low volume capacity but an outlier for SHMI and significantly high for HSMR and SHMI. • Cardiac Dysrhythmias –Incorrect completion of death certificate in 3 cases had been highlighted as part of the review and coding sequences, due to a gap in training for clinical coders which will be addressed through further training. • Septicaemia will be further reviewed by the Mortality Review Group.	**The Committee discussed, reviewed and noted the report.**	
QAC/18/03/32	**Complaints Quality Assurance Group High Level Briefing**	Items escalated to the committee were as follows: • Concerns relating to the backlog and completion of investigations especially in times of high pressures and escalation within the Trust. • 30 had breached the deadline; plans are in place to progress.	**An update on the position to be reviewed in Quality Assurance Committee in May 2018**	**QAC May 2018**
QAC/18/03/33	**Quality Dashboard**	The Committee noted the following: • Nice Compliance - operational pressures had added to the delay in compliance assessment but this was being	**The Committee noted the report**	

		addressed through face to face meetings and clinical effectiveness meetings.		
QAC/18/03/34	**Quality Accounts Priorities for next year**	The Committee approved the following priorities: • Improvement priorities - Patient Safety, Clinical Effectiveness and Patient Experience • Local quality indicators - Safer Surgery, E-Prescribing, Increase Incident Reporting, diagnostics, Ward Accreditation, Discharge, Child Friendly and Rapid Discharge Process	**The Committee reviewed and noted the report, and approved the priorities.**	
QAC/18/03/35	**Strategic Risk Register & BAF**	An update on new and existing risks was provided and it was agreed that a new risk in relation to GDPR would drafted.	**The Committee discussed, reviewed and noted the report.**	**QAC May 2018**
QAC/18/03/36	**DNACPR MIAA review Compliance report**	The Committee received an update against the recommendations following the MIAA Audit completed between December 2016 and April 2017. The following was highlighted: • Significant progress had been made • Improved completion of documentation noted • Improvement reported in the last 2 years in the number of patients that suffer an IHCA and survive to discharge from hospital • Number of in-hospital cardiac arrests decreasing, resulting in improved patient outcomes.	**The Committee noted the ongoing progress following the MIAA Review Compliance Report had been issued and the Chair will report back to the April Audit Committee**	
QAC/18/03/37	**Cancer MIAA review compliance report**	The Committee received an update on the Cancer MIAA review. The deadlines for the completion of the two outstanding actions have been revised to the end of June 2018. The Committee were also advised that a Cancer Manager	**The Committee noted the revised deadlines and the Chair will report back to the April Audit Committee.**	

		had been appointed to support the work.		
QAC/18/03/38	**IM&T / GDPR update**	An update was provided on the Trust's readiness for GDPR launch on 25 May 2018. • Mark Ashton appointed as the Data Protection Officer. • Compliance with GDPR will be measured via the new NHS Digital IG Tool Kit. • Data Protection Policy is under review • Key staff awareness has been progressed • MIAA identified areas for improvement in relation to retention and destruction of records • Following the CQC report highlighting secure storage of case notes, a Pilot on secure equipment is to be trialled on A1.	**The Committee discussed, reviewed and noted the report.** **The Committee were not assured in relation to plans to meet the requirements of the legislation.** **The Committee asked that current non-compliance against certain elements is reflected on the Strategic Risk Register.** **The Committee agreed that the Pilot on A1 needs to be accelerated ASAP.**	**QAC May 2018**
QAC/18/03/39	**Policy Improvement Plan**	The key points highlighted to the Committee were: • All policies will be migrated from CIRIS to DATIX. • Policy ratification will be aligned to the new meetings structure. • 753 policies/procedures/SOPs, with 167 out of date. The process will remove duplication with a data cleanse to reduce the figure • The timeline for completion of the data cleanse and new policies in place is March 2019. • Compliance with guidance will be audited as part of an on-going process.	**The Committee approved the recommended Document Management Policy and supporting document templates.**	

CHAIR'S KEY ISSUES REPORT

AGENDA REF		COMMITTEE OR GROUP:	TRUST OPERATIONAL BOARD	DATE OF MEETING	

Date of Meeting	**24/1/18**
Name of Meeting + Chair	**Finance and Sustainability Committee**
Was the meeting quorate?	**yes**

REF	AGENDA ITEM	LEAD OFFICER	Issue / Exception Report	Recommendation / Assurance/ Action/Decision	Follow up/ Review date
	FSC/18/01/01	**TA**	**Welcome to non-committee members who attended to discuss items on the agenda**		
	FSC/18/01/05 (a)	**MC**	**Pay Assurance item received thorough review and requests for changes such as :-** • **Dashboard to focus not only on agency and bank** • **Rotation of physios to be factored into vacancy factor** • **Use of agency reason of "sickness" is high due to option chosen on the system – this is being reviewed and a pilot to ring a senior nurse to notify of sickness is being trialled.**	**Assurance** **Action – revised dashboard** **Action – feedback on pilot**	 **TBC** **TBC**
	FSC/18/01/05 (b)	**MC**	**The monitoring of the breach cap approval process was discussed with a request for detail on the actions resulting from the monitoring.** **Further work was suggested to understand the rates of pay for bank and agency staff.**	**Assurance**	

	FSC/18/01/05 (c)	**MC**	**The Committee received a joint finance and HR presentation to further analyse the increase in pay expenditure. There was detailed discussion on the actions taken to date and the remaining improvements being implemented. It was requested that the bank and agency slide is reworked with just nursing for medical wards.** **WLI payments were discussed and assurance was given that the process had been tightened up and further improvements are being implemented such as improved productivity in Ophthalmology. Annual leave and shift patterns were discussed and assurance was given that system overrides are reviewed by Deputy Chief Nurse.**	**Assurance** **Action – produce bank and agency slides for nursing on medical wards.**	**February FSC**
	FSC/18/01/06	**AM**	**The financial position was presented to the Committee highlighting the current position and the key drivers were explained, most notably spinal suspension, unclaimed STF, undelivered CIP and pay pressures. Of concern is the impact of variance from plan on cash, and the Trust's continued reliance on loans. It was noted that there are still lots of variables which could impact on the forecast and NHSI has recommended that the Trust formally changes the forecast at month 10. The documentation for changing the forecast with NHSI was attached to the paper and the Committee was advised that this would need to be signed at the next Board meeting in advance of submission to NHSI on the 15th February. The Committee supported this approach.**	**Assurance** **Action – Trust Board to approve the change to the Forecast Outturn on the 31 January 2018.**	**31 January 2018**
	FSC/18/01/08	**AM**	**A further presentation was received by the Committee to understand the financial forecast, highlighting key variances and risks including impact on cash.** **Planning guidance has still not been received from NHSI and it is currently unclear how 2017/18 forecast outturn will be reflected in the 2018/19 plan.** **The Committee considered the underlying financial position over the last 3**	**Recommendation - The Committee was asked to support the revised mitigated forecast and loan request when it is presented to the next Board meeting.**	

			years when STF is removed from the bottom line. **The Committee was advised that the finance team will be working with the Commissioners over the coming weeks to look at 2018/19 plans utilising a localised version of the Combined Expenditure Programme.**	**Action - Report back on the joint working with the Commissioners.**	**February FSC**
		LG	**The team has been working with CBUs to find further mitigations and these will be reflected in the finance forecast before submission on the 15 February.**	**Assurance**	
	FSC/18/01/07	**LG**	**Theatre Presentation received.**	**Assurance**	
	FSC/18/01/11	**LG**	**Operational performance update included need to refocussing on 4 hour waits and noted that type 1 activity at WHH is the best in the region.** **DTOC is at circa 140 and this has been partly due to community sector requiring more information from the Trust. Community Transfers are low compared to other Trusts in the area. LG advised the Trust currently had 14 that required transfer. Sessions have been planned with STHK, WHH and Community partners to compare and look at best practice at the request on the A&E delivery Board.** **Ambulance handovers have been good but further work with WMAS and discharge ambulances is required. The Trust has had 2 cancelled operations not treated within 28 days. All cancer targets are good.**	**Assurance**	
	FSC/18/01/09	**AM**	**The costing paper and demonstration of the new dashboard was postponed to the next meeting to allow time for full discussion.**		
	FSC/18/01/12	**JC**	**Risk register was reviewed with a check that all issues relevant to the Committee had been discussed through the agenda. The new risk that was**	**Action - Full risk to be drafted in time for the next Trust**	**31 January 2018**

			requested at the December Committee was presented and discussion took place.	**Board.**	

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

CHAIR'S KEY ISSUES REPORT

AGENDA REFERENCE:	TOB/18/02/33	**COMMITTEE OR GROUP:**	Finance & Sustainability Committee	**DATE OF MEETING**	21st February 2018

Date of Meeting	21st February 2018
Name of Meeting + Chair	Finance & Sustainability Committee - Terry Atherton
Was the meeting quorate?	Yes

REF	AGENDA ITEM	ISSUE	Recommendation / Assurance/ mandate to receiving body	Follow up/ Review date
FSC/18/02/16	**Service Line Reporting Dashboard presentations**	Received a presentation of the SLR dashboard. This tool will enable better engagement with clinicians and managers, as it will provide current information relevant to specialties such as benchmarking of ward costs, and patient level information in relation to treatments and the costs.	**Felt that the dashboard would be a valuable tool and would like an update once it has been rolled out trust wide**	**Launch date 27th March 2018**
FSC/18/02/17	**Service Line Reporting/Ref Costs 6 month report**	The final reference cost index (RCI) was published on 24th November 2017. The Trust's 2016/17 RCI is 98 (accounting for the Market Forces Factor), an increase of 1 from 2015/16. The average score is 100; therefore, the Trust is 2% lower in cost than the national average. The Trust is ranked 58th out of 135 Acute Trusts.	**The Trust is ranked 58th out of 135 Acute Trusts**	**March 2018 FSC Committee**

FSC 18/02/21	**Pay Assurance Dashboard Monthly Report**	• Total pay spend in January 2018 £15m, £1.5m above plan with contracted pay spend reaching the highest point of the year to date at £13m. • The contracted pay spend of £13m equates to 3570.36 FTE staff. There is an absence rate of 118.FTE across the Trust in addition to FTE vacancies of 294.89. • Vacancies within Nursing and Midwifery had reduced significantly in year; however, Medical and Dental vacancies had increased from 37.7 FTE in February 2017 to 48.3 in January 2018. • A pilot LLP scheme to take place in Ophthalmology in relation to WLIs	**Recommendation to Audit Committee to look at audit work plan and long standing actions with revised deadlines.** **The Committee requested an update on Medical and Dental spend and vacancies at the next Committee.**	**March 2018 FSC Committee**
FSC 18/02/23	**Month 10 Finance Report at 31 January 2018**	For the period ending 31 January 2018 the key financial headlines are: • Monthly deficit of £2.8m (£3.4m worse than plan). • Year to date deficit of £14.0m (£10.2m worse than plan). • Cash balance of £1.2m • Use of Resources Rating of 4. • The Trust will need to apply for loans on a monthly basis as the DoH can only provide loans on need on the current financial position rather than based on a forecast outturn. • Aged creditors value of £16.3m remains a concern.	**The Committee reviewed, discussed and noted the report and the financial challenges faced.**	**March 2018 FSC Committee**
FSC 18/02/24	**Finance Planning and Guidance**	• 2018-19 planning guidance was issued to all providers and commissioners in February.	**The Committee reviewed, discussed and noted the report and the financial**	**March 2018 FSC**

		Key assumptions include • Increase to 1% of the engagement CQUIN and withdrawal of 0.5% CQUIN reserve • In relation to STF, there will be no additional winter funds available and the agency ceiling has reduced from £10m to £8.7m • A&E performance of 90% by September 2018 and 95% by March 2019. NHSI are to provide guidance relating to issue of performance notice if this is not met to Commissioners. • Draft financial plan will be presented in April to FSC, Board and Audit Committee prior to formal approval in May.	**challenges faced.**	**Committee**
FSC 18/02/25	**Transformation Programme**	• Month 10 position £4.19m CIP delivered, £2.48m cost avoidance and income recovery giving a total impact on the bottom line YTD of £6.67m against a YTD CIP target of £8.074m. • Challenging CIP target for 2018-19 of £9.5m and work will continue and schemes be identified to support this. It was highlighted that three recurrent risks would not deliver as expected; they were as follows: • £150k estates rationalisation. • £1m bed utilisation throughout specialist medicine of Intermediate Care beds. • £2m clinical income delivered as a combination of	**The Committee reviewed and discussed and noted the report and the mitigations in place against further financial risk.**	**March 2018 FSC Committee**

		income recovery and CIP but risk around payment from CCG in 2017/18 and recurrently		
FSC 18/02/27	**Annual Capital Programme 2018-19**	Capital resources are limited with funding available for the 2018/19 capital programme of £7.1m. This is made up of £5.5m internally generated depreciation and £1.6m carried forward from 2017/18 for schemes delayed until 2018/19. The 2018/19 capital requests amount to £18.2m which exceeds the available funds. A prioritisation process has been undertaken to establish a programme within the resources available. For those schemes not funded mitigation plans are required by scheme leads to ensure all potential risks are considered and addressed.	**The committee supported the 2018-19 Capital Programme for approval to the Trust Board in March 2018.**	**March 2018 FSC Committee**
FSC 18/02/28	**Capped Expenditure Process (CEP)**	A CEP has been mandated across parts of the healthcare system that face challenges to delivering financial sustainability. C&M STP has designed a CEP 'Lite' process based on national guidance. The Trust has not been mandated to adopt this process but has volunteered with Warrington and Halton CCGs and have met to consider adoption of the 'Lite' process and discussed an approach methodology and framework to work together. Each organisation is presenting this approach to their respective Finance Committees for support.	**The Committee noted and supported this approach.**	**March 2018 FSC Committee**

FSC 18/02/29	**Corporate Performance Report**	• Two reportable targets not met in month, 4 hour performance target and the 2 week wait relating to breast symptomatic. • 4 hour performance standard – 85.56% delivered against 90.1% trajectory, an improvement on the December figure of 83.78%. • Beginning to close escalation beds. • Executive to executive meetings with CCGs and other organisations with the system to work to discharge an extra 45 patients have taken place, with support available to expedite to care homes and out of hospital services. Some delays are due to patient choice but home of choice process and policy is being used collectively as a commitment to discharge this cohort of patients. • Ambulance Handover – over 60 minute improvement since December. Significant challenges to achieve the 30-60 minute. The Trust continue to receive positive feedback from NWAS and West Midlands now attending from10am. • 18 Week Referral to Treatment – achieved.	**The Committee reviewed, discussed and noted the report.**	**March 2018 FSC Committee**

CHAIRS KEY ISSUES REPORT

AGENDA REF	BM/18/03/20 (e)	COMMITTEE OR GROUP:	Trust Board	DATE OF MEETING	28 March 2018

Date of Meeting	**Thursday 22 February 2018**
Name of Meeting + Chair	**Audit Committee**
Was the meeting quorate?	**Yes**

REF	AGENDA ITEM	ISSUE	Recommendation / Assurance/ Action/Decision	Follow up/ Review date
AC/18/ 02/07	Premium Pay Spend Report	• There have been four high value substantive appointments since 1.11.2017 and eight on-gong high value interim engagements from 1.11.2017. • Structure will be discussed at the Board Time Out on 28 February to agree the role of Trust Operational Board and how these high costs appointments to the structure will be reported. The CEO would also report this in her CEO report to the private board.	The Committee reviewed, discussed and noted the report. IJ an TA will agree reports to be presented to FSC and Audit Committee and advise.	**Audit Committee 26th April 2018**
AC/18/ 02/09	Tender and Quotation Waivers Q3	• Concerns were noted regarding the current processes but the Chair acknowledged that there had been a significant improvement to date to reduce the number of waivers • Clarification was sought regarding procedural waivers in relation to STP, governance	The Audit Committee noted the report	

		processes and what the Committee would need to be informed of regarding waiver requests for the STP. The Committee were reassured that the STP follows the WHH governance structure. The Director of Finance from the STP had offered to attend a future AC to answer any questions.		
AC/18/ 02/10	Cheshire & Merseyside STP Hosting Arrangements	• The Committee were briefed on current arrangements of WHH hosting the STP team, including financial management, associated programmes and the governance structure. • A separate budget has been established and is excluded from the Trust's financial reporting to the FSC and Trust Board. • The Chair was assured that the governance processes in place will ensure effective management from both a financial and operational perspective.	The Audit Committee noted the report	
AC/18/ 02/11 (a)	Internal Audit Progress Report	• Payroll Review. **Significant Assurance** level. The review identified that key controls are in place and operating effectively • Complaints Review **Significant Assurance** level. The review concluded that there had been significant improvement in the Trust processes and progress against the backlog, there remain some areas in relation to the management of complaints that the Trust officers are in the process of strengthening. • Financial System **Significant Assurance** level. Key controls are in place and being followed across the Trust financial systems.	The Committee reviewed, discussed and noted the report. Update report to be presented to March Quality Assurance Committee by Exec Medical Director GDPR Presentation to be given to Quality Assurance Committee in March and assurance will be further reviewed in the April Audit Committee	**Audit Committee 26th April 2018**

		• MDT **Limited Assurance** level. Following a never event at the Trust, a part of the review undertaken, MIAA attended four MDT meetings. The review identified the need for: ❖ Formality of MDT meetings to be increased ❖ Consistency in the completion of paperwork ❖ Strong leadership and attendance within MDTs Concerns were expressed regarding the Trust's readiness for the new GDPR regulations that come in to force in May 2018.		
AC/18/ 02/11 (c)	Internal Audit follow up report	Extended deadlines had been requested for seven reviews. Concerns were noted regarding the revised deadlines of the Cancer Review from June 2017 to September 2018 and DNACPR which had been open from 2016-17 Following discussion it was agreed: (i) **Cancer -** the Director of Transformation to provide a report to next Quality Assurance Committee detailing progress and trajectory to achieve compliance. (ii) **DNACPR** The Executive Medical Director to provide a report to next Quality and Assurance Committee detailing progress and trajectory to achieve compliance. On-Call, Call Out and Overtime Arrangements. Five	•Executive Medical Director to provide a report to next QAC detailing progress and trajectory to achieve compliance re DNACPR •Director of Transformation to provide a report to next QAC detailing progress and trajectory to achieve compliance re: Cancer The Audit Committee supported and agreed the closure of on-call, call out and overtime arrangements from Audit Committee to Financial & Sustainability Committee.	**Audit Committee 26th April 2018**

		outstanding actions noted following the follow-up review in July 2017, three had been partially implemented and two remain outstanding at January 2018. The Audit Committee was not assured. The FSC will continue to monitor pay spend with oversight of on-call arrangements.		
AC/18/ 02/12	External Audit Plan and Fees	The report outlined the work to be performed as part of the 2017-18 audit and key reporting timescales. The Committee were asked to note the four significant risks requiring specific audit consideration: • the revenue cycle includes fraudulent transactions • management over-ride of controls • valuation of property, plant and equipment • going concern material uncertainty disclosures.	The Committee reviewed, discussed and noted the report.	
AC/18/ 02/14	Anti-Fraud Progress Report	• The Committee were asked to note the closure of a Fraud Investigation relating to an expense claims and use of Trust equipment. Following a thorough investigation it was concluded that there was no sufficient evidence to uphold this allegation. • The Trust had reported 28 incidences which is in line with organisations of a similar size. • A new referral had been received in January 2018 relating to an individual's private	The Committee reviewed, discussed and noted the report.	

		company.		
AC/18/ 02/18	Progress Report on internal audit follow-up actions	• At 6 February 2018 there are 8 audits that have 34 outstanding management actions of which 31 are overdue. • Due to out timescales of some of these actions, the Audit Committee requested this report is escalated either through the Trust Operational Board or Executives.	The Committee reviewed, discussed and noted the report.	**Audit Committee 26th April 2018**

CHAIRS KEY ISSUES REPORT

AGENDA REF	BM 18/03/20 (f)	COMMITTEE OR GROUP:	Trust Board	DATE OF MEETING	28th March 2018

Date of Meeting	**20 March 2018**
Name of Meeting + Chair	**Workforce Committee – Michelle Cloney, Director HR & OD**
Was the meeting quorate?	**Yes**

AGENDA ITEM	LEAD OFFICER	Issue / Exception Report	Recommendation / Assurance/ Action/Decision	Follow up/ Review date
WC/18/03/38	Equality & Diversity Specialist	**Equality Delivery System 2 (EDS2)**: This year's EDS2 was assessed by 2 groups: • Staff assessments – ***8th February 2018*** • Equality Diversity Sub Committee and External Stakeholder assessments – ***15th February 2018*** All our areas scored achieving, however, we scored ***'Excelling'*** in the following areas: ▪ EDS2 Outcome 3.4 "Staff are free from abuse, harassment, bullying, violence from both patients and their relatives and colleagues, with redress being open and fair to all"	Decision – Action Plan approved for 2018/19 and approved for EDS2 results to be published on extranet	E&D Specialist

		Staff Panel ▪ EDS2 Outcome 3.5 "Flexible working options are made available to all staff, consistent with the needs of the service, and the way people lead their lives" ***Staff Panel*** Our public sector equality duty now require WHH to have an annual action plan for the issues raised during EDS2 assessments. The action plan will be developed and overseen by the Equality Diversity Sub Committee, chaired by the Director of Human Resources. The Committee was asked to approved the submitted actions identified during the presentation – this was approved. The E&D Specialist noted that the results must be published on the Trusts website by 31 March 2018 and therefore asked for approval to publish the results – approval granted.		
WC/18/03/44	Equality & Diversity Specialist	**Gender Pay Report:** Under the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017, WHH are required to report annually on their gender pay gap. The gender pay gap is a figure that shows the difference in the average pay between all men and women in a workforce. It is a measure of women's overall position in the paid workforce and does not compare like roles. A large difference in the gender pay gap does not necessarily indicate unequal pay, which is determined by what people earn in comparable jobs.	Assurance / Decision - Action Plan approved	E&D Specialist

WHH Gender Pay Results:

Gender	Avg. Hourly Rate	Median Hourly Rate
Male	17.8767	11.7634
Female	13.2316	11.3164
Difference	4.6451	0.4471
Pay Gap %	25.9843	3.8005

Quartile	Female	Male	Female %	Male %
1	761.00	228.00	76.95	23.05
2	841.00	108.00	88.62	11.38
3	864.00	153.00	84.96	15.04
4	742.00	262.00	73.90	26.10

How does WHH compare to other Trusts:

Organisation	Average hourly rate	Median Hourly Rate
Warrington and Halton Hospitals	25.90%	3.80%
Countess of Chester Hospital	28%	9.10%
Blackpool Teaching Hospitals NHS Foundation Trust	25.90%	4.90%
East Cheshire NHS Trust	34.50%	15.70%
Mersey Care NHS Foundation Trust	10.10%	4.10%
Northampton General Hospital NHS Trust	30%	9.50%

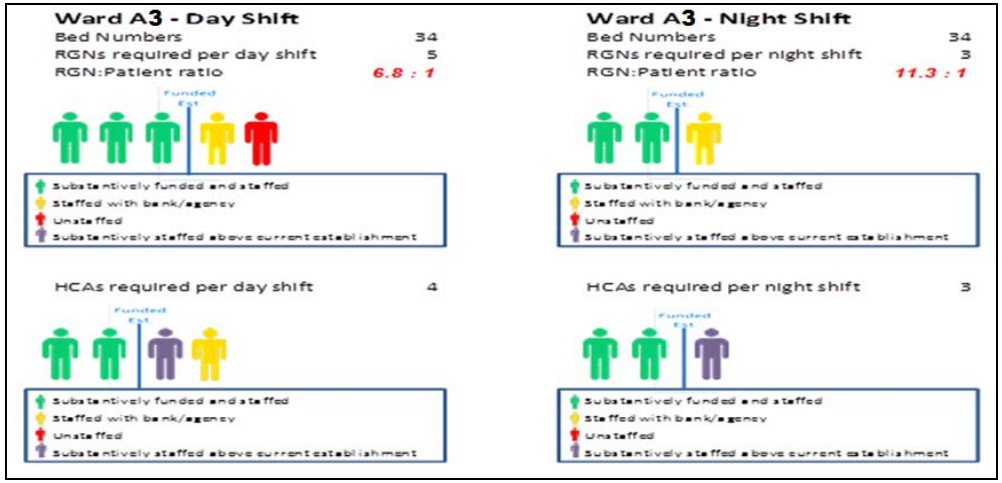
Then what does the Gender Pay Gap show us?
The gender pay gap can indicate that there is some practice to address with regards to if women are ending up in less well paid roles and the reasons for this. This may be due to a range of reasons such as those below. An organisation can look to put together an action plan to improve their Gender Pay Gap.

Possible causes of the gender pay gap in any organisation:

- Discrimination and bias in hiring and pay decisions
- Women and men working in different industries and different jobs, with female-dominated industries and jobs attracting lower wages
- Women's disproportionate share of unpaid caring and domestic work

		• Lack of workplace flexibility to accommodate caring and other responsibilities, especially in senior roles • Women's greater time out of the workforce impacting career progression and opportunities. • Lack of confidence among female staff seeking pay increases/leadership roles • Occupational segregation • Market-rate salaries. There's absolutely nothing wrong with setting market-rate salaries, but when this happens in sectors typically dominated by male workers, a gender pay gap can easily surface as a result. **Action plan** In order to address its Gender Pay Gap, WHH has considered initiatives over the coming 12 months. In order to narrow the pay gap, our action plan relies on access to career development towards higher positions for women. Action Plan approved by Committee		
WC/18/03/40	Head of Workforce Transformation	**Contemporary Ward – Service and Workforce Re-design** Presented by Ruth Heggie, Workforce Transformation Project Manager ***Action, Collaboration, Enablement!*** ***Taking action together through collaboration and empowering our patients through enablement.*** ▪ The Contemporary ward project is a response to the need for revaluation of our current traditional thinking on how the staffing skill mix is utilised within the ward ▪ It provides the opportunity to consider different skill mixes and roles to meet the needs of our patients who no longer need acute care but may	Assurance	

require further therapy or social input



Case Studies:

- **Worcestershire Acute Hospital NHS Trust (Evergreen Ward)**
- Aim: 72 hour LOS for patients waiting for community services and provide rehab to increase and/or maintain independence
- Method and approach: Small team of RN/HCAs, ward based OT and OT asst. Pharmacist, Band 3 physio asst, F/T ANP and consultant support when required
- Impact: 3x more people discharge home with no increase in formal care
  40% fewer patients discharged via inpatient rehab
  Average LOS 5 days

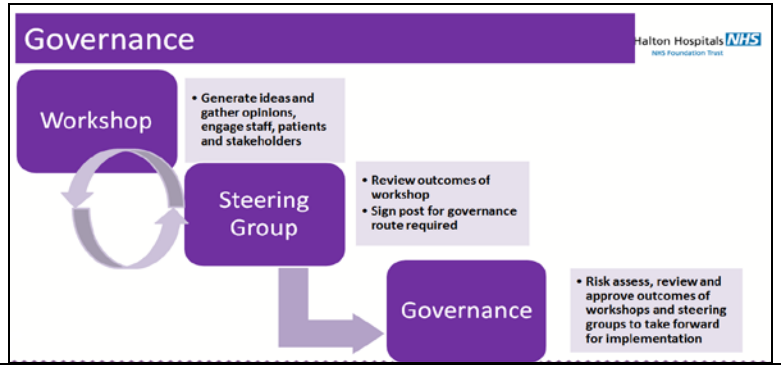
- **Nottingham University Hospital (Ward B49) 23-bedded Community Ward**
- Aim: Provide ongoing care with a re-ablement focus through improving function.
  Expedite discharges through board rounds, internal escalation, links to

community and social care services etc.

- Method and approach: Remodelling of nursing/medical workforce reflective of community settings (while remaining under care of medical consultant with staff grade input), therapy, support and admin remained static
  Ward Manager is Band 7 Occupational Therapist with full therapy and nursing management support
- Impact: Higher than average discharge rate v other Healthcare of Older People wards . Staff sickness ↓from 7.4 to 1.4 per cent

Yeovil District Hospital (Cookson's Nursing Home)

- Aim: Improve patient flow, reduce LOS, maximise clinical outcomes, reduce ongoing costs of care
- Method and approach: Reablement therapy team of physios, OTs and rehab assts who work at Reablement Centre based at Cooksons Court Nursing Home
- Impact:
  - 15% ↓in total number of beds Trust occupies
  - 95% of people discharged home
  - 42% of patients required a ↓in predicted home care packages upon discharge



		 Workforce Committee was asked to note the work to date and schedule for next 5 workshops. In addition members were informed that there were 2 specific patient engagement workshops scheduled and another one in development for external stakeholders. The Contemporary Ward Steering Group will be a subgroup of the Workforce Redesign Group being established from April 2018.		
WC/18/03/41	Director HR & OD	**Terms of Reference** Noted and approved for a further 12 months	Assurance	
WC/18/03/42	Director HR & OD	**Annual Cycle of Business** Noted and approved for next 12 months. Amendments approved: Change of name for new subgroup from Workforce Transformation Group to ***Workforce Redesign Group***- dates to be added from April 2018 onwards Engagement & Recognition Report changed from monthly to quarterly Updates	Assurance	

WC/18/03/44	Director HR & OD	**Director HR & OD Report:** • <u>Moving to Good programme (NHSI / AQuA)</u> – ***Programme completed*** Participating Trusts include: ▪ Warrington & Halton NHS Foundation Trust ▪ Bradford Teaching Hospitals NHS Foundation Trust ▪ Blackpool Teaching Hospitals NHS Foundation Trust ▪ Lancashire Teaching Hospitals NHS Foundation Trust ▪ North Tees & Hartlepool NHS Foundation Trust ▪ Barnsby Hospital NHS Foundation Trust Programme Overview: ▪ Day 1 – Launch Event √ ▪ Day 1 WebEx1 – Compassionate Culture & Leadership for Improvement √ ▪ Day 2 – Focus on Safer √ ▪ Day 2 WebEx – How to get the best from your patient safety collaboration √ ▪ Day 3 – Focus in Quality Improvement √ ▪ Day 4 – Summary, Lessons Learned & Planning for the future – March 2018 √ **Day Four** provided an overview as detailed below: • **'A Sense of Urgency and a Sense of Hope' –** A new paper from AQuA's Chief Executive David Fillingham CBE and Director Lesley Massey exploring how organisations can develop and support a culture and system for continuous improvement.  A-Sense-of-Urgency-A-Sense-of-Hope.pdf • Pecha Kucha presentations – **Our Moving to Good story – WHH Journey**	Assurance	

		 Presentation NHS M2Gv2.pdf • New developments at the CQC – system wide assessments and the Use of Resources domain **Ellen Armistead, Deputy Chief Inspector, Hospitals Care Quality Commissior**   UoR_Brief_Guide_for Use_of_Resources_a _Providers_-_updatessessment_framewor • <u>Getting to Good, Moving to Outstanding (G2G,M2)</u> - Response to the CQC Quality Report - *Requires Improvement* *Good to Great, Moving to Outstanding* (G2G, M2O) Steering Group aimed at creating improvements on the areas highlighted by the WHH CQC Report 2017. In addition, the steering group is seeking to move the organisation to Outstanding through a number of workstreams and embedding the principles outlined in the Moving to Good programme. Workstreams include: ▪ Maternity Improvement Workstream Critical Care Improvement Workstream ▪ Medical care Improvement Workstream ▪ Diagnostics & Outpatients Improvement Workstream ▪ Well Led Workstream ▪ **Culture and Leadership Workstream** **<u>Culture and Leadership Workstream (Inaugural Meeting)</u>:** • **Key findings from Desktop Research and Literature Searches undertaken**		

- Whilst there are a vast number of tools and frameworks available in relation to cultural change, research indicates that there is no such thing as an 'ideal' instrument and that it is up to an individual (or group of individuals) to determine a best fit tool for a particular project.
- The majority of approaches include a diagnosis phase that includes analysis of the current state and confirmation of the future state desired.
- That Leadership is the most significant influence on culture and that culture change is successfully achieved through the delivery of a robust leadership strategy.
- That successful leadership in todays NHS is based on the fundamental principles of:
  - Collective Leadership
  - System and Place Based Leadership
  - Compassionate Leadership
  - Leadership for Quality Improvement.

- **Summary of frequently used Cultural Change tools and frameworks**

Tool/Framework	Origins	Date	Notes
7 factors for successful transformational change	The Health Foundation	2015	Details of 7 factors required for transformational change
Culture of Care Barometer	NHS England	2014	Survey tool designed to help gauge the culture of care provided. Questions based on NHS Staff Survey.
Culture Change Tool	Do OD App – NHS Employers	2016	An app to prompt thinking and action and provide support and advice on culture change.
Changing Culture Resources	AQuA	2014	Focus on shared decision making and patient

		involvement in service transformation.		
Culture and Leadership Toolkit	NHS Improvement	2017	Three phase toolkit piloted across multiple NHS trusts and based on most recent evidence linking culture to leadership.	

- **Recommendation**

To the use of the ***NHSI Culture and Leadership Toolkit*** as the framework for the WHH Culture Change Work stream.

Rationale for this includes,

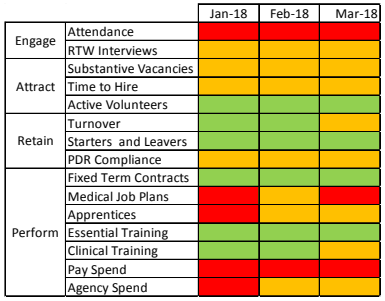
- Three phase approach that provides a ***holistic framework*** across discover, design and deliver
- Pilots well underway with NHS trusts providing a support network for culture change work
- Based on the most recent research linking changing culture to leadership behaviours
- Tool developed in partnership with the Kings Fund and the Centre for Creative Leadership
- NHSI's role as a national partner of the QCQ and NHS England and their commitment to 'speaking as one voice' to the sector.

- Facing the Facts, Shaping the Future – Draft health and care workforce strategy

Consultation closes at 5pm 23rd March 2018. It will be the first system wide workforce strategy for twenty five years and is due to be published for NHS 70th anniversary in June 2018. It has been produced by HEE, with NHSE, NHSI, PHE & the DoH as the main partners but has equally involved partners such as the Chief

		Professional Officers, Regulators, Trade Unions & Staff side, & other stakeholders in many of the key sections. The draft strategy proposes six system wide principles for solutions to workforce problems: 1. Securing the supply of staff the health and care system needs to deliver high quality care in the future. 2. Training, educating and investing in the workforce. 3. Providing broad pathways for staff so that they have careers, not just jobs. 4. Widening participation in NHS jobs. 5. Ensuring that the NHS, and other employers in the system, are model modern employers. 6. Ensuring that in future service, financial and workforce planning are intertwined. WHH has submitted a response to the consultation within the timeframe, and this was shared in full at the Workforce Committee. • Audit Committee - Requested additional assurance around the review of local oncall arrangements within the Trust and Overtime. <u>On Call/Out of Hours Working</u> This issue has been discussed at the ***Premium Pay Spend and Review Group***. Two papers have been considered and it was originally agreed to concentrate on the diagnostic Departments/Areas as part of a phased review and a Project Proposal was produced. This position was reported to the Audit Committee on 22 February 2018 who did not feel assured by the proposed course of action and felt that a paper should be considered initially by Executive Team covering all Departments/Services in scope with a proposed trajectory to capture benefits realisation. This had also been a previous recommendation of an MIAA report on on-call arrangements in the trust.		

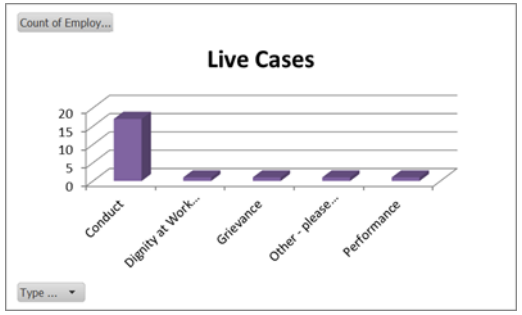
		There are well ***over 20 different on-call and out of hours working arrangements*** in operation in the trust so initially a full scoping exercise is being undertaken to understand the detail of these arrangements and the costs. The trust already has an agreed on-call framework which was recently applied to the Theatres at Night project and will allow other Departments/Services to be costed to assess the savings/increased expenditure. Inevitably when harmonising arrangements, some arrangements will cost more and some will cost less. The underlying driver for harmonisation was to achieve equal pay for equal value across all of the staff groups who provide these services. Once the scoping exercise has been completed a Project Plan will be developed to roll out the harmonisation arrangements. This work is also of keen interest to the Finance and Sustainability Committee who will want to understand the level of savings/increased expenditure. <u>Overtime</u> This issue has also been discussed at the ***Premium Pay Spend and Review Group*** and a Project Proposal was agreed. One of the first actions was to identify the level of overtime worked across the trust from April 2017 and Departments/Services were then RAG rated and 13 Departments/Services were identified for closer scrutiny. Relevant managers were then contacted and assurances received that overtime was contained within budget or if not, what action would be taken to reduce/eliminate overtime working. This exercise will be repeated at the end of the financial year. In addition, an Overtime Policy was produced and implemented within the trust in December 2017. The Policy was partly written to comply with recommendations made by MIAA to increase control, approval and assurance on overtime working. This was also reported at the Audit Committee on 22 February 2018. Overtime expenditure is monitored on a monthly basis and compared with expenditure in 2016/17. For the period from April – January 2018 expenditure on		

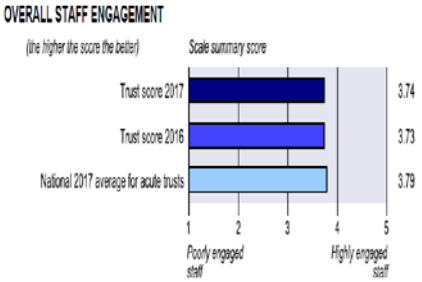
		overtime was c£110 less than in 2016/17 and when all additional plain time hours are included as well as overtime hours, the reduction is c£140k.		
WC/18/03/45	Head of HR Strategic Projects	**Risk Register** Report accepted. ▪ One new risk added to Strategic Risk Register: Expansion of an existing risk but split into two – 'Failure to deliver the financial position and a surplus places doubt over the future sustainability of the trust'. Risk that current and future loans cannot be repaid. ▪ <u>Existing Workforce Risks</u> ▪ *Failure to provide adequate staffing levels in some specialties and wards*: No update and score remains at 20. ▪ *Failure to provide a spinal service for the local population*: No update and score remains at 16. ▪ *Failure to successfully engage the Workforce*: No update and score remains at 12. Committee requested that further detail be added to risk related to engagement on Staff Opinion Survey Results which should improve the score once actions start to be implemented. ▪ <u>Risk Management Strategy Update (For information)</u> ▪ Training for Datix Web for Risks continues to be rolled out	Assurance	
WC/18/03/46	HR & OD Senior Management Team	**People Strategy Report & Dashboard:**  		

		Engage • Sickness Absence 4.82% • Focus on long term sickness absence • Reporting arrangements for nursing staff • Mental Health First Aiders • Return to Work Interviews **79**% New Head of HR Business Partners to review the current plans in place within CBUs with each HRBP and consider a new refreshed approach to holding non-compliant managers to account for timely inputting of RTW interview / and or conducting RTW interviews. To report back to next Workforce Committee **Attract** – • Improving our Time to Hire remains a priority and although it continues to reduce a Workshop to be held on 27th March 2018 will explore: • Process efficiencies • Employee offer to improve both Recruitment and Retention • Factual References: Streamlining introduced the possibility of factual references between NHS Trusts. The pilot is complete; WHH will continue to request factual references but will not solely rely on them as per the updated policy • Partnership – SLA with Wrightington, Wigan and Leigh – 13 posts identified – ECF/CBU engagement required • Royal Colleges – MTI programmes - Direct Applications via the Services to submit Applications • WHH part of "NHS Employers: Workforce Supply, Engage and Exchange" – a forum for the North to share ideas and work in collaboration **Retain** – ▪ Turnover **13.8%**	Engage – Assurance Recommendation for 'Return to Work Interviews' – to escalate to TOB Attract - Assurance Retain – Assurance	Deputy Director HR & OD

		▪ Starters vs Leavers ▪ Work Life Balance most common reason given for staff leaving WHH ▪ PDR Compliance: Medical Appraisal - Calendar Year 89.45% (85%) - GREEN - Achieved Medical Appraisal - Financial Year - 69.23% (85% by 31.03.18 (on target) Airways, Breathing and Circulation 70.43% Diagnostics 77.75% Specialist Medicine 73.26% Urgent & Emergency Care 61.94% Digestive Diseases 70.57% Musculoskeletal Care 65.34% Specialist Surgery 70.44% Womens & Childrens Health 62.01% **Develop** – ▪ Simulation Strategy and Knowledge and Evidence Services Strategy attached to formal paper. ▪ Education Governance Committee minutes from 1st March 2018 attached to formal paper. ▪ Quality Surveillance issues for nursing students. ▪ A further cohort of 7 Trainee Nurse Associates are due to start on 19th March 2018. ▪ The Trust are supporting the need for a Contemporary Ward. The Workforce Planning/Vanguard Ward group has been set up and are meeting monthly and this is on-going. Work is on-going with HR for a joint workforce plan exercise and learning needs analysis. ▪ Apprenticeship Update – High Level Apprenticeships – 2 OPD apprenticeships commence in September. There are also 7 Nursing Associates commencing in March. 2 are commencing CIPD, 3 in Finance	Recommendation for 'PDRs' – to be escalate to TOB for CBU exception reporting and for a presentation on proposed changes to the current system to be present by OD Manager at next Workforce Committee Develop – Assurance	Deputy Director HR & OD

		commencing SEMA and ACCS, plus 1 Assistant Practitioner Therapies Level 5. ▪ Resuscitation Training – awaiting CQC final response on standards. A detailed TNA is being undertaken. ▪ Mentorship for clinical staff – changes to current reporting due to database changes. ▪ Mandatory Training currently under review in order to simplify the reporting. **Perform** – ▪ Employee Relations – 77 cases YTD (average of c1.5 cases per week). Employment Tribunal case – Reconsideration Hearing and then Remedy Hearing to be arranged. ▪ Flexible Retirement and Fixed Term Contracts – No change ▪ Job Planning – 5 more job plans agreed (60%). Status changed from Amber to Red ▪ Apprenticeship Levy – new criteria for measuring progress (Red to Amber). Steady progress being made towards the targets. Levy target (2.3%) has increased from 1.38% to 1.67% and the number of apprentices has increased from 57 to 69 ▪ Clinical Mandatory Training – Rate has fallen below target. Status changed from Green to Amber. Some training sessions cancelled in Jan & Feb due to operational pressures. Core Sills Framework to be revised. ▪ Pay Spend – Reduction from previous month but still well above the budget and Red. ▪ Agency Spend – As a percentage of overall pay spend, agency expenditure has decreased from 6.16% to **5.66**% and is now Amber. The People Dashboard to be reviewed to include the CQC mandated training – including DOLs, Mental Capacity Training and Resuscitation	Perform – Assurance Recommendation – Paper to TOB regarding proposed changes to reporting of Core Skills Framework mandated training and 'Role Specific Training'	
WC/18/03/47	Deputy Director HR & OD	**Employee Relations Cases (including MHPS)** • 7 cases closed	Assurance	

		<table><tr><th>Sanction</th><th>Conduct</th><th>Dignity at Work</th><th>Grievance</th><th>AM Hearing</th><th>Total</th></tr><tr><td>Final Written Warning</td><td>1</td><td></td><td></td><td></td><td>1</td></tr><tr><td>First Written Warning</td><td>1</td><td></td><td></td><td></td><td>1</td></tr><tr><td>Management Counselling</td><td></td><td>1</td><td></td><td></td><td>1</td></tr><tr><td>No Case To Answer</td><td>1</td><td>1</td><td></td><td></td><td>2</td></tr><tr><td>Grievance Not Upheld</td><td></td><td></td><td>1</td><td></td><td>1</td></tr><tr><td>Other</td><td></td><td></td><td>1</td><td>1</td><td>1</td></tr></table> • 9 new cases and 21 live cases  • 3 suspensions and 2 actions short of suspension • 3 high risk cases Specific information was provided on one of the High Risk Cases with assurance that the CNO and individual were being regularly updated on developments and that it was expected that this case would be closed down by 31 March 2018.		
WC/18/03/48	Head of HR Strategic Projects	**Policies & Procedures:** ▪ Policies and Procedures Group met on 8.3.18 and next meeting planned for 10.5.18 ▪ Policies discussed were as follows: - Alcohol, Drug and Substance Misuse Policy - Providing Employment References - Travel Policy	Assurance	KSJ – To take policy eRostering Policy through TOB for approval

		- Annual Leave Policy eRostering Policy still to progress to TOB – Head of Strategic HR Projects to contact CNO and policy lead to ensure that formal sign off proceeds through TOB		
WC/18/03/49	Deputy Director HR & OD	**National Staff Opinion Survey** ▪ The 2017 NHS Staff Survey results were published 5 March 2018. ▪ For 2017 the survey was sent to 3955 WHH staff. ▪ The response rate was 46% up 6% on last year (38%). ▪ Results can be analysed by CBU. ▪ A full report and presentation will be presented at Board on 28 March 2018. ▪ The results demonstrate a 'status quo' ▪ There was <u>one</u> statically significant reduction in the key findings – ***This was a decline in the percentage of staff reporting errors, near misses or incidents in the last month.*** ▪ There was <u>one</u> statically significant improvement in the key findings – ***A decline in the percentage of staff experiencing harassment, bullying or abuse from patients, relatives of the public in last 12 months*** Engagement Score: The Trust overall staff engagement indicator was **3.74**.  	Assurance	

Recommendation as a place to work or receive treatment:

		Your Trust in 2017	Average (median) for acute trusts	Your Trust in 2016
Q21a	"Care of patients / service users is my organisation's top priority"	72%	76%	69%
Q21b	"My organisation acts on concerns raised by patients / service users"	71%	73%	69%
Q21c	"I would recommend my organisation as a place to work"	53%	61%	54%
Q21d	"If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"	60%	71%	57%
KF1.	Staff recommendation of the organisation as a place to work or receive treatment (Q21a, 21c-d)	3.62	3.76	3.59

'Care of Patients is my Organisation's Top Priority':

	Your Trust in 2017	Average for Acute Trusts	Your Trust in 2016
"Care of patients / service users is my organisation's top priority"	72	76	69

Top 5 ranking scores

- **Percentage of staff experiencing discrimination at work in the last 12 months**
- **Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months**
- **Percentage of staff working extra hours**
- **Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion**

		▪ **Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves** **Bottom 5 ranking scores** ▪ **Percentage of staff reporting errors, near misses or incidents witnessed in the last month *(- 5% deterioration since 2016)*** ▪ **Staff recommendation of the organisation as a place to work or receive treatment** ▪ **Fairness and effectiveness of procedures for reporting errors, near misses and incidents** ▪ **Percentage of staff experiencing physical violence from staff in last 12 months** ▪ **Percentage of staff able to contribute towards improvements at work** Over **138** staff left additional comments – compared to 88 in 2016. Initial analysis shows patterns for discontent around the following areas: – Staffing levels leading to work related stress and dislike of sickness policy triggers – Poor access to training – CPD, professional – Level of care able to give below the standard they want to give – Environment poor – clinical areas and non clinical areas – Lots of CBU personnel changes – Issues around Lorenzo – Decisions made about them / services without them – Levels of appreciation and financial constraints Next steps: ▪ Each area will receive individual analysis of their staff survey results ▪ Each of the G2G, M2O work streams will receive a presentation on the SOS results for their area to facilitate a discussion on how will this be addressed		

		within their work plans. Supported by the HR and OD Directorate AND: **W*HH - a great place to work - Workshop event in April 2018*** Using a Hackathon approach Attendees to include: – Exec Team – Chairman & NEDs – People Champions – CBU reps – all disciplines – Leads for H&S – Freedom to Speak Up Champion – HWB Service – Communications etc. Themes and actions developed through Culture and Leadership Workstream Volunteers to help turn ideas into actions from the day Communication via People Champions – ***We Said, We Did***		
WC/18/03/50	Deputy Director HR & OD	**Freedom to Speak Up Report** Reported noted	Assurance	
WC/18/03/51	Head of HR Strategic Projects	**Mersey Bridge Report** Report noted and specific point raised around the reduced impact on travel across the bridge that originally expected.	Assurance	
WC/18/03/52	Head of Education and Wellbeing	**Education Governance Meeting** Chairs Log Noted	Assurance	
WC/18/03/53	Head of Medical Staffing and Education	**Joint Local Consultative Committee** Chairs Log Noted	Assurance	

WC/18/03/54	Head of WT	**Premium Pay Spend and Review Group** Chairs Log Noted	Assurance	
WC/18/03/55	Head of HR Strategic Projects	**Policy & Procedures Group** Chairs Log Noted	Assurance	
WC/18/03/56	Head of WT	**ESR and Systems Report Group:** Chairs Log Noted	Assurance	
WC/18/02/34	All	**AOB:** No other items discussed		

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/18/03/21**	
SUBJECT:	Mortality Review Findings Report	
DATE OF MEETING:	Tuesday 6th March 2018	
ACTION REQUIRED	**For Assurance**	
AUTHOR(S):	Dr P. Cantrell, Lead Clinician for Mortality G. Sutton, Head of Clinical Effectiveness	
EXECUTIVE DIRECTOR SPONSOR:	Professor Simon Constable, Medical Director & Deputy CEO	
LINK TO STRATEGIC OBJECTIVES:	All	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	BAF1.1: CQC Compliance for Quality	
	All	
EXECUTIVE SUMMARY (KEY ISSUES):	This briefing paper overviews Trust mortality data and provides local and national context. It also outlines the actions in place to ensure robust oversight and monitoring, through a comprehensive mortality peer review process, as well as improvement plans to reduce Trust mortality rates and the Trust mortality ratio figures.	
RECOMMENDATION:	The Trust Board is asked to note the contents of the briefing paper and discuss	
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality + Assurance Committee
	Agenda Ref.	QAC/18 03 29
	Date of meeting	6th March 2018
	Summary of Outcome	**The Committee approved the recommended options within the report.**
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

NAME OF COMMITTEE

SUBJECT	Trust Mortality	AGENDA REF:	BM/18/03/21

1. BACKGROUND/CONTEXT

The importance of reporting mortality statistics at Board level was highlighted in the Francis Report into the failures at the Mid-Staffordshire Trust (February 2010) to which Warrington and Halton Hospitals NHS Foundation Trust provided a full position response reported at Board in September 2010.

The CQC has developed a national framework at the request of the Department of Health which was launched in March 2017. There is a requirement for all Trusts to collect and publish specified information on deaths on a quarterly basis. By the end of Quarter 2 of 2017/18, the Trust is required to have a policy and approach as to how it will publish the data. The Trust has a policy which was ratified at Board in October and is available on the Trust website.

2. KEY ELEMENTS

We use the HED (Healthcare Evaluation Data) system to asses our overall mortality data. This allows us to produce graphs and assess our position against other Trusts nationally. We evaluate areas for concern or trends which points us towards focused reviews in these particular areas.

2.1 Screening Reviews

All inpatient and Emergency Department deaths have a 'screening review' by a Consultant (not the Consultant in charge of the patient) for an overview on the quality of care received by that patient. This review assesses whether a more in-depth review by a member of the Mortality Review Group (MRG) is required.

Please note from Quarter 4 onwards, we will no longer be reviewing all inpatient and Emergency Department deaths and will be moving towards the categories of patients that will trigger a Structured Judgement Review by a member of Mortality Review Group as per the Trust's *Learning from Deaths* policy.

2.2 Secondary Reviews

Particular groups of patients are reviewed at the MRG:

1. All deaths of patients on DoLs (Deprivation of Liberty)
2. All deaths of patients with learning disabilities
3. All deaths following admission under the Mental Health Act
4. All deaths of patients admitted for an elective surgical procedure
5. All deaths occurring in theatre

Any member of staff can flag a patient to the MRG if there are concerns regarding a patient death for a secondary review. Secondary reviews are presented to the MRG, an assessment of problems in care is made and any actions or lessons to be learned are sent to the appropriate fora.

2.3 Focused Reviews

We conduct focused reviews where the HED system indicates we are an outlier in a particular diagnosis group, for example Pneumonia. It is important to note that the diagnosis group relates to the condition the patient was being treated for during their stay in hospital and not their cause of death. It is also important to note that excess unexpected deaths does not equate to preventable deaths.

Where we are above our expected number of deaths in a diagnosis group for over three months we will work alongside specialists within the appropriate specialty to perform case note reviews of the patients' stay.

This deep dive provides us with valuable learning as to what is needed to be implemented to ensure we have no further triggers within diagnosis groups. Some aspects of learning are applicable to reduce the likelihood of triggering in the future, such as improved documentation and coding, whereas others are specifically of relevance to that treatment, such as using a dip stick before diagnosing a patient as having a urinary tract infection.

2.4 Mortality Data Analysis

There are three main types of overall data used:

2.4.1 Crude Mortality Rates

This is the percentage/number of deaths against the total number of discharges in a particular timeframe. It needs to be used with caution as it does not take into account complexity of patients.

2.4.2 HSMR (Hospital Standardised Mortality Ratio)

All spells culminating in death at the end of a patient pathway defined by the primary diagnosis for the spell. It uses 56 diagnosis groups which account for about 80% of in-hospital deaths; therefore it does not included 'all' deaths.

Adjustments are made for:

• sex • age • admission method • comorbidities (based on Charlson score) • number of previous emergency admissions • history of previous emergency admissions in the last 12 months	• month of admission • socio economic deprivation quintile (using Carstairs) • primary diagnosis sub-group • palliative care • year of discharge

2.4.3 SHMI (Summary Hospital Mortality Indicator)
All observed deaths in hospital and within 30 days of discharge. Adjustments are made only for age, admission method, comorbidities.

Still births, specialist community, mental health and independent sector hospitals, day cases, regular day and night attenders are excluded.

In 2010 the Department of Health endorsed the national review of HSMR commissioned by the NHS Medical Director who committed to implementing SHMI as the single hospital level of mortality indicator to be used across the NHS. Therefore, although we still look at HSMR and the crude mortality rates, it is the SHMI which is being used and evaluated nationally as the mortality indicator.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

3.1 Screening Reviews

Month	Care Rating					Screening Return
	1: Very Poor	2: Poor	3: Adequate	4: Good	5:Excellent	
September	0	2	5	45	38	95% (81/98)
October	0	1	6	34	32	78% (67/77)
November	0	1	1	47	29	78% (55/73)
December[1]	0	0	4	33	24	74/113

- The four reviews returned as *"2: Poor"* have been put onto Datix and 72hr reviews completed. 1 of the "*3: Adequate*" has been subject to an SJR by a member of MRG and is detailed below in Section 3.2 Secondary Reviews. The remaining 15 scored as 3 where not deemed as requiring a secondary review as:
  - The overall score related to Death Certification improvements.
  - Earlier OGD may have been considered but would not have altered the outcome.
  - Delay in antibiotics on admission – no impact upon outcome for patient.
  - Earlier palliative care could have been considered.[2]

3.2 Secondary Reviews

There have been **6** secondary reviews conducted between October 2017 and December 2017. Two of these reviews were identified via a screening review. Two were triggered as a result of them being NELA deaths, one was due to the patient being under 55 years of age at time of death and one was a surgical death.

Case	Method	Care Rating	Issues/Learning Identified

[1] December reviews are still within their 30 day completion period, hence compliance is expected to be low at this point
[2] This has been identified as a learning point in previous focused reviews.

TJH	Under 55yrs	3: Adequate	SOP to be written for patients that cannot be managed on a medical unit that require sedation.
AB	Surgical	4: Good	Overall good practice. Learning points relatively minor and without a significant bearing on preventability.
VP	NELA	3: Adequate	The patient could have been operated on sooner after admission (plus earlier IV antibiotics and earlier CT scan). However this would not have changed the outcome as exceptionally high risk due to co-morbidities.
EB	NELA	4: Good	Surgery could potentially have been expedited by a few hours but I feel this is very unlikely to have made a difference to the outcome, and delaying overnight was a reasonable clinical decision based on the information available initially.
BJ	Screening review	3: Adequate	Given the patient's frailty and cardiovascular disease, I treatment was adequate during her inpatient stay and the subsequent deterioration at home could not have been prevented.
JS	Coroner Referral	4: Good	It was felt that the patient's PE formed pre admission and any anticoagulation given in ED was not going to stop it blocking pulmonary arteries.

3.3 Focused Reviews

The below table sets out the focused reviews that have been planned to be conducted during Quarter 3 due to being mortality outliers:

Diagnosis Group	Trigger	Observed deaths/ expected deaths	Date due for completion	Learning Identified
Liver Disease, alcohol-related	HSMR & SHMI	31/28	March 2018	Report due 20/03/18
Intestinal Infection	SHMI	24/13	March 2018	Report due 20/03/18

The table overleaf sets out the focused reviews that have been completed during Quarter 2 due to being mortality outliers:

Diagnosis Group	Trigger	Observed deaths / expected deaths	Date of completion	Learning Identified
Cancer of the Rectum & Anus	HSMR & SHMI	7/2.78	November 2017	Report 12/12/17
Cardiac Dysrhythmias	HSMR	14/7	December 2017	Report 13/01/18
Fractured Neck of Femur	SHMI	41/30	January 2018	Report due 20/02/18

Learning and actions identified from these reviews are contained within **Section 3.7**.

3.4 Crude Mortality

- Crude mortality should be viewed with caution, as it does not take into account the complexities of the patients, but it is useful to monitor numbers of observed deaths.
- Because of the relative consistency of the relationship between in hospital crude mortality and crude mortality including deaths with 30 days out of hospital, it can give an 'early warning' with regards to mortality including deaths within 30 days out of hospital.

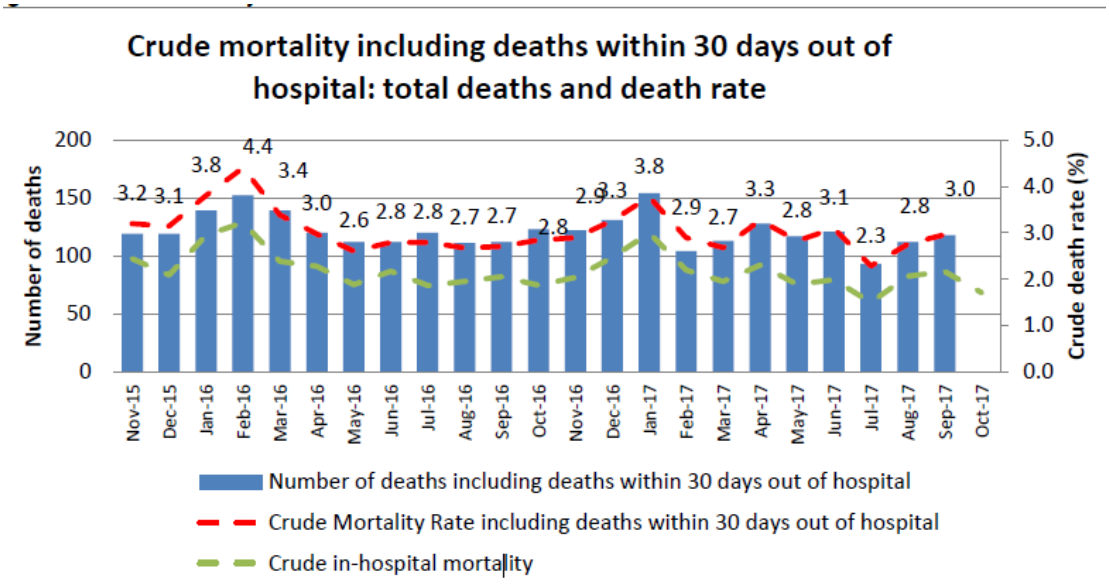


Figure 1: Crude Mortality July 15 to June 17

3.5 HSMR

- **We are not a national outlier, with a HSMR of 101.07 for November 2016 –October 2017.**
  - This result is not significant at 95% level for the latest 12 months.

Quarter 3 HSMR:

Our continuing downward trend is due to the appropriate coding of palliative care patients. Since the first quarter of 2016, our levels of palliative care coding has increased consistently and we are now in line with other acute Trusts nationally. HSMR allows for palliative care, whereas SHMI does not account for this cohort of patients.

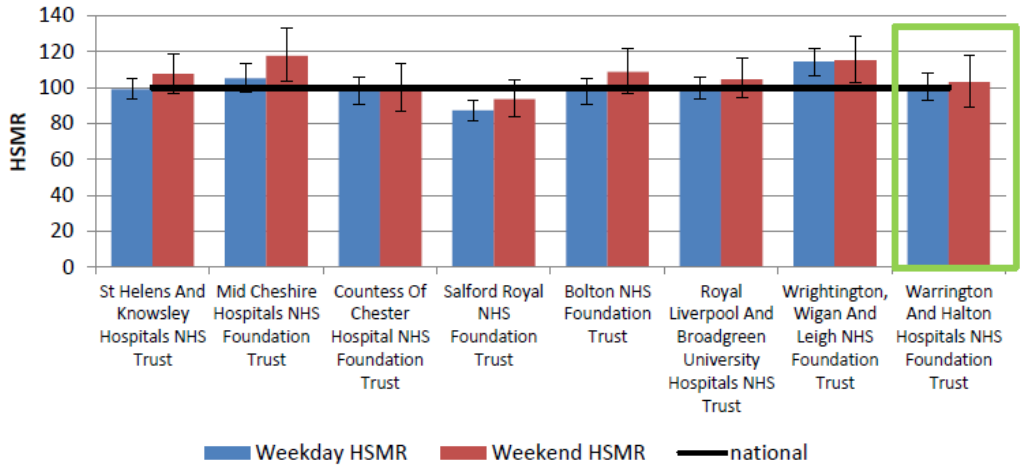
3.5.1 HSMR by diagnostic grouping

HSMR looks at 56 diagnosis groups which cover approximately 80% of in-hospital deaths nationally. Of these groups, this trust is showing a statistically significantly high HSMR result in the 12 month period of July 2016 – June 2017 for the following groups:

The size of the box denotes the number of patients under a diagnosis group.

The darker the colour, the higher the number of observed deaths

3.5.2 Weekend/Weekday HSMR



This graph shows there is very little difference between the weekday and weekend HSMR for Warrington, and neither score is statistically significantly high.

3.6 SHMI

We are a 'green rating' for this indicator, with a SHMI of 106.78 for the period June 2016 to May 2017. We are not an outlier for this indicator.

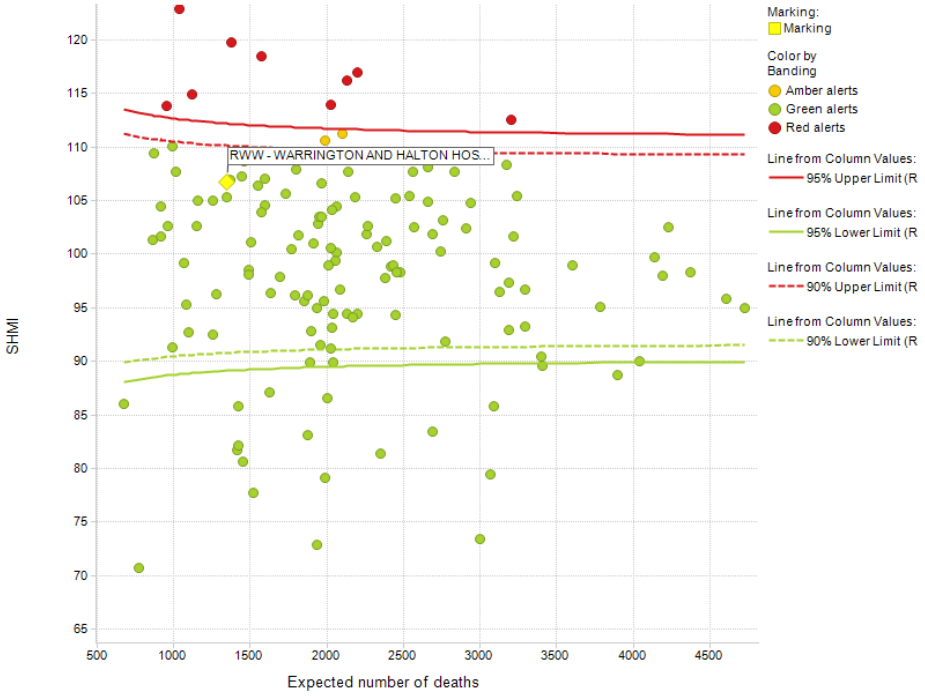
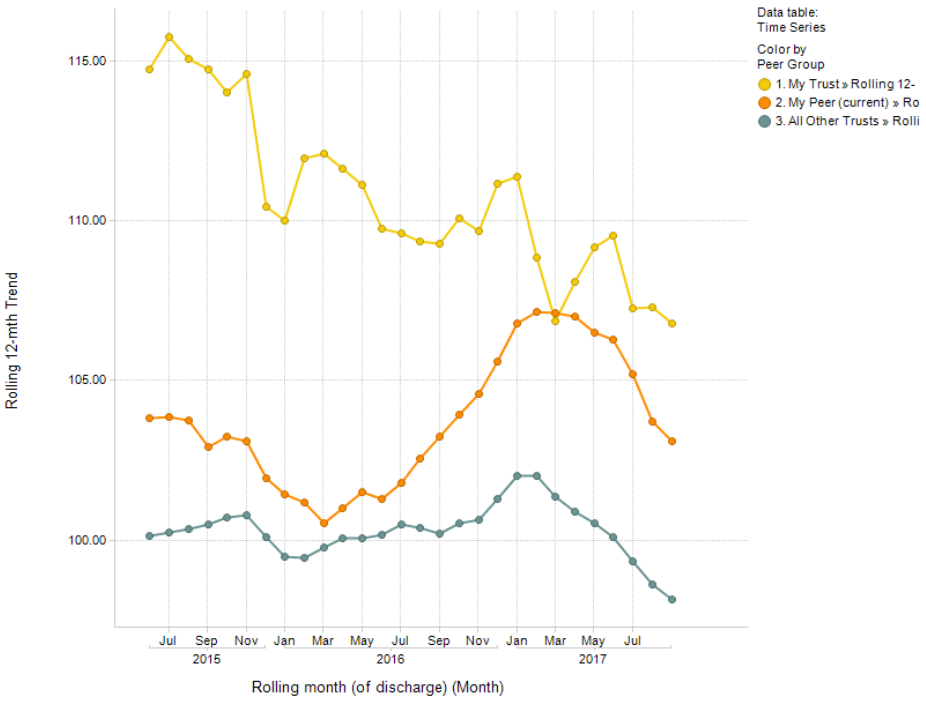


Figure 2: SHMI Funnel Plot (June 2016 - May 2017)



Warrington's downward trend continues, and the same can now be seen for peers and all other acute trusts.

The recent downward trend for the peer group can be seen for each of the individual peers, to varying degrees.

Figure 3: SHMI excess deaths by diagnostic grouping; tree diagram

- CCS groups which are statistically significantly high are ringed red.

3.6.1 Weekend/Weekday SHMI

Figure 4: Weekend / weekday SHMI compared to peers

- Weekend SHMI is slightly lower than the weekday SHMI for Warrington, whereas all of its peers have a higher weekend SHMI than weekday.
- Weekday SHMI is statistically significantly high for Warrington, and Wrightington, Wigan and Leigh.
- Weekend SHMI is significant for St Helens and Knowsley, Countess of Chester, Bolton and Wrightington, Wigan and Leigh.
- SHMI is statistically significantly low for Salford for weekdays.

3.7 Learning Identified from Mortality Reviews (including focused reviews)

Cancer of the Rectum & Anus Summary:

- Three of the patients (Cases 1, 2 & 5) were palliative, end-stage metastatic disease. One of these patients was end-stage lung cancer rather than rectal.
- Three of the cases (Cases 2, 4 & 5) were late presentations with metastatic inoperable disease at diagnosis.
- All of the deaths were unavoidable.
- In three of the cases (Cases 1, 3 & 6) the cause of death was not directly related to bowel cancer.
- The coding was appropriate for all of these cases.
- Death certificate was incorrect in two of the cases (Case 1 & 6).

Cardiac Dysrhythmias Summary:

- All of the deaths were unavoidable.
- Following a coding review, six of these patients would have changed the diagnostic group they would have been under as the coding sequence was incorrect
- Death certificate was incorrect in three of the cases (Case 2, 3 & 5).

3.7.1 Interface with Oncology Team (Cancer of the Rectum & Anus Review)

Case 6 identified an issue where Acute Oncology was not informed during his admission. This meant that the patient's care was suboptimal, although this did not adversely affect the outcome.

ACTION TAKEN: A notification to alert staff that the patient has a known cancer on the Trust's electronic patient record is now available, which will improve care to these patients.

3.7.2 Earlier Diagnosis in the Community (Cancer of the Rectum & Anus Review)

A patient (Case 5) had visited GP several times with altered bowel habit. He was eventually referred for a colonoscopy which confirmed a low rectal tumour.

ACTION: Provide to CCG as an anonymised case for GP learning.

3.7.3 Accuracy of death certification (Cancer of the Rectum & Anus Review and Cardiac Dysrhythmias review)

There were two cases (1 & 6) were the death certificate could have been improved.

ACTION TAKEN: This has previously been identified from previous focused reviews and an improvement project was implemented in 2017 and changes made to the process of death certification. The success of this project is due to be audited in Quarter 2 of 2018.

3.7.4 Sequence of Coding (Cardiac Dysrhythmias review)

The coding sequence for six (Cases 2, 4, 7, 8, 11 & 12) of these patients was corrected following a coding audit and this learning has been passed around the Coding team to ensure accuracy of diagnostic group.

Admission Coding

In 5 of 12 cases the admission diagnosis was incorrect and has been altered. Case 13 is still under review.

ACTION : To discuss having named coder to assist with MRG reviews in the new process to allow for more rapid identification of issues.

3.7.5 End of Life Care (Cardiac Dysrhythmias review)

Palliative care could have been considered much earlier in one case (5) and earlier recognition of end of life in a further two (3 & 8).

ACTIONS :

- Write up cases and send for dissemination through the CBU Governance Meetings.
- End of life management is a recurring theme which is not being managed as well as we could and this should be prioritised as an area for Trustwide quality improvement. To discuss with the relevant Associate Medical Director for the Trust.

3.7.6 Trust Policy on Anticoagulation in Renal Failure (Cardiac Dysrhythmias review)

In light of the findings Pharmacy to be asked to review to assess Policy.

ACTION : Pharmacy to be asked to review this case and one of the other cases, where warfarin was incorrectly prescribed for review of policy and learning.

3.7.7 Inadequate Review of Patients' Previous History (Cardiac Dysrhythmias review)

This is a recurrent theme. Outpatient management of other medical problems e.g. cancer, myasthenia gravis (in this review) and other relevant history is often not picked up on patient's current admission. This has resulted in suboptimal patient care on a number of occasions.

ACTION : To be discussed at MRG.

3.8 Suggested Dashboard for Structured Judgement Review Ratings

This will be completed in Quarter 4

Month	Care Rating Following SJR					Total Deaths
	1: Very Poor	2: Poor	3: Adequate	4: Good	5:Excellent	
January						
February						
March						
Totals	Straight to Root Cause Analysis		Further MRG			

		Discussion & Outcomes			

3.8.1 Previous Quarter's RCA Outcome

Summary	Root cause	Action plan
This will be completed in Quarter 4	This will be completed in Quarter 4	This will be completed in Quarter 4

3.8.2 Discussion on SJRs Having a Care Rating of 3

This will be completed in Quarter 4

3.8.3 Areas of Good Practice

This will be completed in Quarter 4

3.9 Summary

- Warrington is not an outlier for SHMI for the last 12 months, according to the over dispersed model but it would get an amber rating from the early warning Poisson model method also used by HED.
- HSMR is not an outlier for the last 12 months.
- Weekend / weekday mortality is not an issue for Warrington.
- Comorbidity levels have stabilised at a lower level.
- Cancer of rectum and anus – whilst this is a low volume category, it is an outlier for SHMI and statistically significantly high for both HSMR and SHMI. Recorded palliative care levels have increased in line with the increase in SHMI (the two could be connected because SHMI does not adjust for the provision of palliative care.) However, whilst this group is not an outlier for HSMR , the result is still statistically significantly high, so palliative care is not the only issue for this diagnostic group. A review of deaths has previously been recommended.
- Septicaemia (except in labour) – both SHMI & HSMR are better than expected for the latest 12 months, but this category had a CuSum alert for SHMI in January 2017. Deaths in December (10, 5 expected) were the main contributor to this CuSum alert, and may benefit from review.

4. ASSURANCE COMMITTEE

Quality Assurance Committee

5. RECOMMENDATIONS

The Trust Board is asked to note the contents of the briefing paper and discuss

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/18/03/22**	
SUBJECT:	**Learning from Experience Report - Q3 2017/18**	
DATE OF MEETING:	March 2018	
ACTION REQUIRED	**Note the report**	
AUTHOR(S):	Ursula Martin, Director Integrated Governance + Quality	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse	
LINK TO STRATEGIC OBJECTIVES:	All	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	All	
STRATEGIC CONTEXT	The following report relates to implementation of the Trust's Learning Framework.	
EXECUTIVE SUMMARY (KEY ISSUES):	This is the fourth new integrated "Learning from Experience" (LFE) report. It focuses on the learning from incidents, complaints, claims and inquests over Quarter 3, 2017 (October-December).	
RECOMMENDATION:	The Board is asked to; • Note and approve the contents of the report • Receive assurance that the Learning from Experience process continues within the organisation. • The presentation of the data is included within the slide deck provided.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality + Assurance Committee
	Agenda Ref.	
	Date of meeting	March 2018
	Summary of Outcome	Assurance provided
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

BOARD OF DIRECTORS

SUBJECT	Learning from Experience Report Q3	AGENDA REF:	BM/18/03/22

1. BACKGROUND/CONTEXT

This report relates to the period 1st October 2017 to 31st December 2018. It contains a quantitative and qualitative analysis (using information obtained from the Datix risk system) and includes incidents, complaints, claims and inquests. The report includes a summary of key issues identified in Q2 and makes specific recommendations in respect to the findings, which will be followed up in the next report.

The purpose of the report is to:

- Identify themes arising from the incidents, complaints and claims that have been reported during the period,
- Make recommendations to the CBUs highlighting areas of focus for improvement; and
- Provide a summary of incidents, complaints and claims reported during the review period, highlighting any trends apparent from review of the data.

2. Review of recommendations

Recommendations are outlined in Appendix 1 of this report and will appear in subsequent reports to provide progress and feedback to any recommendations made resulting from this report.

2. KEY ELEMENTS

Incident investigation

As reported in the previous LFE report, the most recent results from the National Reporting and Learning System (NRLS), which compares our performance against other acute non-specialist Trusts across the NHS, shows our incident reporting rate was 40.14 per 1,000 bed days for Q3 and Q4 2016/2017. The Trust's previous reporting rate prior to this was 43.66 per 1,000 bed days. The Trust is within the middle 50% of reporters for acute non-specialist trusts. Anonymised reports of all relevant clinical incidents are sent to the NRLS weekly. **Performance will be monitored and reviewed when the next NRLS report is received Q1 in 2018/19.**

Incidents in Q3

- There have been 2,488 incidents reported in Q3 a reduction in reporting from the previous quarter.
- The Trust continues to report a higher number of 'no' to 'low harm' incidents, as expected.
- There was also a significant reduction in incidents causing Moderate to Catastrophic harm in Q3 (39 in Q2 vs 25 in Q3).

- The majority of incidents reported occurred between the hours 08:00-18:00.

Closure of incidents

- There has been improvements in the closure of incidents since the last quarter Q2 n=1065 incidents and in Q3 this has reduced to n= 748.
- The CBUs, Urgent and Emergency Care and Specialist Medicine account for the highest number of open incidents.
- Medication incidents account for the highest category of opened incidents - n=123 at the time of reporting with staffing next at n=92.

Review of incident sub-categories

The most commonly reported incidents have not changed since the last report in Q2 – pressure ulcers, slips, trips and falls, medicines, staffing and those relating to assault/ verbal abuse/ threatening behaviour remain the highest reported categories. A summary is provided below relating to these categories.

Lack of Staff

- Continues to be the highest reported sub-category (n=129) a reduction from Q2 (n=181). Contingency plans are in place to address staffing shortfall, via the development of a business case for nurse staffing, and work regarding recruitment and retention, being led by the nursing workforce team, headed up by the new Associate Chief Nurse of Effectiveness.

Pressure ulcers

- Is still the highest reported incident category with the second highest reported sub-category relating to Grade 2 pressure ulcers that are community acquired (n=93)

Action

- A new Tissue Viability Group has been established to support the review and prevention of pressure ulcers.

Breach of Single Sex Guidelines (Mixed sex accommodation)

- 4th highest sub-category (n=49). Breaches continue to originate from the Intensive Care Unit.

Action

- Escalation of individual cases to the Executive team had been variable in Quarter 3 and this was reviewed.
- RCAs are now conducted for each patient breach and continue to be reported to the CCG.
- There is further work underway to ensure there is a strengthened process via Lead Nurses and CBU Managers.
- From 1st February 1st 2018 the same process of escalation as the '*Decision to Admit*' process in the Emergency Department has been implemented.

- Despite winter pressures impacting significantly on the ability to step down patients in a timely manner, there has been an improvement in Quarter 4 already.
- Mixed Sex Accommodation (MSA) breaches have reduced significantly from 19 reported breaches in December 2017 to 7 cases in January 2018 and it is expected that there will be a continuing downward trajectory.

Assault, verbal abuse and threatening behaviour

- Continues to be one of the highest reported categories

The Health & Safety Advisors have identified the following:

Disruptive Behaviour

- There were (n=50) incidents within this category.
- All incidents were reported on the Warrington site and incidents were primarily completed by the Security staff.
- Of the 50 incidents, 14 were noted as “crash bleeped” (emergency calls) and over half (n=27) were reported in the Department of Urgent and Emergency Care.
- There were 17 incidents that occurred in ED alone of which on 2 occasions, the Police were in attendance.
- 15 incidents occurred where 6 patients had repeated callouts requesting a security presence, some of which occurred on the same day.
- On one day, the Security Team were called 4 times to the same patient as the patient was trying to leave the ward.
- The Adult Safeguarding Team were involved in the management of a number of these incidents

Of these patients:

- 8 patients were on DoLS,
- 11 patients were detoxing/intoxicated (of which 3 lacked capacity)
- 4 were smoking related incidents
- The areas associated were Wards A1, A2, A3 and C22.

Other incidents related to:

- Patients absconding or wandering off the ward/department
- Persons asking for money or sleeping in toilets
- Relatives filming using their phone (scan images)
- Patient with confusion lashing out or shouting
- Patients attending for treatment from Hollins Park Hospital (mental health provider)
- None of the incidents reported under the category resulted in an injury and all incidents were graded with a severity of 1 as ‘negligible’ or ‘none’
- When comparing the previous quarter (Q2), there were 39 incidents, of which there were only 3 patients who had repeated incidents.
- Similar trends such as patients on DoLS, lacking capacity, dementia and intoxication are noted.

Clinical Violence (related to patients)

- There were 37 incidents identified in quarter 3 as clinical violence
- 12 wards and departments are identified where the incidents took place; Ward B1 and CMTC are the only areas identified for Halton hospital, the rest are at Warrington.
- Ward B12 recorded 15 incidents in this category
- 35 incidents recorded patient aggression towards staff
- 2 incidents recorded patient aggression towards another patient
- 79 years old was the average age of patients involved (where age has been recorded on the incident record)
- 5 incidents recorded the need for safeguarding support
- 3 incidents recorded the patient had a DoLS
- 13 incidents recorded the need to involve security

Action

- Review of training for supporting staff in the care and management of patients on DoLS, for Mental Capacity Assessment and for the MHA is currently underway.
- A new Consultant Nurse for Dementia has been appointed to support and manage the service.
- A business case is under review for the development of a learning disabilities lead nurse role.
- During this quarter the Security Team provided more training for staff involved in the support and management of patients who exhibit challenging behaviour.

Transfer of patients from the Halton Site to Warrington

- 41 incidents were identified in this category
- From CMTC 14 incidents were identified - 1 was potentially avoidable, but the patient had COPD and asthma and required transfer on the day of surgery to Warrington with breathing problems. *Listing of a high risk patient for CMTC was identified as an issue in an SI report concluded in 2018.*
- B4 - 9 incidents all unpredictable
- B1 - 10 incidents due to unexpected changes in the patient's condition requiring further monitoring
- MIU 6 - delays in emergency ambulance to transfer acutely ill patients.
- Intermediate Care - 1 incident and PIU - 1 incident, both appear to have been necessary transfers

Action

- Work is underway to review issues related to acuity and the admission protocols for Ward B1. The Interim CD for Specialist Medicine is currently reviewing the admisison criteria and issues related to Length of Stay. An update is to be provided to PSCEC regarding progress of this work.
- Initial review of the incident data has identified reasonable decisions for transfer to the Warrington site with regard to the majority of the incidents, but this are of reporting should continue to be monitored and audited in future if deemed appropriate.

Medication Safety

- Medication incidents are the third highest reported category.
- Incidents reported in this period have been graded as 'no harm' or minor'.
- Medication incidents account for the highest category for incidents that remain open – at the time of reporting 135 reports remain open.
- The highest reported categories relate to dispensing and checking and supply errors.
- There were 14 incidents reported related to Adverse/ Allergic drug reaction – whilst a number of these relate to unknown allergies some of the incidents identify that known allergies were not correctly documented or ascertained from the patient prior to administration, these related to antibiotics and in one incident the drug Buscopan which was contraindicated for the patient's condition. In one incident it was identified in the WHO check list that the patient had an Iodine allergy. It was not documented whether it was topical or intra venous so the procedure could not be completed.
- A report was presented by the Deputy Director of Pharmacy on the management of controlled drugs to the December meeting of PSCEC. The review of the 12 month period showed that 146 incidents had been reported. Of these, 126 were 'no harm' incidents and 20 'minor harm'. The highest numbers of incidents reported were from A1, Pharmacy and A6. The Medicines Governance Group is overseeing the action plan related to this.

Action

- Action is underway to address the number of open incidents. It has been recognised that further work is required with to assign and agree ownership with Pharmacy to ensure that review and closure of medication safety incidents across the Trust is occurring.
- CBU Safety Newsletters to contain advice and reminders around the importance of obtaining and documenting patient allergies.

Serious Incidents

- 11 serious incidents (SI) were reported in Q3 in comparison to 21 Serious Incidents reported in Q2, (categories are in the pp slide for SI s)
- Whilst falls incidents remain one of the highest reported categories, there was no patient falls reported as a serious incident in this period.
- There were 2 Grade 3 pressure ulcers reported in this period, both of these occurred on Ward A3 and 1 incident that related to extravasation in paediatrics
- 2 SIs were reported from Maternity Services
- Other SIs related to a wider range of incidents, but a number were related to treatment, intervention and diagnosis
- A new SI was declared that is linked to the Spinal Services review and will also have an external surgical and anaesthetic review

What did we learn?

15 SIs concluded in this period and learning from these is identified as follow:

- Early access to CT and MRI scanning may have supported the patient's diagnosis and improved intervention
- Close assessment and observation of patients who have taken an overdose is essential
- Patients who are frequent attenders in the Trust need careful assessment when they are admitted
- Patients with a mental health diagnosis need to be assessed using the Mental Health Triage Tool
- Secondary review should be considered when patients are not progressing as planned following a procedure
- SOPs and regular audit of the administrative procedures and systems for booking patients in outpatient clinics and for future investigations are essential
- Multi- agency working and communication with the GP is essential when planning for discharge
- Standardisation is essential for ensuring that MDT processes and meetings function effectively
- The involvement and review by senior clinicians during the patient's stay and when planning for discharge are essential
- The importance of multidisciplinary ward rounds taking place and including junior medical staff
- It is important to accurately document the anatomical location of pressure damage and to complete pressure ulcer risk assessments on admission
- Documenting contemporaneously in the health records is essential
- Review of processes for reviewing pacemaker site complications has been undertaken
- Changes made to the Lorenzo systems to ensure result are easily available to all staff in Endoscopy
- Escalating concerns and patient deterioration is essential

Duty of Candour

The Trust continues to make improvements in meeting Duty of Candour when this is triggered. Patients and families are meeting with clinical teams to help guide investigations and to receive feedback when they are completed.
A new guidance leaflet has been produced and training will commence in March 2018

Complaints and PALS

- The Complaints Department launched a new policy detailing how complaints and concerns should be dealt with and the processes around responding to the same.
- The Trust continued to improve timeliness in responding to concerns reaching 69% in December 2017. This against a backdrop of 26% in April 2017.
- The Complaints Department recruited a new Complaints Officer. This will increase capacity in the team to deal with concerns in a timely fashion.
- The response time for PALS has significantly increased in Q3 – from 20 days to 9 days – a 55% improvement.

Inquests

The following activity relates to the management of inquests in Q3:

- **Inpatient deaths: 288**
- **Coroner's referrals 47**
- **Inquests opened 23 of which 5 closed in the same quarter**
- **Inquests for Trust attendance 5**
- **Legal support instructed 1**
- **Inquests Closed 11**

- 1 inquest was originally heard in April 2017, but adjourned for the Coroner to consider the position around neglect or PFD. This inquest concluded in October 2017 with the conclusion: *The patient died due to an accident which occurred due to the absence of enhanced nursing observation.*
- The Coroner requested further information around the actions from the Level 2 SI report which related to a patient fall and enhanced observation. The Trust sent the response to the Coroner in January 2018 and awaits a response.

Claims

- 43 new clinical claims received in Q3
- 9 non-clinical in Q3
- Trauma & Orthopaedics accounts for the highest increase in claims with an increase noted in Musculoskeletal claims related to spinal services in Q3
- Emergency Medicine has the second highest number of claims – diagnosis and treatment are the 2 highest categories
- There has been a slight increase in Q3 for Radiology imaging - 2 are related to SIs reported in 2017
- Highest damages for a missed cancer (cervical cancer) due to systems error when the patient was placed on the wrong list (not the fast track) resulting in a delay in treatment - total value of claim £159,242

Mortality Review and Learning

- The Learning from Deaths Policy has been launched
- Structured Judgement Review training has commenced and new reviewers have been recruited to support this

- Earlier recognition of end of life care and palliative care input has been a common theme from mortality reviews conducted in this period
- Work has been undertaken to support the Sequence of Coding with Patients under the Diagnosis Group of Cardiac Dysrhythmias - The coding sequence for six patients was corrected following a coding audit and this learning has been conveyed to the Coding Team to ensure accuracy of diagnostic group coding
- Inadequate Review of Patients' Previous History -This is a recurrent theme and has caused issues as a patient's medical problems, Outpatient visits and other relevant history is often not picked up on the patient's current admission. This has impacted on patient care on a number of occasions. This is being discussed with the Deputy Chief Clinical Information Officer.
- Staff need to record a patient's comorbidities in the "Health Issues" section of Lorenzo. This will ensure their history will be available with each admission and will automatically populate Clinical Notes.

We are WHH

And together we

make a difference

Learning From Experience Q3 Report

Ursula Martin

Director of Integrated Governance & Quality

February 2018

Overview

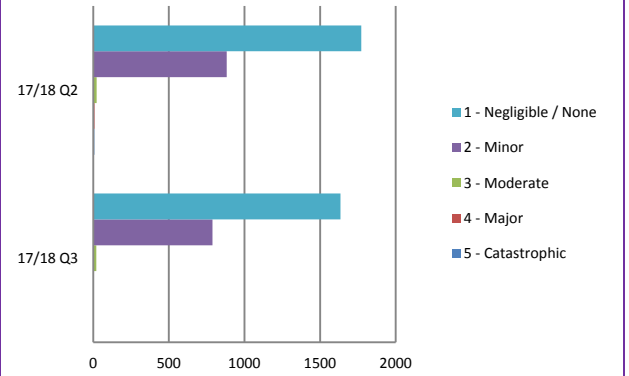
The following slides provide an overview of the information extracted from the Datix system and other clinical governance reports for incidents, complaints, claims and inquests related to Quarter 3, 2017/18. They should be viewed in conjunction with the High Level Briefing Report.

Incident Headlines

Warrington and Halton Hospitals NHS
NHS Foundation Trust

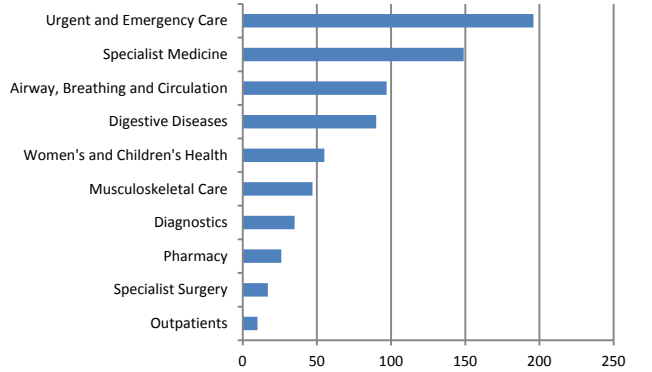
How many staff are raising incidents Q2 vs Q3?

- There was a **decrease** in incident reporting within the Trust in Q3 (2963 in Q2 vs 2448 in Q3).
- There was also a significant reduction in incidents causing Moderate to Catastrophic harm in Q3 (39 in Q2 vs 25 in Q3).



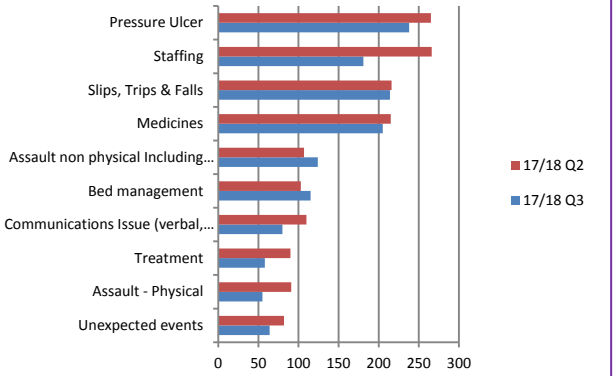
How many incidents are open Q2 vs Q3?

- The Trust reported 1065 incidents open in the Q2 LFE. To date that has reduced significantly to 748. The graph below shows 10 CBUs with open incidents.
- Closing incidents and responding in a timely fashion to them remains a concern and work has commenced to advise managers on how to close their incidents.
- Medication incidents account for the highest category of opened incidents - n=123 at the time of reporting with staffing next at n=92.



What type of incidents are we reporting Q2 vs Q3?

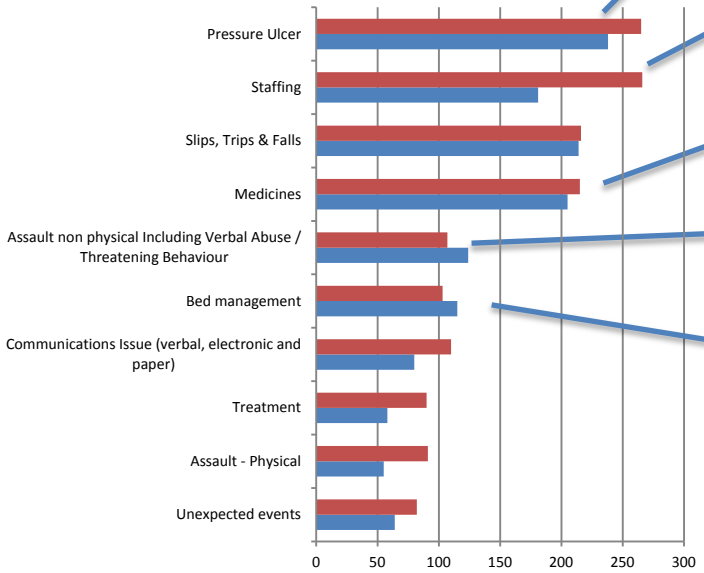
- As stated there was a decrease in the amount of indents reported. Incidents relating to staffing decreased in Q3; however, issues relating to Bed Management and Verbal Assault have increased.



Incident Category Analysis Q2 vs Q3

Warrington and Halton Hospitals NHS
NHS Foundation Trust

The information shows the top categories reported incidents how they differ between the 2 quarters.



Pressure Ulcers:
- Decrease
- Grade 2 Community Acquired are the highest category reported

Staffing:
- Decrease in reporting
- Lack of staff is the highest reported category

Medicines:
- Decrease in reporting but Medication incidents are the highest category of open incidents

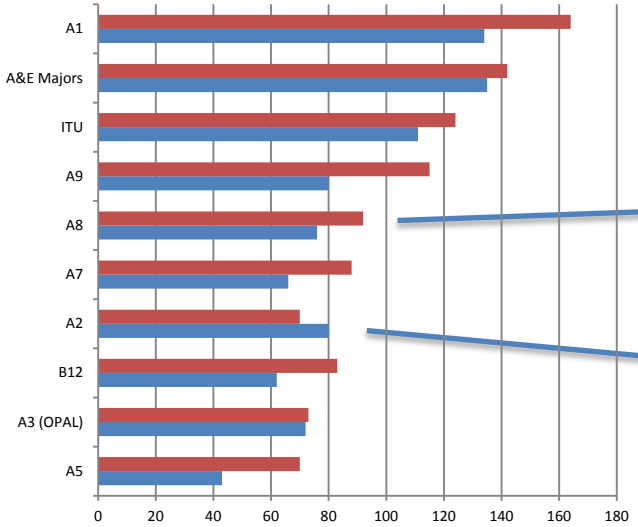
Verbal Assault:
- Increase in reporting
- Disruptive behaviour and incidents related to patients are the highest

Bed Management:
- Increase – will have been impacted by Trust winter pressures

Incident Ward Analysis Q2 vs Q3

Warrington and Halton Hospitals NHS
NHS Foundation Trust

The information shows the top reporting Wards and how they differ between the 2 quarters.



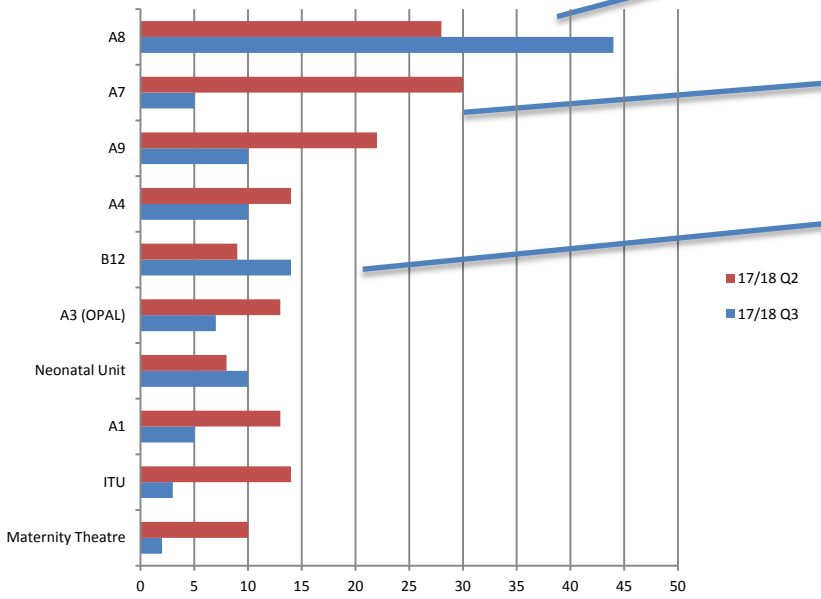
A8:
- **Decrease in reporting**

A2:
- **Increase – may be due to winter pressures**

Staffing Incidents Ward Analysis Q2 vs Q3

Warrington and Halton Hospitals NHS
NHS Foundation Trust

The information shows the top reporting Wards in relation to staffing incidents and how they differ between the 2 quarters.



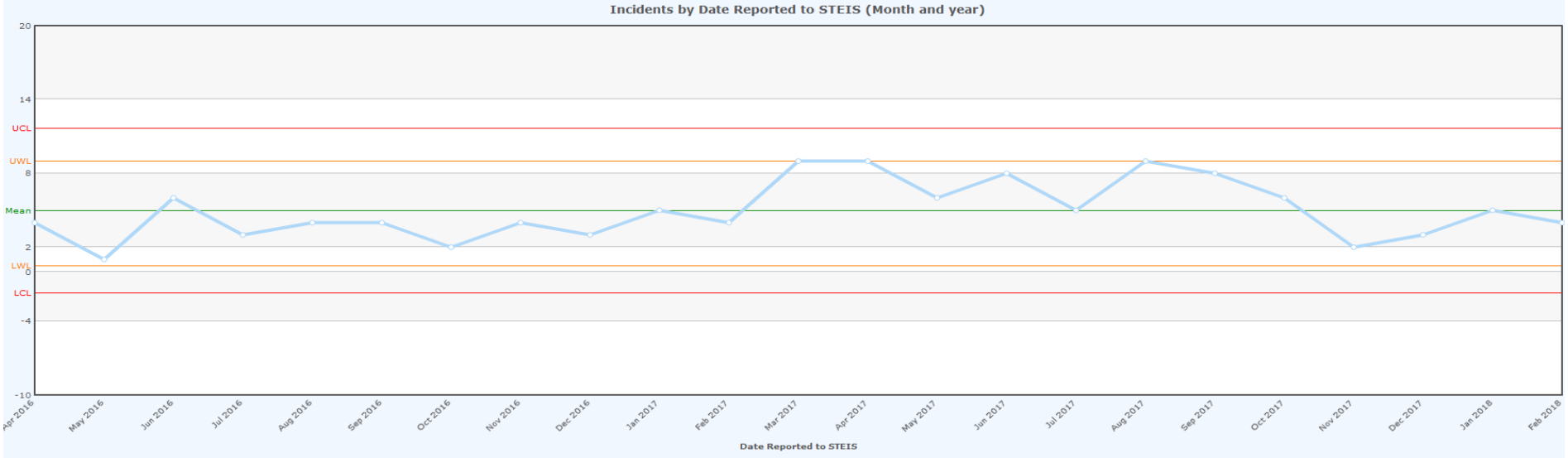
A8:
- Increase in reporting

A2:
- Decrease in reporting

B12:
- Increase in reporting

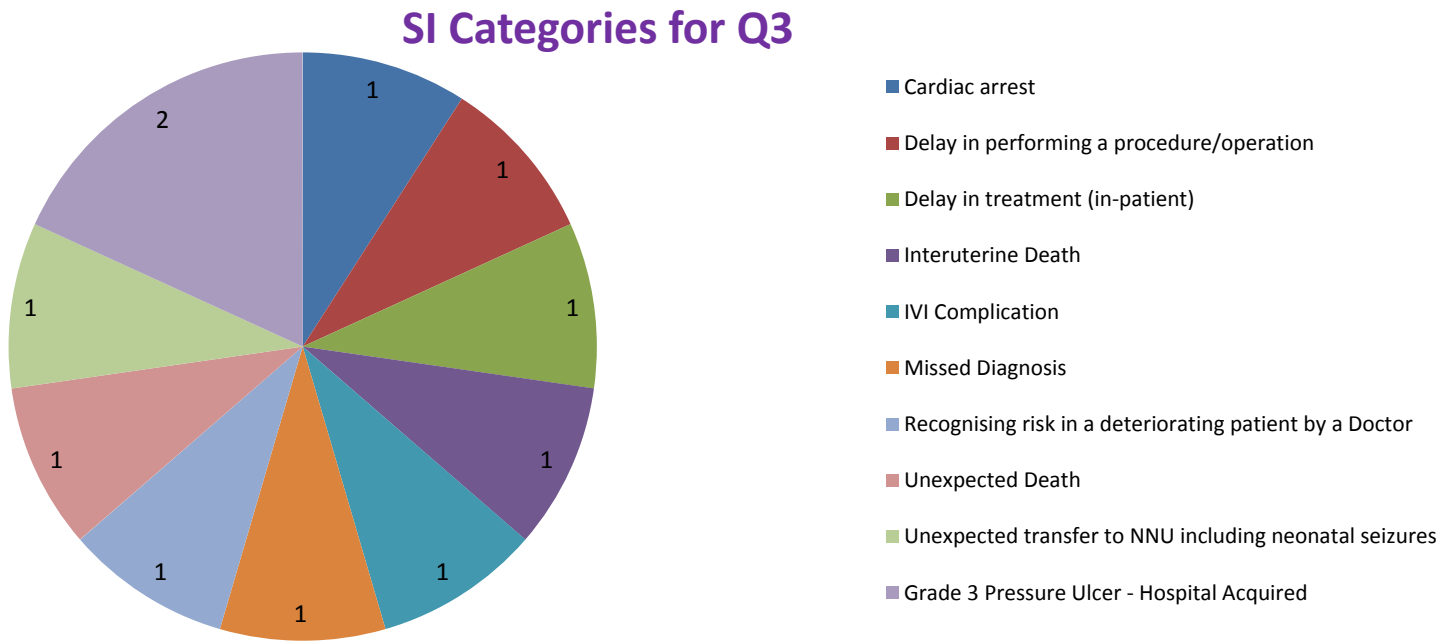
Serious Incident (SI) Reporting

Warrington and Halton Hospitals NHS
NHS Foundation Trust



Reporting of SI investigations has reduced in Q3. *It should be noted that the chart lines (Red and Amber) denote Upper and Lower control limits as defined by the data in the graph.*

SI Cause Groups Q3

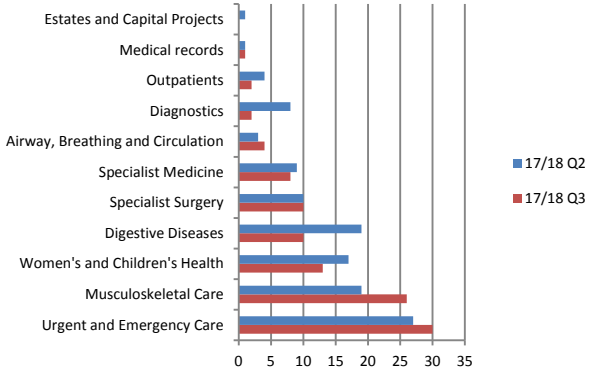


Complaints Headlines

Warrington and Halton Hospitals NHS
NHS Foundation Trust

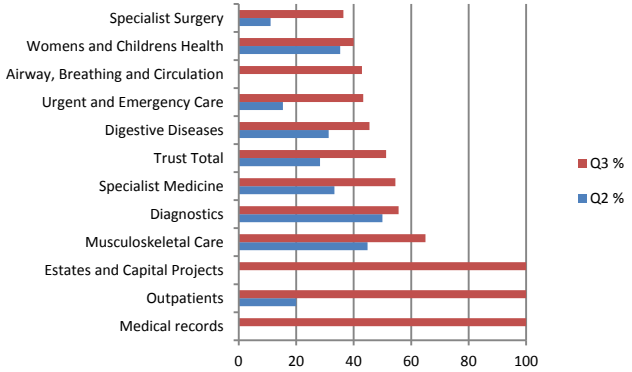
How many people are raising complaints Q2 vs Q3?

- There was a **decrease** in complaints opened Trust wide in Q3 (118 in Q2 vs 106 in Q3)
- All areas had a decrease in complaints or stayed the same as the pervious quarter; except MSK and Urgent and Emergency Care. This is partially due to complaints around Spinal Services (MSK) and the effect of full capacity and Winter Pressures (A&E)



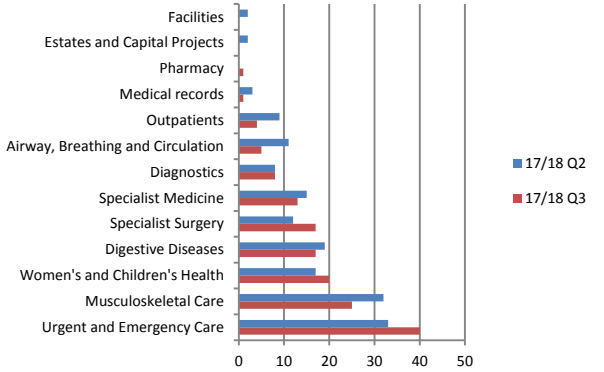
Are we Responsive Q2 vs Q3?

- All areas within the Trust have improved significantly in responding to complaints within Trust timeframes
- This means a huge improvement in patient experience for when service users feel the need to complaint about the care they or a relative has received



How many complaints has the Trust responded to Q2 vs Q3?

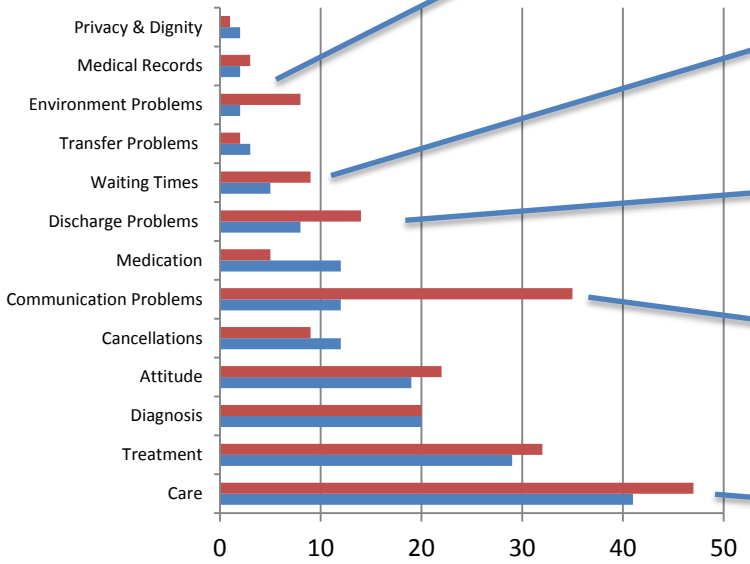
- There was a **decrease** in complaints responded to Trust wide in Q3 (163 in Q2 vs 151 in Q3)
- Urgent and Emergency Care, Specialist Surgery and Woman's and Children's Health are the only CBU's that have increased the amount of complaints they have closed



Complaints Analysis Q2 vs Q3

Warrington and Halton Hospitals NHS
NHS Foundation Trust

The information shows the top subjects in complaints and how they differ between the 2 quarters. Note: Complaints can have more than one subject.



Environment Problems:
- Dirty rooms and cubicles for patients
- Lac of infection control by staff when inserting lines
- Loss of the patients property whilst an inpatient
- Lack of hand sanitizer being used during patient contact

Waiting Times:
- Long waits to be seen in A&E. This is a theme that can be seen when the Trust is under high pressure
- Waiting time in other areas and wards is also a theme due to high pressure
- This has been a continual theme from October 2017 forwards which is in line with winter pressures

Discharge Problems:
- Inappropriate or unsafe discharges
- A lack of communication in relation to discharge procedures and what the next steps of care are for the patients
- Lack of communication of discharges to carer's / families
- Inadequate discharge arrangements for follow up care
- This issue can also be linked to when the Trust is on full capacity

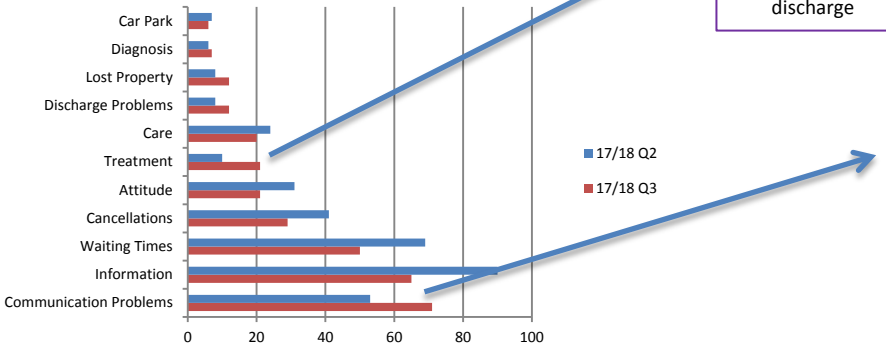
Communication Problems:
- Lack of clear communication with the family / carer's of the patients as to the ongoing management plans
- Lack of communication around transfer plans
- Issues in accessing interpreters when patients have attended
- Lack of communication around the cancellation of appointments / surgery

Care:
- Lack of communication between speciality areas regarding patient treatment
- No provision of care or appropriate follow up
- Failure to inform patients of the diagnosis and treatment plane – this often then leads to a perception of inadequate care

PALS Analysis Q2 vs Q3

Warrington and Halton Hospitals NHS
NHS Foundation Trust

The information shows the top subjects in PALS and how they differ between the 2 quarters. Note: Complaints can have more than one subject.



Treatment:
- Lack of treatment of the patient on the ward
- Inadequate discharge planning
- No clear pathways on the ward or following discharge

Communication Problems:
- Issues with pathways or treatment plans
- Communication with the relatives and families of patients on the ward or around the time of discharge
- Lack of letters i.e. discharge summaries or appointment letters being sent to patients

The average response time for a PALS concern:

Q2	Q3
20 days	9 days

PALS to complaints referrals:

Q2	Q3
15	5

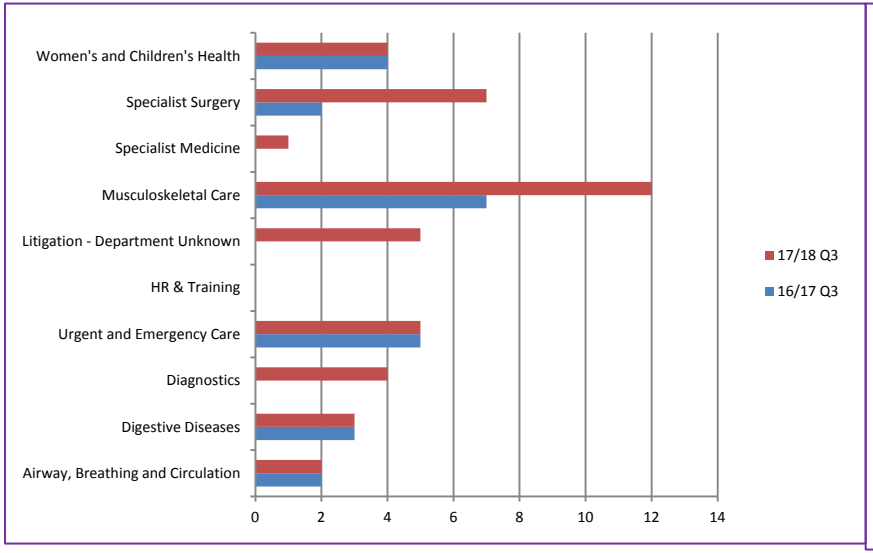
Learning from Complaints and PALS

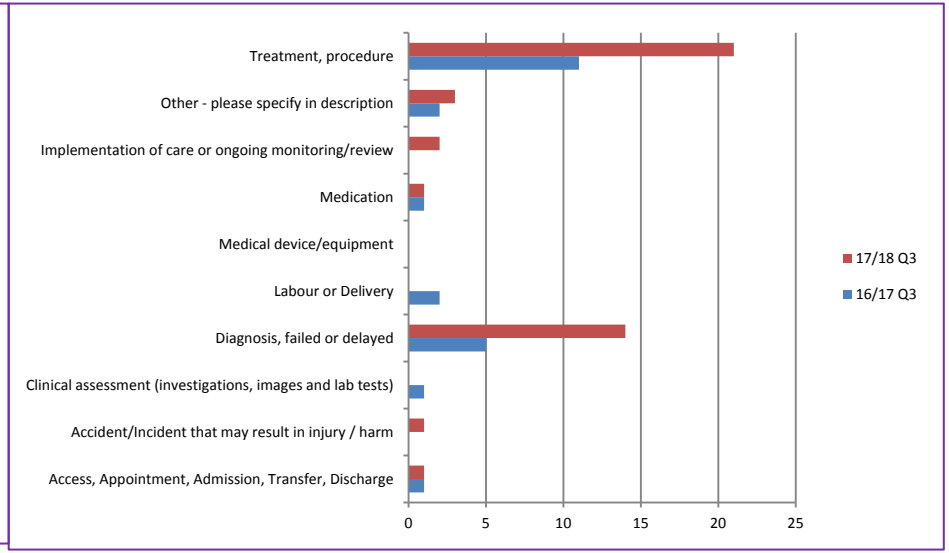
Warrington and Halton Hospitals NHS
NHS Foundation Trust

You Said….	We Did….
The patient had issues with infection control and prevention on the ward.	Regular audits on the wards completed by the Matrons to ensure compliance with infection control.
There was a lack of information and communication on the ward.	The ward in question has introduced a Welcome Booklet to answer some questions patients and their relatives may have about the ward or their admission.
The patient had a poor experience during their maternity care specifically with issues relating to breast feeding.	Training has been arranged for the staff in relation to breast feeding and the complaint will be shared at the Maternity Mandatory Study Day.
There was a delay in diagnosing the patients stroke.	The Specialist Stroke Nurses will deliver continued training to staff about the early diagnosis and recognition of stroke.

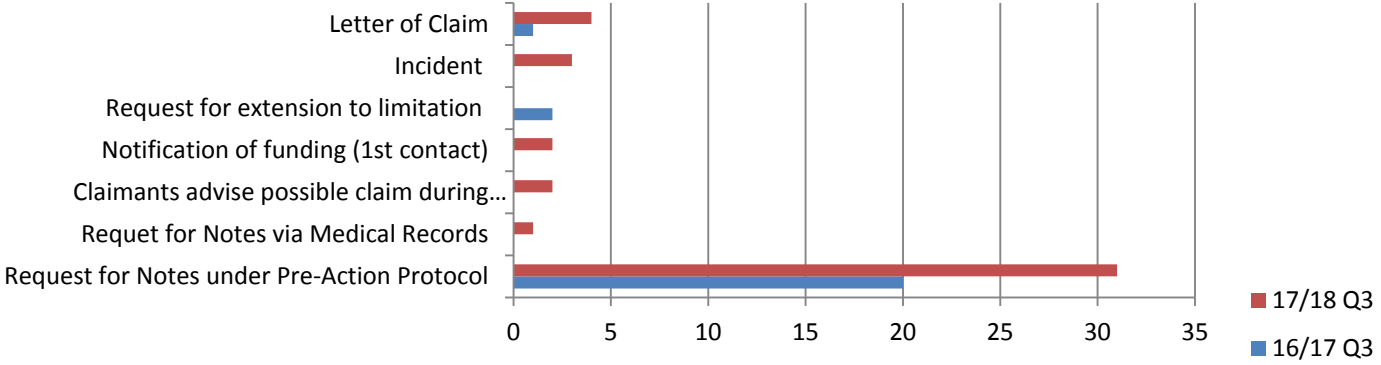
Clinical Claims Received Q3 2016/20187 vs Q3 2017/2018 by department and by category

Warrington and Halton Hospitals NHS
NHS Foundation Trust





Clinical Claims Analysis Q3 2016/17 vs Q3 2017/18



	Request for Notes under Pre-Action Protocol	Requet for Notes via Medical Records	Claimants advise possible claim during complaints process	Notification of funding (1st contact)	Request for extension to limitation	Incident	Letter of Claim
17/18 Q3	31	1	2	2	0	3	4
16/17 Q3	20	0	0	0	2	0	1

Clinical Claims Closed- Q3 2017/18

	With Damages	Repudiated	Withdrawn	Total
Acute Care Services	1	1	1	3
Acute Medicine	1	0	0	1
Emergency Medicine	0	1	1	2
Corporate Departments	0	1	0	1
Medical Staffing	0	1	0	1
Surgery and Women's and Children's	3	2	11	16
CMTC Orthopaedics	0	0	1	1
Upper and Lower Colorectal Surgery	0	1	1	2
General Surgical	0	0	2	2
Gynaecology	1	0	0	1
Obstetrics	0	1	2	3
Ophthalmology	0	0	1	1
Orthopaedic Surgery	0	0	1	1
Trauma & Orthopaedics	2	0	1	3
Urology	0	0	1	1
Vascular	0	0	1	1
Totals:	4	4	12	20

Learning from Clinical Claims closed with Payment Q3, 2017/18

GYNAECOLOGY

Alleged delay in the diagnosis and treatment of uterine and cervical cancer between November 2011 and October 2012

- To be Disseminated to the Governance meeting and by email to colleagues as a learning point.
- Gynaecology Cancer Lead has sent out an email addressing this issue reiterating the importance of tracking CFT patients, expediting their investigations and leaving them on the urgent CFT pathway until a cancer diagnosis has been reliably excluded.

TRAUMA AND ORTHOPAEDIC -

Delay in diagnosing displacement of fractured wrist

- Consultant felt that there was a failure to undertaken repeat x-rays 2-3 weeks post MUA

Failure to carry out the procedure the patient had consented for

- Complaint investigation and ombudsman findings presented and discussed at Orthopaedic Business Meeting
- Share learning from investigation outcome with the Theatre team and at the Theatre Governance meeting
- The importance of ensuring the best practice is followed when consenting patients was highlighted at the MSK Governance Meeting and Orthopaedic Business Meeting
- Ensure best practice is following during the consenting process
- MSK Governance Lead circulated clinical journal on consent and duty of candour to MSK colleagues for reflection and learning from this case
- Audit of delegated consent was planned

ACUTE MEDICINE (2014 incident)

Failure to supervise the patient resulting in numerous falls, during which the patient sustained head injury and subsequently passed away (Previous PFD - 2015)

· Safety Alert sent to all clinical staff to remind them of the importance of 1-1 care and record keeping standards regarding documentation.
· Review of the 1-1 Care Policy to see if any changes need to be made.
· Review of the Falls Training Programme to ensure clear, consistent and important messages run through the educational sessions provided.
· Review of the Falls Pathway to see if any changes are required.
· Review of Level 1 &2 Investigations to the Falls Group and reporting Learning and Improvements Trust wide.
· Review of the Policy for Standard Physiological and Neurological Observations so there is clarity for staff to the level of observations.

Improvement work continues with the Falls Prevention Programme in 2017/18 and the new Neurological Observations chart has been approved in Q3

Number of Claims Open at end of Q3 2017/2018

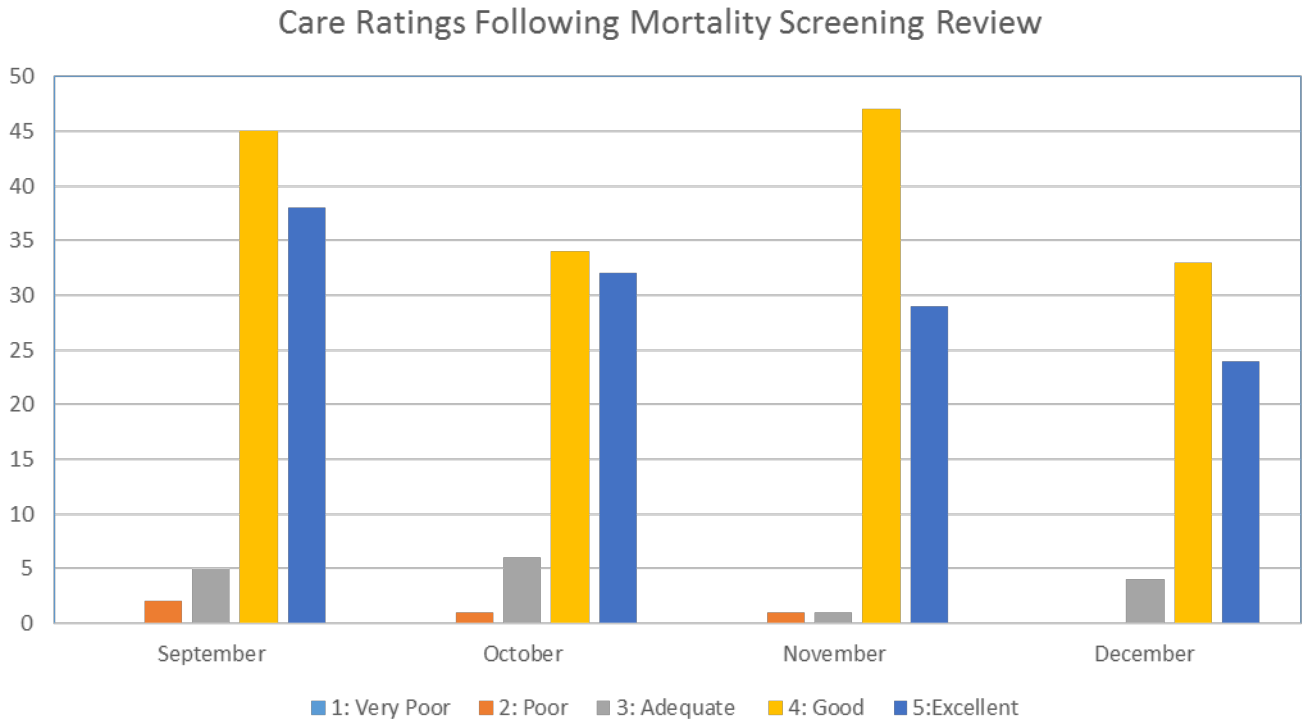
Warrington and Halton Hospitals NHS
NHS Foundation Trust

	A	P	EL	PL	Total
ACUTE CARE SERVICES					
Airway, Breathing and Circulation	3	9	0	0	12
Acute Care Team	1	0	0	0	1
Anaesthetics	1	1	0	0	2
Cardiology	0	5	0	0	5
Respiratory Medicine	1	3	0	0	4
Diagnostics	10	4	0	0	14
Histopathology	2	0	0	0	2
Imaging	8	3	0	0	11
Breast Screening and Mammography	0	1	0	0	1
Specialist Medicine	1	5	1	2	9
Diabetes and Endocrinology (OP)	0	2	0	0	2
Elderly Care	1	3	0	2	6
Stroke Medicine	0	0	1	0	1
Urgent and Emergency Care	18	41	2	2	63
Acute Medicine	0	3	2	0	5
Emergency Medicine	15	34	0	2	51
General Internal Medicine	1	3	0	0	4
MIU	2	1	0	0	3

	A	P	EL	PL	Total
SURGERY, WOMENS AND CHILDREN					
Digestive Diseases	9	27	0	0	36
Upper and Lower Colorectal Surgery	1	7	0	0	8
Gastroenterology	1	3	0	0	4
General Surgical	7	17	0	0	24
Musculoskeletal Care	19	39	2	0	60
CMTC Orthopaedics	0	1	0	0	1
general trauma and ortho	1	0	0	0	1
Orthopaedic Surgery	3	1	0	0	4
Therapy - Musculoskeletal	0	1	0	0	1
Rheumatology	0	2	0	0	2
Trauma & Orthopaedics	15	34	2	0	51
Specialist Surgery	13	20	0	0	33
Day Case	0	1	0	0	1
ENT	4	2	0	0	6
Maxillofacial Surgery	0	2	0	0	2
Ophthalmology	3	3	0	0	6
Orthodontics	1	5	0	0	6
Urology	4	6	0	0	10
Vascular	1	1	0	0	2
Women's and Children's Health	22	27	1	1	51
Breast Surgery	0	2	0	0	2
Gynaecology	5	3	1	0	9
Maternity	3	7	0	0	10
Neonatal ICU	1	0	0	0	1
Obstetrics	9	12	0	1	22
Paediatrics and Neonatology	4	3	0	0	7

	A	P	EL	PL	Total
CORPORATE SERVICES					
Estates and Capital Projects	0	0	1	1	2
Operations (Estates maintenance and environment issues)	0	0	1	1	2
Governance and Risk	0	0	0	1	1
Governance	0	0	0	1	1
HR & Training	0	0	2	0	2
Organisational Development	0	0	1	0	1
Recruitment	0	0	1	0	1
Litigation - Department Unknown	0	11	0	0	11
Litigation - Department Unknown	0	11	0	0	11
Medical records	0	0	1	0	1
Health / Medical Records	0	0	1	0	1
Facilities	0	0	5	0	5
Catering	0	0	2	0	2
Domestic and Portering	0	0	2	0	2
Security	0	0	1	0	1

Learning from Deaths – SJR Reviews, Q3



BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/18/03/23**	
SUBJECT:	**CQC Update report**	
DATE OF MEETING:	22nd March 2018	
ACTION REQUIRED	**Review, Discuss and approve**	
AUTHOR(S):	Ursula Martin, Director of Governance & Quality	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse	
LINK TO STRATEGIC OBJECTIVES:	All	
EXECUTIVE SUMMARY (KEY ISSUES):	The following are key issues to highlight within the report: • An update is given regarding progress against the CQC action plan. A significant number of actions are to be addressed in March 2018. • An analysis of action taken against fundamental breaches is included within the report. • An update of the new Use of Resources Framework is include for information.	
RECOMMENDATION:	Discuss and note the Report	
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	

BOARD OF DIRECTORS

SUBJECT	CQC Update Report	AGENDA REF:	BM/18/03/23

1. BACKGROUND/CONTEXT

The Trust received its CQC report in November 2017, following the inspection in March 2017.

An action plan has been developed, which is being overseen by the Trust's Getting to Good Steering Group, which is chaired by the Chief Executive.

The following report gives an update of the action plan progress to date, an analysis of work that has been undertaken against the fundamental breaches that were highlighted within the report and an update on the Use of Resources framework.

2. KEY ELEMENTS

2.1 CQC action plan performance

The following are key points relating to the CQC action plan.

- There are 230 actions on the CQC action plan
- Action assurance reports have started to be submitted to Executive lead/Director of Governance & Quality and compliance is being assessed at Getting to Good monthly Steering Group
- The first set of compliance reports were submitted to March 2018 Getting to Good Steering Group
- 14 actions were due to be signed off – we were able to review and complete 10, with 4 actions having amendments to dates agreed formally through the Steering Group.
- The following table shows performance against action type. 10 actions were signed off as complete and compliant at the March Getting to Good Steering Group meeting, including 6 'must do' and 'should do' actions.
- 92 actions are due for completion at the end March and assurance will be reviewed at Getting to Good meeting 12th April 2018.

Action type	Number of actions	Actions Completed	Actions due Mar	Actions due April	Actions due May	Actions due June	Actions due July	Actions due Aug	Actions due Sept	Actions due Oct	Actions due Nov	Actions due Dec
However	135	4	47	43	21	8	6	1	2	1	0	2
Must	47	4	17	11	4	1	5	0	2	2	0	1
Should	48	2	28	7	3	1	7	0	0	0	0	0
Grand Total	**230**	10	92	61	28	10	18	1	4	3	0	3

The following table shows action by core service.

Core Service	Number of actions	Actions Completed	Actions due Mar	Actions due April	Actions due May	Actions due June	Actions due July	Actions due Aug	Actions due Sept	Actions due Oct	Actions due Nov	Actions due Dec
Children and Young People	11	2	3	4	0	0	2	0	0	0	0	0
Critical Care	27	0	11	8	3	0	2	0	1	2	0	0
End of Life	5	0	1	2	1	1	0	0	0	0	0	0
Maternity and Gynae	53	3	18	20	5	5	1	1	0	0	0	0
Medical Care (inc Older People's care)	40	0	15	8	10	3	2	0	2	0	0	0
Outpatients and Diagnostic imaging	38	3	17	9	2	0	3	0	0	1	0	3
Surgery	27	0	13	6	4	1	3	0	0	0	0	0
Trustwide	12	2	5	1	2	0	2	0	0	0	0	0
Urgent and Emergency Care	17	0	9	3	1	0	3	0	1	0	0	0
Grand Total	230	10	92	61	28	10	18	1	4	3	0	3

2.2 Fundamental breach Analysis

Within the Trusts CQC report, there were a number of fundamental breaches listed within the CQC report. Appendix 1 of this report outlines the breaches and position, with actions taken to date.

2.3 Use of Resources Assessment

The Use of Resources (UoR) joint assessment framework between NHSI and CQC has been published. NHSI are currently assessing non specialist acute Trusts - this work commenced in October 2017.

For Trusts receiving a UoR assessment after the 5th March, a UoR indicator will be combined with the other five trust level indictors currently inspected by CQC – to give the overall Trust rating. As there will be a 6th indicator, CQC have introduced a new rating principle where the Trust will be limited to 'Requires Improvement' where at least three (rather than two) of the six trust level ratings are requires improvement. UoR will be published in the CQC report – however any factual accuracy/queries will be referred to NHSI. Trusts will be expected to publish their UoR rating, alongside their quality rating.

It is expected that UoR assessments will be carried out prior to the CQC well led assessment. UoR will be carried out by NHSI and focuses on trust level delivery and performance over the previous 12months. There will be a one day site visit from NHSI re UoR .

UoR assesses how well trusts are meeting financial controls and using resources across 5 Key Lines of Enquiry – clinical services, people, clinical support, corporate services (procurement, estates and facilities) and finance. Key questions will include – how does the Trust's performance measure with peer group and nationally, has there been improvement or deterioration over the last 12 months, is there context for the Trust's performance, has the Trust implemented effective improvement plans to improve performance in these areas.

NHSI will use existing intelligence and information already gathered though the year on the Trusts being assessed. GIRFT and model hospital data will be utilised. Before the UoR, NHSI will ask for commentary against the KLOEs as part of the Provider Information Request.

The Director of Finance is leading the work within the Trust regarding UoR.

3 RECOMMENDATIONS

Trust Board are asked to discuss and note the

- CQC action plan progress and update
- The update on fundamental breaches
- Information regarding the new Use of Resources Framework.

Appendix 1 – Fundamental Breach Action Updates

To note – RAG rating will move to green when evidence/assurance is given that we have sustained actions in place.

Fundamental breach	Action/Progress	Executive Lead	RAG Assessment
Regulation 11- Consent and Mental Capacity	Action was put in place at the time of the CQC assessment and after, regarding training and increased surveillance. An audit of MCA and consent is being presented to G2G Steering Group April 2018 to assess current compliance	Chief Nurse	
Regulation 12 – medical devices training	A medical devices training database has been purchased, inventories and training needs analysis are underway. Trust Medical Devices Policy has been approved. Update on paediatrics medical devices to be given to April G2G Steering Group	Chief Nurse	
Regulation 12- checks in theatre Halton to prevent Never Events	We have implemented training, observational audits and are now auditing 100% of WHO checklist completion every month. We are also completing an assurance framework against the new Never Events list published to look at our policies and controls in place. This is being presented to PSESC March 18.	Medical Director	
Regulation 12 – checks of equipment trollies and anaesthetics machines	Additional controls were put in place at the time of the inspection and audits are being undertaken – presented at April Getting to Good meeting	Chief Nurse	
Regulation 12 – equipment and checks in radiology	1. CR reader in Halton – resolved 2. IRR99 compliance – audit presented at G2G Steering Group March 2018 showing 97% compliance (significant improvement) – not	Chief Operating Officer	

Fundamental breach	Action/Progress	Executive Lead	RAG Assessment
	closed as not 100% compliant – further audits being undertaken 3. Ultrasound machines in radiology – resolved		
Regulation 13- Safeguarding training	A review of safeguarding training has been undertaken, with each CBU to report to April G2G meeting a trajectory for compliance Additional training capacity being commissioned	Chief Nurse	
Regulation 15 – premises (radiology, gynae, maternity)	A review and options appraisal is underway regarding maternity and gynae. Radiology review is also underway. Halton – actions taken at the time and audit reports being presented to Getting to Good Steering Group in April to ensure sustainable actions in place • Treatment couches were not wiped down in between patients in outpatient treatment rooms. • Portable x-ray equipment was found to be covered in a thick layer of dust. • Both phlebotomy chairs in outpatients were broken: one had cracked covering on the armrests and the other had a large tear in the seat covering. • Clinic areas were congested and there was inadequate seating for some areas, with patients needing to stand in corridors whilst waiting.	Chief Operating Officer	
Regulation 17 –	a) The risk processes have been reviewed and Datix web for risk is	Chief	

Fundamental breach	Action/Progress	Executive Lead	RAG Assessment
Governance a) Risk Management b) record keeping c) IG and records being maintained securely	being rolled out, with training in place. All risk registers are due to be on the system by end April 2018. b) There is a records audit being undertaken reporting to Getting to Good Steering Group. There is an IG audit underway and results, with an options appraisal regarding records storage which will be presented to Getting to Good Steering Group	Nurse/Medical Director /Director of Informatics	
Regulation 18 – a) staffing b) APLS training for staff	a) Staffing - Acuity and dependency review been undertaken and business case being presented to the Board of Directors for nurse staffing Medical staffing meeting and actions implemented Audit of staffing escalation underway The neonatal unit did not have sufficient numbers of suitably qualified staff. There was no dedicated paediatric pharmacist. A review of neonatal staffing underway. Paediatric pharmacy provision addressed. b) APLS training – additional capacity for APLS training in paediatrics and critical care and recovery in theatres. An update being presented to April G2G Steering Group	Chief Nurse/Medical Director	

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/18/03/24**	
SUBJECT:	**Additional Working Capital Loan 2017/18**	
DATE OF MEETING:	**28 March 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 £1.412m 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 28 February 2018 the difference between the year to date planned and actual control total is £11.668m. To date the Board has approved further applications for working capital loans to support the variance from plan totalling £10.256m, together with a working capital loan of £2.300m to support the payment of aged creditors. This paper seeks to gain approval for an additional working capital loan of £1.412m for the Month 11 variance from plan.	
RECOMMENDATION:	The Board of Directors is requested to approve the application for a working capital loan of £1.412m for the Month 11 variance from plan.	
PREVIOUSLY CONSIDERED BY:	**Committee**	
	Agenda Ref.	
	Date of meeting	

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

1. PURPOSE

This paper seeks approval for the Trust to apply for a £1.412m 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 28 February 2018.

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 28 February 2018 the difference between the planned control total (£3.637m deficit) and the actual control total (£15.839m deficit) is £11.668m. As the Trust has a larger deficit than plan additional cash support is required to meet day to day working capital commitments. To date the Board has approved three applications for loans of £4.133m, £2.661m and £3.462m. This paper seeks to gain approval for an additional working capital loan of £1.412m. If the loan application is approved the loan will be drawn down in May 2018. The Trust has also secured a loan of £2.300m to support working capital balances.

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 28 February 2018 together with the loans required for the remainder of the year are summarised in the table below.

Table: Loan values as at 28 February 2018

Narrative	**Loan Value £m**
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
2017/18 Working Capital Loan to cover planned deficit	3.657
2017/18 Working Capital Loan to cover Q2 STF (1)	1.406
2017/18 Working Capital Loan to cover Aged Creditors	2.300
2017/18 Working Capital Loan to cover actual variance to control total as at 30 November 2017 (2)	4.133
2017/18 Working Capital Loan to cover actual variance to control total as at 31 December 2017 (3)	2.661
2017/18 Working Capital Loan to cover actual variance to control total as at 31 January 2018 (4)	3.462
2017/18 Working Capital Loan to cover actual variance to control total as at 28 February 2018 (5)	1.412
2017/18 Working Capital Loan to cover forecast variance to control total as at 28 February 2018 (6)	1.518
Total	**44.107**

(1) To be repaid March 2018.
(2) Received in February 2018.
(3) To be received in March 2018.
(4) Awaiting approval from NHSI and Department of Health (if approved loan would be received in April 2018).
(5) Approval to apply required from the Trust Board and paper requesting approval to be presented to March Trust Board (if secured the loan would be received in May 2018).
(6) Approval to apply required from the Trust Board and paper requesting approval would be presented to April Trust Board (if secured the loan would be received in June 2018).

After repayment of the £1.406m loan to cover STF Q2 monies in March 2018 the cumulative value of working capital loans covering the period 1 April 2015 to 31 March 2018 would equate to £41.261m.

The 2017/18 forecast outturn submitted to NHSI on 15 February 2018 remains unchanged at £16.843m deficit. A £16.843m deficit will require further working capital loans totalling £2.930m for the variance to plan in February and March 2018. This is in addition to the £13.913m working capital loans approved and applied for to 31 January 2018) to support the cash position and enable the Trust to meet its financial obligations. This is summarised in the table below:

Table: Working capital loans required to support 2017/18 forecast deficit

Narrative	**Loan Value £m**
2017/18 Working Capital Loan to cover planned deficit	3.657
2017/18 Working Capital Loan to cover actual variance to control total as at 30 November 2017	4.133
2017/18 Working Capital Loan to cover actual variance to control total as at 31 December 2017	2.661
2017/18 Working Capital Loan to cover actual variance to control total as at 31 January 2018	3.462
2017/18 Working Capital Loan to cover actual variance to control total as at 28 February 2018	1.412
2017/18 Working Capital Loan to cover forecast variance to control total as at 28 February 2018	1.518
Total	**16.843**

This excludes the £2.300m working capital loan secured to support payment of aged creditors.

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 £1.412m 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.

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM 18/03/25**
SUBJECT:	**Staff Opinion Survey 2017**
DATE OF MEETING:	28 March 2018
ACTION REQUIRED	For noting and approval
AUTHOR(S):	Deborah Smith, Deputy Director of HR and OD
EXECUTIVE DIRECTOR SPONSOR:	Michelle Cloney, Director of HR and OD
LINK TO STRATEGIC OBJECTIVES:	All
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	BAF2.1: Engage Staff, Adopt New Working, New Systems
	BAF2.4: Engaging & Involving Workforce
	BAF2.5: Right People, Right Skills in Workforce
STRATEGIC CONTEXT	
EXECUTIVE SUMMARY (KEY ISSUES):	Overall, the staff survey 2017 results show that organisationally there is opportunity to improve and create a culture of high-level engagement. In the main, the results have not changed since 2016. There are some areas in which the Trust excels in comparison to other Trusts and there are some areas in which we are below average and can improve. This report will outline the results of the 2017 Staff Opinion Survey and make recommendations around a new approach to employee engagement.
RECOMMENDATION:	It is proposed that the Trust take a new approach to employee engagement: <u>'WHH – A Great Place to Work'</u> The HR and OD Directorate will support the Trust Board to bring the workforce together in an event to promote innovation around the staff survey results. The themes, outputs and actions from the event will be developed managed through the 'Cultural Change and Leadership' programme. <u>G2G, M2O - A Targeted Approach</u> Each of the G2G, M2O work streams will receive a presentation on the SOS results for their area to facilitate a discussion on how will this be addressed

	within their work plans. They will be supported to do so by the HR and OD Directorate. <u>CBU / Department Level Information</u> Each CBU / Department will receive individual analysis of their staff survey results via their HR Business Partners however they will not be required to complete and submit detailed action plans.
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None

BOARD OF DIRECTORS

SUBJECT	Staff Opinion Survey 2017	AGENDA REF:	BM 18/03/30

1. BACKGROUND/CONTEXT

The 2017 Staff Opinion Survey was open to the whole organisation between 4 October 2017 and 1 December 2017. The survey response rate increased from 38% in 2016 to 46% in 2017.

This report will outline the results of the 2017 Staff Opinion Survey. The full Staff Opinion Survey report is enclosed at appendix 1. The report will go on to recommend a new approach to employee engagement, based on these results.

2. KEY ELEMENTS

2.1. Summary of Results

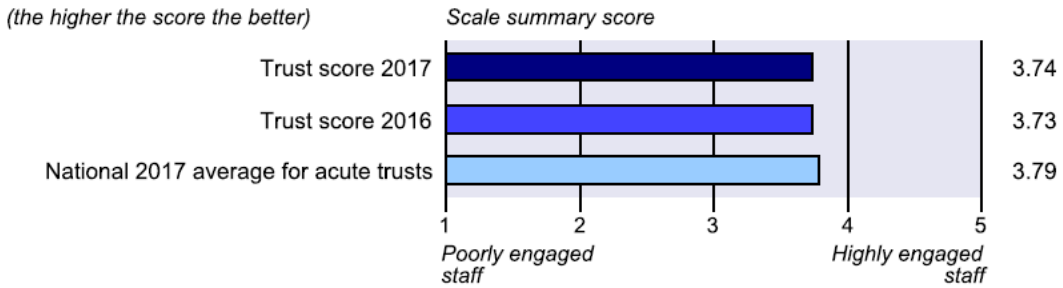
Overall, the staff survey 2017 results show that organisationally there is opportunity to improve and create a culture of high-level engagement. In the main, the results have not changed since 2016. There are some areas in which the Trust excels in comparison to other Trusts and there are some areas in which we are below average and can improve.

Overall Staff Engagement Indicators

The 3 key findings used to calculate overall staff engagement in an organisation are:

- Staff recommendation of the organisation as a place to work or receive treatment;
- Staff motivation at work;
- % of staff able to contribute towards improvements at work.

A scale of 1 to 5 is used to indicate overall staff engagement; 1 being poorly engaged and 5 being highly engaged. The Trust overall staff engagement indicator was 3.74. This is in comparison to our indicator of 3.73 in 2016 and to the average indicators of other acute Trusts in 2017 of 3.79.



The table below shows the Trust's scores for each of the sub-dimensions of this indicator.

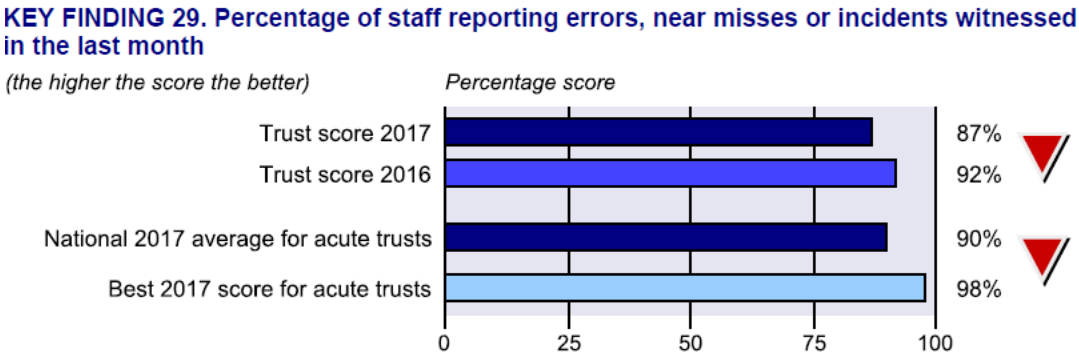
Key Finding	WHH 2017	Average Score	WHH 2016
Staff recommendation of the Trust as a place to work or receive treatment (/5)	3.61	3.75	3.57
Staff motivation at work (/5)	3.89	3.92	3.91
Staff ability to contribute towards improvements at work (%)	69	70	69

Survey Results in Comparison with 2016

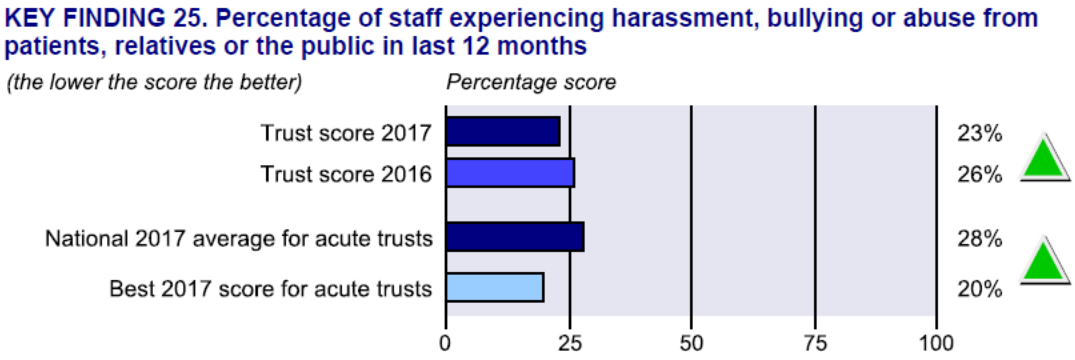
Overall there has been little change from the Staff Opinion Survey results in 2016.

There were only 2 key findings with statistically significant changes:

There was a **decline** in the percentage of staff reporting errors, near misses or incidents in the last month.

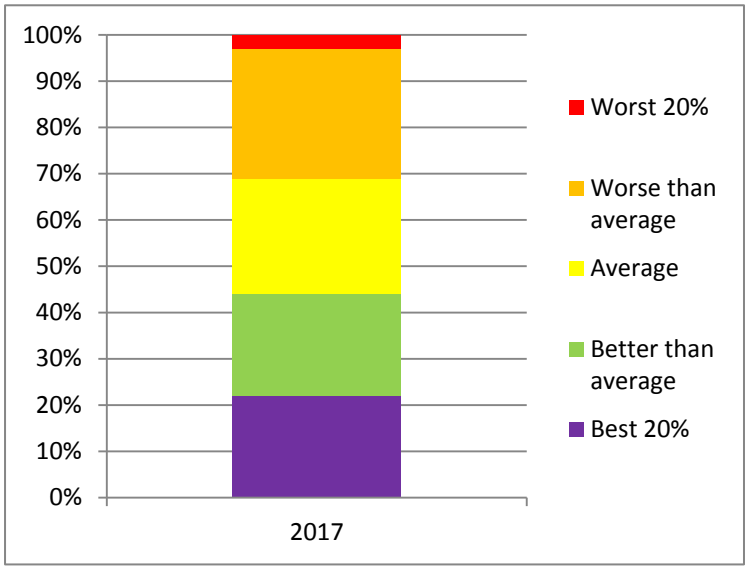


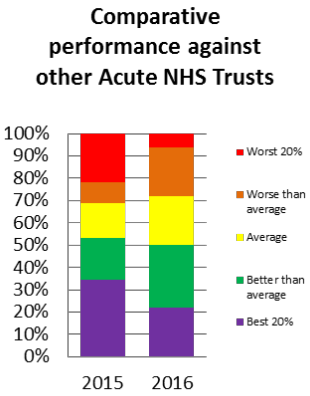
There was a **decline** in the percentage of staff experiencing harassment, bullying or abuse from patients, relatives of the public in last 12 months.



Survey Results in Comparison with Other Acute Trusts

Overall the Trust is performing well in comparison to other Acute Trusts, although there is opportunity to improve performance and action is required in order to address areas where the Trust is performing below average. The graphs below show the Trust's performance against other Acute Trusts in 2017, 2016 and 2015. A full breakdown of the Trust's performance against other Acute Trusts in 2017 can be found at Appendix 2.





Top Ranking Scores

The results identify the following key findings where the Trust performs better than average in comparison with other acute Trusts. These findings represent an opportunity for the Trust to celebrate success and build on current good practice.

Theme	Question	Ranking
Equality and Diversity	% experiencing discrimination at work in last 12 months	Best 20%
Equality and Diversity	% believing the organisation provides equal opportunities for career progression / promotion	Best 20%
Health and Wellbeing	% attending work in last 3 months despite feeling unwell because they felt pressure	Best 20%
Working Patterns	% working extra hours	Best 20%
Violence, Harassment and Bullying	% experiencing harassment, bullying or abuse from patients, relatives of the public in last 12 months	Best 20%
Violence, Harassment and Bullying	% experiencing harassment, bullying or abuse from staff in last 12 months	Best 20%
Violence, Harassment and Bullying	% reporting most recent experience of harassment, bullying or abuse	Best 20%
Appraisal and Support for Development	% appraised in last 12 months	Better than average
Errors and Incidents	% witnessing potentially harmful errors, near misses or incidents in last month	Better than average
Health and Wellbeing	Organisation and management interest and action on health and wellbeing	Better than average
Working Patterns	% satisfied with the opportunities for flexible working	Better than average
Job Satisfaction	Staff satisfaction with resourcing and support	Better than average
Managers	Recognition and value of staff by managers and the organisation	Better than average
Managers	Support from immediate managers	Better than average
Violence, Harassment and Bullying	% reporting most recent experience of violence	Better than average

Top Ranking Scores

The results identify the following key findings where the Trust performs better than average in comparison with other acute Trusts. These findings represent an opportunity for the Trust to improve.

Theme	Question	Ranking
Appraisal and Support for Development	Quality of appraisals	Worse than average
Errors and Incidents	Fairness and effectiveness of procedures of reporting errors, near misses or incidents	Worse than average
Errors and Incidents	Staff confidence and security in reporting unsafe clinical practice	Worse than average
Job Satisfaction	Staff recommendation of the organisation as a place to work or receive treatment	Worse than average
Job Satisfaction	Staff motivation at work	Worse than average
Job Satisfaction	% able to contribute towards improvements at work	Worse than average
Managers	% reporting good communication between senior management and staff	Worse than average
Patient Care and Experience	Effective use of patient feedback	Worse than average
Violence, Harassment and Bullying	% experiencing physical violence from staff in last 12 months	Worse than average
Errors and Incidents	% reporting errors, near misses or incidents in the last month	Worst 20%

2.2. Key Themes

The Staff Opinion Survey results can be categorised into the following themes:

- Appraisals and support for development
- Equality and Diversity
- Errors and incidents
- Health and wellbeing
- Working patterns
- Job satisfaction
- Managers
- Patient care and experiences
- Violence, harassment and bullying

Appraisals and Support for Development

88% of staff who responded to the survey reported that they had had a Personal Development Plan (PDR) in the last 12 months. This is above the national average of 86% however staff ranked the quality of those PDRs as 3.06 (out of 5) which is lower than the national average of 3.11. Following the 2016 staff survey a new PDR process was implemented. This will now be reviewed as part of an overall approach to engaging and developing our workforce.

Staff ranked the quality of non-mandatory training as 4.06 (out of 5), which is in line with the national average.

Equality and Diversity

The percentage of staff reporting that they have experienced discrimination at work remains very low at 8%, putting the Trust in the best 20% of acute Trusts. In addition, 89% of staff reported that they believe the Trust provides equal opportunities for career progression or promotion again putting the Trust in the best 20% of acute Trusts.

Errors and Incidents

Overall, the staff survey results suggest that the Trust performs below average in relation to the reporting of errors and incidents.

The table below shows a breakdown of the results relating to errors and incidents and highlights important areas for improvement.

Key Finding	WHH	Average	WHH

	2017	Score	2016
% staff witnessing potentially harmful errors, near misses or incidents in the last month	29%	31%	30%
% of staff reporting harmful errors, near misses or incidents witnessed in the last month	87%	90%	92%
Fairness and effectiveness of procedures for reporting errors, near misses and incidents (/5)	3.66	3.73	3.65
Staff confidence and securing in reporting unsafe clinical practice (/5)	3.63	3.65	3.60

Health and Wellbeing

The staff survey results demonstrate the Trust support the health and wellbeing of our staff.

In relation to work-related stress, 36% of staff reported that they had experienced this in the last 12 months which is in line with the national average. 48% of staff reported that they had attended work in the last 12 months despite being unwell because they felt pressure to do so; placing the Trust in the best 20% of acute Trusts. Importantly, the majority of staff (3.69/5) reported that they feel the Trust and management are interest in and take action in relation to their health and wellbeing. Again, this is better than the national average. These achievements represent a significant amount of work in relation to the Trusts 'Fit to Care' programme with on-going initiatives including the role out of Mental Health Awareness training and Mental Health First Aider Training.

Working patterns

The majority (52%) of staff reported that they are satisfied with the opportunities for flexible working in the Trust; which is better than the national average. Although 66% reported that they work extra hours, this also compares favourably to the national average of 72%.

Job Satisfaction

The survey askes a number of questions about job satisfaction and this is an area where there is opportunity for the Trust to take focused action for improvement. As detailed in section 2.1 of this report, there is a strong correlation between the results in this theme and overall staff engagement. The table below outlines the response for each of the key findings under this theme.

Key Finding	WHH 2017	Average Score	WHH 2016
Staff recommendation of the organisation as a place to work or receive treatment	3.61	3.75	3.57
Staff motivation at work	3.89	3.92	3.91
% of staff able to contribute to improvements at work	69%	70%	69%
Staff satisfaction with level of responsibility and involvement	3.92	3.91	3.94
Effective team working	3.72	3.72	3.67
Staff satisfaction with resourcing and support	3.36	3.31	3.35

Managers

The majority of staff reported that they feel supported by their immediate managers and feel valued by managers and the organisation. 32% of staff reported good communication between senior managers and staff. This result has improved slightly from 2016 (29%) and is in line with the national average however this is possibly an area for on-going focus. It is expected that there will be an improvement in this score over the next 12 months following the introduction of the People's Champions and the Staff Council.

Patient care and experiences

The results show that the Trust is in line with national average in relation to staff satisfaction with the quality of work they are able to deliver (3.9/5) and with the % of staff agreeing that their role makes a difference to patients (90%). These are important indicators and areas of strength to build on. The Trust scored lower than the national average for the effective use of patient feedback (3.67 compared to an average of 3.71).

Violence, harassment and bullying

The Trust performs well in relation to violence, harassment and bullying. Results show that the % of staff experiencing harassment, bullying or abuse is lower than the national average and that staff at WHH are more likely to report such incidents where they do occur. Unfortunately the results do show that 3% of staff have experienced violence from staff in the last 12 months, compared to an average of 2%.

3. ACTIONS REQUIRED

It is proposed that the Trust take a new approach to employee engagement. In order to achieve high impact and sustainable improvements the Trust should adopt a more strategic, 'OD' approach. This approach will link in with the 'Cultural Change and Leadership' programme headed up by the Director of HR and OD, which is a work stream of the Getting to Good, Moving to Outstanding (G2G, M2O) Steering Group.

'WHH – A Great Place to Work'

The HR and OD Directorate will support the Trust Board to bring the workforce together in an event in May 2018 to promote innovation around the staff survey results. The event will adopt the principles of a 'Hackathon' to create the condition where staff are able to work together to think differently and creatively about making 'WHH A Great Place to Work'.

The event will focus on the following key themes from the staff survey:

- Errors and Incidents
- Recommendation of the Trust as a place to receive care
- Recommendation of the Trust as a place to work
- Motivation at work

The themes, outputs and actions from the event will be developed managed through the 'Cultural Change and Leadership' programme. Staff will be encouraged to be involved in taking ideas forward and outcomes will be communicated through the People's Champion's via a 'We Said, We Did' campaign.

G2G, M2O - A Targeted Approach

Each of the G2G, M2O work streams will receive a presentation on the SOS results for their area to facilitate a discussion on how will this be addressed within their work plans. They will be supported to do so by the HR and OD Directorate.

CBU / Department Level Information

Each CBU / Department will receive individual analysis of their staff survey results via their HR Business Partners however they will not be required to complete and submit detailed action plans.

4. MONITORING/REPORTING ROUTES

'Cultural Change and Leadership' programme
Workforce Committee

5. RECOMMENDATIONS

The Trust Board are asked to approve and champion the proposed actions outlined in section 3 of this report.

Appendix 1

WHH Staff Opinion Survey Report

NHS_staff_survey_2017_RWW_sum.pdf

Appendix 2

	Your trust		National scores for acute trusts				
	Trust score	95% Confidence Interval	Median score	Threshold for lowest 20%	Threshold for highest 20%	Lowest score attained	Highest score attained
Response rate	46	-	44	39	50	29	73
Appraisals & support for development							
KF11. % appraised in last 12 mths	88	[87, 90]	86	81	91	65	96
KF12. Quality of appraisals	3.06	[2.99, 3.12]	3.11	3.01	3.20	2.83	3.52
KF13. Quality of non-mandatory training, learning or development	4.06	[4.02, 4.11]	4.05	4.01	4.10	3.90	4.22
Equality & diversity							
* *KF20. % experiencing discrimination at work in last 12 mths*	8	[6, 9]	12	10	14	8	25
KF21. % believing the organisation provides equal opportunities for career progression / promotion	89	[88, 91]	85	82	88	69	94
Errors & incidents							
* *KF28. % witnessing potentially harmful errors, near misses or incidents in last mth*	29	[27, 32]	31	28	33	24	42
KF29. % reporting errors, near misses or incidents witnessed in last mth	87	[84, 90]	90	89	91	86	98
KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents	3.66	[3.62, 3.69]	3.73	3.64	3.79	3.46	3.88
KF31. Staff confidence and security in reporting unsafe clinical practice	3.63	[3.59, 3.67]	3.65	3.58	3.71	3.43	3.83
Health and wellbeing							
* *KF17. % feeling unwell due to work related stress in last 12 mths*	36	[34, 38]	36	34	40	28	46
* *KF18. % attending work in last 3 mths despite feeling unwell because they felt pressure*	48	[46, 51]	52	49	55	42	59
KF19. Org and mgmt interest in and action on health and wellbeing	3.69	[3.65, 3.74]	3.62	3.51	3.71	3.34	3.92
Working patterns							
KF15. % satisfied with the opportunities for flexible working patterns	52	[50, 55]	51	47	54	40	60
* *KF16. % working extra hours*	66	[64, 69]	72	69	74	62	78

	Your trust		National scores for acute trusts				
	Trust score	95% Confidence Interval	Median score	Threshold for lowest 20%	Threshold for highest 20%	Lowest score attained	Highest score attained
Job satisfaction							
KF1. Staff recommendation of the organisation as a place to work or receive treatment	3.61	[3.57, 3.65]	3.75	3.58	3.94	3.34	4.12
KF4. Staff motivation at work	3.89	[3.86, 3.93]	3.92	3.87	3.96	3.76	4.07
KF7. % able to contribute towards improvements at work	69	[66, 71]	70	67	72	59	78
KF8. Staff satisfaction with level of responsibility and involvement	3.92	[3.89, 3.95]	3.91	3.86	3.96	3.76	4.04
KF9. Effective team working	3.72	[3.69, 3.76]	3.72	3.67	3.80	3.59	3.88
KF14. Staff satisfaction with resourcing and support	3.36	[3.33, 3.40]	3.31	3.23	3.40	3.12	3.58
Managers							
KF5. Recognition and value of staff by managers and the organisation	3.49	[3.44, 3.53]	3.45	3.36	3.53	3.21	3.71
KF6. % reporting good communication between senior management and staff	32	[29, 34]	33	28	38	20	48
KF10. Support from immediate managers	3.81	[3.76, 3.85]	3.74	3.67	3.81	3.55	3.94
Patient care & experience							
KF2. Staff satisfaction with the quality of work and care they are able to deliver	3.90	[3.85, 3.95]	3.91	3.82	3.99	3.69	4.21
KF3. % agreeing that their role makes a difference to patients / service users	90	[88, 91]	90	89	91	86	93
KF32. Effective use of patient / service user feedback	3.67	[3.62, 3.73]	3.71	3.62	3.78	3.41	3.96
Violence, harassment & bullying							
* *KF22. % experiencing physical violence from patients, relatives or the public in last 12 mths*	14	[12, 16]	15	13	17	9	22
* *KF23. % experiencing physical violence from staff in last 12 mths*	3	[2, 3]	2	2	3	1	5
KF24. % reporting most recent experience of violence	72	[66, 79]	66	63	72	55	79
* *KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths*	23	[21, 25]	28	25	30	20	36
* *KF26. % experiencing harassment, bullying or abuse from staff in last 12 mths*	22	[20, 24]	25	22	28	19	38
KF27. % reporting most recent experience of harassment, bullying or abuse	50	[46, 54]	45	42	47	36	59

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM 18/03/26**	
SUBJECT:	**Safe Staffing Assurance Report**	
DATE OF MEETING:	28th March 2018	
ACTION REQUIRED	**The Board of Directors are asked to note the contents of the report**	
AUTHOR(S):	**Rachael Browning – Associate 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. The paper includes a benchmarking exercise which has been undertaken to review the recommendations made in the National Quality Board (NQB) staffing improvement resource, Sustainable and productive staffing, in adult in-patient wards. (January 2018). The NQB have made a number of recommendations to support and aid decision making in acute trusts in determining the nurse staffing requirements for adult inpatient settings and our current position and the expected actions to be taken in order for Warrington and Halton Hospitals to meet the recommendations.	
PREVIOUSLY CONSIDERED BY:	**Committee**	
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	
FREEDOM OF INFORMATION STATUS	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

Safe Staffing Assurance Report

The purpose of this paper is to provide transparency with regard to the nursing and midwifery ward staffing levels during February 2018. 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, and 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 February Trust wide staffing data was analysed and cross referenced for validation by Lead Nurses, Divisional Matrons and the Associate Chief Nurse (clinical effectiveness).

Appendix 1 identifies the fill rates for staff across the Trust for February 2018. The table also triangulates this information by illustrating the harms reported within each area.

Appendix 2 identifies the mitigating actions taken in February 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 planned versus actual staffing data and provides assurance of the divisional actions taken to provide adequate staffing levels on a day to day / shift by shift basis.

Appendix 3 Provides a benchmark summary following the Recent National Quality Board (NQB) staffing publication in January 2018.The benchmarking exercise has been undertaken against the recommendations made in the report, detailing our current position and expected actions to be taken in order for Warrington and Halton Hospitals to meet the recommendations made by the NQB.

Monthly Safe Staffing Report – February 2018

	Day		Day	Day	Day	Day	Day	Night	Night	Night	Night	Night	Night	Patient Harm by ward			
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	840	840	630	600	100.0%	95.2%	0	0	0	0	-	-	0	0	0	0
SWC	Ward A5	1610	1288	1176	1155.75	80.0%	98.3%	966	828	644	782	85.7%	121.4%	4	0	0	2
SWC	Ward A6	1610	1270.75	1176	1184.7	78.9%	100.7%	966	874.5	644	701.5	90.5%	108.9%	5	0	0	1
SWC	Ward CMTC	1185.5	1097.5	736	644	92.6%	87.5%	644	632.5	644	598	98.2%	92.%	5	0	0	1
SWC	Ward B4	1142	1077	452.5	460	94.3%	101.7%	333.5	322	322	333.5	96.6%	103.6%	0	0	0	0
SWC	Ward A9	1610	1251.5	1288	1268	77.7%	98.4%	966	885.5	966	977.5	91.7%	101.2%	3	0	0	0
SWC	Ward B11	1732.1	2235.3	749.2	713.8	129.1%	95.3%	1488.6	1370.6	0	0	92.1%	-	0	0	0	0
SWC	NCU	1610	1292	322	264.5	80.2%	82.1%	1610	1311	322	253	81.4%	78.6%	0	0	0	0
SWC	Ward C20	864	795	644		92.0%	99.4%	542.64	542.64	0	322	100.0%	-	0	0	0	0
SWC	Ward C23	1288	1145.5	644	644	88.9%	91.1%	690	667	644	540.5	96.7%	83.9%	0	0	0	0
SWC	Delivery Suite	2254	1910	322	223.5	84.7%	69.4%	2254	2052	322	264.5	91.0%	82.1%	0	0	0	0
ACS	Ward A1	1750	1575.5	1400	2268	90.0%	162.0%	1627.5	1163.5	651	699	71.5%	107.4%	0	0	0	0
ACS	Ward A2	1288	977	1367.5	1210.4	75.9%	88.5%	966	874	644	874	90.5%	135.7%	8	0	0	1
ACS	Ward A3	1381.5	1086	1610	1492	78.6%	92.7%	966	759	1288	1276.5	78.6%	99.1%	5	0	0	0
ACS	Ward A4	1518	1161	1288	949	76.5%	73.7%	966	782	966	770.5	81.0%	79.8%	8	0	0	0
ACS	Ward A8	1610	1194.5	1610	1335	74.2%	82.9%	966	862.5	1610	1391.5	89.3%	86.4%	1	1	0	0
ACS	Ward B12	966	984.7	2254	1910.25	101.9%	84.7%	644	644	1598.5	1531.5	100.0%	95.8%	6	1	0	0
ACS	Ward B14	1288	1111	1288	1386	86.3%	107.6%	713	644	644	908.5	90.3%	141.1%	2	0	0	0
ACS	Ward B18	1288	1093	1288	1195.5	84.9%	92.8%	966	736	966	989	76.2%	102.4%	6	0	0	0
ACS	Ward B19	966	846.4	1288	1249	87.6%	97%	644	644	966	980.5	100%	101.5%	1	0	0	1
ACS	Ward A7	1610	1305.5	1610	1437.5	81.1%	89.3%	1288	1150	1288	1166	89.3%	90.5%	0	1	0	0
ACS	Ward C21	966	1052	1046.5	667	108.9%	63.7%	644	644	851	655.7	100.0%	77.1%	4	0	0	1
ACS	CCU	1288	1127	322	271	87.5%	84.2%	966	931.5	0	0	96.4%	-	0	0	0	0
ACS	ICU	4508	4335.5	966	667	96.2%	69.0%	4508	4301	644	448.5	95.4%	69.6%	0	0	0	0

Appendix 2

February 2018 - 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%	95.2%	0	0	SAU closes at night, therefore no requirement for staff.
Ward A5	80.0%	98.3%	85.7%	121.4%	RN vacancies on the ward. Extra CSW nights to help support enhanced care and RN shortfall.
Ward A6	78.9%	100.7%	90.5%	108.9%	RN vacancies 4.6 wte, staffing reviewed on a daily basis staff moved depending on acuity across the surgical floor. Extra CSW nights to help support enhanced care and RN shortfall.
Ward A9	77.7%	98.4%	91.7%	101.2%	3 full time RN vacancies- will be filled by Sept 18 .2 full time RN-maternity leave. Extra HCA on nights required for enhanced care.
NCU	80.2%	82.1%	81.4%	78.6%	3.8 wte trained staff off long term sick and 1.6 mat leave. 1.6 posts out to recruitment. Staffing reviewed daily and supported by NHSP.
Ward C20	92.0%	99.4%	100.0%	-	Ward escalated overnight additional staff in place to support escalation.
Ward A1 - AMU	90.0%	162.0%	71.5%	107.4%	5 wte Band 5 and 2 Band 6 vacancies at present. Ward supported by AP and HCA staff. Ward fully escalated to 37, staffing discussed daily at meetings with staff moved from other areas to support.
Ward A2	75.9%	88.5%	90.5%	135.7%	Staffing reviewed on a daily basis by matron, matron on ward supporting, staff moved from other areas to support. 5 vacancies in nurse staffing.
Ward A3 Opal	78.6%	92.7%	78.6%	99.1%	Ward escalated to 33 beds with nursing establishment for 24 beds. All patients medically optimised & awaiting social input. Additional shifts requested via NHSP, ward staffing reviewed daily.
Ward A4	76.5%	73.7%	81.0%	79.8%	RN vacancies are at 4.28 wte- advert out at present, staffing reviewed on a daily basis depending on acuity across the surgical floor.
Ward A8	74.2%	82.9%	89.3%	86.4%	4 x wte Band 5 vacancy. 4 wte Band 2. Sickness and maternity leave on the ward, covered with temporary

					staffing NHSP and Agency. Senior nursing team review daily staffing and staff moved for additional support.
Ward B12 (Forget-me-not)	101.9%	84.7%	100.0%	95.8%	Enhanced care required so additional shifts requested. Regular risk assessment of the ward and enhanced care requirements. Staff moved on occasion to other areas when required to maintain safety.
Ward B14	86.3%	107.6%	90.3%	141.1%	Enhanced care requirements throughout the month, additional shifts requested. Staff moved on occasions to support other areas when required, when acuity and staffing levels permits to maintain safety.
Ward B18	84.9%	92.8%	76.2%	102.4%	Ward reviewed each day by senior team, staff moved to support other wards when activity and staffing levels permit.
Ward B19	87.6%	97%	100%	101.5%	Ward reviewed daily and staffed moved from other areas to support if required.
Ward A7	81.1%	89.3%	89.3%	90.5%	Vacancies on the ward. Staffing reviewed by senior nurse team each day, staff moved from other areas to support.
Ward C21	108.9%	63.7%	100.0%	77.1%	Increase in need for HCA 1:1 support for enhanced care. RN hours supported by the ward manager.
Coronary Care Unit	87.5%	84.2%	96.4%	-	Ward reviewed each day by senior team, staff moved to support other wards when capacity and staffing levels permit.
Intensive Care Unit	96.2%	69.0%	95.4%	69.6%	2.96 wte Band 5 vacancy. Recruitment completed and are awaiting start dates. 1.84 wte RN Long-Term Sick. 2.61 wte RN Mat Leave. 0.92 wte RN seconded to Governance. Temporary Staffing escalated and utilised to maintain safe nurse: patient ratios. Unit Occupancy 105% for February 2018.

Appendix 3

NQB Benchmark Recommendations – February 2018

The National Quality Board (NQB) staffing publication (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

The National Quality Board has recently published (January 2018) a further improvement resource for safe, sustainable and productive staffing, in adult in patient wards. The resource is part of a suite of speciality resources, which underpin the overarching NQB expectations for safe staffing. The NQB have made a number of recommendations to support and aid decision making in acute trusts in determining the nurse staffing requirements for adult inpatient settings.

A benchmarking exercise has been undertaken to review the recommendations, detailing our current position and the expected actions to be taken in order for Warrington and Halton Hospitals to meet their recommendations.

No	Recommendation	Current Position	Actions
1.	A systematic approach should be adopted using and evidence-informed decision support tool triangulated with professional judgement and comparison with relevant peers.	WHH have Safe Care (SNCT) in place to record patient acuity. CHPPD reported in the monthly Board report. Model Hospital comparative data available 6 monthly staffing reviews are in place in the Trust led by the Chief Nurse.	Next 6 monthly review is due to be undertaken in April 2018.
2.	A strategic staffing review must be undertaken annually or sooner if changes to services are planned.	6 monthly updates provide for Trust Board A trust wide strategic staffing review has been undertaken by the senior nursing team, Chief Nurse and transformation manager. A business case has been drafted following this review with regards nurse and health care support worker staffing	Non Ward based Nursing review due to commence. Business case to be presented to the executive team, Finance and Sustainability Committee and Board of Directors for consideration.
3.	Staffing decisions should be taken in the context of the wider registered multi-professional team.	A twice daily staffing meeting is undertaken to review trust wide staffing requirements. This includes a review of ward acuity utilising the Safe Care system. A template of ward staffing is available on the shared drive, with and overall RAG rating of nurse staffing across the trust. Consideration given to non-nursing posts, pharmacy Techs and AHP support – we need to explain what this is	Audit of staffing escalation process to be undertaken in March 2018.
4.	Consideration of safer staffing requirements and workforce productivity should form part of the operational planning process.	Any operational and /or service redesign undertakes a Failure Modes Analysis process. This includes and assessment of staffing and staff management, to ensure a staffing model and staff with the necessary skills are in place. Currently WHH are reviewing a contemporary ward model pilot. Redesigning the model of care for a clinical setting, based on the needs of the patient who no longer need acute care. The staffing model will be determined using an MDT approach.	Contemporary Ward Model Project commenced in March 2018. Plan for TNA's and nurse apprenticeship programme, will be reviewed at the next Recruitment and Retention meeting in March 18
5.	Action plans to address local recruitment and retention priorities should be in place and subject to regular review.	Recruitment and Retention strategy in place, with an associated action plan. 2 senior nurses are the Trust contact for nurse recruitment. Monthly recruitment and retention Group, data and staffing dashboards reviewed.	Recruitment and Retention staff engagement workshop planned for 27th April 2018.

		New post recruited to Workforce Improvement Lead – commences April 18 WHH is part of the Wave 3 National Programme for support for recruitment and retention.	
6.	Flexible employment options and efficient deployment of staff should be maximised across the hospital to limit the use of temporary staff.	Flexible working options are available in the Trust. WHH are looking to introduce a night only contract for staff. Nurses with a specialist interest have been recruited as part of the Registered Nurse with a Special Interest (RNSI) campaign. Staffing escalation processes in place, daily staffing meetings and staffing heat map.	Implementation of the night only contract for staff. Action plans for wave 3 will be formulated in May 2018 when the visit takes place. Recruitment and Retention strategy has been refreshed for 2018 will have a particular focus on night only contracts and a commitment to retaining staff who are due to retire in the next 2yrs.
7.	A local dashboard should be in place to assure stakeholders regarding safe and sustainable staffing. The dashboard should include quality indicators to support decision making	Daily staffing template with rationale for decision making recorded, is update twice daily and stored on the shared drive. E-Roster KPI's in place, these are shared with the senior nursing team on a monthly basis.	E-Roster KPI' report will form part of the Matron Lead Nurse Workforce Operational meeting, which commences in March 2018.
8.	Organisations should ensure they have an appropriate escalation process in cases where staffing is not delivering the outcomes identified.	Escalation process in place for nurse staffing. Daily staffing meetings in place. Late senior nurse on duty for staffing 5-8pm.	Audit of staffing escalation process to be undertaken in March 2018. Review of the Trust On Call to create a 7 day senior nurse presence on site- Review due to be completed 30th May 18 - Lead Deputy Chief Nurse.
9.	All organisations should include a process to determine additional uplift requirements based on the needs of patients and staff	WHH has undertaken a strategic staffing review, which has identified that further uplift is required. 6 monthly staffing review in place and presented to Board by the Chief Nurse.	Business case to be presented to the executive team for consideration as above which requests uplift to move from 20% to 23% using NQB guidance and national recommendations as the benchmark.
10	All organisations should investigate staffing related incidents and their outcomes on patients and staff, and ensure action and feedback.	Datix web system used to identify incidents - need to mention learning Ward staff at WHH can apply a Red Flag to a shift when a staffing issue negatively affects (or when there is a potential effect on) patient care, this is done via the SafeCare module within our e-rostering system. The Red	Action • Remind the Ward Managers about Red Flags and how to apply them. • Remind the Matrons/Lead Nurses about how to appropriately respond to a Red Flag in their area

		Flags are a list of detrimental effects described by NICE in 2014. Up to now the use of the Red Flag system has been very limited. Safety monitoring report, details incidents including staffing incidents -? Quality dashboard presented monthly	• Monitor usage and response to Red Flags • Create Red Flag report o Feed back to Ward Managers around the Red Flags in their department o Use the information to provide assurance on the safe staffing of our wards

Rachael Browning
Associate Chief Nurse, (clinical effectiveness)
March 2018

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/18/03/27**	
SUBJECT:	**Freedom to Speak up update**	
DATE OF MEETING:	28 March 2018	
ACTION REQUIRED		
AUTHOR(S):	Jane Hurst, Deputy Director of Finance and FTSU Guardian	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse	
LINK TO STRATEGIC OBJECTIVES:	SO2: To have a committed, skilled and highly engaged workforce who feel valued, supported and developed and who work togther to care for our patients	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	BAF2.4: Engaging & Involving Workforce	
	BAF1.2: Health & Safety	
STRATEGIC CONTEXT		
EXECUTIVE SUMMARY (KEY ISSUES):	This report will give an update on all Freedom To Speak Up (FTSU) disclosures in the last five months.	
RECOMMENDATION:	The Board is asked to note the content of the report and the progress being made to roll out the FTSU policy.	
PREVIOUSLY CONSIDERED BY:	**Committee**	
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

NAME OF COMMITTEE

SUBJECT	Freedom to Speak up update	AGENDA REF:	BM/18/03/27

1. BACKGROUND/CONTEXT

This report will give an update on all Freedom To Speak Up (FTSU) disclosures in the last five months to 28 February 2018.

2. KEY ELEMENTS

In the last five months up to 28 February 2018 there have been seven disclosures which are broken down in the following table:-

	1 October 2017 – 28 February 2018
Patient Safety	1
Staff dignity at work	2
Staff Safety	1
Total	**4**

Of the four disclosures, the patient and staff safety issues are being reviewed by the Quality Team. The staff dignity at work disclosures are being followed up by the HR team who organised some targeted training for the department and this will followed up in February. The staff safety case is being reviewed by the Quality Team. The four cases have been made by two members of staff relating to two different operational areas.

The number of disclosures remain low so to ensure everyone is aware of the FTSU policy the Communication Team has designed an information leaflet which has been attached to wage slips and posters have gone out to all wards and departments with large poster in the Hospital entrance. A dedicated FTSU email address has been set up, the website has been updated and information has been included in the team brief twice in the last 10 months. Information is also due to go on the desktop in March and is timetabled quarterly thereafter. In addition everyone the FTSU contact information is included in the Communication Newsletter “The Week”. A survey monkey questionnaire went out to all staff the response was limited but showed that 68% of those that responded knew about FTSU and 57% knew how to raise a concern with email and face to face being the preferred options of communication. The exercise will be repeated later in the year and results compared.

The FTSU team had planned to have a stall at the Health and Welling days in January but these were postponed as was the Equality and Diversity Committee. The FTSU team are attending the regional meetings and attended the National meeting 6 March 2018.

Whilst the number of disclosures appear low they are in line with other similar sized Trusts in the North West. The following table shows the draft submission for quarter 3:-

NHS trusts (up to 5000 employees) - North West	Q3 Number of cases raised
Aintree University Hospital NHS Foundation Trust	4
Alder Hey Children's NHS Foundation Trust	1
Bridgewater Community Healthcare NHS Foundation Trust	0
Cheshire and Wirral Partnership NHS Foundation Trust	5
Countess of Chester Hospital NHS Foundation Trust	2
Cumbria Partnership NHS Foundation Trust	1
East Cheshire NHS Trust	4
Greater Manchester Mental Health NHS Foundation Trust	5
Liverpool Heart and Chest Hospital NHS Foundation Trust	3
Mid Cheshire Hospitals NHS Foundation Trust	1
North Cumbria University Hospitals NHS Trust	7
Southport and Ormskirk Hospital NHS Trust	4
St Helens and Knowsley Teaching Hospitals NHS Trust	1
Tameside and Glossop Integrated Care NHS Foundation Trust	6
The Christie NHS Foundation Trust	4
Warrington and Halton Hospitals NHS Foundation Trust	**4**
Wirral Community NHS Foundation Trust	4

3. RECOMMENDATIONS

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

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/18/03/28**
SUBJECT:	**Guardian Quarterly Report on Safe Working Hours for Junior Doctors in Training**
DATE OF MEETING:	28 March 2018
ACTION REQUIRED	**The Board are requested to note the report and progress made with implementing the junior doctor contract and the level of assurance given that the junior doctors are working safely for their own health and wellbeing and the safety of patients.**
AUTHOR(S):	Mark Tighe, Guardian of Safe Working Hours and Mick Curwen, Head of HR Strategic Projects
EXECUTIVE DIRECTOR SPONSOR:	Alex Crowe, Medical Director
LINK TO STRATEGIC OBJECTIVES:	SO2: To have a committed, skilled and highly engaged workforce who feel valued, supported and developed and who work togther to care for our patients
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	BAF1.2: Health & Safety
	BAF2.1: Engage Staff, Adopt New Working, New Systems
	BAF2.3: Medical Staffing
STRATEGIC CONTEXT	The junior doctor contract was implemented in the trust on 7.12.16 but with national safeguards that the junior doctors should not be working excessive hours which could affect their health and wellbeing and the service they deliver to patients. Each trust was required to appoint a Guardian of Safe Working whose primary role is to ensure that junior doctors do work safely and are able to access appropriate training and development opportunities. A system of Exception Reports allows junior doctors to report areas of non-compliance and provides the opportunity for the Guardian to monitor trends and issues. It is a requirement of the national contract that the Guardian submits a quarterly report to the Board so that the Board can gain this level of assurance.

	The Board has previously received two reports, one covering the period from December 2016 to May 2017 and the second from June to September 2017. This is the third Report and covers the period from October to December 2017. Future reports will follow covering the normal quarterly reporting period.
EXECUTIVE SUMMARY (KEY ISSUES):	The new Junior Doctors Contract has been in place since August 2016, and now all our Foundation Doctors have converted over, as well as the newer appointments on the CT and ST grade. There is good engagement from the doctors, who have worked well with rota managers, HR, postgraduate department, and the Clinical and Educational Supervisors. The majority of Exception Reports (ERs) relate to juniors working late past their rotas. This has escalated with the increased acuity and volume over the winter period. A large number of late departures, however, still relate to performing routine tasks eg TTOs and discharge summaries, rather than dealing with sick patients. Again, a perception of understaffing on the medical wards and late senior ward rounds are contributing factors. A spike in ERs has occurred with surgical F1s, who have been covering medical outliers, not just on the surgical wards (which they expect) but also on non-surgical wards. This may incur problems with the Deanery, as they are often missing out on educational opportunities, to complete these tasks. Our Educational Supervisors remain very supportive of the juniors, although there are still large numbers of ERs which have not been completed, in terms of review meetings, and in timing of claims for time-off in lieu (TOIL) and compensatory payment. There is still a preference for juniors to request compensatory payment rather than TOIL, presumably due to lower staffing levels on the wards. Most Supervisors are happy to discuss issues with the Guardian to ensure fair resolution We are continuing to train and engage our Educational

	Supervisors, and we are looking to consolidate the numbers of Supervisors to ensure all the juniors have access to a quick and helpful review	
RECOMMENDATION:	**The Board are requested to note the report and progress made with implementing the junior doctor contract and the level of assurance given that the junior doctors are working safely for their own health and wellbeing and the safety of patients.** **Any concerns that the Board have should be reported back to the Guardian for his attention.**	
PREVIOUSLY CONSIDERED BY:	**Committee**	
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

SUBJECT	Guardian Quarterly Report on Safe Working Hours for Junior Doctors in Training Period: 1 October 2017 – 31 December 2017	AGENDA REF:	BM/18/03/28

1. Executive Summary

The New Junior Doctor Contract is now well established at WHH. All our rotas remain compliant, and in general the juniors are happy with their allocations. Our Junior Doctors' Forum is now very well attended and enjoys robust discussion. The juniors seem happy to engage with their consultants, ES and Guardian, if any persistent issues develop.

We continue to have large numbers of Exception Reports (ER) submitted in the last 3 months. On the whole, this is to be expected, as the role of a Junior Doctor does involve additional and unpredictable work at times. The vast majority of ERs relate to our F1 doctors working past their allocated time, usually on an ad hoc basis, but there have been a large number of ERs from 2-3 areas, which have prompted work schedule reviews. Unfortunately, the issue with the evening medical handover persists, leading to a lot of reporting. This has still not been properly addressed, despite alerts to the senior medical consultants.

Only 2 ERs relate to missed educational opportunities - this is reassuring for our provision of training, and demonstrates engagement of senior colleagues in allowing them to attend.

Most ERs are from juniors working on the medical wards, but this reflects the busier nature of their jobs, and sometimes lack of ward cover from more senior doctors. I have been impressed with the attempts to resolve the staffing shortages on the acute medical wards, and the F1s appear to be getting good support and teaching there.

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

2. Introduction

As a reminder, the role of the Guardian of Safe Working Hours under the Terms and Conditions of Service is to:

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

This Report covers the period from 1 October to 31 December 2017 and follows the format as recommended by NHS Employers.

High level data

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

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

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

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

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

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

3. Exception Reports (with regard to working hours)

Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding including those from previous reports
General Medicine – FY1	**26 (30)**	**43 (60)**	**25 (29)**	**43 (65)**
General Surgery – FY1	**8 (13)**	**11 (14)**	**4 (6)**	**14 (20)**
Trauma and Orthopaedics – FY1	**6 (6)**	**10 (10)**	**2 (2)**	**11 (11)**
Paediatrics – Alder Hey – FY1	**6 (6)**	**Nil**	**Nil**	**7 (7)**
ENT – ST3	**2 (2)**	**Nil**	**Nil**	**4 (4)**
Total	**48 (57)**	**64 (84)**	**31 (37)**	**79 (107)**

NB.

1. The figures in brackets denote the total number of reported incidents. In some instances one Exception Report has been used to report more than one incident/issue

2. Of the 84 incidents reported, these relate to a total of 22 trainees and 19 Educational Supervisors, 11 of which do not appear to have yet engaged in the process over this period.
3. There were no Exception Reports completed which were classified as 'Immediate Safety Concerns'.

Exception reports (response time)				
	Addressed within 48 hours	Addressed within 7 days	Addressed in longer than 7 days	Still open
FY1	9	9	13 (19)	35 (53)

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

The above table shows that 18 reports (27%) have been addressed by the Educational Supervisor within 7 days but 13 (19) reports (20%) were addressed in more than 7 days and 35 (53) reports (53%) still remain open. This latter figure is of some concern as the Educational Supervisors should have met to resolve the incident. All of the Exception Reports which have been resolved were resolved at the 'Initial Stage' but 3 Exception Reports are showing as having been escalated to 'Level 1 Review Stage'.

Exception reports (type of issue)				
	Hours	**Education**	**Service Support**	**Working Pattern**
FY1	**82**	**2**	**0**	**0**

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

Exception Reports (Outcome)				
	Overtime Payment	**Compensation and Work Schedule Review**	**Compensation: Time Off in lieu**	**Compensation or TOIL**
FY1	**17 (20)**	**8**	**5 (6)**	**1 (3)**

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

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

Junior Doctors on the 2002 Contract

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

4. Work Schedule Reviews

There have been 8 Work Schedule Reviews (WSR) recommended by the Education Supervisors at their initial meeting following submission of an exception report. 5 of these relate to the medical rota and primarily relate to additional workload and stay beyond the normal 4/5pm finish of a shift for c 1hour. The remaining 3 shifts were on the surgical rota and again related to additional workload on the ward or in theatre. These issues have been brought to the attention of the Chiefs of Service in Acute Care and Surgery.

The Work Schedule Reviews all relate to the FY1 trainees.

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

Work schedule reviews by grade	
FY1	**8**

Work schedule reviews by department	
Acute medicine	**5**
Surgery	**3**

5. Locum Bookings

Bank and Agency

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

The tables below show the shifts which were escalated to the Medical bank for filling on the TempRe system The first table shows the total shifts by specialty and the second table shows the reason. All of the shifts relate to FY2 trainees.

Locum bookings (bank and agency) by department					
Specialty	**Number of shifts requested**	**Number of shifts worked**	**Number of shifts given to agency**	**Number of hours requested**	**Number of hours worked**
FY2					
Emergency Medicine	26	0	0	210	0
Acute Medicine	44	20	20	564	206.25
Cardiology	15	13	13	120	100.5
Care of the Elderly	350	210	250	3081	1630.07
Trauma & Ortho	132	99	109	1286.5	1140.25
General Surgery	20	17	20	187	201
TOTAL FY2	**587**	**359**	**412**	**5448.5**	**3278.07**

Locum bookings (bank) by reason					
Specialty	**Number of shifts requested**	**Number of shifts worked**	**Number of shifts given to agency**	**Number of hours requested**	**Number of hours worked**
FY2					
Annual Leave	2	1	2	20.5	7.75
Extra	4	4	4	32	29.5
Unknown	174	0	10	1894	0
Vacancy	405	352	394	3477	3218.32
Sickness	2	2	2	25	22.5
Total FY2	**587**	**359**	**412**	**5448.5**	**3278.07**

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

6. Locum Work Carried Out by Trainees

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

Locum work by trainee						
Specialty	**Grade**	**Number of shifts worked**	**Number of hours worked**	**Number of hours rostered per week**	**Actual hours worked per week**	**Opted out of WTR?**
General Medicine	**FY1**	**c6**	**46.75**	**757**	**757**	**N/K**
General Surgery	**FY1**	**c30**	**236**	**544**	**544**	**N/K**
Trauma & Ortho	**FY1**	**c1**	**3**	**89**	**89**	**N/K**
TOTAL	**FY1**	**c37**	**285.75**	**1390**	**1390**	**N/K**
Psychiatry	**FY2**	**c21**	**164**	**1468**	**1468**	**N/k**
Accident and Emergency	**FY2**	**c15**	**114.5**	**352**	**352**	**N/K**
General Medicine	**FY2**	**c5**	**36.5**	**464.5**	**464.5**	**N/K**
Alder Hey	**FY2**	**c25**	**196**	**376**	**376**	**N/K**
General Surgery	**FY2**	**c24**	**193.25**	**464.5**	**464.5**	**N/K**
Total	**FY2**	**c90**	**704.25**	**3125**	**3125**	**N/K**

NB.

1. The number of shifts worked has been estimated as records only show the number of hours worked and have been based on 8 hour shifts
2. The number of hours worked per week takes account of vacancies and trainees on maternity leave but excludes sickness or other absences such as annual leave.
3. It is not known whether any of the trainees exceeded an average of 48 hours per week under WTR and whether they completed an opt-out form.
4. The table reflects the fact that both FY1 and FY2 trainees are happier to cover locum shifts in surgery than medicine. On discussion with our trainees at the regular Junior Doctors Forums, and informally on the wards, this is because they feel the medicine is particularly onerous, and at times they feel unsupported by their seniors out of hours.
5. At the FY2 level the trainees are far more attracted to work in A&E which can give them useful experience.
6. A small number of the extra hours worked relate to Exception Reports and these are all at FY1 level: General Medicine – 12.25 hrs, General Surgery – 6 hrs and Trauma & Ortho – 3 hrs.
7. The volume of locum work does not correspond to the number of Exception Reports which reached an outcome of 'Overtime Payment'. This would suggest that there are still a significant number of payments yet to be made. All of the trainees have received information on how to make claims and this was reiterated at the Junior Doctors Forum meetings in October and December2017

7. Vacancies

The table below shows the vacancies at **FY1 level only** from **Oct – Dec 2017**:

Specialty	Grade	Oct17	Nov 17	Dec 17	Total gaps (average)	Number of shifts uncovered
General Medicine	**FY1**	**0**	**0**	**0**	**0**	**0**
General Surgery	**FY1**	**1.0**	**1.0**	**1.0**	**1.0**	**65**
Trauma & Ortho	**FY1**	**0**	**0**	**0**	**0**	**0**
Paediatrics	**FY1**	**0**	**0**	**0**	**0**	**0**
General Psychiatry	**FY1**	**0.4**	**0.4**	**0.4**	**0.4**	**26**
Total	**FY1**	**1.4**	**1.4**	**1.4**	**1.4**	**91**

NB.

1. One of the trainees is LTFT and works 60% which leaves a gap of 40%
2. There were no trainees who were on maternity leave.
3. The 1.0 wte vacancy in General Surgery was offset by an FY2 trainee who needed to complete this period working as an 1.0 wte FY1 trainee
4. It does need to be recognized that there were other medical vacancies at different grades which would have had some impact on the resources available on wards and departments which could have contributed to difficulties in some trainees leaving wards on time.
5. Another caveat relates to the national reduction in supply of CT1/2 and ST3+ doctors, which will undoubtedly lead to insufficient doctors to enable compliant rotas in the future. As well as rota management, this will have a deleterious effect on training and educational opportunities for those left on the rota.

The table below shows the vacancies at **FY2 level only** from **Oct – Dec 2017:**

Specialty	Grade	Oct 17	Nov 17	Dec 17	Total gaps (average)	Number of shifts uncovered
General Medicine	**FY2**	**0**	**0**	**0**	**0**	**0**
General Surgery	**FY2**	**1.0**	**1.0**	**2.0**	**1.33**	**85**
General Psychiatry	**FY2**	**1.0**	**1.0**	**1.0**	**1.0**	**65**
Public Health	**FY2**	**1.0**	**1.0**	**1.0**	**1.0**	**65**
Total FY2	**FY1**	**3.0**	**3.0**	**4.0**	**3.33**	**215**

NB.

1. The 1.0 wte vacancy in General Surgery was offset by an FY2 trainee working at FY1 level.
2. Although there was another vacancy in General Psychiatry this was mitigated by being able to appoint a LAT to cover so there was no reduction in hours covered.
3. There has been no cover for the 1.0 wte vacancy in Public Health.
4. Over the period from Oct – Nov 2017 there was one trainee who was on maternity leave in Trauma and Orthopaedics.

8. Fines

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

9. Qualitative Information

Junior Doctors Forum: The JDF continues to be very well attended, and usually leads to healthy debate. Some concern, however, has been flagged up that issues raised at the meeting have not been actioned. The joint meeting with medical director and chief executive appears to be appreciated by the juniors. Hopefully, we can continue to develop this meeting in the future.

Education supervisors: good engagement from the majority of ES consultants. However, there has been significant delay in some cases with the review meeting. It is of concern that 79 ERs remain outstanding at the current time. We may need to consolidate the number of ES for the next batch of junior doctors, to allow interested consultants to giver better support.

Exception reports: There has been an increase in the number of Exception Reports over the last 3 months, partly due to increased awareness, and partly due to increased workload with winter pressures. The numbers mirrors other trusts of our size. There have been no further submissions of Immediate Safety Concerns (ISC) since the last report, which is obviously reassuring.

Compensation for extra duties worked: Our juniors overwhelmingly favour compensatory payment rather than TOIL. This is because they feel taking more time off will lead to a further reduction of staff on the wards, and increasing workload of other colleagues. There have been 8 work schedule reviews, to attempt to correct problems for future F1s in the post.

Allocate training: there has been drop-in sessions available for ES to develop their skills in completion of ER reviews, with fair attendance.

10. Issues Arising

Our volume of exception reports (ER) has risen over this 3 month period. However, it is vital the juniors engage with the process, to ensure they are working safely within their allocated rotas. The vast majority of Exception Reports at WHH relate to working excess hours, to ensure their work is completed, and not handed over to busy on call staff. It is very difficult to monitor individual doctors' hours to ensure they do not breach safe working, as it would be calculated as an average over a full rota cycle.

We have had no immediate safety concerns of note since the last report

We have continued issues with resolution following submission of an Exception Report. Most trusts resolve overtime hours with TOIL, but the overwhelming majority of ours lead to compensatory time payments. This is generally because the juniors do not want to overburden their colleagues, especially in understaffed specialties. The downside of this is that our juniors may come dangerously close to exceeding their maximum working hours, or having insufficient rest periods between shifts.

We do rely heavily on in-house locum cover for outstanding shifts, exaggerated by recent changes to IR35 legislation and agency usage. Whilst coverage of shifts in the surgical specialties is usually manageable, this is more difficult in medicine where the juniors are less inclined to cover extra work. In-house cover again has repercussions on the maximum hours that the juniors are permitted to work.

We need ensure continued engagement of our Education supervisors with their junior doctors, and intervene if persistent delays in review meetings occur.

11. Action Taken to Resolve Issues

1) Training sessions for all Educational Supervisors and Guardian of Safe Working in Allocate have taken place.
2) Liaison with HR to calculate average hours for juniors across a rota cycle. The planned in house locum bank should help to spread the extra hours across the juniors to ensure they remain compliant.
3) There has been success in increasing staffing and junior support in high intensity areas. This will also be assisted by the appointment of nurse specialists and physician associates on the wards.
4) There may need to be extra recognition of the workload of some of the Educational Supervisors, whose juniors are in the more challenging posts, with PA allocation adjusted accordingly.
5) Continue to try and encourage TOIL as a solution to excess hours rather than compensatory payments, to avoid possible breach in hours and increased costs.
6) Work schedule reviews should continue to be implemented, especially in the medical rota (eg. handover times), and medicine/surgery to allow regular attendance at educationally beneficial sessions (formal teaching, theatre, clinics).

12. Summary

WHH has maintained good engagement of the new Junior Doctors Contract across the trust. All our rotas remain compliant, the juniors are generally satisfied and engaged, and our HR department, rota managers, and Educational Supervisors have usually been supportive and responsive to any concerns amongst the junior doctors.

The majority of the exception reports still relate to juniors staying late after a particularly onerous shift. This is multi-factorial, being a combination of insufficient availability of juniors and middle grades, juniors being unwilling to transfer this work to the busy on call teams, and the high acuity of patients over the winter period. However, this does reflect a healthy work ethic from our cohort of junior doctors. There have been no immediate safety concerns reported by junior doctors from any of the wards. Apart from two reported occasions, our juniors have been able to attend educational and teaching sessions, without having to return to ward duty.

There are a large number of outstanding ERs (79), and this clearly needs addressing. However, all reports to date have been signed off without resort to level 2 or guardian reviews. This was one of

the main concerns from the BMA prior to implementation of the contract, and it is pleasing to see this continuing in our trust.

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

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

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

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

13. Questions for Consideration

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

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

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

Mark Tighe
Guardian of Safe Working Hours

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/18/03/29**	
SUBJECT:	**Quarterly Board Assurance Framework and Strategic Risk Register report**	
DATE OF MEETING:	28 March 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 has been one additional risk added to the BAF in the last quarter. 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 is provided.	
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	

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

SUBJECT	**Board Assurance Framework**	**AGENDA REF:**	**BM/18/03/29**

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 Assurance 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 and the Board Assurance Framework. The following gives notable updates since the strategic risks were last presented to the Board of Directors.

2. KEY ELEMENTS

2.1 New Risks

There is one new risk which that has been added to the strategic risk register in the last quarter. The risk was added following a recommendation from the Finance & Sustainability Committee and subsequent approval by the Board in January 2018. The new risk expands on an existing risk as opposed to creating a wholly new one and has been divided in to parts a) and b); part b) being the new addition.

Risk	**Risk: Financial Sustainability** **a) Failure to sustain financial viability, caused by internal and external factors, leading to potential impact topatient safety, staff morale and enforcement/regulatory action being taken.** **b) Failure to deliver the financial position and a surplus places doubt over the future sustainability of the Trust. There is a risk that current and future loans cannot be repaid and this puts into question if the Trust is a going concern.**
Controls and Assurances	▪ Core financial policies controls in place across the Trust ▪ Revised governance structure within the Trust to enable strengthened accountability ▪ Finance and Sustainability Committee (FSC) established overseeing financial planning ▪ CIP programme in place aligned to the Transformation agenda

	▪ Monthly financial monitoring with NHSI ▪ Regular review at Executive team meeting and development sessions ▪ Attendance at the STP boards and Committee ▪ Annual plan development process ▪ Health economy commissioning meetings to identify any financial performance issues/demand management etc. – aim to accelerate LDS/STP ▪ Support agreed to help achieve CQUIN monies with weekly Executive review ▪ Performance monitoring of financial governance within the Trust. ▪ Negotiations with Commissioners on Contract income on going ▪ Monitor SLAs and contracts to enable extension of contracts or tenders to be managed ▪ Charitable funds strategy in place ▪ Review of non pay expenditure daily ▪ Fortnightly income meeting – Executive Lead ▪ Mitigating actions to avoid cost remain in place ▪ CBUs are being supported through mandated support to review their financial positions and highlight where changes are required ▪ Signed up to a Controlled Expenditure Programme (CEP) process with main Commissioners to support financial planning, sharing of risk and agreement of schemes that are in the interest of the whole local economy
Gaps	▪ Failure to achieve Financial control total may result in loss of STF and worsening cash position. ▪ The Trust was found in breach of its licence in August 2015 and was subject to enforcement. Significant improvements have been made. The Trust continues to be financially challenged and has a control total for 2017/18 of £3.7 million deficit. The Trust has written to NHSI and completed their template requesting the removal of the current enforcement, if successful this will move the Trust from a rating of 3 to a 2. The request is due to be reviewed at the NHSI Regional support group on the 20th September. ▪ Failure to manage fines and penalties and CQUIN which may result in loss of STF and worsening cash position ▪ Risk to financial stability due to loss of income relating to STP changes ▪ Inability to develop a strategic plan to deliver a breakeven position over the next 5 to 10 years ▪ Loss of contracts due to competitive market which may result in Trust no longer being sustainable. There is a gap in Market analysis and Knowledge of our competitors ▪ Loss of income through the failure of WHH Charity ▪ Risk of under delivery of CIP ▪ Failure to repay existing loans leading to the inability to apply for future financial support and threat to the Trust as a going concern.
Residual Risk Score	20 (5x4)
Actions	Continue to seek support from Commissioners Director of Finance – ongoing Continue to seek support from NHSI approach to management and repayment of loans Director of Finance – ongoing

	Development of a Market analysis of Trust competitors to understand imminent and future risk to income Director of Finance – end May 2017- revised date end July 2017 Market analysis tool was rolled out in June for use across the Trust and training given where requested – this will also be utilised with CBU managers as part of the business planning cycle which is due to commence in September, further enhancements to the Market share information are planned. Development of a Financial Strategy (aligned to the Trust Strategy) with a sensitivity analysis of delivery COMPLETED - Was presented and discussed at the Trust Board Development on the 7th July Greater involvement of the Corporate Trustee in Charitable Funds strategy development (planned for Board Workshop in 2017) Director of Communications – end December 2017 The Transformation Team is working closely with all CBUs to find savings and transform services Regular updates to Executive Team, FSC and Trust Board Regular updates to NHSI regarding the risks linked to the current financial position; including regular performance review meetings to discuss the current position and financial risk. These meeting have resulted in the Trust's recent change from segment three to segment two.

2.2 Existing Risks – updates

Detailed in the table below are updates of existing risks in the last quarter.

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

Strategic Risk	Update since last Risk review	Impact of update on risk rating
	A Nursing Establishment Business case will be presented to the Trust Board in March.	
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, M8 & M9 the Trust incurred sanctions relating to performance to the sum of £118,349.	No impact on risk rating
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.	A weekly meeting is in place and looks at the following 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. The Royal College of Surgeons report (embargoed) has been received by the Trust and a communications plan is being developed.	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) falls for four months were reported in January, February and March2018. The new Falls policy was approved in January 2018. The Falls Action plan continues to be implemented and the impact of staffing assessed on a regular basis. Audit to validate these results (from spring 2017) to be undertaken –March 2018 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

Strategic Risk	Update since last Risk review	Impact of update on risk rating
	There is a gap in the controls due to the current lack of a Falls Nurse.	
Failure to prevent harm to patients, caused by lack of timely and quality discharge summaries being sent to primary care, resulting in a lack of appropriate handover of care, with patient safety, operational, financial and reputational consequences.	A task and finish group for e-discharge letters has been convened and met on 6th February 2018 and will meet again on 28 March 2018.	No impact on risk rating
Failure to comply with the Thromboprophylaxis procedure/policy caused by poor completion of thromboprophylaxis risk assessments and follow up investigation (Root Cause Analysis) of hospital associated VTE in some areas, resulting in the risk of patients not receiving the appropriate, preventative treatment for VTE in hospital.	A VTE improvement plan is currently being developed and will be presented at Patient Safety & Effectiveness sub-committee in March.	No impact on risk rating
Failure to achieve the highest level of corporate governance, caused by the requirement to review and embed new structures, which may impact on statutory and regulatory requirements	With regard to the Trust Well Led framework, we are currently scoping out the requirements to ensure actions are put in place; this has involved visits to other Trusts who have recently undergone a Well Led assessment with CQC.	No impact on risk rating

There are a number of risks that will be reviewed by PSESC as outlined below

Strategic Risk	Update since last Risk review	Impact of update on risk rating
Lack of assurance regarding complaints handling within the Trust, caused by ineffective systems and processes, resulting in a poor experience for complainants, the Trust not meeting statutory and contractual complaints targets and not having effective systems in place to learn lessons from complaints	An update will be given at Patient Safety and Effectiveness Sub Committee in March 2018, and the sub-committee will consider whether the risk score can be reduced/whether the risk can be archived.	No impact on risk rating
Failure to comply with the Thromboprophylaxis procedure/policy caused by poor completion of thromboprophylaxis risk assessments and follow up	An update will be given at Patient Safety and Effectiveness Sub Committee in March 2018, and the sub-committee will consider whether the risk score can be reduced/whether the risk can be archived.	No impact on risk rating

Strategic Risk	Update since last Risk review	Impact of update on risk rating
investigation (Root Cause Analysis) of hospital associated VTE in some areas, resulting in the risk of patients not receiving the appropriate, preventative treatment for VTE in hospital.	.	
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.	An update will be given at Patient Safety and Effectiveness Sub Committee in March 2018, and the sub-committee will consider whether the risk score can be reduced/whether the risk can be archived.	No impact on risk rating
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	An update will be given at Patient Safety and Effectiveness Sub Committee in March 2018, and the sub-committee will consider whether the risk score can be reduced/whether the risk can be archived.	No impact on risk rating
Review required of paediatric urgent and emergency care due to escalated staffing issues, which may impact on patient care	An update will be given at Patient Safety and Effectiveness Sub Committee in March 2018, and the sub-committee will consider whether the risk score can be reduced/whether the risk can be archived.	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 was rolled out on 1st February 2018 and training has been taking place since 14th December 2017.

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

- The first meeting of the CQC Getting to Good Steering Group met 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.

- Risks relating to IG, GDPR, Radiology and Anaesthetics are currently being reviewed for potential escalation to the Board Assurance Framework.

3 RECOMMENDATIONS

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

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	Score at last review 15/02/18	Score at last review 13/03/18
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)	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)	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)	20 (5x4)	20 (5x4)
Failure to provide a spinal service for the	N/A	N/A	N/A	N/A	N/A	N/A	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)

Risk	Residual Risk Rating (Impact x Likelihood) March 2017	Residual Risk Rating (Impact x Likelihood) April 2017	Residual Risk Rating (Impact x Likelihood) May 2017	Residual Risk Rating (Impact x Likelihood) June 2017	Residual Risk Rating (Impact x Likelihood) July 2017	Score at last review 21/09/17	Score at last review 14/11/17	Score at last review 17/01/18	Score at last review 15/02/18	Score at last review 13/03/18
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.										
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	20 (5x4)	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4

Risk	Residual Risk Rating (Impact x Likelihood) March 2017	Residual Risk Rating (Impact x Likelihood) April 2017	Residual Risk Rating (Impact x Likelihood) May 2017	Residual Risk Rating (Impact x Likelihood) June 2017	Residual Risk Rating (Impact x Likelihood) July 2017	Score at last review 21/09/17	Score at last review 14/11/17	Score at last review 17/01/18	Score at last review 15/02/18	Score at last review 13/03/18
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)	16 (4x4)	16 (4x4
Failure to provide timely information caused by increasing internal and external demands for datasets,	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)

Risk	Residual Risk Rating (Impact x Likelihood) March 2017	Residual Risk Rating (Impact x Likelihood) April 2017	Residual Risk Rating (Impact x Likelihood) May 2017	Residual Risk Rating (Impact x Likelihood) June 2017	Residual Risk Rating (Impact x Likelihood) July 2017	Score at last review 21/09/17	Score at last review 14/11/17	Score at last review 17/01/18	Score at last review 15/02/18	Score at last review 13/03/18
implementation of new systems and a lack of skilled staff with capacity to respond. This may cause financial impact, external reputation damage and poor management decision making due to lack of quality data.										
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)	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	15 (5x3)	15 (5x3)	15 (5x3)	15 (5x3)	15 (5x3)	15 (5x3)	15 (5x3)	15 (5x3)	15 (5x3)	15 (5x3)

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	Score at last review 15/02/18	Score at last review 13/03/18
patient population and organisation, potential impact on patient care, reputation and financial position.										
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)	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)	12 (3x4)	12 (3x4)
Failure to	N/A	N/A	N/A	N/A	12	12	12	12	12	12

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	Score at last review 15/02/18	Score at last review 13/03/18
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.					(4x3)	(4x3)	(4x3)	(4x3)	(4x3)	(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)	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	N/A	N/A	N/A	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)

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	Score at last review 15/02/18	Score at last review 13/03/18
standards, thereby increasing the risk of reputational harm and litigation for the organisation.										
Failure to comply with the Thromboprophylaxis procedure/policy caused by poor completion of thromboprophylaxis risk assessments and follow up investigation (Root Cause Analysis) of hospital associated VTE in some areas, resulting in the risk of patients not receiving the appropriate, preventative treatment for VTE in hospital.	N/A	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)
Clinical variation, caused by lack of systems/process or failure of systems/to follow process leading to lack of evidence based practice, potential patient	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)

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	Score at last review 15/02/18	Score at last review 13/03/18
harm and reputational impact.										
Failure to successfully engage the Workforce, causing the potential for a negative working environment and the consequential loss of discretionary effort and productivity, or loss of talented colleagues to other organisations, which would impact patient care, staff morale and delivery of the Trust's strategic objectives	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	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)	12 (4x3)	12 (4x3)
Failure to achieve the highest level of corporate governance,	12 (4x3)	12 (4x3)	12 (4x3)	12 (3x4)	12 (3x4)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)

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	Score at last review 15/02/18	Score at last review 13/03/18
caused by the requirement to review and embed new structures, which may impact on statutory and regulatory requirements										

We are WHH

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/18/03/30 i**	
SUBJECT:	**Trust Board Cycle of Business 2018-19**	
DATE OF MEETING:	28 March 2018	
ACTION REQUIRED	**Approval**	
AUTHOR(S):	John Culshaw, Head of Corporate Affairs	
EXECUTIVE DIRECTOR SPONSOR:	Pat McLaren, Director of Community Engagement	
LINK TO STRATEGIC OBJECTIVES:	All	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):		
	All	
STRATEGIC CONTEXT	In accordance with the Foundation Trust's Constitution 'Board of Directors – Standing Orders' the Board is required to identify items of business to be carried out throughout the year.	
EXECUTIVE SUMMARY (KEY ISSUES):	The Trust Board is required to review and refresh its Cycle of Business on an annual basis and publish this in its public papers.	
RECOMMENDATION:	The Trust Board is asked to approve the Cycle of Business 2018-19.	
PREVIOUSLY CONSIDERED BY:	**Committee**	
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

DRAFT PUBLIC TRUST BOARD – CYCLE OF BUSINESS JANUARY 2018-MARCH 2019

	OWNER	JAN 2018	MARCH 2018	MAY 2018 YEAR END	JULY 2018	SEPT 2018	NOV 2018	JAN 2019	MARCH 2019
Patient or staff story (30 Mins)		X	X		X	X	X	X	X
OPENING BUSINESS									
Chairman's Opening Remarks, Welcome, Apologies & Declarations	**CHAIR**	X	X	X	X	X	X	X	X
Minutes of Previous Meeting & Action Log	**CHAIR**	X	X	X	X	X	X	X	X
Chief Executive's Report	**CHAIR**	X	X	X	X	X	X	X	X
Chairman's Report (Inc CoG Report)	**CHAIR**	X	X	X	X	X	X	X	X
QPS ASSURANCE									
Integrated Performance Dashboard	**Execs**	X	X	X	X	X	X	X	X
Performance Assurance Framework	**Execs**		X				X		X
Spinal Services update	**MD**	X	X	X	X	X	X	X	X
Trust Integrated KPI Indicators	**DoF**			X					
QUALITY									
Annual Complaints Report	**CN**				X				
Learning From Experience Summary Report	**CN**	X		X	X		X	X	
Annual Health & Safety Report	**CN**					X			
DIPC Report Annual	**MD**					X			
Safeguarding Annual Report	**CN**				X				
Quarterly Mortality Review report	**MD**		X			X	X		X
Medicines Management Annual Report	**MD**			X					
Annual SIRO Report	**DIMT**			X					
PEOPLE									
NHS Staff Opinion Survey	**HRD**			X					
Nurse Staffing report	**CN**	X	X		X	X	X	X	X
Nurse Staffing report – Bi-Annual	**CN**	X			X			X	
GMC Re-validation Annual Report	**MD**					X			
Guardian of Safe Working Quarterly Report (Mark Tighe)	**Guardian**	X		X	X		X		
Freedom To Speak Up – Guardian bi-annual report (Jane Hurst)	**Guardian**		X			X			
SUSTAINABILITY									
Operational Plan & Budgets Approval	**DoF**						X		

	OWNER	JAN 2018	MARCH 2018	MAY 2018 YEAR END	JULY 2018	SEPT 2018	NOV 2018	JAN 2019	MARCH 2019
Capital Programme	**DoF**		X						
Emergency Preparedness Annual Report	**COO**					X			
Quarterly Response to Lord Carter	**DoF**	X		X	X		X		X
KEY ISSUES FROM COMMITTEE CHAIRS									
Audit Committee	**Chair**		X		X		X		X
Quality Assurance Committee (Inc CQC Steering Group)	**Chair**	X	X		X	X	X	X	X
Finance & Sustainability Committee	**Chair**	X	X		X	X	X	X	X
Trust Operational Board	**Chair**	X	X		X	X	X	X	X
Charitable Funds Committee	**Chair**		X		X	X		X	
YEAR END									
Annual Report & Accounts Sign Off (inc Quality Account)	**DoF/CN**			X					
Annual NHSFT Code of Governance	**DCE**			X					
GOVERNANCE – Sub Committee yearly Reports Committee Chairs									
Quarterly Strategic Risk Register + BAF	**CN/DCE**		X		X		X		X
Strategic Risk Update	**CN**	X	X	X	X	X	X	X	X
Risk Management Strategy	**CN**				X				
Board Annual Cycle of Business	**DCE**		X						
Board Sub-Committee ToRs + Cycle of Business Ratification	**DCE**		AC, QAC & TOB	FSC	COG+CFC				
Quality Assurance Committee Annual Report	**Chair**				X				
Finance & Sustainability Committee Annual Report	**Chair**			X					
Charitable Funds Committee Annual Report	**Chair**				X				
Audit Committee Annual Report	**Chair**			X					
Trust Operational Board Annual Report	**Chair**				X				
CLOSING BUSINESS									
Any other business & Date of next meeting	**Chair**	X	X		X	X	X	X	X

We are WHH

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/18/03/30 ii & iii**	
SUBJECT:	**Terms of Reference and Cycle Of Business 2018-19– Quality Assurance and Audit Sub Committees of the Trust Board**	
DATE OF MEETING:	28th March 2018	
ACTION REQUIRED	**Approval**	
AUTHOR(S):	John Culshaw, Head of Corporate Affairs	
EXECUTIVE DIRECTOR SPONSOR:	Pat McLaren, Director of Community Engagement + Corp Affairs	
LINK TO STRATEGIC OBJECTIVES:	All	
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):		
	All	
	All	
STRATEGIC CONTEXT	In accordance with the Foundation Trust's Constitution 'Board of Directors – Standing Orders' Committees of the Board are required to review their Terms of Reference and Cycles of Business on an annual basis.	
EXECUTIVE SUMMARY (KEY ISSUES):	Each ToR and CoB has been reviewed and approved by the relevant committee.	
RECOMMENDATION:	The Trust Board is required to ratify the Terms of Reference and Cycles of Business of the Quality Assurance Committee and the Audit Committee for 2018-19	
PREVIOUSLY CONSIDERED BY:	**Committee /date**	• Quality Committee – approved by the Quality Assurance Committee 9th January 2018. • Audit Committee – approved by the Audit Committee 22nd February 2018.
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***		

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DRAFT TERMS OF REFERENCE

QUALITY ASSURANCE COMMITTEE

1. PURPOSE

The purpose of the Quality Assurance Committee (the Committee) is to be accountable to the Board of Directors (the Board) for providing oversight and assurance on all aspects of quality, including strategy, improvement, delivery, clinical risk management and governance, clinical audit and the regulatory standards relevant to quality and safety.

The Quality Assurance Committee is accountable to the Board for ensuring that the integrated quality governance framework is implemented throughout the organisation and that organisational risks are managed appropriately in line with professional and regulatory standards..

2. FREQUENCY OF MEETINGS

Meetings shall be held bi-monthly

3. QUORUM

Quorum shall be seven members, of which at least two should be Non-Executive Directors.

4. MEMBERSHIP

The Committee shall be composed of three Non-Executive Directors, one of whom shall be appointed by the Board to be Chair of the Committee

Core Members

- Chief Nurse
- Medical Director
- Chief Operating Officer
- Director of Integrated Governance and Quality
- Deputy Chief Nurse
- Deputy Medical Director
- Director of Transformation
- Deputy Director of Workforce and Organisational Development
- Deputy Director of IM&T
- Head of Corporate Affairs
- Associate Medical Director – Quality + Safety
- Associate Medical Director – Clinical Effectiveness
- Associate Medical Director – Patient Experience
- Associate Nurse Director - Quality+Safety
- Associate Nurse Director – Clinical Effectiveness
- Associate Nurse Director – Patient Experience

Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute

presence in person at the meeting and count towards the quorum. Should the need arise, the Committee may approve a matter in writing by receiving written approval.

5. AUTHORITY

The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee.

The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of people external to the Trust, with relevant experience and expertise if it considers this necessary, subject always to compliance with Trust delegated authorities.

6. REPORTING

The Committee will have the following reporting responsibilities:

- The minutes of the Committee meetings will be formally recorded. The Chair of the Committee shall draw to the attention of the Board and Audit Committee any issues that require disclosure to it, or require executive action.
- The Chair of the Committee will provide a written key issues report to the Board monthly following each meeting providing assurance of the quality governance arrangements in place within the Trust and provide an annual report to be presented at the May Board meeting on its work and performance in the preceding year.

The sub committees listed below are required to submit high level briefing papers to the Committee:

- Patient Safety & Clinical Effectiveness Sub-Committee
- Patient Experience Sub-Committee
- Health, Safety & Welfare Sub-Committee
- Information Governance and Corporate Records Sub Committee
- Safeguarding Sub Committee
- Risk Review Group
- Complaints Quality Assurance Group
- Research and Development Sub Committee

7. DUTIES & RESPONSIBILITIES

The Committee will undertake the following duties:

- Oversee the development and implementation of the Trust's strategies aligned to integrated governance and quality, including the overarching Quality Strategy, Risk Management Strategy, Clinical Effectiveness Strategy, Patient Experience Strategy, Quality Improvement Strategy, with a clear focus on upholding the tenants of quality and integrated governance and avoiding harm, ensuring that all strategies and performance indicators are consistent with the Trust's Mission, Vision and strategic objectives;
- Be the Trust Board of Directors delegated Committee responsible for risk management, ensuring that there is scrutiny and oversight of the strategic risk register and Board Assurance Framework, prior to approval at the Board of Directors and that there is

appropriate liaison with the Audit Committee, to ensure internal audit resources within the Trust are aligned appropriately to risk;

- Overseeing 'Deep Dive Reviews' of identified risks to quality identified by the Board or the Committee, particularly "Serious Incidents Requiring Investigation" and how well any recommended actions have been implemented;
- The Committee may also initiate such reviews based on its own tracking and analysis of quality trends flagged up through the regular performance reporting to the Board;
- Review the quality dashboard and information presented to the Committee, with regard to ensuring assurance is received on all quality and safety of patient care matters, which fulfils the Trust's strategic goals regarding quality and assurance, as well as statutory, regulatory and contractual requirements;
- Ensure there is a process in place regarding assessing and monitoring the impact on quality from Trust transformation and efficiency plans;
- To consider all appropriate matters of clinical and non-clinical, quality governance including patient care, patient experience and patient and staff safety, via a planned integrated quality governance assurance system, giving assurance either directly to the Committee or indirectly via its reporting Sub Committees, and all risks are appropriately escalated;
- Ensure there is an appropriate investigations framework within the Trust i.e. ensure all incidents and complaints are appropriately investigated, ensure that the Trust's Mortality Review process aligns to the Royal College of Physicians Standard Judgment Review process, and that people have the skills and expertise to undertake these investigations;
- Ensure there is an appropriate policy development and review framework within the Trust, and that staff education strategy and organisational development is aligned to policy development within the Trust;
- Ensure there is an action planning framework in place within the Trust, so that actions from investigations, risk assessments and internal and external reviews are implemented, monitored appropriately and escalated when off track;
- Ensure that there is a learning framework in place within the Trust, so that aggregate learning from incidents, Serious Incidents, complaints, claims, audit and assessments are communicated appropriately and changes in practice are facilitated;
- Oversee the implementation of key national reports and inquiries recommendations and provide assurance to the Board on its delivery;
- Ensure all external accreditations are monitored within the Trust, so that the Board of Directors has assurance that the Trust is meeting external quality requirements, and where there is variance or risk, actions are put in place appropriately;
- Obtain assurance of the Trust's on-going compliance with the Care Quality Commission registration through appropriate systems of control.
- Ensure that the Trust has effective communication channels in place for ward to Board monitoring and that the Clinical Business Unit, directorate, speciality, ward and department governance and quality assurance structures are robust;
- Monitor the process for the production of the Trust's year end quality (Quality Accounts) and risk management (Annual Governance Statement) reports before they are presented to the Trust Audit Committee and Board for formal approval;
- Ensure all reporting Sub Committees have effective reporting structures in place and that planned assurance reports are scrutinised through a business and assurance cycle;
- To inform the Board where it has significant concerns about:
  - Standards of care in the Trust
  - Or where it considers any service (or part of) to be unsafe
  -

8. ATTENDANCE

A record of attendance will be kept; attendance of 75% per year is expected
Members unable to attend must send a deputy who is able to make decisions on their behalf.
Other executive directors and officers of the Trust will be invited to attend the meeting as appropriate when an issue relating to their area of operation or responsibility is being discussed. Officers who are unable to attend a meeting of the Committee may appoint a deputy who will attend. It is the responsibility of the core member to inform the Chair of the Committee if they are unable to attend and who will attend as their deputy.

9. ADMINISTRATIVE ARRANGEMENTS

Unless prior agreement is reached with the Chair of the Committee the Agenda and Papers will be sent out 5 working days before the date of the meeting. No Papers will be tabled at the meeting without prior approval of the Chair. The Committee will be supported by the Secretary to the Trust Board.

- The ToR will be reviewed annually by Trust Board
- A Cycle of Business will be established

Papers to this Committee must be submitted for inclusion one week in advance of the meeting. Papers will be distributed by 5pm on the Tuesday preceding the Quality and Assurance Committee.

Papers are to be submitted in the following format:

1. Front sheet – with FOI exemptions duly applied if appropriate
2. Sub-Committees – Chairs key issues reports using the prescribed template
3. Divisional leads/service leads – reporting via the prescribed template
4. An Action Log will be maintained and distributed, alongside the CEO report, by the Friday following the Executive Board.
5. Presentations must be sent to the Administrator ahead of the meeting
6. No tabled papers will be accepted unless in an emergency and with permission of the Chief Executive.

10. REVIEW / EFFECTIVENESS

The Committee will undertake an annual review of its performance against its duties in order to evaluate its achievements. These terms of reference will be reviewed every 12 months by the Committee.

We are WHH

TERMS OF REFERENCE REVISION TRACKER

Name of Committee:	Quality & Assurance Committee
Version:	V1
Implementation Date:	
Review Date:	6 December 2016, 0 January 2017, 7 February 2017, 2 January 2018
Approved by:	
Approval Date:	

REVISIONS			
Date	**Section**	**Reason on Change**	**Approved**
6 December 2016	5 - Membership	Revised to include Non-Executive Directors to be amended to read **two** Core Attendees – to read **Core Members** Delete Divisional Operational Directors from the Core Membership **ADD Transformation Director** **ADD - Co-Opted Members from the Workforce Sub Group.** The Quality Committee to receive minutes from the WSG and appropriate colleagues to be invited to the Quality Committee where assurance is required for specific matters in relation to staffing, quality and safety. Quorum – change from 10 **to maximum of 7, to include 1 Executive Director, 1 Non-Executive Director and 1 representative from each Division.**	

	10 – Administrative Arrangements	The Committee will be supported by the Secretary to the Trust Board.	7.2.17
10 January 2017	5 - Membership	Membership further reviewed to include Head of Midwifery and Associate Director Infection Control + Prevention.	7.2.17
7 February 2017	5 – Membership	Delete Director of IM&T	7.2.17
02 January 2018	4 – Membership	Delete Chief Pharmacist, Chiefs of Service, Surgery, Women's & Children and Acute Care Services, Associate Directors of Nursing, Associate Director of Infection Control.	
02 January 2018	2 – Frequency of Meetings	Meetings to move from monthly to bi-monthly	
02 January 2018	6 – Reporting	Removal of Infection Control Committee, medicines management, Inclusion of Risk Review Group, Complaints Quality Assurance Group, Research and Development Sub Committee and Safeguarding Committee,	

TERMS OF REFERENCE OBSOLETE		
Date	**Reason**	**Approved by:**

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

Quality & Assurance Committee Cycle of Business 2018-19

Safety	Lead	Jan 18 Tuesday 9th	Mar 18 Tuesday 6th	May 18 Tuesday 1st	July 18 Tuesday 3rd	Sept 18 Tuesday 4th	Nov 18 Tuesday 6th	Jan 19 Tuesday 8th
Deep Dive Reviews **AS RQD**	Chief Nurse/ Director Integrated Governance and Quality							
SI Lessons Learning Audit quarterly report	Director Integrated Governance and Quality		✓	✓		✓		✓
Safeguarding (Bi-Annual Report)	Director Integrated Governance and Quality			✓			✓	
Safeguarding Committee (Annual Report)	Deputy Chief Nurse				✓			
Medicines Management/Controlled Drugs Annual Report	Medical Director			✓				
Learning from Experience Report	Director Integrated Governance and Quality		✓	✓		✓	✓	
6 monthly staffing report	Chief Nurse				✓			✓
DIPC Infection Control (1/4 ly)	Medical Director		✓	✓		✓	✓	
DIPC Infection Control Annual Report	Medical Director				✓			
Health and Safety Annual Report	Head of Safety + Risk				✓			
Patient Safety and Clinical Effectiveness Sub Committee High Level Briefing	Director Integrated Governance and Quality	✓	✓	✓	✓	✓	✓	✓
Safeguarding Committee High Level Briefing	Deputy Chief Nurse	✓	✓	✓	✓	✓	✓	✓
Health and Safety Sub Committee High Level Briefing	Director Integrated Governance and Quality		✓	✓	✓	✓	✓	✓
Clinical Effectiveness								
Clinical Forward Audit Plan	Director Integrated Governance and Quality	✓						
Mortality Review Quarterly report	Medical Director		✓	✓		✓	✓	
Clinical Audit Quarterly report	Director Integrated Governance and Quality	✓		✓		✓	✓	
Clinical Audit Annual Report	Director Integrated Governance and Quality				✓			
Patient Experience								
Complaints Quality Assurance Group High Level Briefing	Director Integrated Governance and Quality	✓	✓	✓	✓	✓	✓	✓
Patient Experience Sub Committee High Level Briefing	Deputy Chief Nurse	✓	✓	✓	✓	✓	✓	✓
Dementia Strategy Annual Review	Deputy Chief Nurse		✓					
Dementia Strategy 6 month report	Deputy Chief Nurse		✓			✓		
Compliance & Oversight								
Quality Dashboard	Chief Nurse/Medical Director	✓	✓	✓	✓	✓	✓	✓

Quality Accounts End of Year Report	Director Integrated Governance and Quality		✓	✓				
Quarterly Quality Report	Director Integrated Governance and Quality		✓	✓		✓	✓	
Strategic Risk Register and Board Assurance Framework	Head of Corporate Affairs	✓	✓	✓	✓	✓	✓	✓
Risk Review Group High Level Briefing	Director Integrated Governance and Quality		✓	✓	✓	✓	✓	✓
Risk Management Strategy annual review	Director Integrated Governance and Quality			✓				
Quality Impact Assessment ¼ ly report	Director of Transformation	✓		✓	✓		✓	✓
Information Governance and Corporate Records Group	Deputy Director IM&T	✓	✓	✓	✓	✓	✓	✓
Getting to Good Steering Group High Level Briefing	Chief Nurse	✓	✓	✓	✓	✓	✓	✓
High Level Enquires (when notified)	Director Integrated Governance and Quality	✓	✓	✓	✓	✓	✓	✓
Summary (assurances and risks to escalate to Board) as required	Chair	✓	✓	✓	✓	✓	✓	✓
Monitoring of Committee Attendance	Chair	✓	✓	✓	✓	✓	✓	✓
Chair's annual report to the Board	Chair			✓				

DRAFT TERMS OF REFERENCE

AUDIT COMMITTEE

1. PURPOSE

The Audit Committee has primary responsibility for monitoring and reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (clinical and non-clinical), that supports the achievement of the organisation's objectives.

The Audit Committee shall provide the Board of Directors with a means of independent and objective review of assurance processes and risk management across the whole of the Trust's activities (clinical and non-clinical), both generally and in support of the Annual Governance Statement. In addition the Audit Committee shall:

- provide assurance of independence for external and internal audit;
- ensure that appropriate standards are set and compliance with them monitored in all areas that fall within the remit of the Audit Committee ; and
- monitor compliance with corporate governance requirements (e.g. compliance with the terms of the Licence; Constitution; codes of conduct; standing financial instructions; maintenance of registers of interest).

2. AUTHORITY

The Audit Committee is constituted as a standing committee of the Trust's Board of Directors. Its constitution and terms of reference shall be as set out below, subject to amendment at future Board of Directors meetings. The Audit Committee shall not have any executive powers in addition to those delegated in these terms of reference.

The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any member of staff, and all members of staff are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Board of Directors to obtain external legal or other independent professional advice on any matter within its Terms of Reference to the total of £10,000 per annum, and to request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions.

3. REPORTING

The Committee shall report to the Board of Directors and Council of Governors annually on how it discharges its responsibilities; specifically on its work in support of the annual governance statement, commenting on:

- The fitness for purpose of the assurance framework
- The completeness and 'embeddedness' of risk management in the organisation
- The integration of governance arrangements

- The appropriateness of the evidence that shows the organisation is fulfilling regulatory requirements
- The robustness of the processes behind the quality account

This annual report should also describe how the Committee has fulfilled its terms of reference and give details of any significant issues that the Committee considered in relation to the financial statements and how they were addressed.

The minutes of the Committee's meetings shall be formally recorded and submitted to the Board. The Chair of the Audit Committee shall draw to the attention of the Board any issues that require disclosure or require executive action via a Key Issues Report.

4. DUTIES & RESPONSIBILITIES

The Committee's responsibilities fall broadly into the following areas:

Integrated Governance, Risk Management and Internal Control

The Audit Committee will review the adequacy and effectiveness of:

- All risk and control related disclosure statements (in particular the governance statement), together with any accompanying Head of Internal Audit Opinion, external audit opinion or other appropriate independent assurances, prior to submission to the governing body.
- The underlying assurance processes that indicate the degree of achievement of the organisation's objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications.
- The policies and procedures for all work related to counter fraud and security as required by NHS Protect.

In carrying out this work the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

This will be evidenced through the Committee's use of an effective assurance framework to guide its work and the audit and assurance functions that report to it.

As part of its integrated approach, the Committee will have effective relationships with other key committees (for example, the Quality Assurance Committee) so that it understands processes and linkages. However, these other committees must not usurp the Audit Committee's role.

Internal Audit
The Committee shall ensure that there is an effective internal audit function that meets the *Public Sector Internal Audit Standards, 2013* and provides appropriate independent assurance to the Committee, Accountable (or Accounting) Officer and governing body. This will be achieved by:

- Considering the provision of the internal audit service and the costs involved
- Liaising with the Quality Assurance Committee Chair and the Chair of the Trust's Operational Board to plan and approve the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation, including areas identified in the assurance framework
- Considering the major findings of internal audit work (and management's response), and ensuring coordination between the internal and external auditors to optimise the use of audit resources
- Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation
- Monitoring the effectiveness of internal audit and carrying out an annual review.

External Audit
The Committee shall review and monitor the external auditors' independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:

- Considering the appointment and performance of the external auditors, as far as the rules governing the appointment permit (and make recommendations to the governing body when appropriate)
- Discussing and agreeing with the external auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan
- Discussing with the external auditors their evaluation of audit risks and assessment of the organisation and the impact on the audit fee
- Reviewing all external audit reports, including the report to those charged with governance (before its submission to the governing body) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses
- Ensuring that there is in place a clear policy for the engagement of external auditors to supply non audit services.

Counter Fraud
The Committee shall satisfy itself that the organisation has adequate arrangements in place for counter fraud and security that meet NHS Counter Fraud standards and shall review the outcomes of work in these areas.

Management
The Committee shall request and review reports, evidence and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

The Committee may also request specific reports from individual functions within the organisation after taking briefings from Quality Assurance Chair or the Chair of the Trust's Operational Board.

The Committee will also periodically review the Trust's Standing Orders, Standing Financial Instructions, Scheme of Delegation and Standards of Business Conduct (Managing Conflicts of Interest) and examine the circumstances of any significant departure from the requirements of any of the foregoing, and whether those departures relate to a failing, an overruling or a suspension

Financial Reporting
The Committee shall monitor the integrity of the financial statements of the organisation and any formal announcements relating to its financial performance.

The Committee should ensure that the systems for financial reporting to the governing body, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided.

The Committee shall review the annual report and financial statements before submission to the governing body, focusing particularly on:

- The wording in the annual governance statement and other disclosures relevant to the terms of reference to the Committee
- Changes in, and compliance with, accounting policies, practices and estimation techniques
- Unadjusted mis-statements in the financial statements
- Significant adjustments resulting from the audit
- Letters of representation
- Explanations for significant variances.

Raising Concerns (Whistleblowing)

The Committee shall review the effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties in financial, clinical or safety matters and ensure that any such concerns are investigated proportionately and independently.

Periodically review the Whistleblowing register and the Freedom to Speak Up register.

Other

Review performance indicators relevant to the remit of the Audit committee.

Examine any other matter referred to the Audit committee by the Board of Directors, the Chair of the Quality Assurance Committee or the Chair of the Trust Operations Board and initiate investigation as agreed with the members of the Audit Committee.
Develop and use an effective assurance framework to guide the audit committee's work. This will include utilising and reviewing the work of the internal audit, external audit and other assurance functions as well as reports and assurances sought from directors and managers and

other investigatory outcomes so as to fulfil its functions in connection with these terms of reference.

Review the work of the CQC 'Getting to Good' Committee in connection with the Audit Committee's assurance function.

Consider the outcomes of significant reviews carried out by other bodies which include but are not limited to regulators and inspectors within the health [and social care] sector and professional bodies with responsibilities that relate to staff performance and functions.

5. MEMBERSHIP

The Committee shall be composed of all (5) the Trust's independent non-executive directors, at least one of whom should have recent and relevant financial experience (Monitor Code C.3.1), as follows:

- at least one member of the Trust's Quality Assurance Committee will be a member of the Trust's Audit Committee
- the Chair of the Trust shall not be a member

The Board will appoint one of the Non-Executive Director members of the Committee to be Chair of the Committee. Should the Chair be absent from the meeting the committee may appoint a Chair of the meeting from amongst the Non-Executive Directors present.

Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum. Should the need arise, the Committee may approve a matter in writing by receiving written approval from all the members of the Committee, such written approval may be by email from the members Trust email account.

The Trust chair may be invited to attend meetings of the Audit committee if required

The Lead Governor (or nominated deputy) may be invited to attend meetings of the Audit committee where items of specific interest or concern raised by Governors are being addressed.

6. ATTENDANCE

Only members of the Audit Committee have the right to attend meetings, but the following individuals shall normally be in attendance:

- Director of Finance & Commercial Development
- Director Community Engagement and Corporate Affairs (Company Secretary designate)
- Director of Integrated Governance
- Representative(s) of the external audit service provider
- Representative(s) of internal audit service provider
- Representative(s) of counter fraud service provider
- Head of Corporate Affairs
- Secretary to the Board

The Chief Executive may also be invited to attend and should in any case, attend at least annually, to discuss with the Audit Committee the process for assurance that supports the Annual Governance Statement.

Other Trust Directors and/or staff shall be invited to attend those meetings in which the Audit Committee will consider areas of risk or operation that are their responsibility.

7. QUORUM

The quorum necessary for the transaction of business shall be two members.

8. FREQUENCY OF MEETINGS

Meetings shall be held at least five times per year with additional meetings where necessary.

The internal auditor and external auditor shall be afforded the opportunity at least once per year to meet with the Audit Committee without Executive Directors present.

9. ADMINISTRATIVE ARRANGEMENTS

Unless prior agreement is reach with the Chair of the Committee, Agenda and Papers will be sent out 5 working days before the date of the meeting. No papers will be tabled at the meeting without prior approval of the Chair. The Committee will be supported by the Secretary to the Trust Board and the Head of Corporate Affairs.

10. REVIEW / EFFECTIVENESS

The Committee will undertake an annual review of its performance against its duties in order to evaluate its achievements and report on this to the Trust Board.

These terms of reference will be reviewed every two years by the Council of Governors and the Trust Board.

DATE: February 2018
Approved:
REVIEW DATE: February 2020

TERMS OF REFERENCE REVISION TRACKER

Name of Committee	Audit Committee
Version	V3
Implementation Date	Immediate
Review Date	February 2020
Approved By	Audit Committee

REVISION

Date	Section	Reason for Change	Approved By
6.1.2017	10	- Review date amended from at least annually to every 2 years - Committee to be supported by the Secretary to the Trust Board.	Audit
22.2.18	4	- Change Quality Committee to Quality Assurance Committee - Internal Audit to include liaison with the Trust's Q&A and TOB committees - Audit Committee to review SORD, SFIs, Standards of Business Conduct (MCoI) arrangements - Review Freedom to Speak Up Register - Review performance indicators relevant to remit of AC - Commission any investigations or 'deep dives' or request any other committee to do so - Develop and use an effective assurance framework to guide the audit committee's work - Review the work of the Trust Board's other Committees - Consider any external reviews by regulators and/or professional bodies that relate to staff performance and functions.	Committee
	5	Membership - The Trust chair may be invited to attend meetings of the Audit committee if required - The Lead Governor (or nominated deputy) may be invited to attend meetings of the Audit committee where items of specific interest or concern raised by Governors are being addressed	
	6	Attendance – to include: - Director of Integrated Governance - Head of Corporate Affairs - Secretary to the Board - A minimum of 75% attendance is required by members of the committee	
	10	Committee will review effectiveness annually and report on this to Trust Board and Council of Governors	

TERMS OF REFERENCE OBSOLETE	
Date	**Reason**

DRAFT AUDIT COMMITTEE – CYCLE OF BUSINESS JAN 2018 –MAR 2019

		FEB 2018	APRIL 2018	MAY 2018	JUL 2018	NOV 2018	FEB 2019
	OWNER			YEAR END			
STANDING ITEMS							
• Review Minutes and Action Log	**CHAIR**	X	X		X	X	X
• Audit Committee Annual Tracker (progress on all items)	**JC**	X	X		X	X	X
• Private discussions with Internal and External Auditors and Counter-Fraud specialist as required – but at least annually	**CHAIR**					X	
• Review rolling attendance log	**CHAIR**	X	X		X	X	X
• Approve Chair's key issue report items for escalation (post meeting)	**CHAIR**	X	X		X	X	X
• Review meeting effectiveness	**CHAIR**	X	X		X	X	X
QPS ASSURANCE							
• Update from Chairs of F&S, Q&A (inc Clinical Audit) & CFC	**TA/MB/ JNE**	X	X		X	X	X
• Changes or Updates to BAF	**JC**	X	X		X	X	X
• Review Risk Management Strategy	**UM**		X			X	
• Premium Pay Spend Report – appointments to B8C and above	**MC**	X	X		X	X	X
DEEP DIVE REVIEWS							
• Rolling programme of progress review of the Trust's principle key risks	**UM**	X	X		X	X	X
• Commission and receive ANY additional scrutiny projects	**AS RQD**						
FINANCE							
• Review Losses & Special Payments	**AMcG**	X	X		X	X	X
• Review Breaches/ Waivers of Standing Financial Instructions	**AMcG**	X	X		X	X	X
• Annual review of standing orders, standing financial instructions/prime financial policies and changes to accounting policies	**AMcG**		X				
• Going Concern Report	**AMcG**		X				
INTERNAL AUDIT							
• Internal Audit Plan & Fees	**MIAA**	X					
• Internal Audit Progress Report	**MIAA**	X	X		X	X	X
• Head of Internal Audit Opinion	**MIAA**		X	X			
• Internal Audit Charter Annual Report	**MIAA**		X				
• Insight Report	**MIAA**				X		

		FEB 2018	APRIL 2018	MAY 2018	JUL 2018	NOV 2018	FEB 2019
	OWNER			YEAR END			
• Progress report on internal audit follow-up actions	**AMcG**	X	X		X	X	X
EXTERNAL AUDIT							
• External Audit Plan & Fees	**GT**	X					
• Report and Updates from External Audit	**GT**	X	X		X	X	X
• Renewal/Refresh of External Audit Contract (at term)	**GT/AMcG/PMC**						
COUNTER FRAUD							
• Annual Counter Fraud Plan	**MIAA**	X					
• Counter Fraud Progress Updates	**MIAA**	X	X		X	X	X
• Annual Counter Fraud Annual Report	**MIAA**				X		
QPS GOVERNANCE AND COMPLIANCE							
• Annual report and accounts timetable and plans	**JC**	X					
• Draft Annual Governance Statement	**PMC**		X				
• Quality Account / Report	**UM**			X			
• Annual accounts draft accounting policies	**AMcG**	X					
• **Draft** unaudited Accounts & Financial Statements	**AMcG**		X				
• **FINAL** and Audited Accounts & Financial Statements	**AMcG**			X			
• Head of Internal Audit Opinion and External Audit Statements	**PMC**		X	X			
• Review Whistleblowing arrangements	**PMC**				X		
• Receive Whistleblowing and F2SU report	**JH**	X				X	
• Review other reports and policies as appropriate – eg changes to standing orders – as arise	**ALL**						
• Code of Governance Compliance and Compliance with Licence Annual Return	**PMC**			X			
• Code of Governance Compliance Declaration – eg changes as required	**PMC AS RQD**						
• Review of Trust Registers (eg Conflicts of Interest)	**JC**		X		X		
• Terms of Reference & Cycle of Business	**PMC**	X					
EFFECTIVENESS							
• Committee Objective Setting	**ALL**		X				
• Chairs report on Audit Committee for Board & Council of Governors	**CHAIR**		X				
• Receive the Chair's annual reports for the Q&A, CoG, NARC and CFC	**Cttee Chairs**				X		

		FEB 2018	APRIL 2018	MAY 2018	JUL 2018	NOV 2018	FEB 2019
	OWNER			YEAR END			
committees and review work plans							
• Audit Committee Effectiveness Review	**PMC/JC**						X

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/18/03/31 a**
SUBJECT:	**Reappointment of the Chairman**
DATE OF MEETING:	28th March 2018
ACTION REQUIRED	**For Assurance**
AUTHOR(S):	John Culshaw, Head of Corporate Affairs
EXECUTIVE DIRECTOR SPONSOR:	Pat McLaren, Director of Community Engagement + Corporate Affairs
LINK TO STRATEGIC OBJECTIVES:	All
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	All
EXECUTIVE SUMMARY (KEY ISSUES):	Under the Trust's Constitution, the Governors' Nominations and Remuneration Committee (GNARC), should: *On expiry of the initial Non-Executive Directors' current terms of appointment (or the period of 12 months, whichever is the greater) and on any subsequent vacancy, to consider whether to recommend to the Council of Governors the reappointment of the retiring Non-Executive Director*. The Chairman will come to the end of his first term of office on 31st March 2018. Mr Steve McGuirk expressed his interest in serving a second term of three years to commence on 1st April 2018. The Governors' Nominations and Remuneration Committee (GNARC) convened on 15th February 2018, where the extension of the Chairman's terms of office for a second term, at the existing remuneration, to 31 March 2021 was unanimously supported. The Council of Governors (CoG) subsequently met and unanimously approved the reappointment of Mr Steve McGuirk as Chairman.

RECOMMENDATION:	The Board is asked to note the report	
PREVIOUSLY CONSIDERED BY:	**Committee**	Council of Governors
	Agenda Ref.	COG/18/03/16
	Date of meeting	8th March 2018
	Summary of Outcome	Approved
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: *(if relevant)*		

NAME OF COMMITTEE

SUBJECT	Reappointment of the Chairman	AGENDA REF:	BM/18/03/31 a

1. BACKGROUND/CONTEXT

The Chairman will come to the end of his first term of office on 31st March 2018. Mr Steve McGuirk expressed his interest in serving a second term of three years to commence on 1st April 2018.

Under the Foundation Trust Constitution the Governors' Nominations and Remuneration Committee should, *On expiry of the initial Non-Executive Directors' current terms of appointment (or the period of 12 months, whichever is the greater) and on any subsequent vacancy, to consider whether to recommend to the Council of Governors the reappointment of the retiring Non-Executive Director.*

Mr Steve McGuirk was appointed on 1st April 2015 for a term of three years

The NHS Foundation Trust Code of Governance main principle B.7.a states:
All non-executive directors and elected governors should be submitted for re-appointment or re-election at regular intervals. The performance of executive directors of the board should be subject to regular appraisal and review. The council of governors should ensure planned and progressive refreshing of the non-executive directors.

The Code provision B.7.1 further clarifies:
B.7.1. In the case of re-appointment of non-executive directors, the chairperson should confirm to the governors that following formal performance evaluation, the performance of the individual proposed for re-appointment continues to be effective and to demonstrate commitment to the role. Any term beyond six years (eg, two three-year terms) for a non-executive director should be subject to particularly rigorous review, and should take into account the need for progressive refreshing of the board. Non-executive directors may, in exceptional circumstances, serve longer than six years (eg, two three-year terms following authorisation of the NHS foundation trust) but this should be subject to annual re-appointment. Serving more than six years could be relevant to the determination of a non-executive's independence.

A copy of the Chairman's appraisal, undertaken by the Senior Independent Director, Mr Ian Jones in June 2017, was presented to the GNARC.

The motion to recommend the extension of the Chairman's tenure to a second term of office was supported by all present.

A meeting of the Council of Governors was convened on 8th March 2018, when in line with the authority of the Council, the reappointment of the Chairman for a second term of office was unanimously approved.

2. KEY ELEMENTS

Extension of Term of Office of Steve McGuirk, Chairman

Mr Steve McGuirk joined the Trust as Chairman in April 2015. Steve, who lives in Warrington, was a County Fire Officer and Chief Executive of Greater Manchester Fire and Rescue Service and joined the Trust upon his retirement from that role. Steve joined the fire service in 1976. He was previously County Fire Officer and Chief Executive for Cheshire Fire and Rescue Service before taking on the post in Greater Manchester in 2009. He has also been a board member and president of the Chief Fire Officers Association and has been the principal adviser on fire and rescue matters to the Local Government Association. He was awarded the long service and good conduct medal in 1996, the Queen's Fire Service Medal in 2002, and the CBE in 2005. He has also gained extensive experience in governance of public authorities. Steve has also recently been appointed as an expert witness to the Grenfell Tower Enquiry.

Mr McGuirk was appointed as chairman following an extensive external recruitment process that involved the Trust's elected public and staff governors on the selection panel.

Mr McGuirk's role includes:

- Chair of the Board of Directors
- Chair of the Council of Governors
- Chair of the Board Nominations and Remuneration Committee
- Chair of the Governor Nominations and Remuneration Committee

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

The Board is asked to note the report

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/18/03/31 b**
SUBJECT:	**Amendment of the Foundation Trust Constitution**
DATE OF MEETING:	28th March 2017
ACTION REQUIRED	**For approval of the described amendments RECORDED VOTE REQUIRED**
AUTHOR(S):	John Culshaw, Head of Corporate Affairs
EXECUTIVE DIRECTOR SPONSOR:	Pat McLaren, Director of Community Engagement
LINK TO STRATEGIC OBJECTIVES:	SO3: To deliver well managed, value for money, sustainable services
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	BAF3.2: Monitor Undertakings: Corporate Governance & Financial Management
STRATEGIC CONTEXT	The Trust conducts its business according to the terms set out in its Constitution. As per Article 45 'Amendment to the Constitution' within the Constitution document, the Trust may make amendments to its constitution if more than half of the members of the Board of Directors of the Trust voting approve the amendments.
EXECUTIVE SUMMARY (KEY ISSUES):	The Council of Governors has been engaged over recent months in addressing a number of proposals to enhance our member and public engagement which may require amendments to our FT Constitution. Three amendments to the Constitution were discussed at a Working Party of the Council of Governors and subsequently supported by the Council of Governors in February 2018: 1. <u>Amendment to Constituencies</u> Merge Area 15 with the 'Rest of England and Wales' and correspondingly increase the number of Governors affiliated with the 'Rest of England and Wales' from one to two Governors. 2. <u>Amendment to Partnership Governors</u> Change to the existing public partners to the

	following: **Proposed** • Warrington Collegiate (Including 1 co-opted young person rep) (NEW) • Warrington Borough Council • Halton Borough Council • University of Chester • Warrington Wolves • Widnes Vikings (NEW) 3. <u>Alignment of Elections</u> In order to stabilise the Council of Governors in terms of turnover per year, the Council of Governors supported the following: a) Reduce the tenure of those elected in June 2018 from 3 years to 2 years 5 months to align all future elections to November; b) Reduce the existing tenures of five Governors whose tenures end in either December 2019 or December 2020 to conclude in November of the same year, therefore aligning future elections. As per Article 45 'Amendment to the Constitution' within the Constitution document, the Trust may make amendments to its constitution if more than half of the members of the Board of Directors of the Trust voting approve the amendments.	
RECOMMENDATION:	The Board is asked to consider the requested amendments to the constitution and to approve, by recorded vote, these amendments which will be entered to create v3.5	
PREVIOUSLY CONSIDERED BY:	**Committee**	Council of Governors
	Agenda Ref.	COG/18/02/05
	Date of meeting	15th February 2018
	Summary of Outcome	Approved
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

SUBJECT	Amendment to the Constitution	AGENDA REF:	BM/18/03/31 b

1. BACKGROUND/CONTEXT

The Council of Governors has been engaged over recent months in resolving a number of initiatives to enhance our member and public engagement which now require amendments to our FT Constitution.

As per Article 45 'Amendment to the Constitution' the Trust may make amendments to its constitution if more than half of the members of the Board of Directors of the Trust voting approve the request.

2. KEY ELEMENTS

There are three amendments required at this time:

1. <u>Amendment to the Public Constituency</u>

A Working Party of the Council of Governors met on 10th November 2017 and suggested to remove Area 15 'North Mersey', which is to move in to 'Rest of England and Wales', and the number of Governors affiliated with the 'Rest of England and Wales' to increase from one to two Governors. The proposal was supported by the Council of Governors who met on 15th February 2018.

The rationale for this is:

1. That due to Governor (constituency) vacancies there are many constituents which are not represented or supported across the WHH geographical footprint
2. That by having two Governors representing the 'Rest of England and Wales' constituency, the ability to attract additional Governors from a wider demographic is increased.

The Constitution requires amendment at **Annex 1 - The Public Constituency**, to reflect this change.

2. <u>Amendment to Partnership Governors</u>

A Working Party of the Council of Governors met on 10th November 2017 and following the recognition of the value that the existing partners provided and it was suggested that these could be improved further. There was universal support for encouraging a younger demographic to join the CoG and the benefits and insight they would bring. Further debate included approaching Widnes Wikings to join the partners.

Following the discussion, the working party proposed a change to the existing public partners to the following:

- Warrington Collegiate (Including 1 co-opted young person rep) (NEW)
- Warrington Borough Council
- Halton Borough Council
- University of Chester
- Warrington Wolves
- Widnes Vikings (NEW)

The proposal was supported by the Council of Governors who met on 15th February 2018.

The Constitution requires amendment at **Annex 3 – Composition of the Council of Governors**, to reflect this change.

3. Alignment of Elections

A Working Party of the Council of Governors met on 10th November 2017 to discuss aligning future Governor Elections in order to stabilise the CoG in terms of Governor turnover. The table below highlights that following the June 2018 Elections, approximately two thirds of our Governors would have faced elections.

Governors for Elections	June	November	December
2017		6	
2018	6		
2019			5
2020		5	

The proposal would moreover reduce costs associated with Governor Elections (approx £10,000 plus VAT), and address the difficulty in promoting the Governor Elections to the wider community during the early part of the year. It was proposed that Governor Elections should take place in November of each year, as opposed to twice per year (every three years). This would result in approximately a third of Governors being due for election each November.

The proposal would require:

a) Reduction of the tenure of those elected in June 2018 from 3 years to 2 years 5 months to align future elections;
b) Reduction of the existing tenures of five Governors whose tenures end in either December 2019 or December 2020 to conclude in November of the same year, therefore aligning future elections.

The proposal was supported by the Council of Governors who met on 15th February 2018.

The Constitution requires the removal of paragraph 12.2 (overleaf) to reflect this change.

12.2 Not less than one half of the initial Public Governors and Staff Governors (comprising those who polled the highest number of votes if elections took place, and otherwise to be chosen by

lot) will serve a term of office of three years. The remaining initial Public Governors and Staff Governors will serve a term of office of two years.

If approved, 9 of potential 26 Governors would serve a term of office of three years.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

1. Recorded vote of the Board of Directors taken (more than half voting members must approve)
2. Foundation Trust Constitution amendments made, published to website and noted to Monitor – Head of Corporate Affairs

4. ASSURANCE COMMITTEE

The Council of Governors

5. RECOMMENDATIONS

The Board note the request for amendments and vote accordingly.