We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

WHH Board of Directors Meeting Part 1

Wednesday 25 September 2019
10.00am-12.45pm
Trust Conference Room

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

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

Wednesday 25 SEPTEMBER 2019 time 10.00am -12.45pm

Trust Conference Room, Warrington Hospital

REF BM/19	ITEM	PRESENTER	PURPOSE	TIME	
	- Patient Story – Learning Difficulties, Dr Anne Robinson, Associate Medical Director Patient Safety		Presentation	10.00	N/A
BM/19/09 /78	Welcome, Apologies & Declarations of Interest	Terry Atherton, Deputy Chairman	N/A	10.15	Verb
BM/19/09 /79 PAGE 5	Minutes of the previous meeting held on 31 July 2019	Terry Atherton, Deputy Chairman	Decision		Encl
BM/19/09 /80 PAGE 12	Actions & Matters Arising	Terry Atherton, Deputy Chairman	Assurance	10:17	Encl
BM/19/09 /81 PAGE 13	Chief Executive's Report (a) Rapid Diagnostic Centres (b) Summary of NHS Providers Board papers (c)	Mel Pickup, Chief Executive	Assurance	10:20	Verb
BM/19/09 /82	Chairman's Report	Terry Atherton, Deputy Chairman	Information	10:40	Verb

Quality People Sustainability

BM/19/09 /83 PAGE 16	Integrated Performance Dashboard M5 and Assurance Committee Reports	All Executive Directors	Assurance	10.45	Enc
(a)	- Quality Dashboard including ○ Monthly Nurse Staffing Report July				Enc
(b)	- Key Issues report Quality and Assurance Committee (3.09.2019)	Margaret Bamforth, Committee Chair			Enc
(c)	People Dashboard - Key Issues Strategic People Committee (18.09.2019 – verbal update)	Anita Wainwright, Committee Chair			
(d)	Sustainability Dashboard - Key Issues Finance and Sustainability Committee (21.08.2019) + (18.09.2019)	Terry Atherton, Committee Chair			Enc
(e)	- Key Issues Audit Committee (1.08.2019)	Ian Jones, Committee Chair			Enc

Quality

BM/19/09 /84 PAGE 96	Learning From Experience Report Q1	Kimberley Salmon-Jamieson, Chief Nurse	To note	11.25	Enc
BM/19/09 /85 PAGE 142	Care Quality Commission (CQC) Action Plan	Kimberley Salmon-Jamieson, Chief Nurse	To note	11.30	Enc

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BM/19/09/86 PAGE 179	Director Infection Prevention + Control (DIPC) Q1 report	Kimberley Salmon-Jamieson, Chief Nurse	To note	11.40	Enc
BM/19/09/87 PAGE 197	Learning from Deaths Q1 Report	Simon Constable, Deputy Chief Executive Officer & Executive Medical Director	To note	11.45	Enc

Sustainability

BM/19/09/88 PAGE 207	Quarterly Progress on Carter Report Recommendations and Use of Resource Assessment and CQC report	Andrea McGee, Director of Finance + Commercial Development	To note	11.50	
BM/19/09/89 PAGE 260	ePMA Business Case	Phill James Chief Information Officer	Decision	11.55	Enc

People

BM/19/09/90 PAGE 276	Nurse Staffing Bi-Annual Report (def from July)	Kimberley Salmon-Jamieson, Chief Nurse	To note	12.00	Enc
BM/19/09/91 PAGE 301	Freedom to Speak Up Bi-Annual Report	Kimberley Salmon-Jamieson, Chief Nurse	To note	12.05	Enc
BM/19/09/92 PAGE 304	GMC Survey Trainee results 2018-19	Alex Crowe, Deputy Medical Director	To note	12.10	Enc
BM/19/09/93 PAGE 312	Flu vaccination of healthcare workers Plan – *To follow*	Michelle Cloney, Director of HR & OD	To note	12.15	

GOVERNANCE

BM/19/09/94 PAGE 317	Strategic Risk Register + BAF	Mel Pickup, Chief Executive	Approve	12.20	Enc
BM/19/09/95 PAGE 326	Request to amend Constitution – Trust name change	John Culshaw, Head of Corporate Affairs	To note	12.25	Enc
BM/19/09/96 PAGE 331	Emergency Preparedness, Resilience and Response (EPRR) Assurance 2019/20 spreadsheet not to be circulated	Chris Evans, Chief Operating Officer	To note	12.30	Enc
BM/19/09/97 PAGE 338	EU Exit preparation	Chris Evans, Chief Operating Officer	To note	12.35	Enc

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Warrington and Halton Hospitals NHS Foundation Trust

MATTERS FOR APPROVAL

	ITEM	Lead (s)				
BM/19/09 /98	Risk Management Strategy Annual Report + Revised Stategy for Approval	Kimberley Salmon-Jamieson, Chief Nurse	Committee	Quality Assurance Committee	12.40	Enc
			Agenda Ref.	QAC/19/07/120		
			Date of meeting	02.07.2019		
			Summary of Outcome	Approved		
BM/19/09 /99	Director Infection Prevention + Control (DIPC) Annual Report (to note)	Kimberley Salmon-Jamieson, Chief Nurse	Committee	Quality Assurance Committee		Enc
			Agenda Ref.	QAC/19/09/145		
			Date of meeting	03.09.2019		
			Summary of Outcome	Noted and supported		
BM/19/09 /100	Board Sub Committee Terms of Reference For Approval (a) Council of Governors	John Culshaw, Head of Corporate Affars		Council of Governors		Enc
			Agenda Ref.	COG/19/08/52		
			Date of meeting	13.08.2019		
			Summary of Outcome	Approved		
BM/19/09 /101	Cycle of Business For Approval - Charitable Funds Committee	Pat McLaren, Director of Community Engagement +Fundraising	Committee	Charitable Funds Committee		Enc
			Agenda Ref.	CFC/19/09/34		
			Date of meeting	12.09.2019		
			Summary of Outcome	Approved		
			Agenda Ref.	SPC/19/09/84		
			Date of meeting	18.09.2019		
			Summary of Outcome	Noted and discussed		

	Any Other Business	Terry Atherton, Deputy Chairman		Verb
	Date of next meeting: Wednesday 27 November 2019 , Trust Conference Room			

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D R A F T

Warrington and Halton Hospitals NHS Foundation Trust

Warrington and Halton Hospitals NHS Foundation Trust
Minutes of the Board of Directors meeting held in Public (Part 1) on Wednesday 31 July 2019
Trust Conference Room, Warrington Hospital

Present	
Steve McGuirk (SMcG)	Chairman
Mel Pickup (MP)	Chief Executive
Terry Atherton (TA)	Deputy Chair, Non-Executive Director
Margaret Bamforth (MB)	Non-Executive Director
Simon Constable (SC)	Executive Medical Director/ Deputy Chief Executive
Chris Evans (CE)	Chief Operating Officer
Ian Jones (IJ)	Non-Executive Director / Senior Independent Director
Andrea McGee (AMcG)	Director of Finance and Commercial Development
Cliff Richards (CR)	Non-Executive Director
Anita Wainwright (AW)	Non-Executive Director
In Attendance	
John Culshaw (JC)	Head of Corporate Affairs
Alex Crowe (AC)	Medical Director, Director of Medical Education + Clinical CIO
Lucy Gardner (LG)	Director of Strategy
John Goodenough (JG)	Deputy Chief Nurse
Phillip James (PJ)	Chief Information Officer
Pat McLaren (PMcL)	Director of Community Engagement + Fundraising
Julie Burke (JB)	Secretary to Trust Board (Minutes)
Hayley McCaffery (HMcC)	Head of Clinical Effectiveness + Quality *(patient story item only)*
Sharron Neilson (SN)	Sister A&E *(patient story item only)*
Apologies	
Michelle Cloney (MC)	Director of HR + OD
Kimberley Salmon-Jamieson (KSJ)	Chief Nurse
Observing Norman Holding	Public Governor
Tina Dixon	Salford Primary Care Together

BM/19/07	Patient Story HMcC explained how the Trust had worked as part of a collaborative across Halton and Warrington to improve services for people with mental health needs presenting at A&E through a holistic approach. The Trust continues its work with Halton and Warrington CCGs for high intensity users to signpost patients to the most appropriate setting for their care, including 'social' prescribing to support patients in their own environment, with focus on the top 50 patients high intensity users of A&E and UC. Across the 2 years the programme has been in place, there had been a significant reduction in A&E attendances for this cohort of patients, a reflection of patients being sign-posted to the most appropriate care setting for them. In response to query raised by AW how patients are identified in the pathway, SN explained this is through telephone contact with patients who are frequent attenders, ie 3 x week with appropriate signposting/support with continued referrals from primary care and MDT teams to avoid admissions. A video patient story was shared with the Committee of a patient with mental health needs who explained they had been a repeat attender to A&E over a number of years and with

	support from a range of health professionals including secondary and primary care and social care a tailored care plan was put in place to support in a number of areas enabling the patient to manage their care. They had become involved in a number of community activities supporting people with learning disabilities. The patient thanked all staff that had supported her in her two year journey for helping to change her life. JG conveyed thanks to all colleagues involved in supporting this patient, reflected in the Team finalist nomination for the HSJ Patient Safety Awards on 2 July.
BM/19/07/57	**Welcome, Apologies & Declarations of Interest** The Chair opened the meeting and welcomed colleagues. Congratulations were conveyed to the CEO and Head of Corporate Affairs on their new appointments and thanks for their support and work during their tenure. Apologies noted above. SC declared his joint post wef 1 July 2019 as Medical Director responsibility for WHH and Bridgewater. It was agreed this declaration did not need to be made at each meeting and the declaration will stand until agreement ceases. If additional declarations need to be declared in respect of other agenda items, this will be made separately. No other declarations in relation to the agenda were noted.
BM/19/07/58	**Minutes of the meeting held 29 May 2019** Page 7 BM/19/05/45 Annual Siro Report. 2nd para, delete reference to Subject Access Requests. PMcL explained our average response was in line with that of other NHS Trusts and that the Trust respond to a range of requests including media, politicians, suppliers. PMcL to include breakdown of FOIs as part of bi-annual Engagement Dashboard reported to Trust Board and Council of Governors. With these amendments, minutes of 29 May 2019 were agreed as an accurate record.
BM/19/07/59	**Actions and Matters Arising.** **Action log and rolling actions were noted.**
BM/19/07/60	**Chief Executive's report** The CEO provided an update on matters for the Board to note since the last meeting both nationally and locally. The Trust had received its CQC Inspection report on 24 July 2019 following the inspection of Core Services, Well Led and Use of Resources. The CEO was pleased to report significant improvement across all areas to achieve 'Good' with Critical Care rated Outstanding. On behalf of the Board, thanks were conveyed to all staff for the efforts and tenacity to achieve this improvement. Urgent Treatment Centre (UTC) – The Trust had received notification from Commissioners on 7 June 2019 that the Trust had been unsuccessful in its bid to provide services at two UTC's, one based in Runcorn and one in Widnes, which had been awarded to a non-NHS provider. Following challenge from the Trust on the decision making process, procurement had been abandoned. The Trust awaits further clarification on next steps and changes to the UTC. One to One Midwifery – the Trust had received notification on 27 July 2019 that One to One Midwifery, independent midwifery provider, had notified the lead Commissioner of its intention to cease trading at 5pm on 31 July 2019. MP reassured the Board as the Trust had anticipated this scenario, effective plans had been developed and implemented Some of the 244 women affected are already receiving care at WHH. Risk stratification approach taken and a number of the ladies had already been individually contacted to discuss their care plans (130), WHH continue to operate a helpline 8am-8pm to ensure that all affected women

	are contacted by the end of the week. To support One to One staff, the Trust is looking to maintain skills in the area with an offer to join WHH bank. The Board conveyed thanks to all staff for the excellent operational response to ensure ladies receive their care in their preferred environment. A procurement exercise went live 30 July 2019, submission due 30 August 2019, prior to presentation to the Finance and Sustainability Committee in August. Debt owed to the Trust is £800k. Improving People Practices. The CEO referred to recent correspondence and recommendations from Baroness Harding, following an independent review of care and treatment of an individual who was subject to an investigation and disciplinary. The Trust had reviewed its policies and processes against the recommendations. An action plan is in place and implementation of the recommendations will be reported and monitored at Strategic People Committee. AW added a request had been made to HRD for lessons learned and appeals training/briefings for NEDs to take place at the time of the appeals to ensure that the most recent guidance is taken into account. Healthwatch Halton Quality Account 2018-19 response. Correspondence noted. My-Choice – CEO and Chair's response to R Cooper MP shared, reiterating this is not privatisation and that My Choice has been paused for consideration. Request for additional information will be responded to through the FOI process. MB queried impact of NHSE/I Commissioning document in November 2018 that Trusts are not expected to undertake these procedures and the Trust decision to pause. SC explained that the November 2018 guidance had been sent to Commissioners, which the Trust did not receive until after it had supported My-Choice. However more recent national guidance/ correspondence dated 8 July 2109 had been received and will be circulated outside of the meeting. Capital Spend - correspondence received from NHSE/I 2 July 2019 asking Trusts to review further review and reduce capital investment plans by a further 20%. Following discussions and agreement with NHSE/I the Trust had resubmitted its plan based on the £10.6m capital plan submitted in the original financial plan, who acknowledged that the Trust's capital plan has been increased to £13.5m with no plans or ability to reduce from £13.5m. NHSE/I are to monitor capital spend across the economy and provide further updates and possible actions depending on the position later in the year. AMcG stressed that any additional capital requirements will need to be funded within the current Capital Programme. NHS Implementation Plan – as a C&M Health Care Partnership, 5 Year Plan being developed to support implementation, WHH high level briefing of the implementation framework to be circulated following the meeting.
BM/19/07/61	**Chairman's Report** The Chairman highlighted the following for note: - Impact of recent election and continued Brexit momentum. - Series of meetings planned with Interim Chair of Bridgewater CHT, with substantive appointment anticipated in September. - Committee in Common meeting on 1 August 2019 with Bridgewater colleagues, and meetings agreed for the remainder of the year to progress the collaboration agenda. - The Chairman had attended a successful Schools Fundraising event for WHH Charity. - The Chairman thanked for colleagues for feedback to inform his annual appraisal.

BM/19/07/62 *(b)*	**IPR Dashboard** Quality measures. JG was asked to provide an update on number of open incidents over 40 days and mitigations in place to achieve trajectories. JG reassured the Board that mitigations are in place to reduce this number through weekly harm meetings with enhanced scrutiny of CBU performance and mitigations. Significant improvement reported in quality of investigations being reported by CBUs' reflecting embedding of processes and training. Quality Assurance Committee Chairs Key Issues Report (2 July 2019) noted. Due to strengthened governance and reporting from sub committees to the Committee, QAC agenda will move to a more strategic focus; End of Life Strategy had been approved; Medicines Management deep dive reported improvement in reduction of incidents which will be further supported by the implementation of ePMA; progress of Urgent + Emergency Care Improvement Committee (U+ECIC) action plan reported through high level briefings. Access and Performance measures. CE was asked to address areas of variation in performance and mitigations relating to RTT standard, achieving 92.03% in June. CE explained increasing difficulty to achieve in some specialities, particularly T&O, Ophthalmology, Endoscopy within Gastroenterology due to Consultant vacancies or unforeseen absences and growing reluctance from Consultant body to undertake this activity due to HMRC tax and pension implications. Growing issue relating to radiology report turnaround, due to the same reasons. A Regional response to the impact of loss of additional consultant WLI activity had been submitted highlighting impact upon these specialities. Mitigations for July to maintain position include T&O Consultant now in post with two to commence in August and outsourcing has been progressed by Ophthalmology to deliver activity with continued weekly monitoring at Performance Review Group meeting. The Trust remains one of three Trusts maintaining the RTT standard in C&M. CE highlighted that the Trust had been nominated to participate in the clinical standard review, specifically in relation to the proposed Cancer Standards. The Trust would be one of 14 taking part in the pilot, the main proposal of the pilot will be to change the standard from the current 2 week wait from primary care referral to appointment, to a 28 day faster diagnosis standard which in essence means that a patient would be communicated of a cancer diagnosis within 28 days of referral. There are also RTT and ED pilots which have already commenced, Phase 1 of the Cancer standard review will run from August-October 2019, a Memorandum of Understanding will be put in place including how the Trust will report the standard. Phase 2 will run from November 219 to April 2020. A&E standard – the Trust achieved 81.5% against NHS trajectory 81% in June 19, actions to sustain performance being driven through UEC Improvement Committee and include launch of ED dashboard for real-time patient flow data, LLoS collaborative on wards, joint post with local authority supporting Super Stranded (SS) and system pathways, test of change undertaken for 24/7 Ambulatory Care in June and test of change for co-location of medical assessment and SAU on GPAU from September 2019. CE highlighted potential risk relating to capacity on B3 following notification on 23 July 2019 from Halton Council and Halton CCG that funding was to cease on 31 July 2019. CEO had responded requesting what their mitigations would be to provide additional capacity in the community out of the acute

(c)	setting for packages of care to be put in place for this cohort of patients, currently the LoS on B3 is c.22 days. The capacity on B3 has both activity and financial implications for the Trust now and on future winter capacity. People measures. MP to discuss mitigations to arrest deterioration in workforce indicators Strategic People Committee Chairs Key Issues (24 July 2019) AW highlighted that whilst licence for LiA had ceased, momentum will continue internally through 'Be The Change' Finance + Sustainability Measures. AMcG was asked to address mitigations relating to financial risk £6m in 2019-20 financial plan particularly in relation to CIP and cost pressures. AMcG explained risk is in year primarily due to cost pressures and unidentified CIP. Executive leads identified for each cost pressure to provide an update to Finance and Sustainability Committee (FSC). Mitigation at 30th June 2019 equates to £1.5m leaving outstanding unfunded cost pressures of £3.8m. Within the financial position to 30 June 2019 there is £1.2m spend in relation to these unfunded cost pressures. AMcG reassured the Board that ideas to address the CIP gap currently of £4.5m had been discussed at Finance Resource Group (FRG) and CBUs are developing plans to support implementation of these ideas. Diagnostics and Outpatient had over achieved plans, there are challenges to U+EC CIP target and work is underway with finance and operational colleagues to reapportion some CIP, performance is also reviewed and monitored at monthly deep dive meetings Chaired by the COO. Use of agency remains a risk with no plan at this time to reduce agency spend over the remainder of the year. A plan is required. Revenue – Q1 position delivered, £3.3m deficit. CBUs have been asked to prepare forecast outturn reports to FRG in August. Working with Bridgewater CHFT and Commissioners to prepare system wide recovery plan to be submitted to NHSE/I by 2 August 2019. • **The Board noted, reviewed and discussed the report.** • **The Board approved the change to the 2019-20 Capital Programme for the IT Device refresh of £188k, which had been supported at the FSC on 24 July 2019.** • **The Board approved the change to the Quality Indicators in the IPR Dashboard which had been supported at the Quality Assurance Committee on 2 July 2019.**
(d)	Finance + Sustainability Committee (FSC) Chairs Key Issues, June and July 2019. As Chair of FSC, TA had no additional issues to highlight to discussions earlier.
(a)	Monthly Safe-staffing reports May, June + July 2019. JG was pleased to report recruitment of 72 Registered Nurses with 46 to commence in September 2019. Ongoing work to reduce turnover, NHSE/I standard to achieve to 1.5% in 12 months, currently 2.5% in first 8 months due to a number of initiatives put in place. The Trust had received £50k funding to support recruitment of additional 40 student nurses and will be supported by University of Chester. • **The Board noted and reviewed the report.**

BM/19/07/63	**C&M Maternity Safety SIG – Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Year 2** The Executive Medical Director explained as part of regulatory monitoring, the Trust had submitted evidence to support the 10 safety actions, providing assurance these had been met and discussed with the CCG. The Trust had achieved full compliance. Evidence for submission had been approved at the Quality Assurance Committee on 2 July 2019. Thanks were conveyed to all staff involved in collating the evidence for submission. • **The Board approved the formal sign-off of full compliance and evidence to be submitted to NHSE/I in August 2019.**
BM/19/07/64	**Quality Strategy 2019-2020** The Executive Medical Director highlighted the progress made relating to the Trust Quality Strategy and pledges which are becoming embedded across the Trust. In relation to the assurance statement for each quality pledge, SMcG recognised the future role of the Quality Academy to support implementation, particularly around embracing new technology to support innovation and research. • **The Board reviewed, discussed noted the report and supported FOI and SAR information to be included as part of the Bi-Annual Engagement Dashboard.**
BM/19/07/66	**Guardian of Safe Working Q4 Report** The Deputy Medical Director highlighted key points to note: - On track for training and teaching for Junior Doctors - Q4, 60 exception reports from 69 incidents, mainly relating to Jnr Doctors working late past their rota, 3 highlighted safety concerns which were immediately addressed. Q4 exception reports mainly due to winter pressures, with reduction in exception reports from Medicine, mirroring rota on-call work within medicine. - 30 exception reports remain open, requiring sign-off from Educational Supervisors, reflecting regional picture. - As the Guardian cannot be a signatory due to Conflict of Interest, AC has proposed himself and Post Graduate Dean Medical Education to be signatories to expedite sign-off. - 64% of exception reports related to time taken off in lieu. Trend continues relating to shift requests exceeding shifts taken due to robust processes put in place by CBUs. Of exception reports - AC explained letter had been received from HEE following latest GMC trainee survey, recognising significant improvements since the last survey, all areas down-graded, 20% reduction in red flags and 30% reduction to pink flags, a more comprehensive report which will be reported to SPC and September Trust. - New Terms and Conditions for Jnr Doctors to go live 9 August 2019. - Future reports to include vacancy reason in relation to locum bookings by department. <u>Annual Report</u> - 260 exception reports. T&O identified as an area for improvement which is being addressed through appropriate forums to increase support in FY2. Other work streams include appointments of Physician Associates, Nurse Associates and International Training Fellows to support and enabling flexibility across the workforce. - In relation to query raised by MB relating to excess rota hours and bank opt-out forms,

	MC explained this forms part of their contract of employment with the Trust, but the Trust are unable to monitor hours worked externally. MT has reinforced this to Jnr Doctors. - AC reiterated importance of progressing E-Rostering as soon as possible and is meeting with Procurement colleagues to progress at pace, which had been supported at SPC on 24 July 2019. AC commented that notification had been received from NHSE/I of Health & Social of available capital funding to expedite E-Rostering including E-Job Planning across C&M but each organisation is to bid separately • **The Board reviewed, discussed and noted the report.**
BM/19/07/67	**Strategic Risk Register and BAF** Head of Corporate Affairs explained the proposed the changes BAF for Board approval which had been approved at the Quality Assurance Committee on 2 July 2019. - no new risks escalated to the BAF; - risk rating of one risk currently on the BAF to be reduced, #138; - description of one risk amended #138; - three risks de-escalated from the BAF #138 increasing demand for datasets, #701 (Brexit), #123 timely sending of discharge summaries. In relation to #701, CE explained that following the recent election of Prime Minster, communications reinforcing that Brexit Plans and teams are in place by the end of August, a regional event is being planned in September. The default position is still to exit by 31.10.2019 from the Centre. The risk will be reviewed at the Risk Review Group in August and re-escalate if necessary. • **The Board reviewed, discussed and approved the proposed amendments**
	Matters for Approval
BM/19/07/68	**Refreshed Integrated Performance Report (IPR) Quality Indicators** Refer to minute BM/19/07/62.
BM/19/07/69	**Annual Complaints Report** — **The Board approved the report.**
BM/19/07/70	**Health and Safety Annual Report** — **The Board approved the report.**
BM/19/07/71	**Safeguarding Annual Report** — **The Board approved the report.**
BM/19/07/72	**Medicines Management + Controlled Drugs Annual Report** • **The Board approved the report.**
BM/19/07/73	**Emergency Preparedness, Resilience and Response Annual Report** • **The Board approved the report.**
BM/19/07/74	**Quality Assurance Committee Chair's Annual Report** — **The Board approved the report.**
BM/19/07/75	**Council of Governors Cycle of Business** — **The Board approved Cycle of Business.**
BM/19/07/75	**End of Life Strategy** — **The Board approved the Strategy.**
BM/19/05/57	**Any Other Business – No matters raised.**
	Next meeting to be held: Wednesday 25 September 2019

Signed …… Date ……

Chairman ……

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

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NHS Warrington and Halton Hospitals NHS Foundation Trust

BOARD OF DIRECTORS ACTION LOG

AGENDA REFERENCE:	BM/19/09/80	SUBJECT:	TRUST BOARD ACTION LOG	DATE OF MEETING	25 September 2019

1. ACTIONS ON AGENDA

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

2. ROLLING TRACKER OF OUTSTANDING ACTIONS

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
BM/18/07/57		Junior Doctor/Trainee Engagement update Trello)	6 mth update presentation.	**Medical Director**	**27.11.2019**		14.01.2019. Deferred to March 27.03.2019. Referred to future BTO 29.05.2019. Update to September Board to include results from GMC survey results. 06.09.2019. Deferred to November Board	
BM/19/05/50	29.05.2019	Engagement Dashboard	Future 6 monthly reports to include breakdown of numbers and sources of FOI requests.	**DCE + Fundraising**	**27.11.2019**		Next report to November Board	

3. ACTIONS COMPLETED AND CLOSED SINCE LAST MEETING

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

RAG Key

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

Cheshire & Merseyside Cancer Alliance

The Clatterbridge Cancer Centre
NHS Foundation Trust
Clatterbridge Road
Bebington
Wirral
CH63 4JY

Tel: 0151 556 5078
Email: linda.devereux@nhs.net

Mrs P Gillis
Lead Cancer Manager
St Helens and Knowsley NHS Trust

Mrs K Mason
Cancer Nurse Transformation Manager
Warrington and Halton Hospital NHS Foundation Trust

20th August 2019

Dear Pat and Karen

Rapid Diagnostic Centres – expression of interest – Eastern Sector

Thank you for submitting an expression of interest for the development of a first wave Rapid Diagnostic Centre (RDC) in the Cheshire and Merseyside Cancer Alliance (CMCA) area. A panel met yesterday to review submissions and I am pleased to inform you that your proposal has been selected for submission to the National Cancer Programme Team as one of the RDCs within the Alliance.

In line with national timescales we are now required to submit an outline plan including required revenue to NHS England by the end of next week. I know that Anna Murray, Senior Project Manager from CMCA has already contacted you to discuss compiling the information needed for the submission.

Many thanks again for an ambitious but exciting proposal, particularly as timescales were very tight. We look forward to working with you to develop the plan in line with the national specification.

Yours sincerely

Linda Devereux
Programme Director

cc.

Ann Marr	Mel Pickup	Rob Cooper	Chris Evans
Dr Ernie Marshall	Dr Ash Bassi	Dr Sue Burke	Kerry Gerrard
David Marteau	Dr Rhian Thomas	Jackie Connell	

Summary of board papers – statutory bodies

Care Quality Commission – 17 July 2019

For more details, the agenda and papers are available online here.

Chief Executive's report

- A cross-directorate workshop was held in early July to review the Safeguarding and Whistleblowing process and related indicators. Proposals for improvement of the process and how CQC measure success will be reported to the Executive Team and Board.
- 52% of Hospital reports were published on target. The Hospitals team is reviewing the information to assess issues, although it is reported that inspectors have been responding to information of concern as a consequence of the scrutiny on Whorlton Hall and this has had an impact on report timeliness. May had the highest percentage of inspections undertaken based on information of concern at 19% - significantly higher than the standard of around 7%.

Chief Inspector of Hospital's report

Recent publications

- Mental Health Act Code of Practice. The report analysed the extent to which the revised code met its objectives following its publication in April 2015.
- Effective staffing. The report featured case studies showcasing different approaches to staffing and improvement in this area without relying on deploying staff from other wards.

Update on thematic review of restraint, seclusion and segregation

An update was provided on the progress of each of the recommendations contained in the interim report:

- DHSC will shortly present options to the Secretary of State around undertaking independent and in-depth reviews of each person cared for in segregation.
- CQC will convene a meeting of a group to consider the key features of a better system of care in early August. A second meeting, involving experts from other countries, will be organised by the British Institute of Learning Disabilities in early November.
- DHSC is leading work to consider options for how to strengthen the system of safeguards.
- CQC reviewing and revising its approach to regulating and monitoring hospitals that use segregation will be taken forward through the work initiated in response to events at Whorlton Hall; including the independent review led by Glynis Murphy.
- The focus for phase two of the review will consider the implications of segregation for the person's human rights.

Health Education England – 17 July 2019

For more details, the agenda and papers are available online here.

Chief Executive's report

The new National People Board (NPB) has been meeting fortnightly to take forward aspects of the interim people plan. This group is chaired by Prerana Issar, with Wendy Reid leading workforce supply, Patrick Mitchell leading workforce re-design, and Rob Smith leading data and analysis.

Medical Education Reform Programme

Three reports were presented to the board as part of the Medical Education Reform (MER) Programme:

1. Supported from the start; ready for the future, The Postgraduate Medical Foundation Programme Review – this review explores the programmes' work into addressing geographic and specialty shortages in doctors, improving flexibility and junior doctor morale. The review has developed 16 draft recommendations.
2. The Enhancing Junior Doctor Working Lives progress report – details the ongoing improvements in training resulting from HEE's work with partners to address the concerns of doctors in training. Over the past year HEE has continued to work with doctors in training and system partners to build on existing initiatives and explore areas of need. Highlights include expanding flexible training options, implementing and sharing best practice, addressing deployment concerns and continuing efforts to improve concerns about the cost of training.
3. The Supervision report and associated suite of resources - produced in response to concerns raised about supervision standards and the possible risks to trainee and patient safety. The report provides clarity about the roles and responsibilities of those supervising doctors in training.

The MER Programme will also be running two consultations later this year: one on the principles which should govern an expansion in the use of pre-allocation due to 'special circumstances' to make it accessible to a broader range of students. A second consultation will explore the policy options to support Widening Participation initiatives for graduates entering the Foundation Programme.

Learning Disability workforce

HEE has identified immediate actions to increase uptake of training places on both Trainee Nursing Associate Programmes and Registered Nurse Learning Disability Programmes.

LEBTB Operating Model

HEE is moving to seven Local Education Training Boards (LETBs) to support the seven workforce systems (and People Boards) (i.e. the seven regions). LETBs will work alongside People Boards. Their purpose is to be the forum for providers and professionals to work collectively to improve the quality of education and training outcomes within their local area.

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REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	BM/19/09/83
SUBJECT:	**Integrated Performance Report Dashboard**
DATE OF MEETING:	25th September 2019
AUTHOR(S):	Marie Garnett – Head of Contracts and Performance
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Deputy Chief Executive & Medical Director Kimberley Salmon-Jamieson, Chief Nurse Michelle Cloney – Director of Human Resources & Organisational Development Andrea McGee - Director of Finance & Commercial Development Chris Evans - Chief Operating Officer
LINK TO STRATEGIC OBJECTIVES:	All
EXECUTIVE SUMMARY (KEY ISSUES):	The Trust has 65 IPR indicators which have been RAG rated in August as follows: **Red: 18 (decreased from 19 in July)** **Amber: 12 (the same number as July)** **Green: 34 (increased from 33 in July)** **Non RAG Rated: 1 (the same number as July)** Quality areas highlighted for improvement are Friends and Family Test for ED, Mixed Sex Accommodation Breaches, Incidents and Medication Safety. The Trust reported a Never Event in August, relating to a wrong site interscalene block being performed using ultrasound on a patient scheduled for surgery. Immediate actions were implemented following review. The investigation is underway. It should be noted that whilst the Friends and Family Test for ED has not met the Trust internal standard, the recommendation rate is comparable to other organisations across the Cheshire and Mersey footprint and an ED action plan is being monitored via the ED Improvement Committee.

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	The Mixed Sex Accommodation breaches are patients who are awaiting step down from the Intensive Care unit. Where appropriate, patients are cohorted within the unit to minimise the impact however, it is noted that patient feedback is consistently positive and environmental changes to create additional side rooms are being progressed. Open Incidents are monitored with progress tracked weekly via the Trust Meeting of Harm. Whilst there has been an increase noted, specifically with Integrated Medicine and Urgent and Emergency Care CBUs, there is a proactive focus to ensure timely closure. With regard to medication safety, Pharmacy is currently in the process of implementing the 7 day services business case. This is aligned to improving the medicines reconciliation quality indicator. The remaining quality indicators are green and on track as a result of work plans that are monitored and aligned to each quality indicator to ensure continual improvement supported where necessary by Trust QI collaborative programmes. The Trust deficit for the period ending 31 August 2019 is £3.4m, which is £0.2m better than plan. The actual control total (excluding Provider Sustainability, Financial Recovery and Marginal Rate Emergency Tariff funding) is £8.8m which is on plan. The Trust has two working capital loans due for repayment in 2019/20. The 2015/16 loan of £14.2m is due for repayment and has been extended to November 2019 and the 2016/17 loan of £7.9m is due for repayment in January 2020. The Trust is awaiting a response from NHSI to confirm arrangements for these loans.

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PURPOSE: (please select as appropriate)	Information	Approval	To note X	Decision
RECOMMENDATION:	The Trust Board is asked to: **1.** Note the contents of this report. **2.** Note the emergency approved change to the capital programme.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
FREEDOM OF INFORMATION STATUS (FOIA):	Choose an item.			
FOIA EXEMPTIONS APPLIED: *(if relevant)*	Choose an item.			

SUBJECT	Integrated Performance Report Dashboard	AGENDA REF:	BM/19/09/83

1. BACKGROUND/CONTEXT

The RAG rating for all 65 indicators from September 2018 to August 2019 is set out in **Appendix 1**. The Integrated Performance Dashboard (**Appendix 2**) has been produced to provide the Board with assurance in relation to the delivery of all KPIs across the following areas:

- Quality
- Access and Performance
- Workforce
- Finance Sustainability

2. KEY ELEMENTS

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

Table 1: RAG Rating Movement

	June	July	August
Red	16	19	18
Amber	11	12	12
Green	36	33	34
Other	8	1	1
Total:	71	65	65

The Board agreed at the meeting in July to remove Total Deaths, Safer Surgery and the 5 Sepsis indicators from the IPR dashboard and to add a new Continuity of Carer indicator. Therefore the total number of indicators has reduced from 71 to 65. In addition, the Care Hours per Patient Day indicator is now being RAG rated.

Due to validation and review timescales for Cancer, the RAG rating on the dashboard for these indicators is based on July's validated position. VTE has not been RAG rated in month as this indicator is reported as a quarterly position.

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

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

Quality

Quality KPIs

There are 5 indicators rated Red in August, the same number as July.

The 4 indicators which were Red in July and remain Red in August are as follows:

- Incidents – there were 43 open incidents over 40 days old at the end of August, an increase from 39 at the end of July against a target of 0. There was 1 never event reported in month.
- Medication Safety – 27.00% of patients had medicines reconciliation within 24 hours in August, increased from 26.00% in July against a target of 80.00%.
- Friends & Family Test (ED and UCC) – the Trust achieved 83.00% in August, an increase from July's position of 82.00%, against the Trust target of 87.00%. It should be noted that the Trust is comparable to other Cheshire & Mersey organisations. An action plan for improvement is in place and is overseen by the ED Improvement Committee and the Patient Experience Committee.
- Mixed Sex Accommodation Breaches (MSA) – there were 10 Mixed Sex Accommodation Breaches reported in August (all within critical care), an increase from 3 in July, against a target of 0. However, patient experience feedback remains consistently positive.

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

- Healthcare Acquired Infections (MRSA) – there were 2 cases of MRSA reported in August, an increase from 0 in July, therefore this indicator will remain Red for the remainder of the year.

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

- Friends & Family (Inpatients) – the Trust achieved 95.00% in August, increased from 94.00% in July against a target of 95.00%.

VTE performance is validated quarterly and therefore has not been RAG rated in month.

Access and Performance

Access and Performance KPIs

There are 7 Access and Performance indicators rated Red in August, a decrease from 8 in July.

The 7 indicators which were Red in July and remain Red in August are as follows:

- A&E Waiting Times 4 hour national target – the Trust achieved 85.03% excluding walk ins in August, an increase from July's position of 82.11%, against a target of 95.00%.
- Breast Symptomatic – the Trust achieved 83.12% in July, a decrease from 89.04% in June against a target of 93.00%.
- Ambulance Handovers 30>60 minutes – there were 91 patients who experienced a delayed handover in August, a decrease from 186 in July against a target of 0.
- Ambulance Handover at 60 minutes or more – there were 24 patients who experienced a delayed handover in August, a decrease from 27 in July against a target of 0.
- Discharge Summaries % sent within 24 hours – the Trust achieved 87.88% in August, a decrease from July's position of 88.30% against a target of 95.00%.
- Cancelled Operations (not rebooked within 28 days) – there was 1 patient in August, a decrease from 2 in July against a target of 0.
- Super Stranded Patients – there were 118 super stranded patients as at the end of August, an increase from 102 at the end of July against a trajectory of 95.

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

- Cancer 14 days – the Trust achieved 93.97% in July, increased from 89.79% in June against a target of 93.00%

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PEOPLE

Workforce KPIs

There are 4 indicators rated Red in August, the same number as July.

The 4 indicators which were Red in July and remain Red in August are as follows:

- Sickness Absence – the Trust's achieved 5.34% in August, an improvement from July's position of 5.42% against a target of less than 4.20%.
- Monthly Pay Spend – was £0.22m above budget of £16m in August, an improvement from £0.34m above budget in July.
- Bank/Agency Reliance – the Trust reliance was 12.54% in August, an increase from July's position of 11.84% against a target of less than 9%.
- Agency Shifts Compliant with the Cap – 44.38% of shifts were compliant with the Cap in August 2019, a slight increase from 44.28% in July, against a target of 49%.

SUSTAINABILITY

Finance and Sustainability KPIs

There are 2 indicators rated Red in August, the same number as July.

The 2 indicators which were Red in July and remain Red in August are as follows:

- Capital Programme – to date the actual spend is £2.9m which is £2.8m below the planned spend of £5.7m. This is due to a combination of under spend across all areas.
- Better Payment Practice Code (BPPC) – the challenging cash position results in a monthly performance of 37% which is 58% below the national standard of 95%.

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

The Trust has signed up to a break even control total. The Trust is currently achieving plan however the current mitigated forecast is £2.3m variance from plan. The Trust is working with system partners on a system recovery plan and has been reporting progress to NHSE/I. Should the plan not be delivered, the PSF and FRF of c£17m in total will not be fully achieved as achievement is based upon delivery of the plan each quarter. An adverse variance from plan may mean the Trust would need to request a loan. Further mitigations are therefore required. The Trust is awaiting a response from NHSE/I regarding the loans due to expire in this financial year.

Capital Programme

In April 2019, the Trust increased the 2019/20 capital programme from £10.6m to £13.5m to reflect increased depreciation charges resulting from the change in RICS guidance on asset lives and the finalisation of the 2018/19 underspend. This £2.9m increase in the capital programme is resource backed and was after Board approval and the submission of the 2019/20 financial plan to NHSI, which included at the time a £10.6m capital plan.

Table 2: Change to the 2019/20 capital programme.

Scheme	Value £000
Additional Funding Required	
Paediatric MRI Scanning (1)	11
Funded by	
Contingency	11

(1) Emergency request approved by the Deputy Director of Finance on 22 August 2019.

The Board is requested note the emergency approved change to the 2019/20 capital programme.

A number of emerging urgent capital schemes have been highlighted and a reprioritisation exercise has taken place. This will be presented to the Board for discussion and approval.

To date the planned capital spend is £5.7m and the actual spend is £2.9m. The £2.8m under spend is mainly due to the spend on the Kendrick Wing Fire scheme.

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

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

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

4. ASSURANCE COMMITTEE

The following committees provide assurance to the Trust Board:

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

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5. RECOMMENDATIONS

The Trust Board is asked to:

1. Note the contents of this report.
2. Note the emergency approved change to the capital programme.

Appendix 1 – KPI RAG Rating September 2018 – August 2019

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

Appendix 1 – KPI RAG Rating September 2018 – August 2019

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

Appendix 1 – KPI RAG Rating September 2018 – August 2019

	KPI		Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19
	WORKFORCE													
46	Sickness Absence	↓ (% Monthly Performance)	↓	↓	↑	↑	↑	↓	↓	↓	↓	↑	↑	↓
47	Return to Work	↑ (% Monthly Performance)	↓	↓	↓	↓	↓	↓	↓	↓	↓	↓	↑	↓
48	Recruitment	↓ (Number of Days)			↓	↔	↑	↓	↓	↓	↓	↓	↑	↑
49	Vacancy Rates	↓								↓	↓	↓	↑	↓
50	Retention	↑								↑	↓	↑	↑	↑
51	Turnover	↕ (% Monthly Performance)	↑	↓	↑	↓	↓	↑	↓	↑	↑	↑	↑	↓
52	Bank & Agency Reliance	↓								↓	↕	↕	↓	↑
53	Agency Shifts Compliant with the Cap	↑								↑	↕	↕	↓	↑
54	Monthly Pay Spend (Contracted & Non-Contracted)	↕ (% of Budget)	↑	↔	↓	↑	↓	↓	↑	↕	↓	↓	↑	↓
55	Core/Mandatory Training	↑ (% Monthly Performance)	↑	↑	↑	↑	↓	↓	↓	↑	↑	↓	↑	↓
56	PDR	↑ (% Monthly Performance)	↓	↓	↑	↓	↑	↓	↑	↓	↓	↑	↓	↓
	FINANCE													
57	Financial Position	↑ (Cumulative against plan)	↓	↑	↑	↓	↓	↑	↑	↑	↓	↑	↓	↓
58	Cash Balance	↑ (Balance against plan)	↔	↔	↔	↔	↔	↔	↔	↔	↔	↑	↑	↓
59	Capital Programme	↑ (Performance against plan)	↓	↓	↓	↓	↓	↓	↓	↑	↓	↓	↓	↓
60	Better Payment Practice Code	↑ (Monthly actual against plan)	↓	↓	↓	↔	↑	↓	↓	↑	↑	↓	↓	↑
61	Use of Resources Rating	↑ (Rating against plan)	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
62	Agency Spending	↓ (Monthly planned vs actual)	↓	↑	↓	↓	↓	↑	↑	↑	↓	↑	↓	↓
63	Cost Improvement Programme – Performance to date	↑ (Monthly vs target)	↓	↓	↑	↑	↓	↓	↔	↔	↑	↑	↑	↑
64	Cost Improvement Programme – Plans in Progress (In Year)	↑ (Monthly vs plan)	↓	↓	↓	↑	↓	↓	↔	↔	↔	↔	↓	↑
65	Cost Improvement Programme – Plans in Progress (Recurrent)													

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

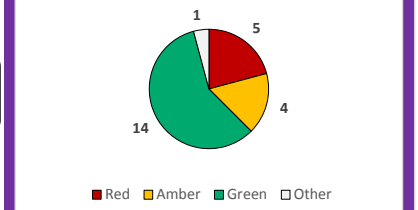
Warrington and Halton Hospitals NHS
NHS Foundation Trust

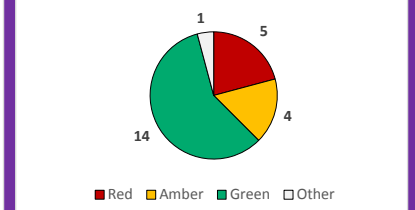
Integrated Dashboard - August 2019

Appendix 2

Key Points/Actions

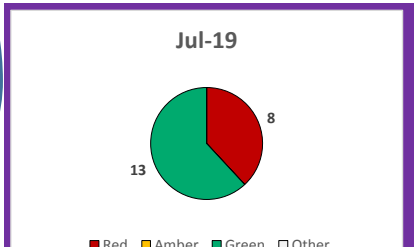
Quality Improvement

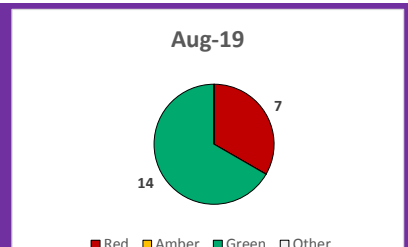




There are 447 open incidents that required review and sign off. There was 1 never event reported in month. Compliance in month in relation to Duty of Candour remains 100%. The Trust has achieved targets in all 3 categories of the Safety Thermometer. Gram negative bloodstream infections YTD: 2 MRSA bacteraemia cases, 6 MSSA bacteraemia cases, 18 C. difficile cases include community onset/healthcare associated and hospital onset cases, 20 E. coli bacteraemia cases, 7 Klebsiella bacteraemia cases, 1 P. aeruginosa bacteraemia case. Falls; The Trust recorded no harm incidents as a result of an inpatient falls in August 2019. There were 0 category 3 or 4 pressure ulcers and 3 Category 2 pressure ulcers reported in month. There has been an increase in the number of mixed sex accommodation breaches compared to the previous month, from 3 to 10 in month.

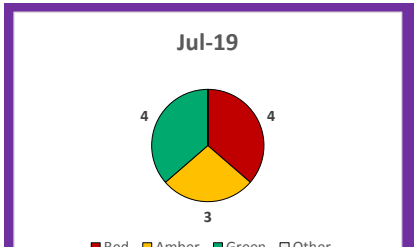
Access & Performance

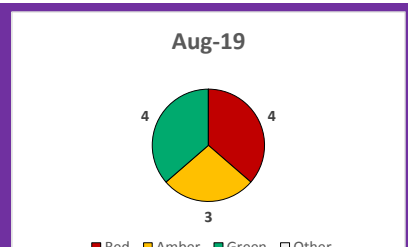




In August 2019, 14 out of the 21 indicators were RAG rated as Green. The Trust has continued to achieve the RTT and 6 weeks diagnostic standards in month. The Trust did not achieve the breast symptomatic standard in July, however a recovery plan has been implemented and performance has improved in draft data for August. The Trust did not meet the 4 hour A&E standard; however the improvement trajectory was met. The number of ambulance handover delays for both 30-60 minutes and 60 minutes plus has reduced. Cancelled operations for non-clinical reasons has reduced in month to 0.07%. There was 1 patient whose operation was cancelled and not rebooked within 28 days in month. The Trust continues to work with system partners to address the number of stranded and super stranded patients.

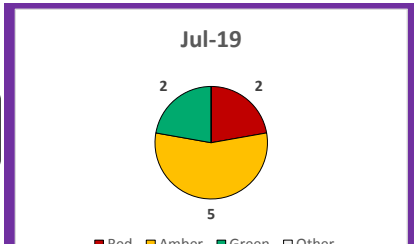
Workforce

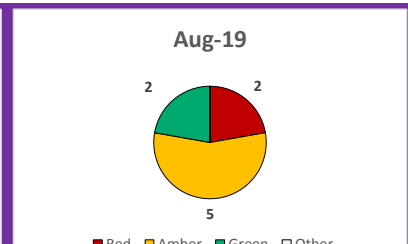




Trust sickness absence in month was 5.34%. Short term actions are in place in relation to Additional Clinical Services staff group and longer term actions are being taken forward in line with NHS Improvement recommendations. Return to work compliance was 76.90%; timeliness of completion is being addressed. Recruitment timeframes have reduced over the 12 month rolling period at an average of 62 days. Turnover and Vacancy rates remain positive. Pay spend is above budget in month. Bank and Agency reliance is above target at 12.54%. Core Skills Training compliance continues to be positive at 90.72%. PDR compliance is below the target in month at 73.49% and managers will be asked to attend Operational People Committee (OPC) to present detailed plans for recovery. Progress at CBU/Department level will be monitored and managers held to account in OPC. Agency shift compliance pay cap is at 44.38%.

Finance





In month the Trust recorded a deficit of £0.2m which increases the year to date deficit to £3.5m which is £0.2m better than plan. The year to date control total (excluding Provider Sustainability, Financial Recovery and Marginal Rate Emergency tariff funding) is a £8.8m deficit which is on plan. Year to date income is £1.6m above plan, however clinical income is £0.5m below plan, after removed of pass through drugs is £0.9m below plan expenditure is £1.4m above plan and non operating expenses are on plan. Capital spend is £2.9m which is £2.8m below the planned capital spend of £5.7m. Annual saving schemes identified are £6.7m which is £0.8m below the £7.5m annual target and to date savings achieved are £1.5m which is £0.3m above the planned savings. At month end, the cash balance is £2.6m which is £1.4m better than plan. The year to date performance against the Better Payment Practice Code is 38% which is 57% lower than the 95% target. The Trust has recorded a Use of Resources Rating of 3.

Warrington and Halton Hospitals NHS
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Key:
Single Oversight Framework
Care Quality Commission
Trust Strategy

Quality Improvement - Trust Position

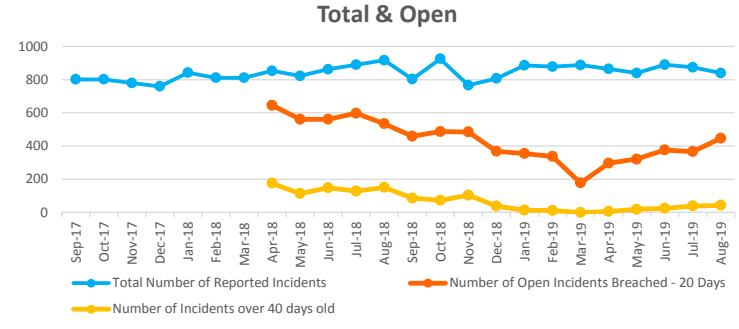
Trust Performance	Trend	What are the reasons for the variation?	How are we going to improve the position (Short & Long Term)?

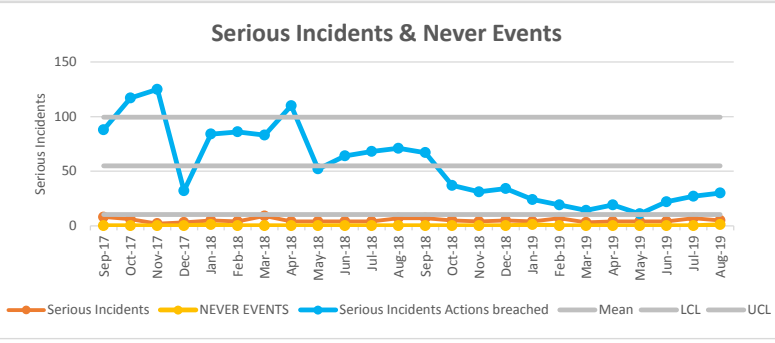
Patient Safety

Incidents

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

There was 1 never event reported in August 2019. There were 43 incidents open over 40 days old in August across the 8 CBUs.





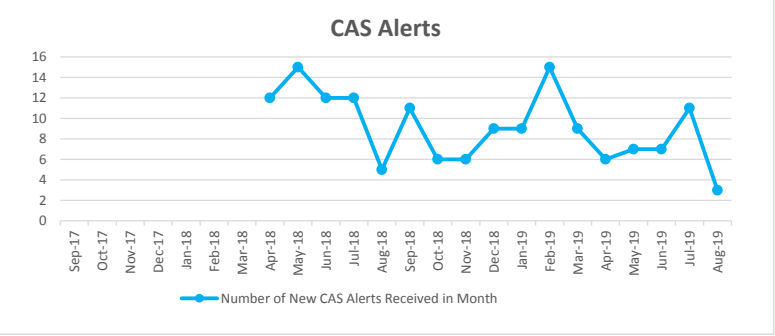
There were 5 Serious Incidents and 1 Never Event reported in August 2019. The Never Event was a wrong site procedure. Immediate actions and investigations are underway. The Trust has seen an increase in incidents over 20 and 40 days old. Whilst a marked improvement from the previous position, work is underway to understand the reasons for this variance.

The Trust's 'Reporting to Improve' campaign continues with 182 managers trained on the use of Datix for incident reviewing. Training will continue from September into October 2019.

The Trust's Moving to Outstanding meeting has been convened and alongside the weekly Meeting of Harm, will track compliance with the Trust's incident reporting policy.

CAS Alerts -
Green - All relevant CAS Alerts actioned within timescales
Red - Applicable CAS Alert not actioned within the timescale.

There were 3 new CAS Alerts received in month. There were no CAS alerts which breached the timescale in month.



The Trust received 3 CAS alerts in month with no breaches. There is no variation to note.

Ongoing monitoring and oversight at the Health and Safety and Patient Safety and Effectiveness Sub Committees.

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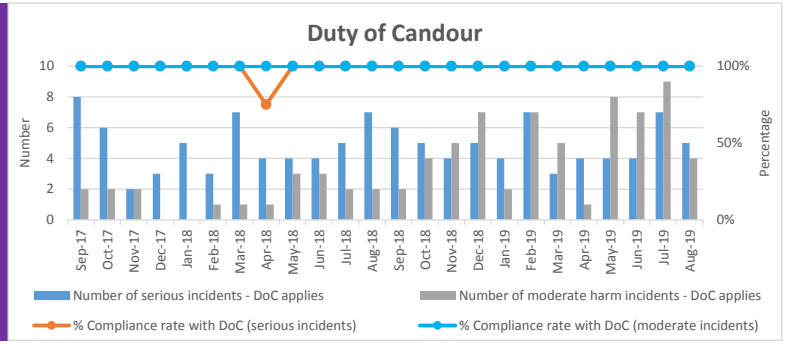
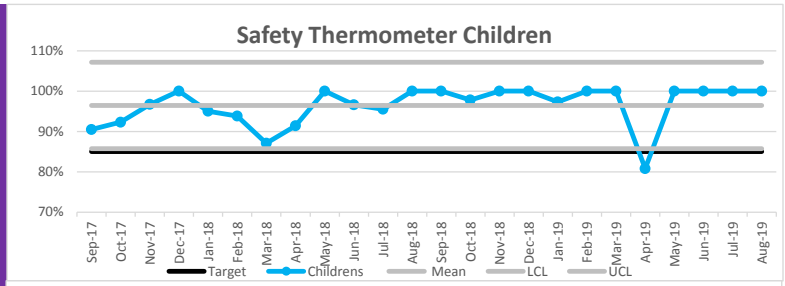
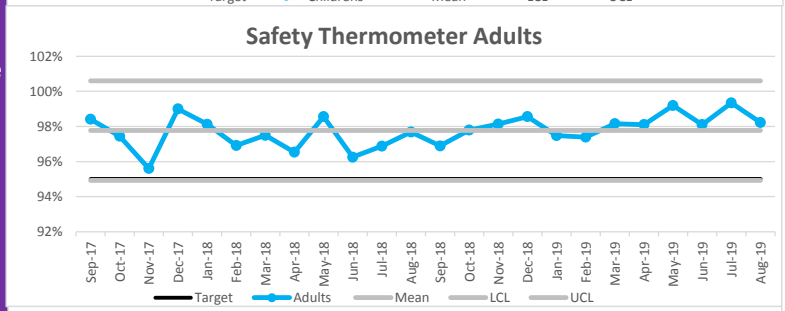
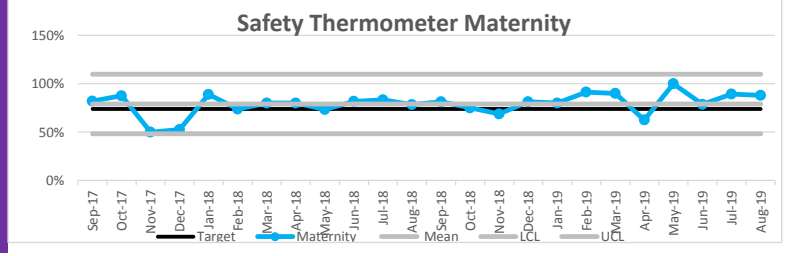
Duty of Candour Red: <100% Green: 100%	The Trust achieved 100% for Duty of Candour in month.		Compliance with Duty of Candour remains in line with Trust policy and continues to be supported through monitoring via the Datix system with oversight by the clinical governance department in relation to all correspondence/contact.	Weekly scrutiny and monitoring is in place with the Director of Clinical Governance.
Childrens Safety Thermometer Red: Less than 80% Amber: 81% to 84% Green: 85% or more **Adult Safety Thermometer** Red: Less than 90% Amber: 90% to 94% Green: 95% or more **Maternity Safety Thermometer** Red: Less than 70% Amber: 70% to 73% Green: 74% or more	The Trust achieved 98.23% on the Adult Safety Thermometer, 100% on the Children's Safety Thermometer and 87.9% on the Maternity Safety Thermometer in month. SPC - These indicators are within common cause (expected) variation.	  	Children's – 100% Adult - 98.23% - 1 VTE, 3 CAUTI and 4 Pressure Ulcers. No wards of concern, all above the threshold. Maternity – 87.9% - whilst there is a slight reduction from the previous month, this relates to two patients whose concerns were dealt with appropriately, compliance is above the threshold.	In month, the Trust achieved targets across each of the 3 Safety Thermometer domains. In relation to the Maternity Thermometer the service has implemented a text reminder for community midwives to ensure timely collection of data in order to achieve maximum compliance.

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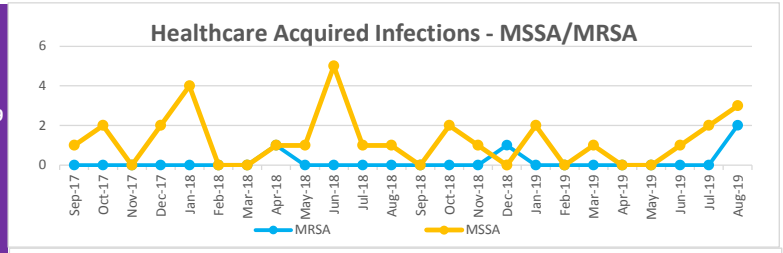
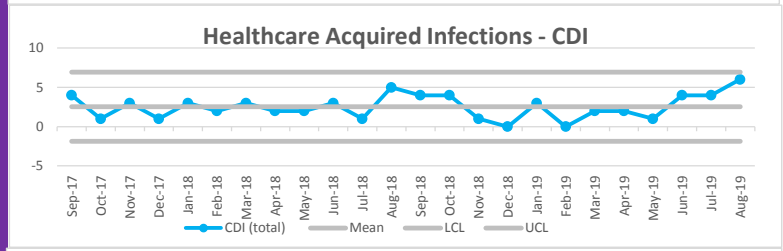
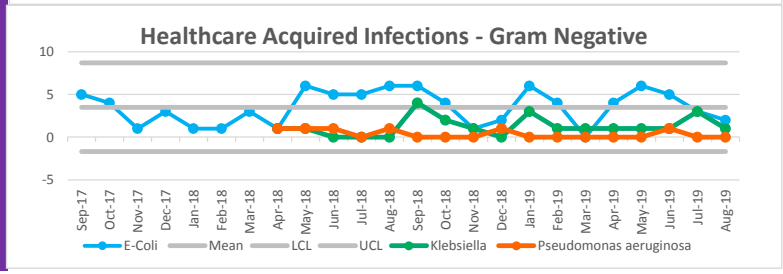
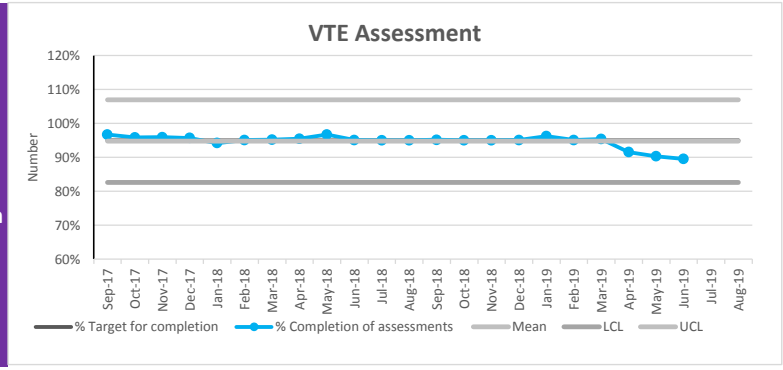
Healthcare Acquired Infections **MRSA** **Red: 1 or more** **Healthcare Acquired Infections** **C-Difficile** **Red: More than 44 YTD** **Green: Less than 44** **Healthcare Acquired Infections - Gram Negative** **E-Coli** **Red: More than 47 YTD** **Green: Less than 47**	Performance for April - August 2019 Zero tolerance to avoidable MRSA bacteraemia cases - 2 cases. 6 MSSA bacteraemia cases. C. difficile cases include community onset/healthcare associated and hospital onset cases - 18 cases. 20 E. coli bacteraemia cases reported FYTD. 7 Klebsiella bacteraemia cases reported FYTD. 1 P. aeruginosa bacteraemia case reported FYTD. No targets set for MSSA; Klebsiella, P. aeruginosa bacteraemia cases. SPC - these indicators are within common cause (expected) variation.	  	The Trust is over trajectory for GNBSI reduction target. We have seen 2 cases of MRSA in month, 1 on A5 likely due to urinary catheter care and 1 on A8 due to long term MRSA colonisation. Both cases have been reviewed and actions are in place.	Quality improvement collaborative action plans are in place with agreed tests of change. Focus areas include urinary catheter care and ANTT training; patient hand hygiene and hydration. Education on the UTI pathway is underway, this is linked to the CQUIN which is reviewing antimicrobial resistance in lower UTIs.
VTE Assessment **Red: <95%** **Green: 95% or above based on previous months' figures due to timescales for validation of data**	The Trust achieved 90.45% for VTE assessments on average in Q1 2019. SPC - VTE is within common cause (expected) variation.		The Trust achieved 90.45% for VTE assessments on average in Q1 2019. VTE is reported quarterly.	There are ongoing actions in relation to VTE. Focussed work with clinical teams to improve compliance with the VTE electronic risk assessment processes. Escalation supported by the Deputy Medical Director is now in place to ensure ongoing actions are completed.

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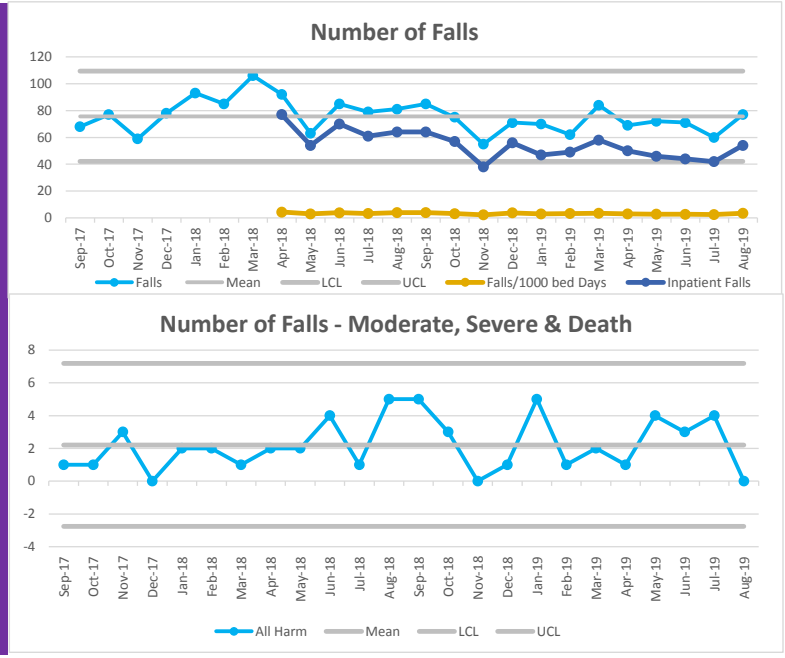
There were a total of 77 falls in month of which 54 were inpatient falls. SPC - Falls are within common cause (expected) variation.		The Trust recorded no harm incidents as a result of falls in August 2019. A reduction of 27.6% is noted for inpatient falls FYTD as of August 2019/20 compared with the same reporting period for 2018/19.	Good progress is being made by the QI collaborative project, innovation walk arounds continue with tests of change aligned to CQUIN standards for falls. A downward trend continues with falls per 1000 occupied bed days (OBD) through continued focus on risk reduction. Bathroom work to commence 1st October 2019.

Total number of Inpatient Falls & harm levels
Red: <10% decrease from 18/19
Amber: 10-19% decrease from 18/19
Green 20% or more decrease from

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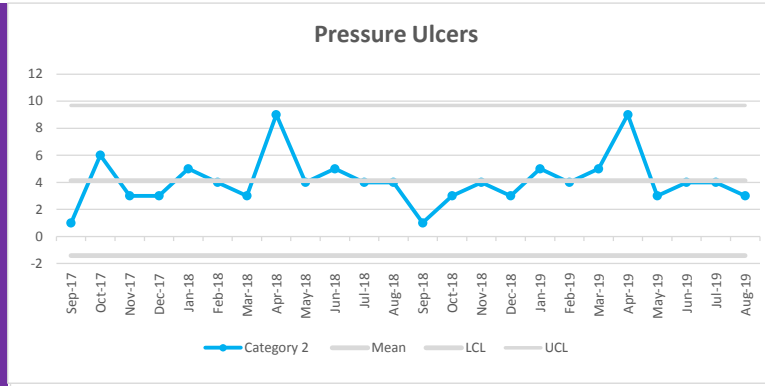
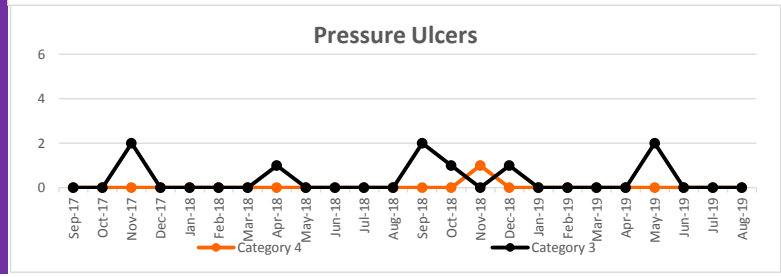
Pressure Ulcers Based on 57 in 2018/19 **Red: 4% reduction or below** **Amber: 5%-9% reduction** **Green: 10% reduction or above.**	**There were 0 hospital acquired Category 4 pressure ulcers, 0 Category 3 pressure ulcers and 3 Category 2 pressure ulcers reported in month. SPC - Pressure ulcers are within common cause (expected) variation.**	 	**There is evidence of variation in accuracy of risk assessments and ongoing monitoring in change of patients condition. There have been instances where there has been a delay in obtaining or upgrading pressure relieving mattresses.**	**The Quality Improvement collaborative work is ongoing with good progress being made in areas of innovation. Tests of change have commenced and innovation walk arounds are underway, updates reported through the Trust Tissue Viability Steering Group which is overseen by the Patient Safety and Effectiveness Sub Committee.** **Pressure ulcer prevention face to face training continues with additional training in the clinical areas where necessary.**

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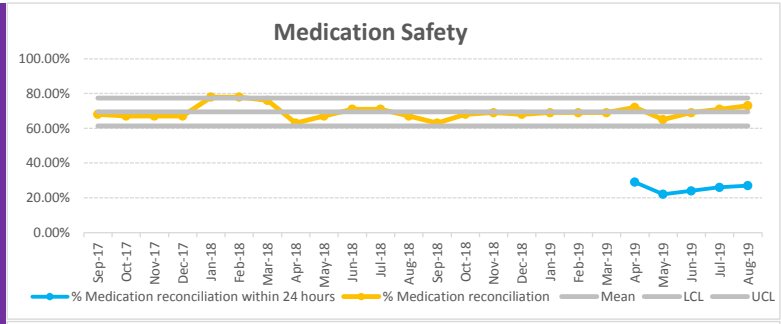
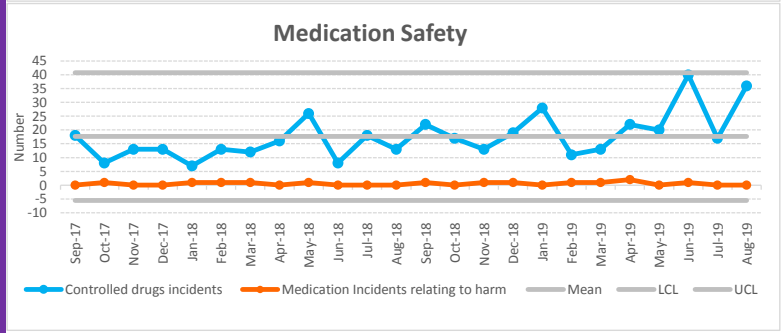
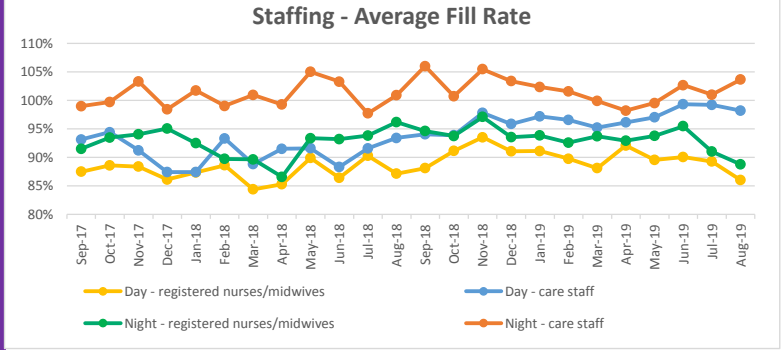
Medication Safety Reconciliation within 24 hours **Red: below 60%** **Amber: 60% - 79%** **Green: 80% or above**	Medication Reconciliation within 24hrs was 27% in August. There were 0 incidents of harm relating to medication safety in month. SPC - Controlled Drugs Incidents and Medication Reconciliation are within common cause (expected) variation.	 	With regards to medicines reconciliation, there has been a slight improvement from June to August. It is anticipated that following implementation of phase 1 pharmacy 7 day service, that this will improve significantly. Discussions are underway regarding roll out of the seven day service pharmacy business plan timeframes and how this will support implementing the action and trajectory outlined on the CQC action plan.	The Patient Safety and Effectiveness Sub Committee has requested a review of medication safety relating to critical medications and learning from incidents. The planned implementation of ePMA and 7 day on ward pharmacy service will support an increase in pharmacy ward staffing levels, leading to improvements in medicines reconciliation figures and prescribing and therefore patient safety.
Staffing - Average Fill Rate **Red: 0-79%** **Amber: 80-89%** **Green: 90-100%**	In month the average staffing fill rates were: Day (Nurses/Mwife) 86.03% Day (Care Staff) 98.21% Night (Nurses/Mwife) 88.78% Night (Care Staff) 103.66%		The Trust is achieving over 90% for Care Staff, both Day and Night. Nurses and Midwives for Day and Night is consistently over 85%. Any individual ward that falls below 90% provides mitigation to ensure it is safe and that high quality care is consistently delivered in those areas.	This position will improve as the 45 WTE nurses, which the Trust has recruited, commence in post. Start dates for these posts are between August and October. The Trust continues to make progress in the Trust wide Recruitment and Retention Strategy which will improve the positon further.

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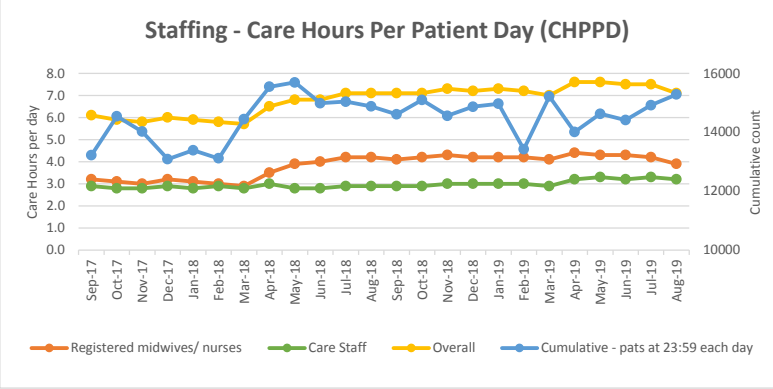
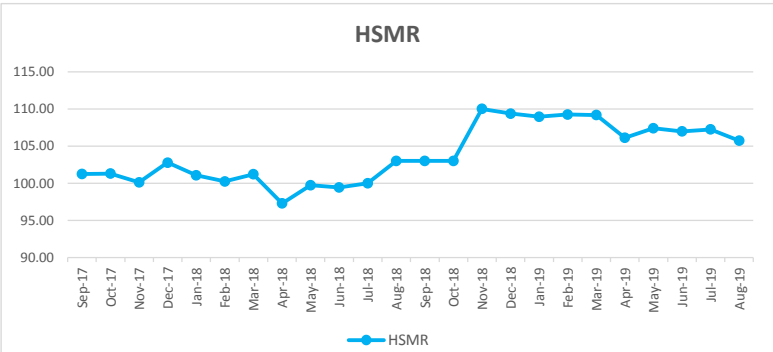
Staffing - Care Hours Per Patient Day (CHPPD) Red: Below 6.0 Amber: 6.0 - 7.8 Green: 7.9 or More	In month, the average CHPPD were: Nurse/Midwife: 3.9 hours Care Staff: 3.2 hours Overall: 7.1 hours		The overall Trust CHPPD has decreased to 7.1 and continues to be monitored monthly by the Senior Nursing Team.	Ward staffing data continues to be systematically reviewed, which includes Planned vs Actual staffing levels. These are reported monthly as part of the Unify submission and any ward that falls below 90% provides mitigation to ensure safe, high quality care is consistently being delivered in those areas. As the 45 nurses recruited commence in post, this will positively impact the position.
Mortality ratio - HSMR Red: Greater than expected Green: As or under expected	The HSMR ratio in month was 105.72.		The most recent HSMR/SHMI are still within the expected range. Work continues at Mortality Review Group to undertake deep dives and continuation of Standard Judgement Reviews.	The Ward Round Accreditation will review the quality of documentation which impacts on these results. Focussed reviews in relation to R codes and COPD are underway as the Trust has previously been flagged as an outlier in these areas. The Trust has had confirmation that we are no longer an outlier in relation to R Codes.

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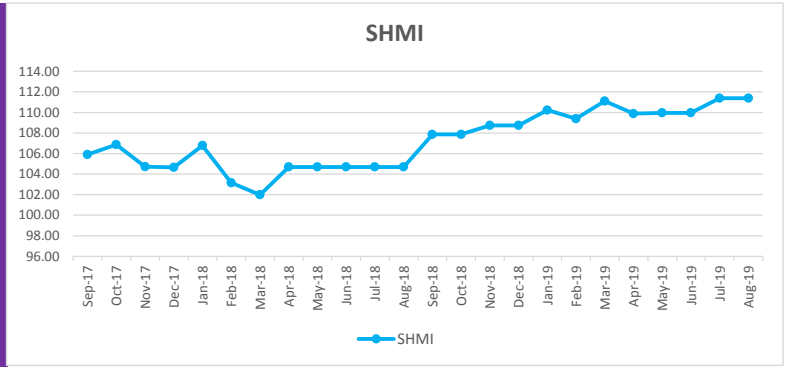
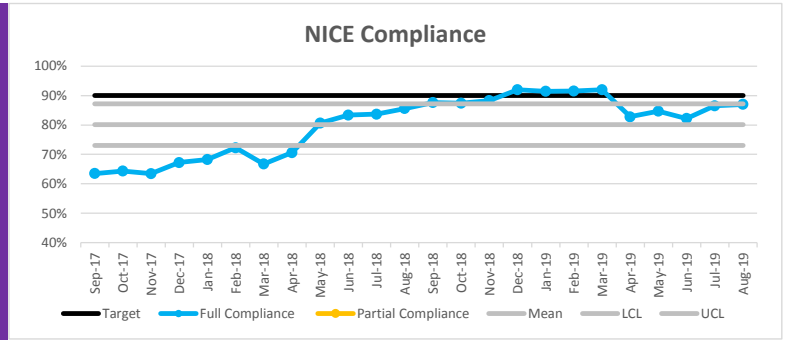
Mortality ratio - SHMI Red: Greater than expected Green: As or under expected	The SHMI ratio in month was 111.38.		The most recent HSMR/SHMI are still within the expected range. Work continues at Mortality Review Group to undertake deep dives and continuation of Standard Judgement Reviews.	The Ward Round Accreditation will review the quality of documentation which impacts on these results. Focussed reviews in relation to R codes and COPD are underway as the Trust has previously been flagged as an outlier in these areas. The Trust has had confirmation that we are no longer an outlier in relation to R Codes.
NICE Compliance Red: Below 75% Amber: 75% to 89% Green: 90% or Above	NICE Compliance was 87.01% in month. SPC - there is evidence of special cause variation.		The overall Trust compliance level is 87.01%, the Trust is implementing the action plan to reach the agreed target of 90%.	The Trust is currently risk assessing all partial compliance NICE Guidance to ensure that any risks are elevated to the risk register with robust action plans in place to ensure compliance. This is reported to Patient Safety and Effectiveness Sub Committee.

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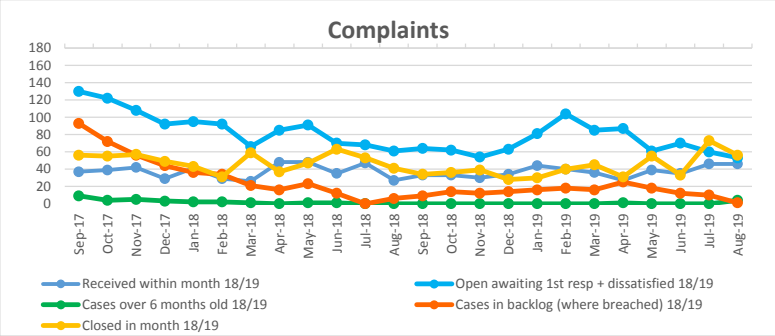
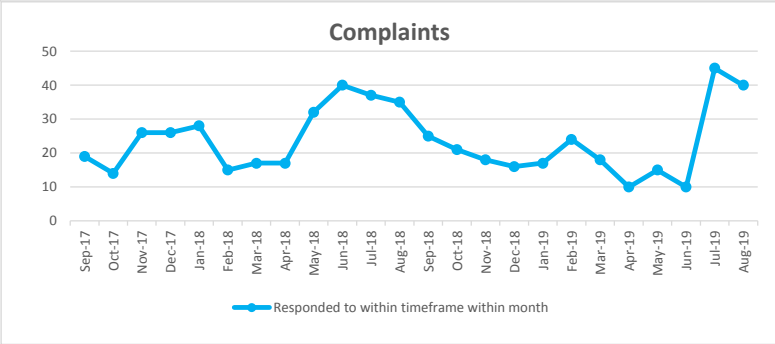
Patient Experience

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

The Trust has continued to implement the Quality Account target of 90% complaints responded to within agreed timescale. The position in August is no complaints in backlog and a significant improvement.





Timeliness of responses to complaints has increased from 62% in July to 71% in August. There is a quality priority for 2019/20 which is aligned to the Quality Strategy to improve timeliness of responses to complaints, this is monitored via the Trust dashboard and is reported to Quality & Assurance Committee.

A Quality Improvement action plan is in place with regard to ensuring the Trust responds to complainants within timeframes to achieve the 90% target. This is being effectively implemented within demonstrated improvement.

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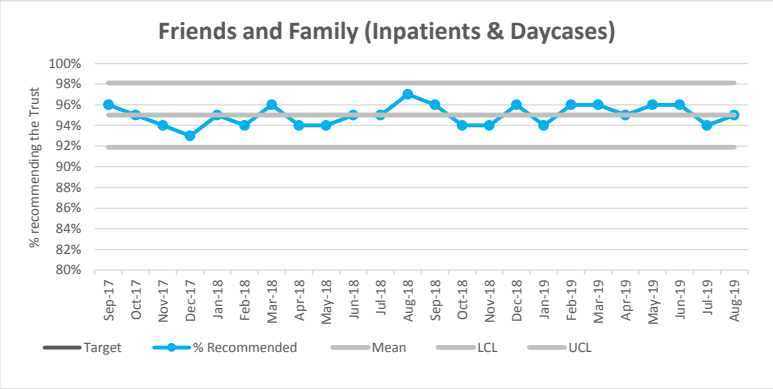
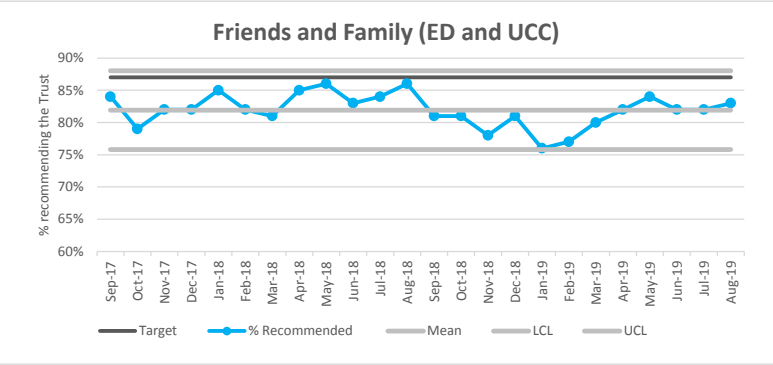
Friends and Family (Inpatients & Day cases) Red: Less than 95% Green: 95% or more	The Trust achieved 95% in month. SPC - FFT Inpatients is within common cause (expected) variation.		The Trust achieved a 95% recommendation rate against a target of 95%.	Response rates for both Day cases and Inpatients have increased 10.5% and 2.9% respectively with an overall response rate of 36.2%. Tracker reports have been provided by Healthcare Communications to provide assurance that all WHH feedback cards received have been entered on to the Envoy system. CBUs have been providing high level briefing papers to the Patient Experience Subcommittee monthly since August 2019 and FFT feedback response and recommendation rates are monitored.
Friends and Family (ED and UCC) Red: Less than 87% Green: 87% or more	The Trust achieved 83% in month. SPC - FFT ED & UCC is within common cause (expected) variation.		The Trust achieved 83% recommendation rate against a target of 87%.	It should be noted that whilst the Friends and Family Test for ED has not met the Trust internal standard, there has been a 1% improvement from July. The Trust's Information team has reviewed the national guidance for “eligible patients” and compared this with the actual numbers of A&E attendances. The ED action plan is being monitored via the ED Improvement Committee.

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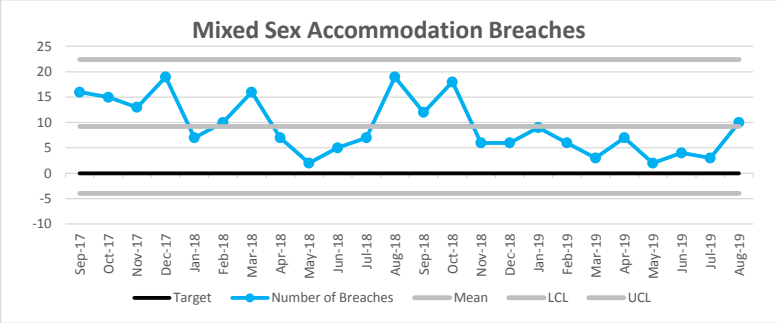
Mixed Sex Accommodation Breaches Red: 1 or more Green: Zero	There were 10 mixed sex accommodation breaches reported in month. SPC - Mixed Sex Accommodation Breaches are within common cause (expected) variation.		There were 10 MSA breaches in August. All breaches are in Critical Care as there are no step down facilities in this area.	Patients are cohorted to minimise breaches and step down is expedited as soon as is practicable. Additional side rooms are to be created as part of the capital programme going forward.

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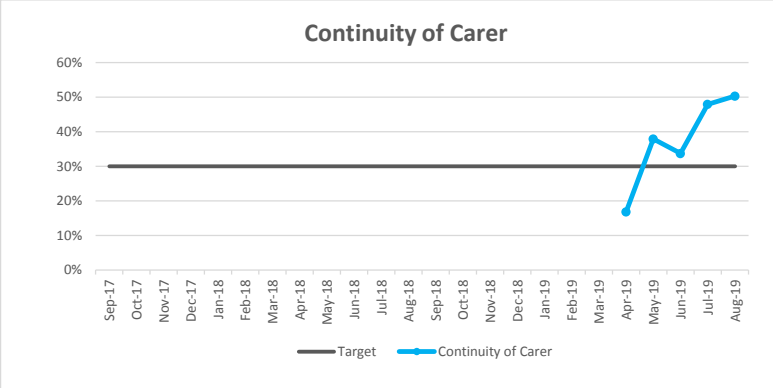
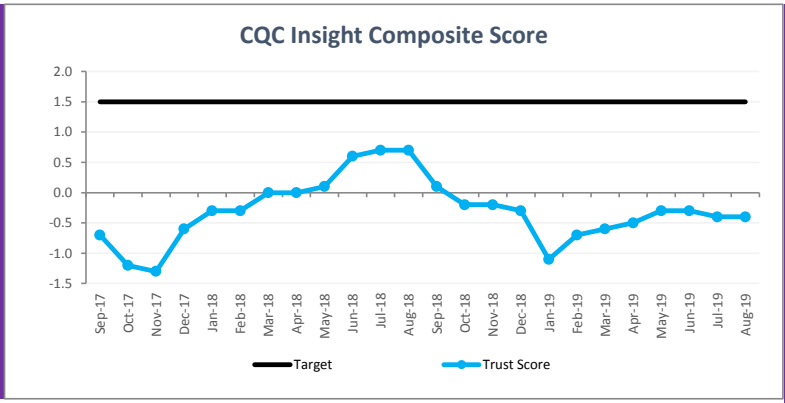
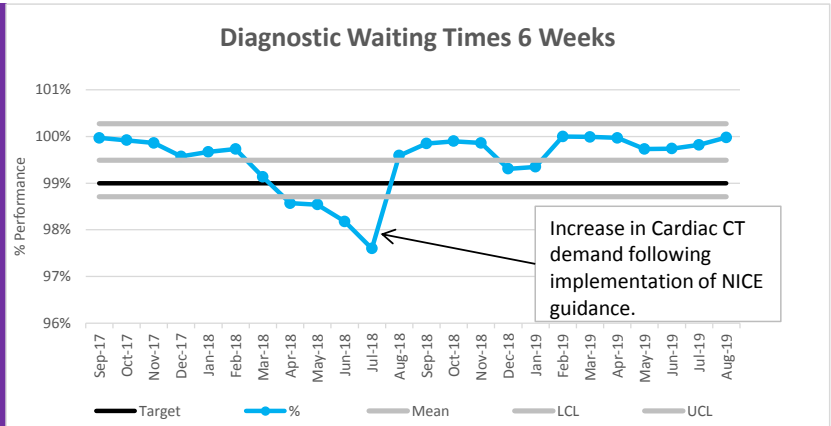
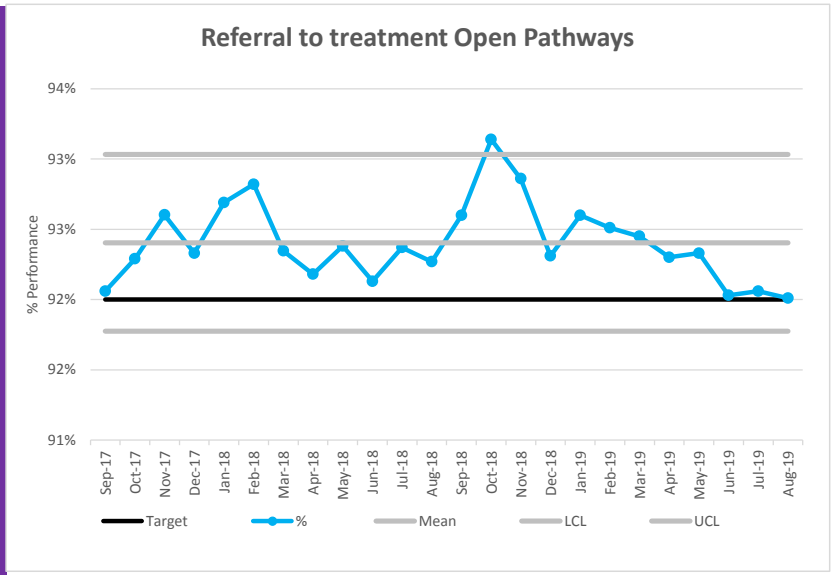
Quality Improvement - Trust Position

	Trust Performance	Trend	What are the reasons for the variation?	How are we going to improve the position (Short & Long Term)?
Continuity of Carer Green: 30% or Above Amber: 20% - 29% Red: below 20%	The target percentage for women being booked onto a continuity of carer pathway in 2019 is at least 20%. The target by March 2020 is over 35%, and from March 2021, the target is over 51%.		The Trust achieved 50.3% in August 2019 against a target of 30%.	Community midwives are working on the midwife led unit to increase intrapartum continuity. Therefore all women who are midwife led (low risk) and are living within the area of Warrington are automatically placed on a continuity of carer pathway. The elective section team provides some care for women during late pregnancy. This has increased the number of higher risk women receiving continuity of carer.
CQC CQC Insight Composite Score Red (inadequate): <-3 Amber (req improvement): >-2.9 - 1.5 Green (good/outstanding): >1.5	The Trust CQC Insight Composite Score is -0.3		Areas where the Trust has improved are in; Patient-led assessment of environment for dementia care, Proportion of reported patient safety incidents that are harmful, Deaths in low-risk diagnosis groups, Safety Culture, Staff Engagement, Digital scores and Inpatient response rate.	The Trust had a CQC Emergency Department inspection in February and has established an improvement committee to oversee the action plan. The Moving to Outstanding Steering Group has also been established to track and oversee the Trust response to the CQC inspection report and the Moving to Outstanding Framework within the organisation.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Key:
Single Oversight Framework SOF
Care Quality Commission CQC

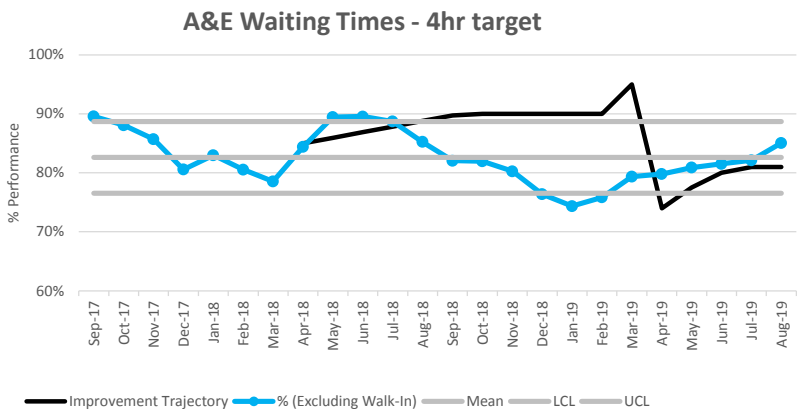
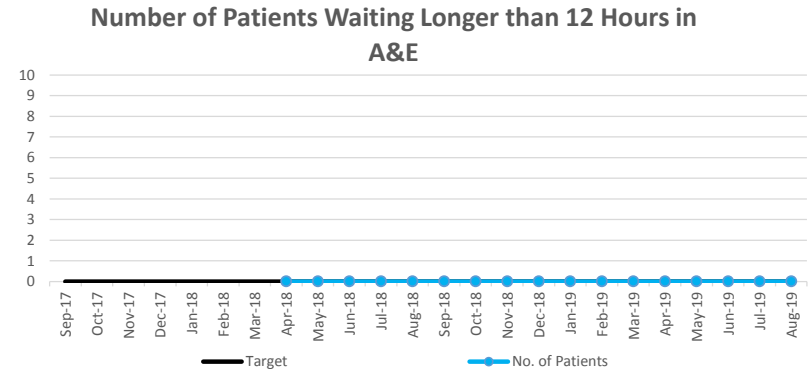
Access & Performance - Trust Position

	Trust Performance	Trend	What are the reasons for the variation?	How are we going to improve the position (Short & Long Term)?
Diagnostic Waiting Times 6 Weeks Red: Less than 99% Green: 99% or above	SOF CQC The Trust achieved 99.98% in month. SPC - There has previously been evidence of special cause variation for Diagnostic Waiting Times however this has stabilised.		The diagnostic target was achieved in August 2019 and has been consistently achieved over the last 12 months, although pressures have increased whilst maintaining capacity within all modalities. This continues to be monitored on a daily basis with appropriate actions being taken to sustain this standard.	A business case has been approved to outsource some diagnostic reporting. This has had a positive impact on the position.
Referral to treatment Open Pathways Red: Less than 92% Green: 92% or above RTT - Number of patients waiting 52+ weeks Green = 0, otherwise Red	SOF CQC The Trust achieved 92.01% in month. SPC - RTT pathways are within common cause (expected) variation. The Trust has consistently achieved this standard.		The Trust continues to achieve the 18 week referral to treatment target, achieving 92.01% in August 2019 against a target of 92%. Trajectories have been developed for 2019/20 to maintain focus within all sub-specialties. The MSK CBU have developed a recovery plan for T&O and aims to achieve compliance by March 2020. This is being monitored weekly by the Performance Review Group.	There are significant challenges sustaining the RTT standard due to underperformance of elective work in high volume specialities driven by pension and HMRC income tax changes. This has impacted the waiting list which has grown by 5.5%. The Associate Director for Elective Care Performance is leading on RTT and has instigated a number of actions; approval to outsource / insource 150 cataract operations, development of alternative models of delivery within T&O and a targeted increase in activity amongst a number of other Trust specialties to support compliance of this constitutional standard.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Key:
Single Oversight Framework
Care Quality Commission

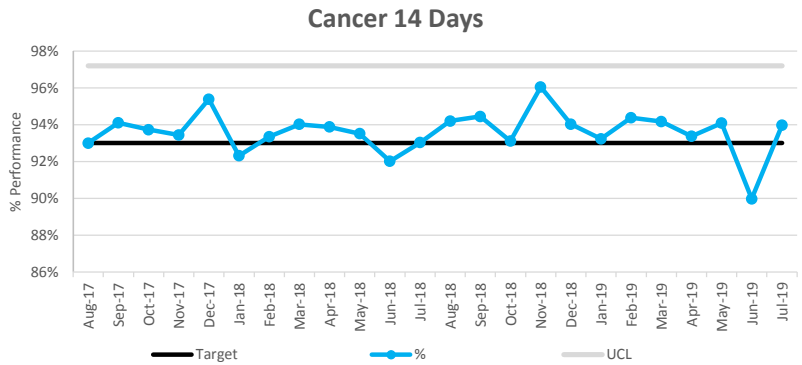
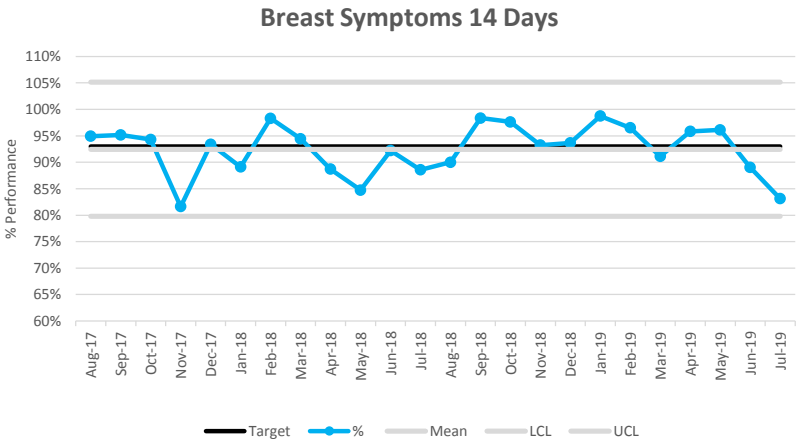
Access & Performance - Trust Position

	Trust Performance	Trend	What are the reasons for the variation?	How are we going to improve the position (Short & Long Term)?
Four Hour Standard - National Target Red: Less than 95% Green: 95% or Four Hour Standard Waiting Times - STP Trajectory Red: Less than trajectory	The Trust achieved 85.03% excluding walk ins in month. SPC - There is special cause variation present in the Four Hour A&E standard.		Performance against the ED emergency access standard has positively continued to improve from April 2019. Performance in Month 5, excluding Widnes Walk-In activity has met the agreed trajectory of 81.0%, achieving 85.03% in August 2019.	A CQC action plan around Urgent Care has been developed. The additional investment in assessment capacity (ED Ambulatory & GPAU) has continued to have increased throughput.
The number of patients who has experienced a wait in A&E longer than 12 hours from the decision to admit. Green = 0 Red = > 0	There were 0 patients waiting longer than 12 hours in A&E in month.		The Trust has achieved the standard in not having any patients wait longer than 12 hours from the decision to admit in August 2019. This has been consistently achieved over time.	Maintain compliance against the 12 hour standard from decision to admit.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Key:
Single Oversight Framework
Care Quality Commission

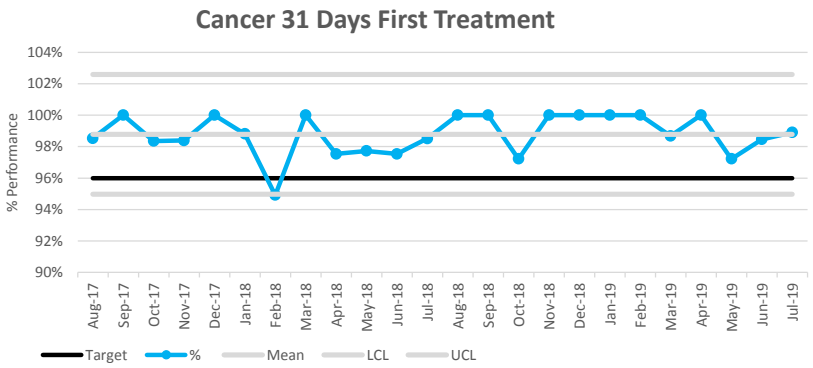
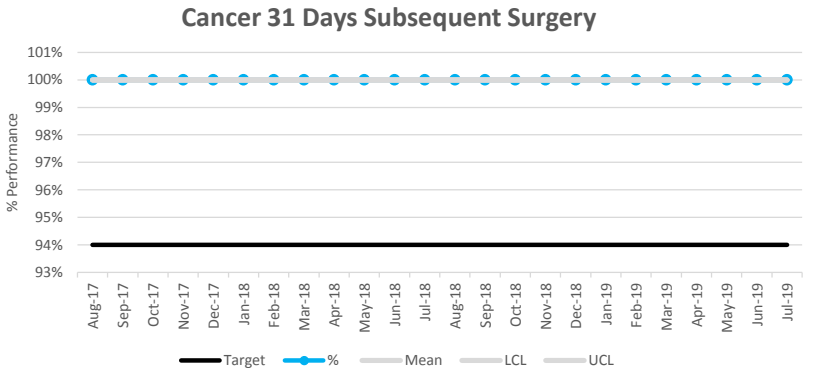
Access & Performance - Trust Position

	Trust Performance	Trend	What are the reasons for the variation?	How are we going to improve the position (Short & Long Term)?
Cancer 14 Days Red: Less than 93% Green: 93% or above	The Trust achieved 93.97% in July 2019. SPC - Cancer 14 days is within common cause (expected) variation.		The Trust achieved the Cancer 14 Day target in July 2019 recovering the position from June.	Maintain compliance against the 2 week wait standard.
Breast Symptoms 14 Days Red: Less than 93% Green: 93% or above	The Trust achieved 83.12% in July 2019. SPC - Breast Symptoms is within common cause (expected) variation.		The 2 week wait for Breast Symptomatic was not achieved in July 2019. The two week wait standard was recovered in July however the breast symptomatic was not. This was due to the high level of patient choice in the system due to holidays.	A recovery plan was implemented in August to offer patients an appointment in 7 days to reduce the number of breaches. Draft August data shows this has been successful and the position has recovered.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Key:
Single Oversight Framework
Care Quality Commission

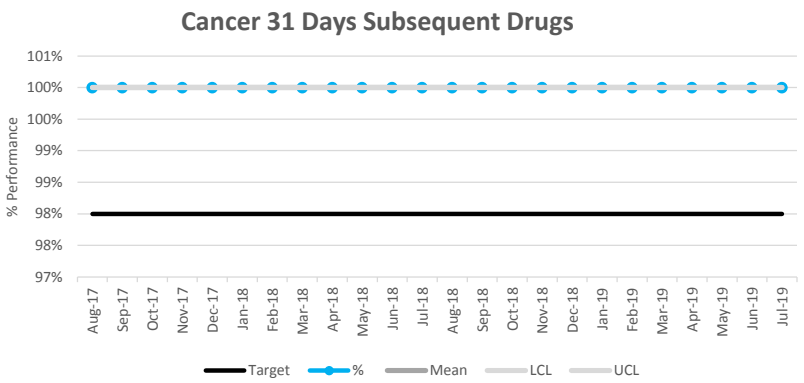
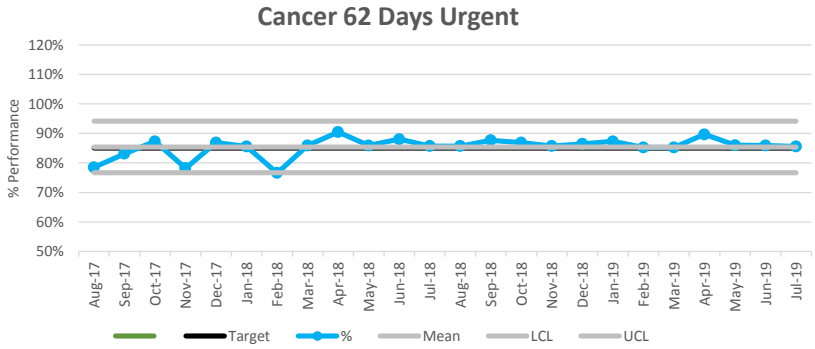
Access & Performance - Trust Position

	Trust Performance	Trend	What are the reasons for the variation?	How are we going to improve the position (Short & Long Term)?
Cancer 31 Days First Treatment Red: Less than 96% Green: 96% or above	SOF CQC The Trust achieved 98.90% in July 2019. SPC - Cancer 31 days is within common cause (expected) variation.		The Trust achieved 98.90% in July 2019.	Maintain compliance against the 31 day first treatment standard.
Cancer 31 Days Subsequent Surgery Red: Less than 94% Green: 94% or above	SOF CQC The Trust achieved 100% in July 2019. SPC - Cancer 31 days surgery is within common cause (expected) variation. The Trust has consistently achieved this standard.		The Trust achieved 100% in July 2019.	Maintain compliance against the 31 day subsequent treatment (surgery) standard.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Key:
Single Oversight Framework
Care Quality Commission

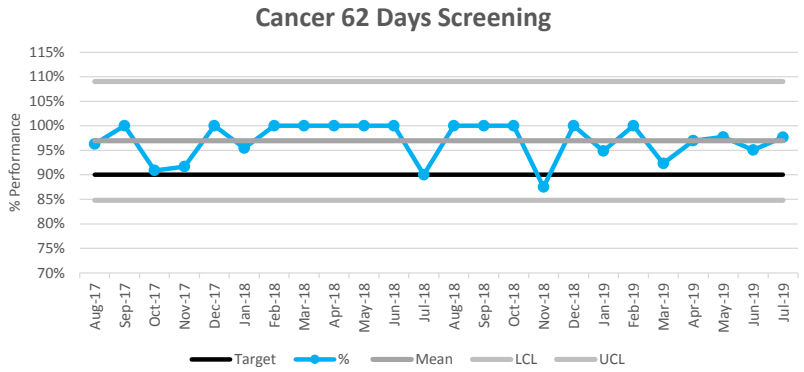
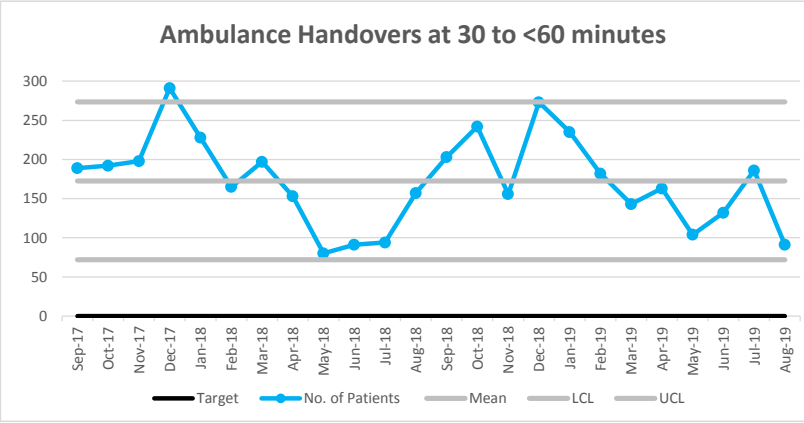
Access & Performance - Trust Position

	Trust Performance	Trend	What are the reasons for the variation?	How are we going to improve the position (Short & Long Term)?
Cancer 31 Days Subsequent Drug Red: Less than 98% Green: 98% or above	The Trust achieved 100% in July. SPC - Cancer 31 days drugs is within common cause (expected) variation. The Trust has consistently achieved this standard.		The Trust achieved 100% in July 2019.	Maintain compliance against the 31 day subsequent treatment (drug) standard.
Cancer 62 Days Urgent Red: Less than 85% Green: 85% or above	The Trust achieved 85.54% in July 2019. SPC - Cancer 62 days urgent is within common cause (expected) variation.		The Trust achieved 85.54% in July 2019.	Maintain active monitoring of all pathways to maintain compliance against the 62 day standard. Positively, this standard has consistently achieved which has only been possible through full engagement with the CBU Teams and supportive leadership via the Cancer Team.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Key:
Single Oversight Framework
Care Quality Commission

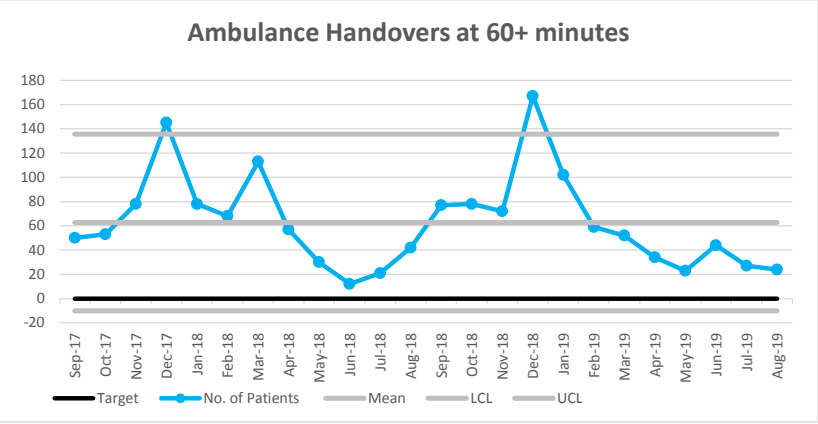
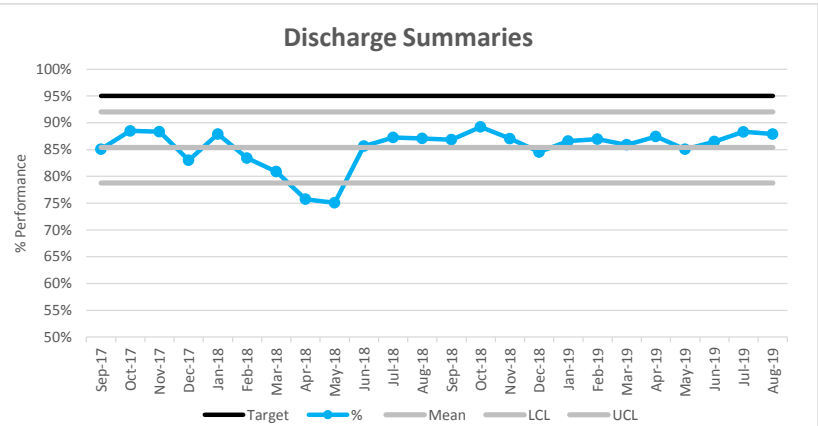
Access & Performance - Trust Position

	Trust Performance	Trend	What are the reasons for the variation?	How are we going to improve the position (Short & Long Term)?
Cancer 62 Days Screening Red: Less than 90% Green: 90% or above	The Trust achieved 97.67% in July 2019. SPC - Cancer 62 days Screening are within common cause (expected) variation.		The Trust achieved 97.67% in July 2019.	Maintain compliance against the 62 day screening standard.
Ambulance Handovers 30 to <60 minutes Red: More than 0	There were 91 patients waiting between 30 and 60 minutes for handover in month. SPC - There has previously been special cause variation present for Ambulance Handover Times however this has stabilised.		Ambulances handovers remained challenging in August 2019 with an improved performance across both 30-60 and 60+ minute delays. The operational team continues to focus on maintaining and further improving by ensuring flow in the hospital is optimised thus allowing ambulances to off load in a timely manner.	A monthly meeting with NWAS is scheduled to monitor the high proportion of arrivals not resulting in admission.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Key:
Single Oversight Framework
Care Quality Commission

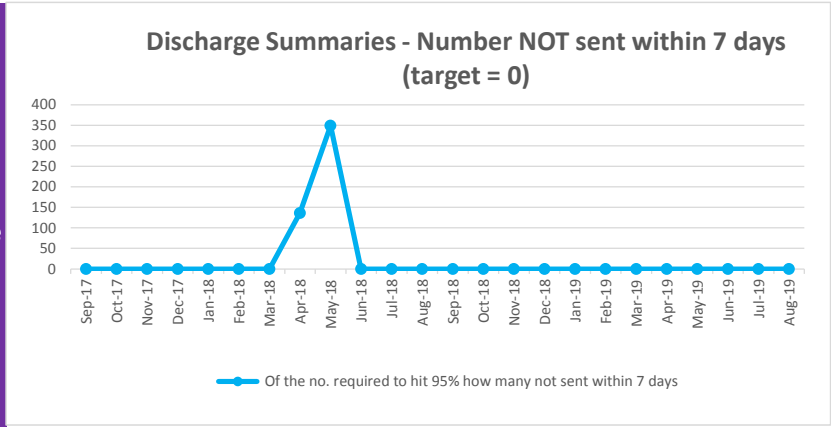
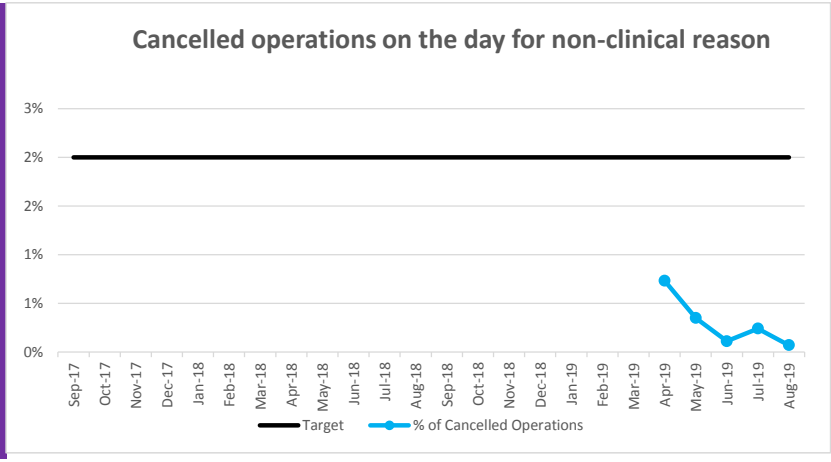
Access & Performance - Trust Position

	Trust Performance	Trend	What are the reasons for the variation?	How are we going to improve the position (Short & Long Term)?
Ambulance Handovers at 60 minutes or more Red: More than 0 Green: 0	There were 24 patients waiting over 60 minutes for handover in month. SPC - There has previously been special cause variation present for Ambulance Handover Times however this has stabilised.		Ambulances handovers remained challenging in August 2019 with an improved performance across both 30-60 and 60+ minute delays. The operational team continues to focus on maintaining and further improving by ensuring flow in the hospital is optimised thus allowing ambulances to off load in a timely manner.	A monthly meeting with NWAS is scheduled to monitor the high proportion of arrivals not resulting in admission.
Discharge Summaries - % sent within 24hrs Red: Less than 95% Green: 95% or above	The Trust achieved 87.88% in month. SPC - There has previously been special cause variation in Discharge Summaries however this has stabilised.		The Trust continues to monitor compliance across all CBUs. This is monitored via the weekly PRG & monthly KPI meetings. An SoP has been in place however, this is being reviewed in conjunction with the medical teams to ensure effective processes are embedded.	This standard remains challenging for the Trust with performance remaining static in recent months. Although an SoP has been in place, a review has been requested via the monthly KPI forum in conjunction with the medical team to improve current processes and drive improvement.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Key:
Single Oversight Framework
Care Quality Commission

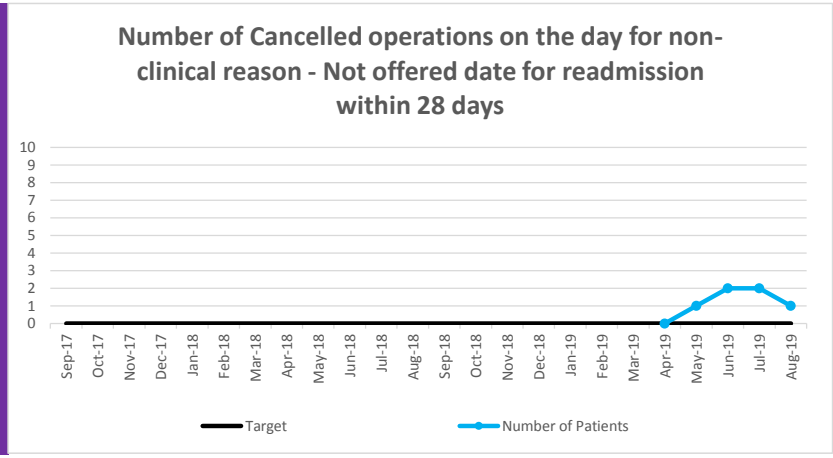
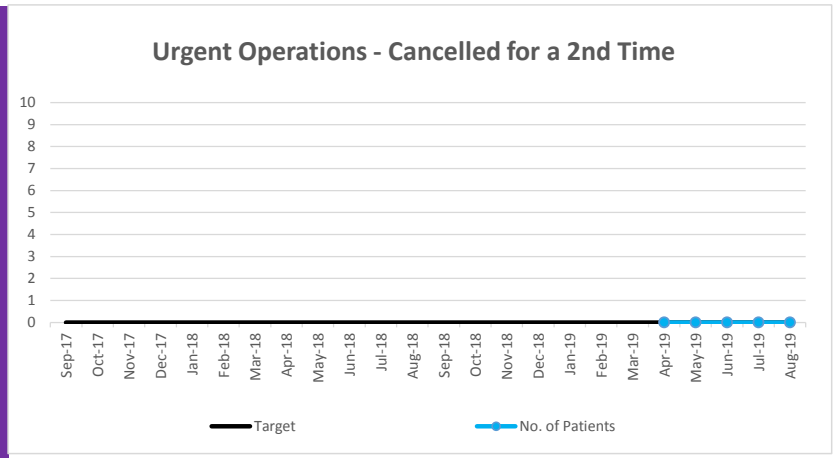
Access & Performance - Trust Position

	Trust Performance	Trend	What are the reasons for the variation?	How are we going to improve the position (Short & Long Term)?
Discharge Summaries - Number NOT sent within 7 days Red: Above 0 Green: 0	There were 0 discharge summaries not sent within 7 days which was above the 95% threshold.		The Trust achieved compliance against the 7 day discharge summary standard in August 2019.	The Trust KPI group will continue to monitor at CBU level to maintain performance against this standard.
Cancelled Operations on the day for a non-clinical reason Red: > 2% Green: < 2%	0.07% operations were cancelled on the day for non clinical reasons in month.		The Trust cancelled 0.07% of operations on the day for non-clinical reasons. Benchmarking would suggest that although the Trust continues to maintain a zero tolerance to cancellations, a rate of less than 2% compares favourably.	A dedicated sub-group of the Theatre Productivity Group to focus on reducing cancellations on the day remains in place focusing on the escalation process, reporting and validation. A deep dive into non-clinical cancellations to inform actions has been undertaken which is supporting improvement.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Key:
Single Oversight Framework SOF
Care Quality Commission CQC

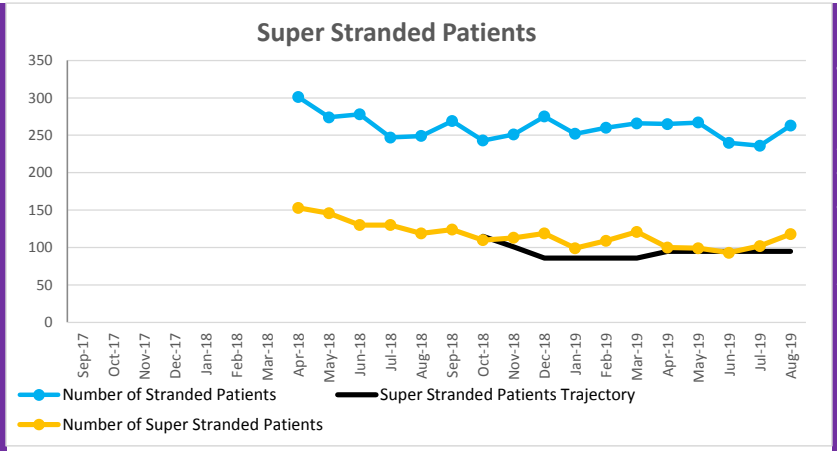
Access & Performance - Trust Position

	Trust Performance	Trend	What are the reasons for the variation?	How are we going to improve the position (Short & Long Term)?
Cancelled Operations on the day for a non-clinical reason - Not offered a date for readmission within 28 days of the cancellation Red: Above zero	There were 1 cancelled operation on the day for non clinical reasons in month, where the patient was not booked in within 28 days.		Unfortunately, there was one case whereby a cancelled operation for non-clinical reasons was not offered a re-admission date within 28 days. This was related to a consultant having planned leave and inability to reschedule prior to this.	Improve compliance against the 28 day rule standards. RCA's undertaken whereby breaches of this standard occur. Monitored via weekly PRG and monthly KPI meetings.
Urgent Operations - Cancelled for a 2nd Time Green = 0 Red = > 0	There were 0 urgent operations cancelled for a second time in month. The Trust has consistently achieved this standard.		This is an additional standard to enhance monitoring of cancelled operations.	Maintain the standard that operations are not cancelled for a second time.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Key:
Single Oversight Framework
Care Quality Commission

Access & Performance - Trust Position

	Trust Performance	Trend	What are the reasons for the variation?	How are we going to improve the position (Short & Long Term)?
Super Stranded Patients Green: Meeting Trajectory Red: Missing Trajectory	There were 263 stranded and 118 super stranded patients at the end of the reporting period.		The number of super stranded patients has risen slightly in August. This is largely attributed to it being peak annual leave time for both health and social care teams across the system. Additional focus has commenced in relation to this standard at the end of August to support recovery in September.	Corporate Patient Flow meetings have been embedded and now take place three times per week with leadership from the Associate Director Integrated Care and Clinical Director Integrated Medicine & Community. In addition, wards now receive a daily report detailing the top 3 delays to ensure appropriate escalation and support to a safe discharge.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Workforce - Trust Position

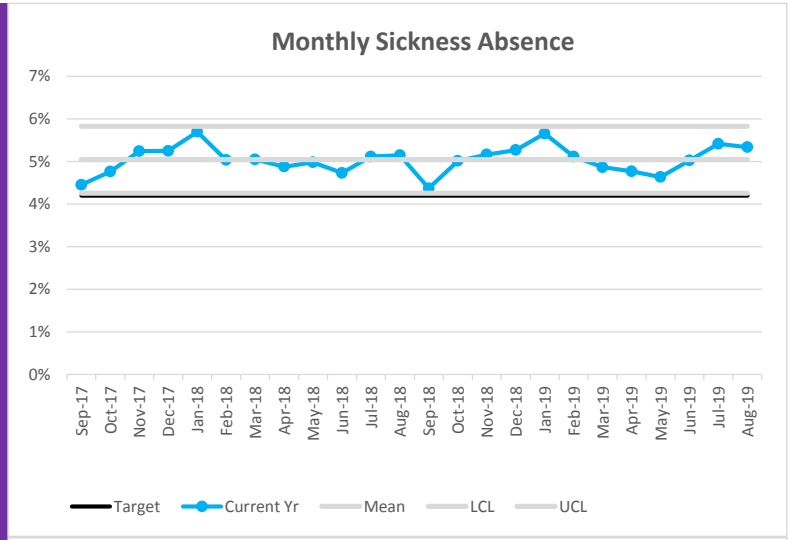
Key:
Single Oversight Framework
Care Quality Commission
Use of Resources Assessment
Trust Strategy

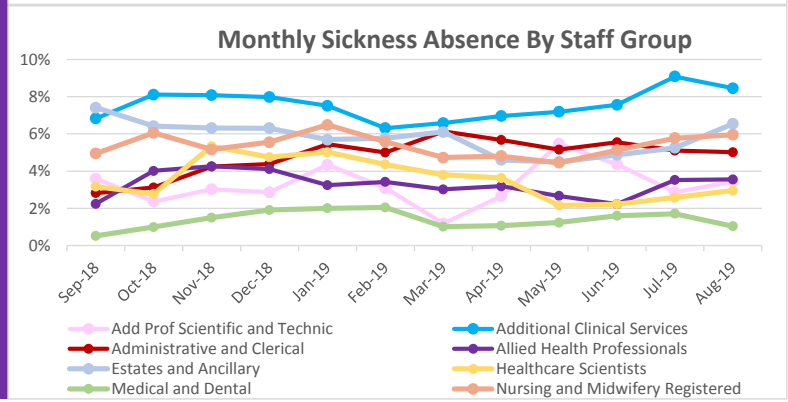
Trust Performance	Trend	What are the reasons for the variation?	How are we going to improve the position (Short & Long Term)?

Sickness Absence

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

The Trust's sickness absence was 5.34% in month.
SPC - Sickness Absence is within common cause (expected) variation.





Additional Clinical Services:
Sickness absence in this staff group is significantly higher than the Trust level of absence and higher than all other staff groups.

Mental Health Related Sickness Absence:
25% of all sickness absence across the Trust relates to Anxiety/stress/depression/other psychiatric illnesses.

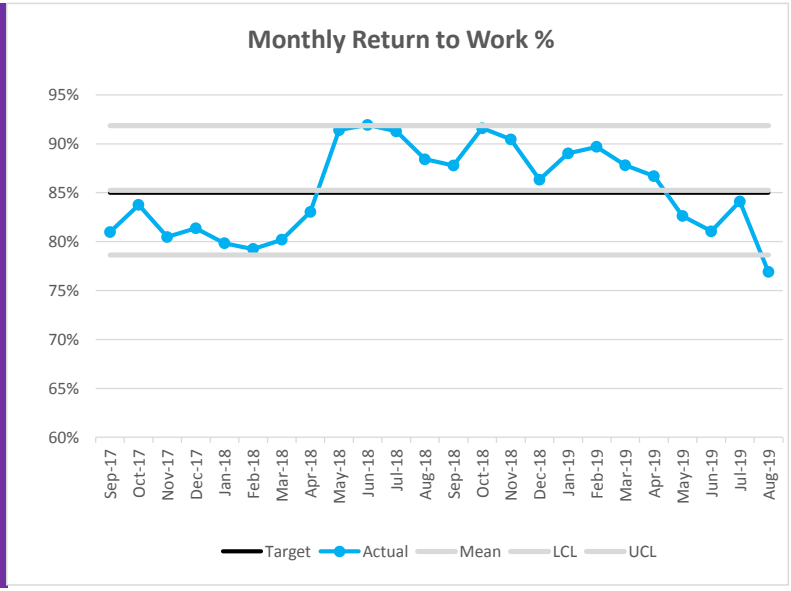
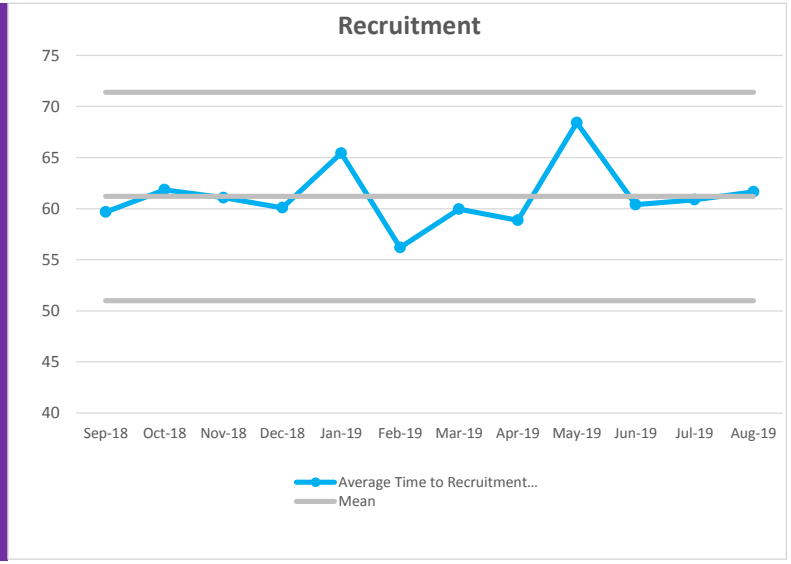
Short Term – Additional Clinical Services
Sickness absence for this staff group was highlighted in Operational People Committee (OPC) in August 2019. The OPC Chair has requested a 4 week deep dive task and finish group to review this and propose immediate actions. The group will meet with the Chair to seek sign off in September 2019 and will provide a formal update on the impact of agreed actions to OPC in October 2019.

Long Term – Sickness Absence Reduction Programme
The HR and OD Team have liaised with NHSI, who have recommended the use of their Health and Wellbeing Framework diagnostic tool.
The HR and OD Team will lead the completion of the diagnostic tool, through engagement with staff, managers and leadership teams.
The tool will recommend the high impact areas for the Trust to focus on – this will be triangulated with our workforce data.
Outcomes and proposed actions (with clear responsibilities and measurable outcomes) will be presented to OPC in October 2019.
The framework and tool include a focus on mental health related absence.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

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

Workforce - Trust Position

	Trust Performance	Trend	What are the reasons for the variation?	How are we going to improve the position (Short & Long Term)?
Return to Work Red: Below 75% Amber: 75% to 85% Green: Above 85%	The Trust's return to work compliance was 76.90% in month. SPC - There is evidence of special cause variation for Return to Work compliance.		Non-compliance with this target is mainly driven by failure to record completion of the interviews in a timely manner. Previous audits have shown that the majority of interviews are taking place between managers and staff members, utilising the paper work as required within the Attendance Management Policy. The manager is then required to log the completion of the interview on ESR/E-Rostering and delays in taking this action result in low compliance. There is also some element of staff members returning from sickness absence to annual leave, meaning that completion of the interviews is delayed.	A review of essential manager training has been completed and is now running - this includes information about the importance of timeliness of policy application. The revised training also includes a session on 'Difficult Conversations' to help managers feel confident in completing RTWIs and to get the best out of the interviews. There is 1:1 Coaching by the HR team with line managers on an ongoing basis.
Recruitment Red: 76 days or above Amber: 66 to 76 days Green: 65 days or below	The average number of working days to recruit is 62, based on the last 12 months average. SPC - Recruitment time is within common cause (expected) variation.		Average time to hire has reduced over the 12 month rolling period; however there has been a slight increase in the last 2 months.	The Head of Workforce Systems and Intelligence will review the data for the last 2 months to understand and address the drivers for the slight increase. Long Term Improving recruitment processes and reducing time to hire – a task and finish group has been set up to review current processes, identify and suggest improvements. Recruitment and Retention champion role: The launch of this role will act as a Role Model for all managers, as a resource anyone can access to acquire some support with Recruitment and Retention. In the longer term, work with IM&T colleagues to improve the on-boarding system for our new candidates.

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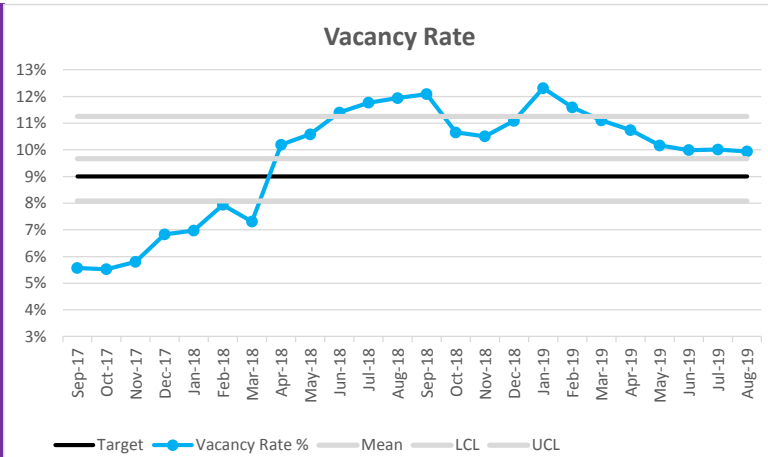
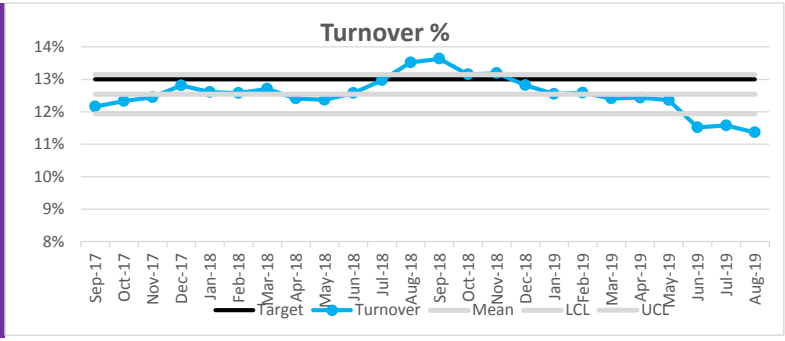
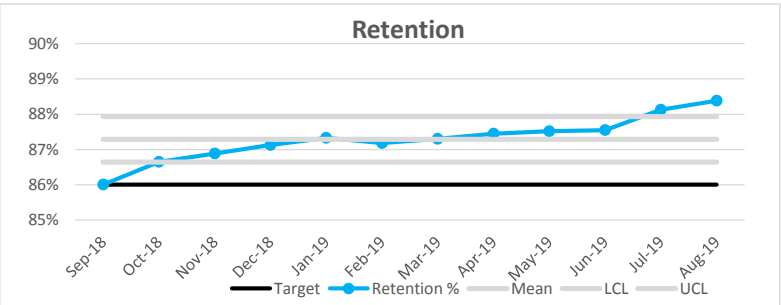
Vacancy Rates Red: 11% or Above Amber: 11% to 9% Green: 9% or Below	UoR Trust vacancy rate was 9.94% in month. SPC - there is evidence of special cause variation for Vacancy Rates.		The continued reduction in vacancy rate is linked to improved retention and improved turnover, as well as overall reductions in average time to hire.	The Trust's Recruitment and Retention Group continues to focus on opportunities to increase attraction and recruitment through the development of Candidate Coffee Clubs, and enhancing the Work at WHH webpage. In addition, the Workforce Redesign Group has an overview of the Workforce Planning process which supports CBUs to identify opportunities to utilise their workforce differently in order to address labour market challenges.
Turnover Red: Above 15% Amber: 13% to 15% Green: Below 13%	CQC UoR SOF Trust turnover was 11.37% in month. SPC - There is evidence of special cause variation for Turnover.		Turnover has remained below target (positive) and continues to reduce. This is linked to improved employee engagement (as evidenced by the 2018 Staff Survey results and BtC pulse check survey results) and to the work commenced as part of the NHSI Retention Programme.	The programme of work to implement the NHSI nursing retention programme and roll out to other staff groups includes: Improve our workforce's ability to achieve a better work life balance through promoting what we offer and reviewing our processes/policies. Support our staff to explore and pursue career progression within the Trust. The Careers cafés have been set up throughout the year promoting development and career opportunities. The promotion of the Recognising and Valuing Experience (RAVE) role/initiative. Develop and empower our Line Manager's to retain their staff through developing our managers. Retaining our experienced staff is vital to support this, we are currently reviewing the Trust's retire and return policy.
Retention Red: Below 80% Amber: 80% to 85% Green: Above 86%	UoR Trust Retention was 88.38% in month. SPC - There is evidence of special cause variation for Retention.		Retention has remained below target (positive) and continues to reduce. This is linked to improved employee engagement (as evidenced by the 2018 Staff Survey results and BtC pulse check survey results) and to the work commenced as part of the NHSI Retention Programme.	

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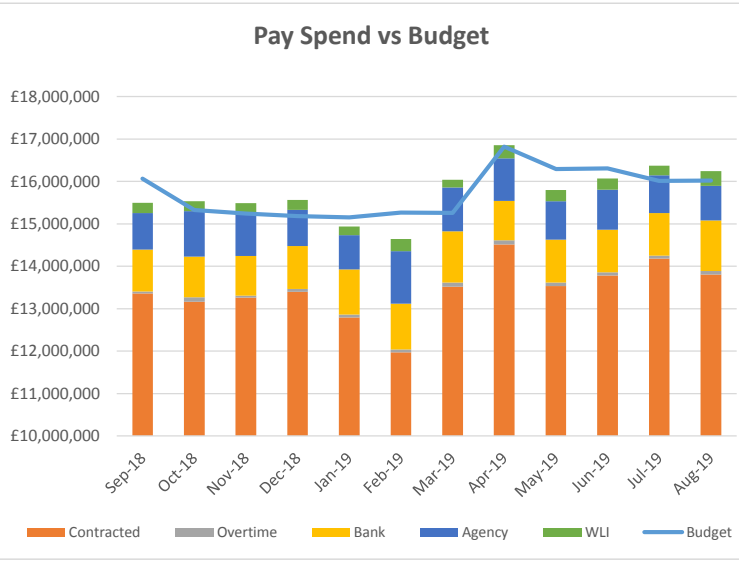
Pay Red: Greater than Budget Green: Less than Budget		Total pay spend in August 2019 was £16.2M against a budget of £16M. Contracted pay spend was £13.8M and the remaining £2.4M was spent on temporary staffing including agency, bank, overtime and WLIs.	Short Term As part of the system recovery plan, the use of temporary staffing is being reviewed by the Trust Executive Team to reduce the rates being charged and will seek to reduce .usage where appropriate. Long Term 6 month progress meetings for each CBU are being set up to review the people element of the Business Plans on a Page to understand if any additional support is required and/or see if any changes need to be made. Supporting the Trusts intention to control pay costs through increased substantive recruitment, increased retention, reduction in non-substantive pay costs and workforce transformation.

Trust pay was above budget in month.

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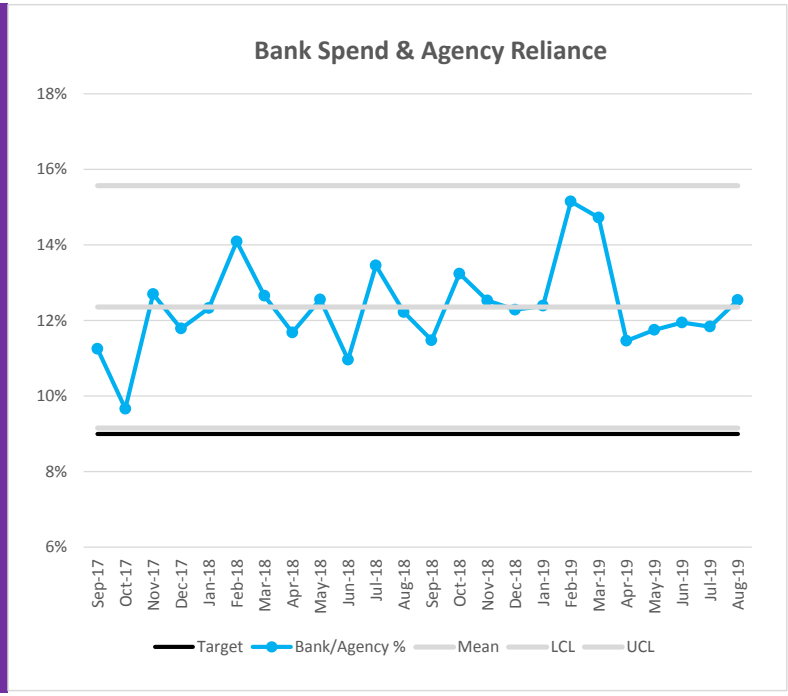
Bank and Agency Reliance Red: 11% or Above Amber: 11% to 9% Green: 9% or	UoR **Bank and Agency Reliance reduced to 12.54% in month.** **SPC - Bank/Agency reliance is within common cause (expected) variation.**		**The most common reason for temporary staffing usage across all staff groups is vacancy.**	**As part of the system recovery plan, the use of temporary staffing is being reviewed by the Trust Executive Team to reduce the rates being charged and will seek to reduce the usage where appropriate.** **The Premium Pay Spend Review group continues to meet on a monthly basis to monitor progress against work streams relating to controls on premium pay, including:** **Refining Centralised Agency Booking Processes** **Developing WHH Banks** **Cheshire and Mersey Temporary Staffing Board** **Additional Scrutiny - Medical & Dental, AHP and Additional Scrutiny – Nursing Agency Usage** **Overtime** **On Call Harmonisation**

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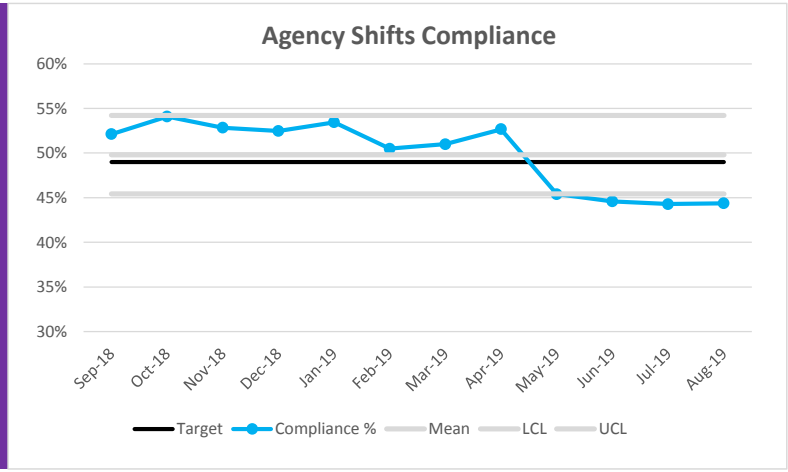
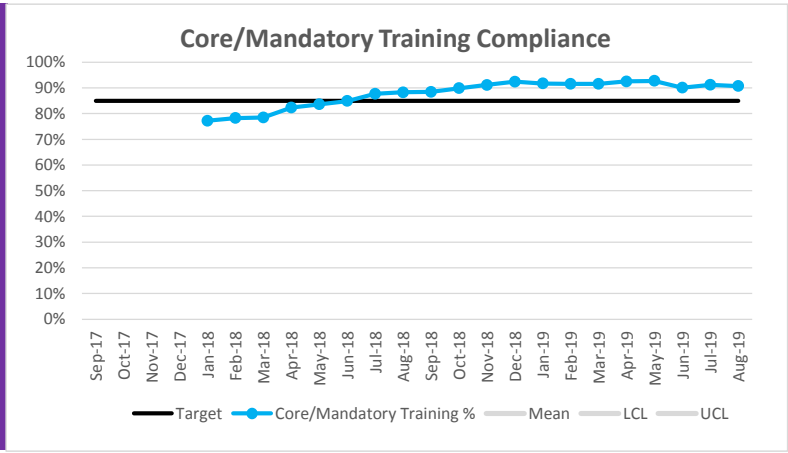
	Trust Performance	Trend	What are the reasons for the variation?	How are we going to improve the position (Short & Long Term)?
Agency Shifts Compliant with the Cap Red: below 49% Green: above 49%	44.38% of shifts were compliant with the NHSI Price Cap. SPC - Agency shift compliance is within common cause (expected) variation.		The majority of shifts that are not compliant with the NHSI Price Cap relate to Medical and Dental agency bookings.	The Trust is part of the Cheshire and Mersey Collaborative group, which has been working to create a new rate card (Medical and Dental Staff) for implementation across the region. Whilst these will initially be higher than the cap rates, they will be a step change towards the cap rates. The Rate Card will be presented to CEO Provider Forum for approval on 27 September 2019.
Core/Mandatory Training Red: Below 70% Amber: 70% to 85% Green: Above 85%	Core/Mandatory training compliance was 90.72% in month.		Mandatory Training compliance has remained above target (positive) since June 2018. The Trust's approach to Mandatory Training has been reviewed and expectations clarified. Compliance with Mandatory Training has now become 'business as usual' for staff and managers.	Compliance with Mandatory Training is closely monitored at CBU/Department and topic level via Educational Governance Committee and by Subject Matter Experts.

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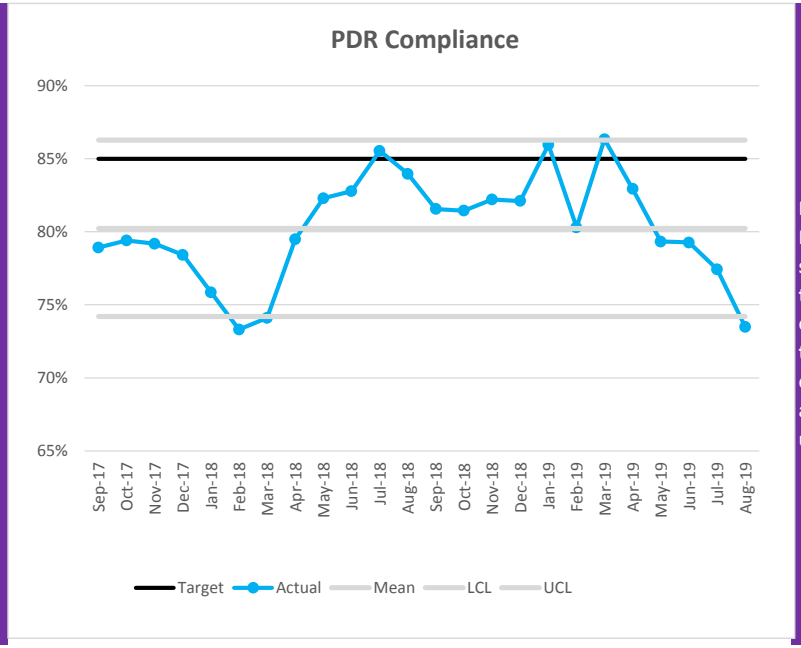
PDR Red: Below 70% Amber: 70% to 85% Green: Above 85%		PDR compliance was above target in March 2019 (positive) recognising the significant focused effort applied in the context of year end. The continued decline in compliance since that date reflects the fact that PDR compliance is not yet embedded across the organisation as business as usual.	Short Term The Operational People Committee has extended membership to CBU Teams and Corporate Leads, with a particular focus on localised short terms plans to address non-compliant workforce KPIs. PDR compliance will be a priority. Long Term A piece of work is being undertaken in line with the People Strategy to ensure our workforce receive a meaningful appraisal, reflecting the requirement for improvement highlighted in our staff survey. The focus is on little paperwork, big conversation. A task and finish group lead by the OD Team will utilise a new appraisal tool which will be piloted in clinical and non-clinical areas between September 2019 – October 2019 using a PDSA cycle test of change. In addition, a training video is being developed to support appriasers which will be available on the extranet.

PDR compliance was 73.49% in month.
SPC - there is evidence of special cause variation for PDR compliance.

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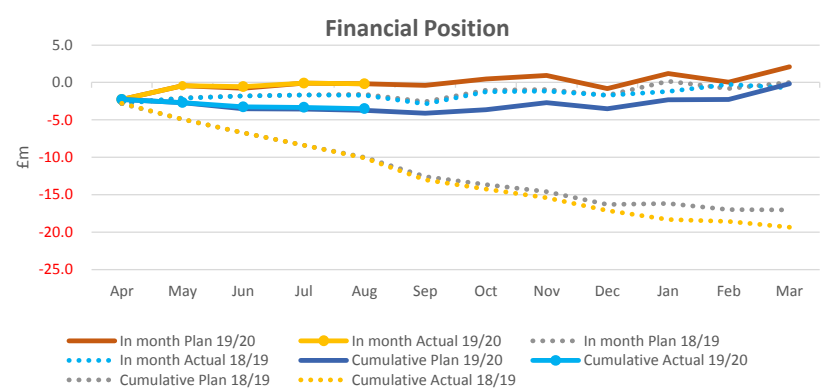
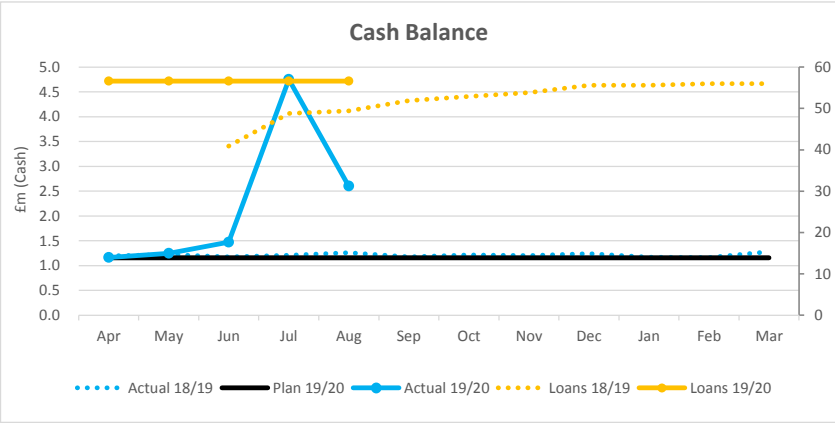
Trust Performance	Trend	What are the reasons for the variation?	How are we going to improve the position (Short & Long Term)?
The actual deficit in the month is £0.2m which increases the year to date deficit to £3.5m.		The cumulative deficit of £3.5m is £0.2m better than plan. The monthly control total (excluding Provider Sustainability, Financial Recovery and Marginal Rate Emergency Tariff funding) is a £8.8m deficit which is in line with plan.	The Trust has worked with providers and commissioners across the local healthcare system to develop a financial recovery plan. The Trust continues to drive improvements by working closely with CBUs and corporate services to manage financial performance.
The current cash balance of £2.6m equates to circa 4 days operational cash.		The current cash balance of £2.6m is £1.4m better than plan.	Cash is monitored on a daily basis. An annual cash plan is supported by a rolling 13 week plan. All debtors are actively pursued to support liquidity.

Financial Position

Red: Deficit Position
Amber: Actual on or better than planned but still in deficit
Green: Surplus Position

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

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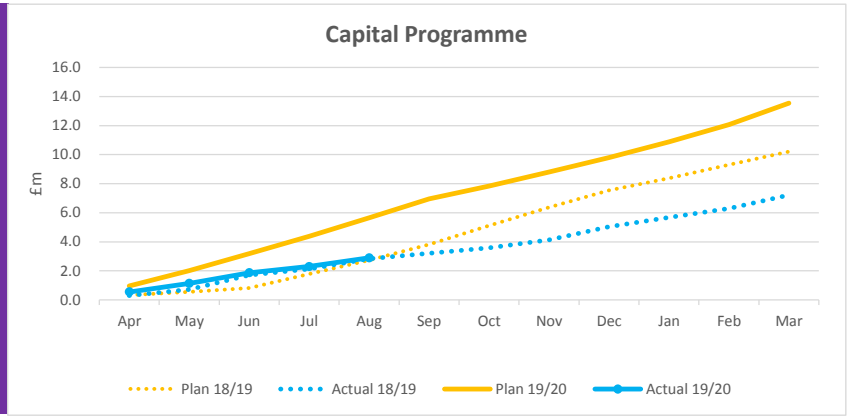
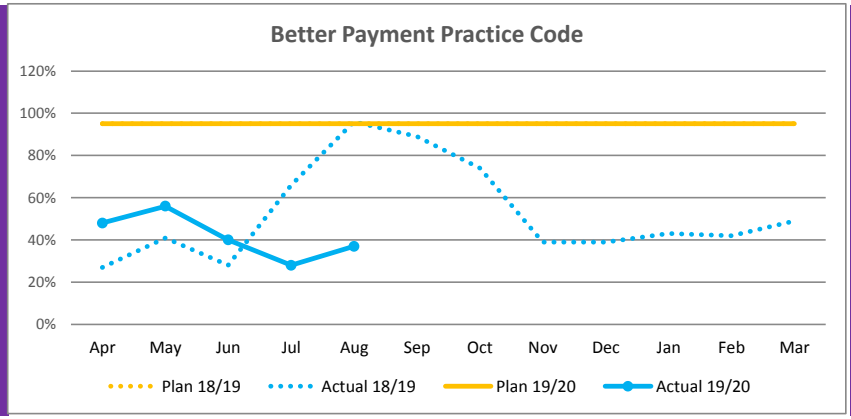
Capital Programme Red: Off plan <80% - >110% Amber: Off plan 80-90% or 101 - 110% Green: On plan 90%-100%	UoR SOF The actual capital spend in the month is £0.5m which increases the year to date spend to £2.9m.		The cumulative capital spend of £2.9m is £2.7m below the planned capital spend of £5.6m (mainly due to limited spend on the Kendrick Wing Fire).	To monitor, report and manage capital planning and spend through the Capital Planning Group to ensure the most effective use of the limited capital resource.
Better Payment Practice Code Red: Cumulative performance below 85% Amber: Cumulative performance between 85% and 95% Green: Cumulative performance 95% or better	UoR SOF In month the Trust has paid 37% of suppliers within 30 days which moves the year to date performance to 38%.		The cumulative performance of 38% is 57% below the national standard of 95%, this is due to the challenging cash flow and the need to manage cash very closely.	Cash is monitored on a daily basis. An annual cash plan is supported by a rolling 13 week plan. All debtors are actively pursued to support liquidity.

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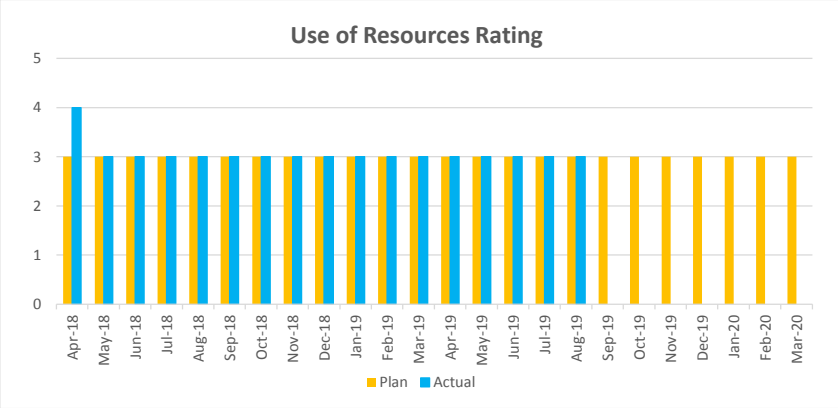
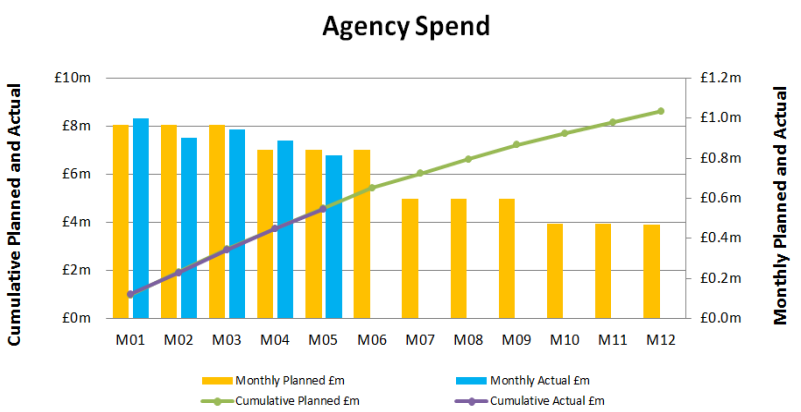
Trust Performance	Trend	What are the reasons for the variation?	How are we going to improve the position (Short & Long Term)?
Use of Resources Rating Red: Use of Resource Rating 4 Amber: Use of Resource Rating 3 Green: Use of Resource Rating 1 and 2			
UoR SOF **The current Use of Resources Rating is 3 (Capital Servicing Capacity, Liquidity, I&E margin are 4 and Distance from Financial Plan and Agency Ceiling is 1).**		**The current Use of Resources Rating of 3 which is the planned rating.**	**To monitor, report and manage financial performance to ensure a minimum rating of 3.**
Agency Spending Red: More than 105% of ceiling Amber: Over 100% but below 105% of ceiling Green: Equal to or less than agency ceiling.			
UoR SOF **The actual agency spend in month is £0.8m which increases the year to date spend to £4.5m.**		**The cumulative spend of £4.5m is in line with the cumulative agency ceiling. However the ceiling drops in Q3 and again in Q4, plans are required in order to remain within the agency ceiling.**	**The Trust is part of a Cheshire & Merseyside collaborative that is working to establish a standard rate card across all staff groups and specialties to reduce rates and is enhancing processes and controls to ensure appropriate and the best usage of agency staff.**

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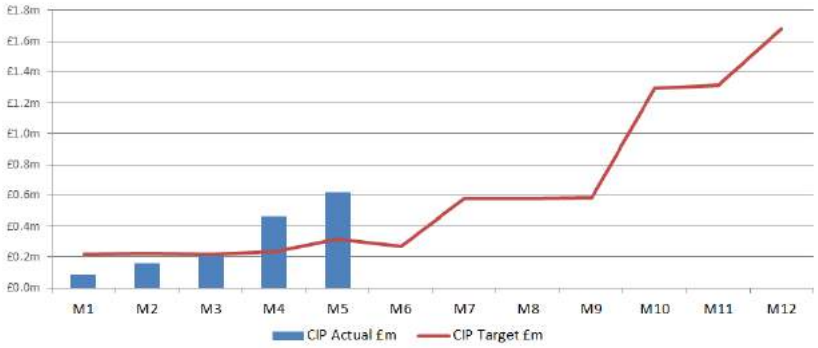
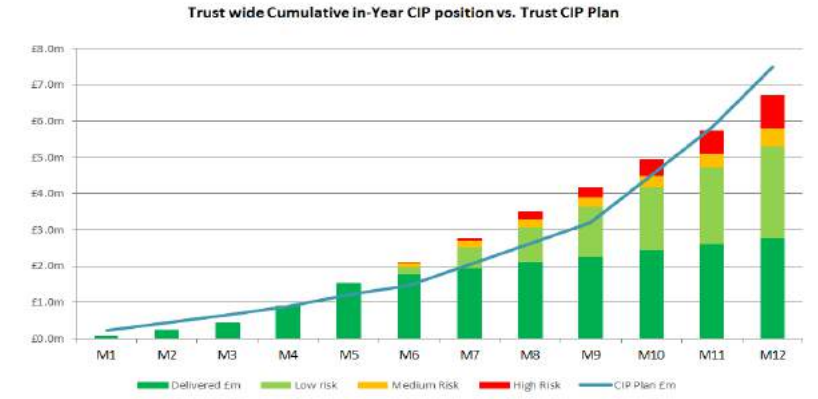
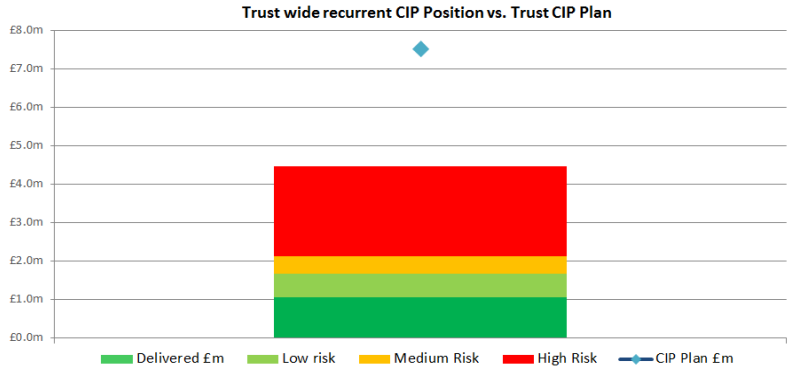
UoR The monthly savings are £0.6m which increases the year to date savings to £1.5m.		The cumulative savings of £1.5m which is £0.3m better than plan.	
Cost Improvement Programme - In year performance to date Red: 0-70% Plan delivered YTD Amber: 70-90% Plan delivered YTD Green: >90% Plan delivered YTD			
UoR In-year forecast for CIP is £6.7m (89% of target).		In-Year forecast for CIP is £6.7m, £0.8m below £7.5m target. This includes £0.9m high risk CIP.	To support all CBUs and Corporate Divisions with schemes utilising all tools and benchmarking information available such as Model Hospital, GIRFT, NHSI support. CIP progress is reviewed on a weekly and monthly basis. Where possible, the Trust seeks to accelerate schemes and is reviewing additional areas to support further cost reductions.
Cost Improvement Programme - Plans in Progress - In Year Red: Forecast is less than 50% of annual target Amber: Forecast is between 50% and 90% of the annual target Green: Forecast is more than 90% of the annual target			
UoR Recurrent forecast for CIP is £4.5m (60% of target).		Recurrent forecast for CIP is £4.5m which is £3.0m below the £7.5m target. This will have an impact on the Trust's financial position in 2020/21.	
Cost Improvement Programme - Plans in Progress - Recurrent Red: Forecast is less than 50% of annual target Amber: Forecast is between 50% and 90% of the annual target Green: Forecast is more than 90% of the annual target			

Appendix 3 – Trust IPR Indicator Overview

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

Medication Safety	Overview of the current position in relation to medication, to include; medication reconciliation, controlled drugs incidents and medication incidents relating to harm.
Staffing Average Fill Levels	Percentage of planned verses actual for registered and non-registered staff by day and night. Target of >90%. The data produced excludes CCU, ITU and Paediatrics.
Care Hours Per Patient Day (CHPPD)	Staffing Care Hours Per Patient Per Day (CHPPD). The data produced excludes CCU, ITU and Paediatrics.
HSMR Mortality Ratio	Hospital Standardised Mortality Ratio (HSMR 12 month rolling). The HSMR is a ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in-hospital deaths (multiplied by 100) for 56 specific Clinical Classification System (CCS) groups.
SHMI Mortality Ratio	Summary Hospital-level Mortality Indicator (SHMI 12 month rolling). SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.
NICE Compliance	The National Institute for Health and Clinical Excellence (NICE) is part of the NHS and is the independent organisation responsible for providing national guidance on treatments and care for people using the NHS in England and Wales and is recognised as being a world leader in setting standards for high quality healthcare and are the most prolific producer of clinical guidelines in the world.
Complaints	Overall review of the current complaints position, including; Number of complaints received, number of dissatisfied complaints, total number of open complaints, total number of cases over 6 months old, total number of cases in backlog where they have breached timeframes, number of cases referred to the Parliamentary and Health Service Ombudsman and the number of complaints responded to within timeframe.
Friends and Family Test (Inpatient & Day Cases)	Percentage of Inpatients and day case patients recommending the Trust. Patients are asked - How likely are you to recommend our ward to friends and family if they needed similar care or treatment?
Friends and Family (ED and UCC)	Percentage of AED (Accident and Emergency Department) patients recommending the Trust: Patients are asked - How likely are you to recommend our AED to friends and family if they needed similar care or treatment?
CQC Insight Composite Score	The CQC Insight report measures a range of performance metrics and gives an overall score based on the Trust's performance against these indicators. This is the CQC Insight Composite Score.
Continuity of Carer	Better Births, the report of the National Maternity Review, set out a clear recommendation that the NHS should roll out continuity of carer, to ensure safer care based on a relationship of mutual trust and respect between women and their midwives. This relationship between care giver and receiver has been proven to lead to better outcomes and safety for the woman and baby, as well as offering a more positive and personal experience.
Access & Performance	
Diagnostic Waiting Times – 6 weeks	All diagnostic tests need to be carried out within 6 weeks of the request for the test being made. The national target is 99% or over within 6 weeks.

	This metric also forms part of the Trust's Sustainability and Transformation Plan (STP) Improvement trajectory. The proposed tolerance levels applied to the improvement trajectories are also illustrated.
RTT Open Pathways and 52 week waits	Percentage of incomplete pathways waiting within 18 weeks. The national target is 92% This metric also forms part of the Trust's STP Improvement trajectory. The proposed tolerance levels applied to the improvement trajectories are also illustrated.
Four hour A&E Target and STP Trajectory	All patients who attend A&E should wait no more than 4 hours from arrival to admission, transfer or discharge. The national target is 95% This metric also forms part of the Trust's STP improvement trajectory. The proposed tolerance levels applied to the improvement trajectories are also illustrated.
A&E Waiting Times Over 12 Hours (Decision to Admit to Admission)	The number of patients who has experienced a wait in A&E longer than 12 hours.
Cancer 14 Days	All patients need to receive first appointment for cancer within 14 days of urgent referral. The national target is 93%. This target is measured and reported on a quarterly basis.
Breast Symptoms – 14 Days	All patients need to receive first appointment for any breast symptom (except suspected cancer) within 14 days of urgent referral. The national target is 93%. This target is measured and reported on a quarterly basis.
Cancer 31 Days - First Treatment	All patients to receive first treatment for cancer within 31 days of decision to treat. This national target is 96%. This target is measured and reported on a quarterly basis.
Cancer 31 Days - Subsequent Surgery	All patients to receive a second or subsequent treatment for cancer within 31 days of decision to treat/surgery. The national target is 94%. This target is measured and reported on a quarterly basis.
Cancer 31 Days - Subsequent Drug	All patients to receive a second or subsequent treatment for cancer within 31 days of decision to treat – anti cancer drug treatments. The national target is 98%. This target is measured and reported on a quarterly basis.
Cancer 62 Days - Urgent	All patients to receive first treatment for cancer within 62 days of urgent referral. The national target is 85%. This metric also forms part of the Trust's STP Improvement trajectory. The proposed tolerance levels applied to the improvement trajectories are also illustrated.
Cancer 62 Days – Screening	All patients must wait no more than 62 days from referral from an NHS screening service to first definitive treatment for all cancers. The national target is 90%. This target is measured and reported on a quarterly basis.
Ambulance Handovers 30 – 60 minutes	Number of ambulance handovers that took 30 to <60 minutes (based on the data record on the HAS system).
Ambulance Handovers – more than 60 minutes	Number of ambulance handovers that took 60 minutes or more (based on the data record on the HAS system).
Discharge Summaries – Sent within 24 hours	The Trust is required to issue and send electronically a fully contractually complaint Discharge Summary within 24 hrs of the patients discharge. This metric relates to Inpatient Discharges only.
Discharge Summaries – Not sent within 7 days	If the Trust does not send 95% of discharge summaries within 24hrs, the Trust is then required to send the difference between

	the actual performance and the 95% required standard within 7 days of the patients discharge.
Cancelled operations on the day for non-clinical reasons	% of operations cancelled on the day or after admission for non-clinical reasons.
Cancelled operations on the day for non-clinical reasons, not rebooked in within 28 days	All service users who have their operation cancelled on the day or after admission for a non-clinical reason, should be offered a binding date for readmission within 28 days.
Urgent Operations – Cancelled for a 2nd Time	Number of urgent operations which have been cancelled for a 2nd time.
Super Stranded Patients	Stranded Patients are patients with a length of stay of 7 days or more. Super Stranded patients are patients with a length of stay of 21 days or more. The number relates to the number of inpatients on the last day of the month.
Workforce	
Sickness Absence	Comparing the monthly sickness absence % with the Trust Target (4.2%) previous year, and peer average.
Return to Work	A review of the completed monthly return to work interviews.
Recruitment	A measurement of the average number of days it is taking to recruit into posts. It also shows the average number of days between the advert closing and the interview (target 10) to measure if we are taking too long to complete shortlisting and also highlights the number of days for which it takes successful candidates to complete their pre-employment checks.
Vacancy Rates	% of Trust vacancies against whole time equivalent.
Retention	Staff retention rate % over the last 12 months.
Turnover	A review of the turnover percentage over the last 12 months.
Bank & Agency Reliance	Trust reliance on bank/agency staff against the peer average.
Agency Shifts Compliant with the Price Cap	% of agency shifts compliant with the Trust cap against peer average.
Pay Spend – Contracted and Non-Contracted	A review of Contracted and Non-Contacted pay against budget.
Core/Mandatory Training	A summary of the Core/Mandatory Training Compliance, this includes: Conflict Resolution, Equality & Diversity, Fire Safety, Health & Safety, Infection Prevention & Control, Information Governance, Moving & Handling, PREVENT, Resuscitation and Safeguarding.
Performance & Development Review (PDR)	A summary of the PDR compliance rate.
Finance	
Financial Position	Operating surplus or deficit compared to plan.
Cash Balance	Cash balance at month end compared to plan (excluding cash relating to the hosting of the Sustainability and Transformation Partnership).
Capital Programme	Capital expenditure compared to plan (The capital plan has been increased to £10.2m as a result of additional funding from the Department of Health, Health Education England for equipment and building enhancements).
Better Payment Practice Code	Payment of non NHS trade invoices within 30 days of invoice date compared to target.
Use of Resources Rating	Use of Resources Rating compared to plan.
Agency Spending	Agency spend compared to agency ceiling.
Cost Improvement Programme – In Year Performance	Cost savings schemes deliver Year to Date (YTD) compared to plan.

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

Appendix 4 - Statistical Process Control

What is SPC?

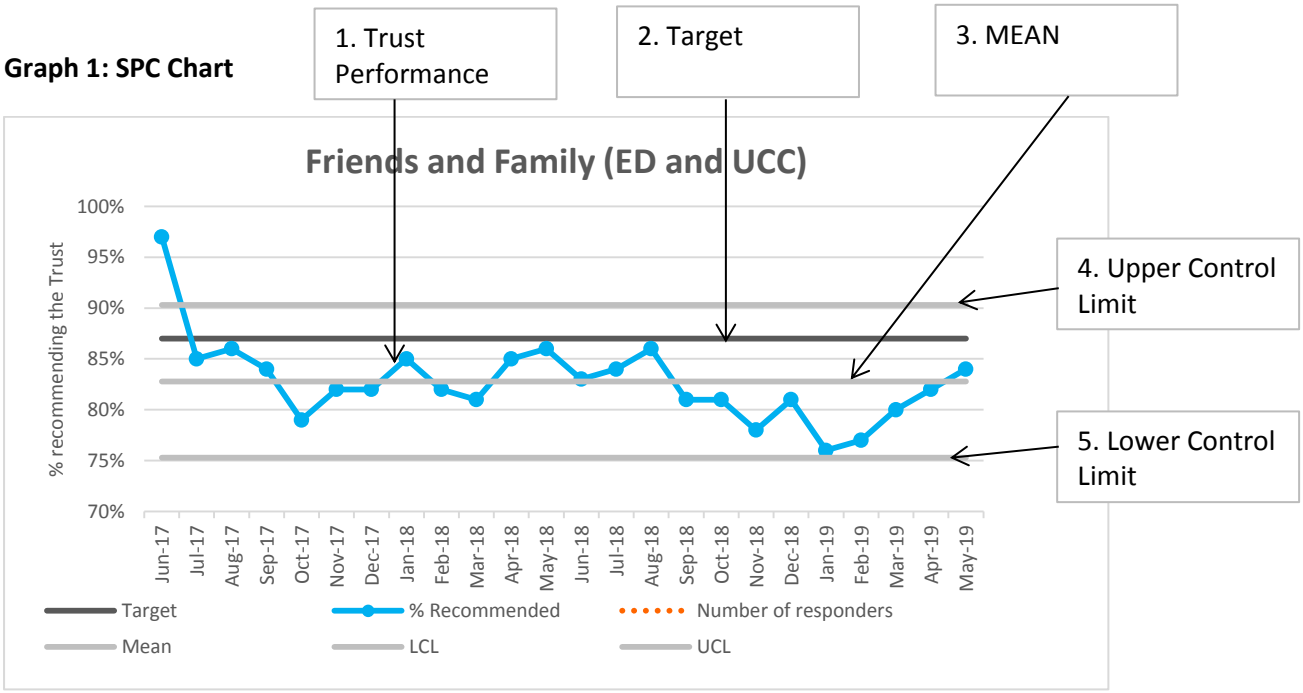
Statistical Process Control (SPC) is method used to measure changes in data/processes over time and is designed to move away from month to month data comparisons. SPC charts help to overcome the limitations of RAG ratings, through using statistics to identify patterns and anomalies, distinguishing changes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

SPC Charts

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

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

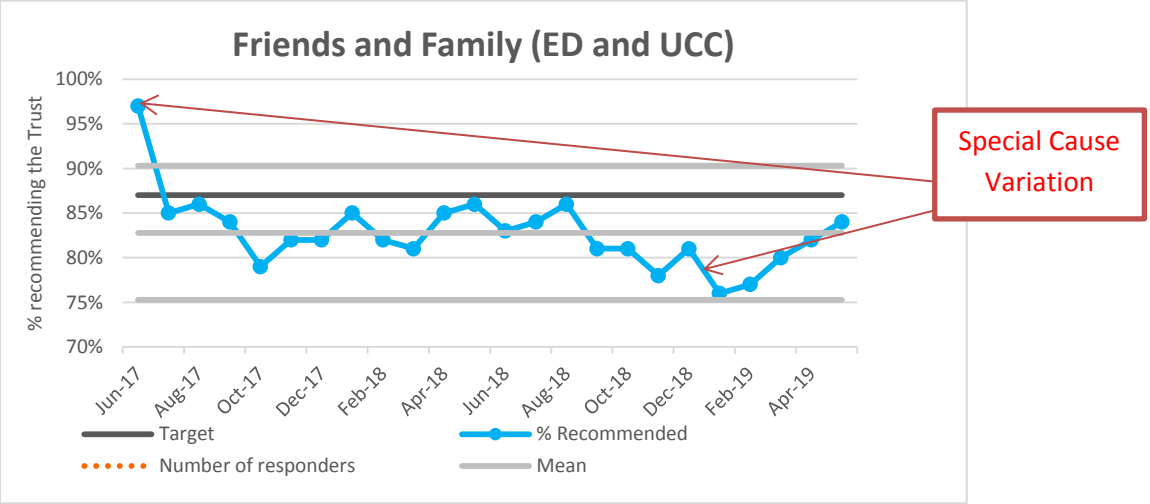
Graph 1: SPC Chart



Interpreting a SPC Chart

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

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



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

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

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

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

Appendix 5

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

Income Statement	Month			Year to date		
	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Operating Income						
NHS Clinical Income						
Elective Spells	2,744	2,416	-327	13,920	12,356	-1,564
Elective Excess Bed Days	14	15	1	69	88	19
Non Elective Spells	5,319	5,519	199	27,081	29,436	2,355
Non Elective Bed Days	163	129	-34	830	650	-180
Non Elective Excess Bed Days	257	115	-141	1,284	510	-775
Outpatient Attendances	3,166	2,918	-249	15,433	15,503	70
Accident & Emergency Attendances	1,375	1,362	-13	6,987	7,049	62
Other Activity	5,525	5,800	274	27,179	26,784	-395
Sub total	**18,563**	**18,274**	**-289**	**92,782**	**92,375**	**-407**
Non NHS Clinical Income						
Private Patients	21	14	-7	113	56	-57
Non NHS Overseas Patients	6	3	-3	30	63	33
Other non protected	85	100	15	429	371	-58
Sub total	**112**	**117**	**5**	**572**	**490**	**-82**
Other Operating Income						
Training & Education	609	614	5	3,046	3,072	26
Donations and Grants	0	0	0	0	0	0
Provider Sustainability Fund (PSF)	325	325	0	1,380	1,607	227
Financial Recovery Fund (FRF)	801	801	0	3,404	3,404	0
Marginal Rate Emergency Tariff (MRET)	81	81	0	405	405	0
Miscellaneous Income	1,158	1,719	562	5,768	7,628	1,860
Sub total	**2,974**	**3,541**	**567**	**14,003**	**16,116**	**2,113**
Total Operating Income	**21,649**	**21,932**	**283**	**107,357**	**108,980**	**1,623**
Operating Expenses						
Employee Benefit Expenses	-16,020	-16,239	-220	-81,449	-81,334	116
Drugs	-1,175	-1,185	-10	-6,190	-6,570	-380
Clinical Supplies and Services	-1,641	-1,787	-147	-8,242	-9,017	-775
Non Clinical Supplies	-2,179	-2,104	75	-11,167	-11,620	-453
Depreciation and Amortisation	-594	-577	17	-2,963	-2,865	98
Net Impairments (DEL)	0	0	0	0	0	0
Net Impairments (AME)	0	0	0	0	0	0
Restructuring Costs	0	0	0	0	0	0
Total Operating Expenses	**-21,609**	**-21,893**	**-284**	**-110,012**	**-111,407**	**-1,395**
Operating Surplus / (Deficit)	**40**	**39**	**-1**	**-2,655**	**-2,427**	**228**
Non Operating Income and Expenses						
Profit / (Loss) on disposal of assets	0	0	0	0	0	0
Interest Income	3	10	7	15	39	24
Interest Expenses	-73	-76	-3	-371	-375	-4
PDC Dividends	-148	-148	0	-736	-736	0
Total Non Operating Income and Expenses	**-218**	**-214**	**4**	**-1,092**	**-1,072**	**20**
Surplus / (Deficit)	**-178**	**-175**	**3**	**-3,747**	**-3,499**	**248**
Adjustments to Financial Performance						
Add I&E Impairments/(Reversals)	0	0	0	0	0	0
Less Impact of I&E (Impairments)/Reversals DEL	0	0	0	0	0	0
Less Donations & Grants Income	0	0	0	0	0	0
Add Depreciation on Donated & Granted Assets	14	16	2	66	81	15
Total Adjustments to Financial Performance	**14**	**16**	**2**	**66**	**81**	**15**
Performance against Control Total inc PSF, FRF & M	**-164**	**-159**	**5**	**-3,681**	**-3,418**	**263**
Less PSF, FRF & MRET Funding	-1,207	-1,207	0	-5,189	-5,416	-227
Performance against Control Total exc PSF, FRF &	**-1,371**	**-1,366**	**5**	**-8,870**	**-8,833**	**36**

Activity Summary	Planned	Actual	Variance	Planned	Actual	Variance
Elective Spells	2,875	2,743	-132	14,637	13,867	-770
Elective Excess Bed Days	51	58	7	255	333	78
Non Elective Spells	3,029	3,336	307	15,288	16,267	979
Non Elective Bed Days	463	367	-96	2,357	1,845	-512
Non Elective Excess Bed Days	985	449	-536	4,927	1,935	-2,992
Outpatient Attendances	26,858	24,976	-1,882	130,913	130,268	-645
Accident & Emergency Attendances	9,923	9,445	-478	50,587	48,755	-1,832

Use of Resources Ratings	Planned Metric	Actual Metric	Variance Metric	Planned Metric	Actual Metric	Variance Metric
Metrics						
Capital Servicing Capacity (Times)				0.29	0.25	-0.04
Liquidity Ratio (Days)				-46.1	-47.5	-1.4
I&E Margin - Metric (%)				-3.43%	-3.14%	0.29%
I&E Margin - Distance from financial plan (%)				0.00%	0.29%	0.29%
Agency Ceiling (%)				0.00%	-0.87%	-0.87%
Ratings						
Capital Servicing Capacity (Times)				4	4	0
Liquidity Ratio (Days)				4	4	0
I&E Margin - Metric (%)				4	4	0
I&E Margin - Distance from financial plan (%)				1	1	0
Agency Ceiling (%)				1	1	0
Use of Resources Rating				**3**	**3**	**0**

Appendix 6

2019/20 Capital Programme

Proposed Amendments

Description	Approved Programme 2019/20	Approved Amendments M1 - M4 2019/20	Proposed Amendments M5 2019/20	Total Revised Programme 2019/20
	£000	£000	£000	£000
Estates Schemes				
Estates Schemes b/f from 18/19				
Backlog - All areas, fixed installation wiring test 68982	50	0	0	50
Backlog - Water Safety Compliance 68959	3	(3)	0	0
Halton Endoscopy Essential power supply to rooms 1 & 2 68942	20	0	0	20
Backlog - Air Con/ Cooling Sys upgrade. Ph1-Survey 68948	12	0	0	12
Automatic sliding / entrance doors across all sites 68960	20	0	0	20
External Fire Escapes Replace (Kendrick & Appleton) 68950	41	(41)	0	0
Estates Minor Works 68955	12	0	0	12
High Voltage Maintenance 68938	20	0	0	20
Substation B air circuit breakers and HV ring main unit 68998	202	0	0	202
Electrical Infrastructure Upgrade 68961	42	0	0	42
North Lodge fire compartmentation 68988	150	0	0	150
Appleton Wing fire doors 68981	100	0	0	100
Thelwall House emergency escape lighting 68973	4	0	0	4
Cheshire House fire doors 68919	23	0	0	23
Installation of Dishwashers 68996	1	(1)	0	0
CCU relocation to Ward A3	8	0	0	8
Discharge Lounge/Bereavement Office 68922	17	0	0	17
Essential Power Supply - Halton Pharmacy 68920	6	0	0	6
Bathroom A4 68910	24	0	0	24
Bathroom A8 68932	24	0	0	24
N20 Exposure 68952	100	0	0	100
Catering EHO Works 68957	9	(9)	0	0
CQC (Environmental Improvements) 68962	369	0	0	369
CQC (Prep Room Doors) 68904	24	0	0	24
CQC (MLU) 68903	600	0	0	600
Halton Outpatients Refurbishment 68906	69	(69)	0	0
Emergency Generator Repairs - Halton 68967	7	0	0	7
Cheshire House Drainage	0	0	0	0
Butterfly Suite 68911	19	0	0	19
ITU UPS Replacement 68926	7	0	0	7
AER Machines (4 W 2 H) 68839	350	0	0	350
Subtotal	**2,333**	**(123)**	**0**	**2,210**
Estates Schemes Mandated 19/20				
Substation B air circuit breakers and HV ring main unit 68998	202	0	0	202
AER Machines (4 W 2 H) 68839	350	0	0	350
CQC (Environmental Improvements) 68962	554	(225)	0	329
Replacement Lift - Phase 1 Halton 68944	250	0	0	250
Staffing	177	6	0	183
Halton 30 Minute Fire Compartmentation	150	0	0	150
Appleton Wing 60 Minute Fire Doors 68951	100	0	0	100
Warrington & Halton Gas Meter Replacement 68953	100	0	0	100
North Lodge Basement - Fire Compartmentation Part 2/2	100	0	0	100
Backlog - All areas, fixed installation wiring test 68982	100	0	0	100
Six Facet Survey (annual rolling programme) to include dementia & disability 68965	60	0	0	60
North Lodge & Catering Emergency Lighting 68992	50	0	0	50
External Fire Escapes Replace (Kendrick & Appleton)	40	0	0	40
Backlog - Water Safety Compliance	50	0	0	50
Backlog - Asbestos re-inspection & removals	30	0	0	30
Pharmacy Fire Doors 68965	30	0	0	30
Halton Residential Blocks 2 & 3 Fire Doors 68966	25	0	0	25
Daresbury Plant Room - Alternative Fire Escape	20	0	0	20
Estates Dept Fire Doors 68969	20	0	0	20
Cheshire House Emergency Lighting 68976	20	0	0	20
Thelwall House - Improvements to Fire Alarm System 68978	20	0	0	20
Estates Dept Fire Compartmentation of Risk Areas 68979	10	0	0	10
Subtotal	**2,458**	**(219)**	**0**	**2,239**
Estates Schemes Approved 19/20				
Backlog - Appleton Wing, replace 5 No LV changeover switches	40	0	0	40
Backlog - High Voltage Annual Requirements 7 Maintenance	40	(20)	0	20
Backlog - Patient Environment Improvements	100	(65)	0	35
Induction of Labour Ward (CQC)	78	0	0	78
Diagnostics Business Case	1,365	0	0	1,365
Chillers Day Case Theatre & MRI	0	65	0	65
Contact Centre Relocation (OPD)	0	24	0	24
Paediatric Outpatients	0	0	0	0
Ward Bathroom Falls Prevention	0	0	0	0
Conversion of 6 Accommodation Rooms	0	0	0	0
Front Entrance	0	0	0	0
Subtotal	**1,623**	**4**	**0**	**1,627**
Total Estates	**6,414**	**(338)**	**0**	**6,076**
IM&T				
IM&T Schemes b/f from 18/19				

Technology & Devices refresh and developments	141	0	0	141
Security (Stonesoft firewall replacement/renewal)	2	0	0	2
IPPMA/ePrescribing/ePMA	69	0	0	69
VDI Roll Out	117	0	0	117
Meditech Restoration	5	0	0	5
Deontics Pathway Development	8	0	0	8
Falsified Medicines Directive	83	0	0	83
BI Interactive Screens	11	0	0	11
BI Tool Physical Servers	0	0	0	0
Subtotal	**436**	**0**	**0**	**436**
IM&T Schemes Approved 19/20				
EPMA	250	65	0	315
EPMA - E Prescribing/Drugs Trolleys	229	0	0	229
Ice Upgrade	0	31	0	31
Devices Refresh Phase 1	0	188	0	188
Molis Infection Control Module	0	0	0	0
Subtotal	**479**	**284**	**0**	**763**
Total IM&T	**915**	**284**	**0**	**1,199**
Medical Equipment				
Medical Equipment Schemes b/f from 18/19				
Oral Surgery Dental Chair x1	1	(1)	0	0
Door Lock (FAU)	5	0	0	5
Bladder Scanner (FAU)	8	0	0	8
Ultrasound Rheumatology	29	0	0	29
ECG stress test system	31	0	0	31
Subtotal	**74**	**(1)**	**0**	**73**
Medical Equipment Schemes Approved 19/20				
Replacement Anaesthetic Machines & Monitors	260	0	0	260
Recovery Monitors	390	0	0	390
Foetal CTG Monitor Labour Ward	39	0	0	39
Anaesthetic Ultrasound for Vascular	70	0	0	70
Patient Transfer Ventilators	55	0	0	55
Laparoscopic Video Imagery Systems	160	0	0	160
Ultrasound Machines	150	0	0	150
Ultrasound Transducer	0	7	0	7
Curvilinear Transducer	0	6	0	6
Replacement Patient Monitoring System in ED	300	0	0	300
NIV Machines	47	0	0	47
Osmometer	0	11	0	11
Paediatric MRI Scanning	0	0	11	11
CT Scanner	0	0	0	0
Theatres Anaesthetic Machines	0	0	0	0
Screening Quality Assurance Service - cold Coagulation	0	0	0	0
Screening Quality Assurance Service - Monitors	0	0	0	0
Subtotal	**1,471**	**24**	**11**	**1,506**
Total Medical Equipment	**1,545**	**23**	**11**	**1,579**
Contingency				
Prior Year Adjustments (Vat Rebates)	0	0	0	0
General Contingency	972	(169)	(11)	792
CQC Contingency	0	200	0	200
Total Contingency	**972**	**31**	**(11)**	**992**
Trust Funded Capital Schemes	**8,874**	**(31)**	**11**	**8,854**
Externally Funded				
CANTREAT Modifications (Macmillan)	84	0	0	84
Outdoor Play Area (Charitable Funds)	5	0	0	5
Cancer Trans Prog - MDT Equipment (PDC)	7	0	0	7
EPR Developments WA Digital Maturity (PDC)	81	0	0	81
Training Simulation Equipment (HEE)	10	0	0	10
Tomosynthesis (Boot Out Breast Cancer)	10	0	0	10
Parent Bathroom Childrens Ward (Charitable Funds)	0	8	0	8
Subtotal	**197**	**8**	**0**	**205**
Kendrick Wing Fire				
Kendrick Wing Fire	3,500	0	0	3,500
Kendrick Wing Fire - Estates	0	0	0	0
Kendrick Wing Fire - F & F	0	0	0	0
Kendrick Wing Fire - Electrical Items	0	0	0	0
Kendrick Wing Fire - Miscellaneous	0	0	0	0
Kendrick Wing Fire -Medical Equipment	0	0	0	0
Kendrick Wing Fire - IT	0	0	0	0
Subtotal	**3,500**	**0**	**0**	**3,500**
Grand Total	**13,543**	**8**	**0**	**13,551**

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/19/09/83 a**			
SUBJECT:	**Safe Staffing Assurance Report – July 2019**			
DATE OF MEETING:	25 September 2019			
AUTHOR(S):	Rachael Browning, Associate Chief Nurse, Clinical Effectiveness			
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse			
LINK TO STRATEGIC OBJECTIVES:	All			
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 a ward falls below 90% of planned staffing levels. In the month of July 2019 it was noted that 11 of the 23 wards were below the 90% target during the day. In order to ensure safe staffing levels, mitigation and responsive plans continue to be put in place to ensure that the safe delivery of patient care is discussed at every bed meeting and escalated as appropriate. It is a recommendation of the National Quality Board (NQB 2018) that the Board of Directors receives a monthly Safe Staffing report, which includes the measure of Care Hours Per Patient Day (CHPPD) and 'planned' versus 'actual' staffing levels, highlighting areas where average fill rates fall below 90%, along with mitigation to ensure safe, high quality care is consistently delivered for those areas. The report demonstrates the progress that continues to be made across the organisation in Nursing and Midwifery staffing as the number of wards reporting staffing levels below the 90% reduces.			
PURPOSE: (please select as appropriate)	**Information** *	Approval	**To note** *	Decision
RECOMMENDATION:	Trust Board asked to note the contents of this report as discussed and received at the Strategic People Committee			
PREVIOUSLY CONSIDERED BY:	**Committee**	Strategic People Committee		
	Agenda Ref.	SPC/19/09/89		
	Date of meeting	18 September 2019		
	Summary of Outcome			
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

NAME OF COMMITTEE

SUBJECT	Safe Staffing Assurance Report	AGENDA REF:	BM/19/09/83

1. BACKGROUND/CONTEXT

Safe Staffing Assurance Report

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

2. KEY ELEMENTS

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

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

Care Hours Per patient Day

Warrington and Halton Hospitals NHS Trust currently collects and reports CHPPD data on a monthly basis. CHPPD is the total time spent on direct patient care based on the number of occupied beds at midnight. Updated guidance from NHSI/E has recently been shared with NHS Trusts (July 2019) and we are currently reviewing the guidance to ensure all the appropriate staff are included in the Unify monthly submission. The July 2019 Trust wide staffing data was analysed and cross-referenced, with ward level data for validation by the Deputy Chief Nurse, Lead Nurses, and the Associate Chief Nurse (Clinical Effectiveness).

Chart 1 illustrates this data to July 2019 demonstrating a Trust overall position of 7.5. This is in comparison to the peer median of 7.8 and the national median figure of 8.1 hours over the same period and represents an improvement from 2018 / 19 where we ended the year with an overall rate of 7.0.

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

Chart 1 – CHPPDD 2019

Financial year	Month	Cumulative count over the month of patients at 23:59 each day	CHPPD - Registered	CHPPD - Care Staff	CHPPD All
2019/20	April	14008	4.4	3.2	7.6
	May	14623	4.3	3.3	7.6
	June	14410	4.3	3.2	7.5
	July	14917	4.2	3.3	7.5
2019/20 Total		57958	4.3	3.3	7.5

Key Messages

Although there are areas above the 90% fill rate in month, it is acknowledged that the percentage of registered nurses/midwives on 11 of the 23 wards is below target during the day. In order to ensure safe staffing levels, mitigation and responsive plans continue to be put in place to ensure that the safe delivery of patient care is discussed at every bed meeting and escalated as appropriate. Shift fill rates continue to improve month on month.

Maternity (ward C23) although showing below the 90% target on the ward, use their responsive staffing plans in the unit to move staff to support if acuity requires additional staffing. This month the Maternity unit have transferred the care of women booked with One to One Maternity services into the care of WHH as they are no longer operating. This has not had an adverse effect on the staffing within the department in the short term, however in the longer term the Head of Midwifery will review the staffing requirements against the Birth Rate Plus methodology.

Recruitment and retention remains a priority for the senior nursing team. Further recruitment events are planned for both registered nurses and health care assistants.

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

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

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

The aim of the collaborative is to reduce the turnover of our Nursing and Midwifery workforce by 1.5% over the next 12 months. Good progress has been made under these work streams, it is pleasing to note at month 8 we have seen a reduction of 2.55% in nursing and midwifery turnover.

Additional bed capacity has been utilised to support the operational pressures in the Trust in July 2019. The General Practitioner Assessment Unit (GPAU) (16 beds), on occasion, has been used as an inpatient overnight facility, and Ward A9 is currently located on 2 wards (K25 and C22) both of these areas required additional nurse staffing. Staffing levels are reviewed daily to determine the additional staffing required ensuring patient safety as part of the daily operational staffing plans.

Patient Harm by Ward

In July 2019 we have reported 4 category 2 pressure ulcers on wards A2, ACCU, A8 and ITU and 1 category 3 pressure ulcer on ward C22, which are currently being investigated. There has been 1 patient fall with moderate harm reported on ward A4 and 1 patient fall with catastrophic harm on ward C21. An SI investigation is underway.

Infection Incidents

No cases of MRSA bacteraemia have been reported in July 2019

Appendix 1		MONTHLY SAFE STAFFING REPORT – July 2019															
Monthly Safe Staffing Report – July 2019																	
		Day	Day	Day	Day	Day	Day	Night	Night	Night	Night	Night	Night	CHPPD			
CBU	Ward	Planned RN hours	Actual RN hours	Planned HCA hours	Actual HCA hours	% RN fill rate	% HCA fill rate	Planned RN hours	Actual RN hours	Planned HCA hours	Actual HCA hours	% RN fill rate	% HCA fill rate	Cumulative count over the month of patients at 23:59 each day	RN	HCA	Overall
		= above 100%		= above 90%			= above 80%			= below 80%							
DD	SAU	930	900	697.5	697.5	96.8%	100%	-	-	-	-	-	-	0	-	-	-
DD	Ward A5	1782.5	1351.3	1426	1328.5	75.6%	93.2%	1069.5	966	1069.5	1069.5	90.3%	100%	992	2.3	2.4	4.8
DD	Ward A6	1782.5	1396.3	1426	1349.8	78.3%	94.7%	1069.5	943	1069.5	1069.5	88.2%	100%	992	2.4	2.4	4.8
DD	Ward B4	699.5	688	793	781.5	98.4%	98.5%	253	230	253	241.5	90.9%	95.5%	55	16.7	18.6	35.3
DD	Ward A4	1690.5	1437.5	1426	1415	85%	99.2%	1069.5	954.5	1069.5	1069.5	89.2%	100%	990	2.4	2.5	4.9
MSK	Ward CMTC	1127	1114	724.5	713.5	98.8%	98.5%	713	701.5	448.5	448.5	98.4%	100%	231	7.9	5.0	12.9
MSK	Ward A9	1782.5	1671	2139	1839.5	93.7%	86%	1426	1426	1426	1426	100%	100%	1169	2.6	2.8	5.4
W&C	Ward B11	2890.3	2783.3	917.5	867.5	96.3%	94.6%	1638.4	1562.8	270.4	322.4	95.4%	119.2%	376	11.6	3.2	14.7
W&C	NNU	1782.5	1516.5	356.5	310.5	85.1%	87.1%	1782.5	1403	356.5	241.5	78.7%	67.7%	159	18.4	3.5	21.8
W&C	Ward C20	1069.5	1092.5	713	708	102.2%	99.3%	713	448.5	0	0	62.9%	-	428	3.6	1.7	5.3
W&C	Ward C23	1426	1184.5	713	835	83.1%	117.1%	770.5	759	713	678.5	98.5%	95.2%	324	6.0	4.7	10.7
W&C	Birth Suite	2495.5	2401	356.5	455	96.2%	127.6%	2495.5	2079.5	460	421	83.3%	91.5%	246	18.2	3.6	21.8
UEC	Ward A1	2325	1937.5	2325	2837.5	83.3%	122%	1627.5	1449.7	1293.3	1272.5	89.1%	98.4%	1132	3.0	3.6	6.6
UEC	Ward A2	1426	1169	1548	1392.5	82%	90%	1069.5	1069.4	1184.5	1253.5	100%	105.8%	868	2.6	3.0	5.6
IM&C	Ward C21	1069.5	938.5	1069.5	1387.5	87.8%	129.7%	713	713	1069.5	1161.5	100%	108.6%	744	2.2	3.4	5.6
IM&C	Ward A8	1426	1345	1426	1385	94.3%	97.1%	1426	1229	1426	1213	86.2%	85.1%	1054	2.4	2.5	4.9
IM&C	Ward B12	1069.5	947	2495.5	2279	88.5%	91.3%	713	713	1782.5	1785.5	100%	100%	651	2.5	6.2	8.8
IM&C	Ward B14	1426	1297.5	1426	1414	91%	99.2%	713	713	713	1092.5	100%	153.2%	744	2.7	3.4	6.1
IM&C	Ward B18	1426	1088.8	1782	1453	76.4%	81.5%	1069	943	1426	1380	88.2%	96.8%	744	2.7	3.8	6.5
IM&C	Ward B19	1069.5	1069.5	1426	1445	100%	101.3%	713	713	1069.5	1189	100%	111.2%	744	2.4	3.5	5.9
MC	Ward A7	1782.5	1491	1426	1506.7	83.6%	105.7%	1426	1345.5	1069.5	1184.5	94.4%	110.8%	1023	2.8	2.6	5.4
MC	ACCU	2495.5	2362.5	1081	1138.5	94.7%	105.3%	1782.5	1782.5	1069.5	1151	100%	107.6%	782	5.3	2.9	8.2
MC	ICU	4991	4496.5	1069.5	994.8	90.1%	93%	4991	4473.5	1069.5	845.3	89.6%	79%	469	19.1	3.9	23.0

Appendix 2

July 2019 - Mitigating Actions

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

- Day care wards
- CDU/other clinical assessment units
- Additional capacity wards (B3 and C21)

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

	DAY		NIGHT		MITIGATING ACTIONS
	Average fill rate - registered nurses/midwives (%)	Average fill rate – Health Care support staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - Health Care support staff (%)	
SAU	96.8%	100%	-	-	**Vacancy:** - band 5 0.17 wte **Sickness rate** 7.57 % **Action taken:** - Attendance management policy followed.
Ward A5	75.6%	93.2%	90.3%	100%	**Vacancy:** Band 5 1.62 wte band 2 2.72 wte **Sickness rate:** 3.76% **Action taken:** Daily review by the matron to review staffing levels and acuity, staff moved from other areas to support. Attendance management policy followed, monthly meeting with HR and welfare meetings arranged. Ongoing recruitment plans in place
Ward A6	78.3%	94.7%	88.2%	100%	**Vacancy:** - Band 6 2.08wte Band 5 7.02 wte Band 2 1.53 wte **Sickness rate** – 7.67% **Action taken:** Daily review by the matron to review staffing levels and acuity, staff moved from other areas to support. Attendance management policy followed, monthly meeting with HR and welfare meetings arranged. Targeted recruitment plan in place
Ward B4	98.4%	98.5%	90.9%	95.5%	**Vacancy**: band 6 1.0wte Band 2 2.63wte **Sickness rate** –9.70% **Action taken:** Daily staffing review against acuity and activity. Recruitment plan in place. Band 6 recruited and awaiting start date. Sickness absence reduced in month and being managed in line with Trust policy.
Ward A4	85%	99.2%	89.2%	100%	**Vacancy:** - Band 5 3.92 wte band 2 1.26 wte **Sickness rate** – 3.31% **Action taken:** Staffing and activity reviewed daily. Recruitment programme in place. Attendance management policy followed, Sickness absence being managed in line with the Trust policy.
Ward CMTC	98.8%	98.5%	98.4%	100%	**Vacancy:** ward establishment currently under review **Sickness rate –** 8.09% **Action taken**: Sickness absence being managed in line with the Trust policy.
Ward A9	93.7%	86%	100%	100%	**Vacancy:** band 5 – 2.0 wte band 2 5.02wte **Sickness rate** – 6.22% **Action taken:** Staffing reviewed daily and support provided if necessary. Ward has

					moved to 2 areas (C22/K25) during refurbishment. Increase in 6 beds. Staffing adjusted to cover both areas. Band 5 vacancies will be filled in Sept. Advert to go out for Band 2s. Sickness absence being managed in line with the Trust policy.
Ward B11	96.3%	94.6%	95.4%	119.2%	**Vacancy:** band 5 – 4.0 wte **Sickness Rate:** 5.23% **Action taken:** - recruitment process in place. 2 band 5's due to start in September. Staffing reviewed daily and support provided if necessary.
NNU	85.1%	87.1%	78.7%	67.7%	**Vacancy rate:** 1.0wte band 5 **Sickness Rate:** 25% **Action taken:** sickness is managed via the Trust policy. Staffing reviewed daily and support provided if necessary. Recruitment process in place
Ward C20	102.2%	99.3%	62.9%	-	**Vacancy: :** fully established **Sickness Rate:** 9.96% **Action taken:** Staffing reviewed daily by the matron and staff moved to support if required and additional shifts request via NHSP. RN vacancies filled. Sickness is being managed in line with Trust policy.
Ward C23	83.1%	117.1%	98.5%	95.2%	**Vacancy:** fully established **Sickness rate** – 13.13% **Action taken:** Daily review of staffing and staffed moved from other areas depending on acuity and occupancy.
Delivery Suite	96.2%	127.6%	83.3%	91.5%	**Vacancy:** - Band 2 1.37 wte **Sickness rate** – 8.82% **Action taken:** Daily review of staffing and acuity, staff moved from other areas to support and additional staff access via NHSP. Sickness is being managed in line with Trust policy.
Ward A1	83.3%	122%	89.1%	98.4%	**Vacancy :** - 8.67wte Band 5 **Sickness Rate:** 3.98% **Action taken:** All vacancies filled awaiting start dates Daily review of staffing and acuity, staff moved from other areas to support and additional staff access via NHSP.
Ward A2	82%	90%	100%	105.8%	**Vacancy:** Band 5 10.58wte **Sickness Rate:** 3.83% **Action taken:** Daily review of staffing and acuity, staff moved from other areas to support and additional staff access via NHSP. Band 5 recruitment plans in place.
Ward C21	87.8%	129.7%	100%	108.6%	**Vacancy :-** Band 5 0.54 wte **Sickness Rate:** 8.31% **Action taken:** - Daily review of staffing and acuity, staff moved from other areas to support and additional staff access via NHSP.
Ward A8	94.3%	97.1%	86.2%	85.1%	**Vacancy :** - band 6 2.0 wte band 5 –5.0wte Band 2 2.0wte **Sickness Rate: 7.96%** **Action taken:** Recruitment plans in place/ 2 band 5 recruited and awaiting start dates Ward support by the continued use of NHSP and agency to ensure safe staffing levels. Pharmacy Technician support morning and lunchtime supports nursing staff.
Ward B12	88.5%	91.3%	100%	100%	**Vacancy :** - Band 5 1.0wte Band 2 6.0 wte **Sickness Rate:** 7.77% **Action taken**: - Recruitment plan in place. Daily review by the matron to review staffing levels and acuity, staff moved from other areas to support.

Ward B14	91%	99.2%	100%	153.2%	**Vacancy :-** 1.0 Band 5 **Sickness Rate:** 6.52% **Action taken:** - recruitment plan in place Staffing reviewed daily against acuity and activity.
Ward B18	76.4%	81.5%	88.2%	96.8%	**Vacancy :** -band 5 2.94 wte band 2 2.89wte **Sickness Rate:** 3.79% **Action taken:** - Recruitment ongoing, band 2 posts recruited to via central recruitment awaiting start dates, staffing reviewed on daily basis by matron and ward manager
Ward B19	100%	101.3%	100%	111.2%	**Vacancy :** -band 5 1.51wte band 2 1.95 **Sickness Rate:** 3.42% **Action taken:** - band 2 vacancies filled awaiting start dates. Ward reviewed daily for acuity and staffing.
Ward A7	83.6%	105.7%	94.4%	110.8%	**Vacancy :** B5 3.92wte band 2 0.56wte **Sickness Rate:** 3.42% **Action taken:** - Staffing reviewed daily against acuity and activity. 2 RN's to start in September.
ACCU	94.7%	105.3%	100%	107.6%	**Vacancy :** fully established **Sickness Rate:** 5.7% **Action taken:** Staffing reviewed daily against acuity and activity, staff support accessed from other areas when required. Sickness is being managed in line with Trust policy
ICU	90.1%	93%	89.6%	79%	**Vacancy :** – 4.36wte band 5 **Sickness rate** – 4.19% **Action taken:** - Sickness absence managed robustly in line with Trust Attendance Management Policy. Rota shortfall managed with temporary staffing, mainly own staff via NHSP. Recruitment plan in place

3. ASSURANCE COMMITTEE

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

4. RECOMMENDATIONS

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

Kimberley Salmon-Jamieson
Chief Nurse and DIPC
July 2019

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

BOARD OF DIRECTORS CHAIR'S KEY ISSUES REPORT

AGENDA REFERENCE:	BM 19/09/83 b	COMMITTEE OR GROUP:	Trust Board	DATE OF MEETING	25th September 2019

Date of Meeting	3rd September 2019
Name of Meeting + Chair	Quality Assurance Committee, Chaired by Margaret Bamforth
Was the meeting quorate?	Yes

The Quality Assurance Committee met on 3rd September 2019. The following matters were discussed:

- A Patient Story was received;
- Details of a deep dive in to falls was received;
- The Committee received the Moving to Outstanding Finalised Action Plan
- The Committee reviewed the Quality Dashboard and associated KPIs,
- A HLB was received from the Patient Safety and Clinical Effectiveness Sub-Committee, the Urgent & Emergency Care Improvement Committee, the Safeguarding Sub-Committee, the Health and Safety Sub-Committee, the Complaints Quality Assurance Group, the Patient Experience Sub-Committee, the Infection Control Sub-Committee, the End of Life Steering Group & Strategy and the Information Governance & Corporate Records Sub Committee.
- An update was provided on Maternity Services and on the Maternity Safety Champions work;
- An update was provided following SI's Learning Audit
- The Committee reviewed and considered Clinical Audit Q1 Report and Clinical Audit Annual Report;
- The Committee supported the DIPC Annual Report to be submitted to the Trust Board;
- The Strategic Risk Register, Board Assurance Framework and Corporate Risk Register were reviewed and considered;
- The Risk Management Annual Report and revised Risk Management Strategy was approved by the Committee
- An update was provided on ePMA
- The Committee received an update following the following Mersey Internal Audit CBU Governance audit

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

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/ mandate to receiving body	Follow up/ Review date
QAC/19 /09/128	Moving to Outstanding	The Committee noted the following in respect of the action plan following the recent CQC inspection: • 61 actions, 54 aligned to 'should do' recommendations following the recent CQC inspection. • WHH 'Outstanding' Framework is to be developed following assessment and benchmarking of all core services and standards against Outstanding organisations, which will support the Trust in its journey to 'Outstanding'.	The Committee noted the update and received high assurance.	**QAC November 2019**
QAC/19 /09/129	Fall Deep Dive	The following key areas were particularly noted by the Committee: • 25% reduction in in-patient falls with harm in 2019-2020 against same reporting period in 2018-19 • 30% reduction of total in-patient falls for 2019-20 against same reporting period in 2018-2019. • In August 2019 there had been no reported falls with harm. • A number of actions are being implemented alongside Falls Quality Improvement collaborative.	The Committee received substantial assurance noted the improvement in in-patient falls and falls with harm.	**Ongoing in Patient Safety & Clinical Effectiveness Sub-Committee**
QAC/19 /09/130	Quality Dashboard and Review and refresh of KPIs	The Committee received the Quality Dashboard which highlighted the following matters which are included in the IPR which will be received by the Trust Board at this meeting. Of particular note were the following matters: • Friends & Family – variation between Trusts in the numbers of eligible patient via the U&EC pathway. • MRSA Nil return for MRSA bacteraemia cases in Q1, 2 report in August. • E-Coli is above trajectory with 15 hospital onset cases in Q1, • VTE – mitigations in place to achieve compliance • Medication Safety – matters discussed in Medicines Governance Group and	The Committee received moderate assurance and the Board will review the full IPR as part of the meeting today	**Trust Board September 2019**

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

		Nursing & Midwifery Group. A Pharmacist an Technician to be based in ED for prescription oversight from November 2019.		
QAC/19 /09/131	High Level Briefing - Patient Safety + Clinical Effectiveness Sub Committee	The Committee particularly noted the following matters: • Outpatient follow-up report to November PSCE • Trauma Review – full report to November Quality Assurance Committee • DNACPR – deep dive to be undertaken and report to March 2020 Quality Assurance Committee and PSCE. • Currently the Committee is not assured in DNACPR compliance following the recent Audit result.	The Committee received moderate assurance Further updates to be presented at next meeting and DNACPR Deep dive in March 2020	**QAC + PSCE November 2019**
QAC/19 /09/132	High Level Briefing - Safeguarding Sub Committee – July + August 2019	The following key points were noted by the Committee: • Safeguarding Training full compliance reported; • Change in the Deprivation of Liberty Process (DoLs) to Liberty Protection Safeguarding (LPS) resulting in operational challenges due to operational responsibility transferring to the Trust; • The implementation of LPS will require further consideration in due course as it constitutes a major change in practice and currently, the full implications are unknown.	The Committee received moderate assurance Further updates to be presented at next meeting	**QAC November 2019**
QAC/19 /09/135	High Level Briefing – Patient Experience Sub Committee:	The following key points were highlighted for the Committee to note: • Patient Experience Strategy is being refreshed to formulate 2019-21 Patient Experience Strategy and associated development plan. • Challenges reported relating to MSA breaches and isolation cubicles. • Inpatient and day cases FFT_- May and June achieved 96%, achieving internal target of 95%. National review underway relating to feedback process, changes have been proposed, regarding the mandatory question asked, follow up questions and timing requirements for feedback. • UEC FFT – WHH had benchmarked its data against other Trusts in C&M and an anomaly identified in the “eligible patients”. WHH have escalated to NHSE and	The Committee received moderate assurance Further updates to be presented at next meeting	**QAC November 2019**

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		CCG and await a response. National In-Patient Survey results 2018 • Response rate 41%, improvement of 35% compared to 2017 response. • 4 questions of the lowest 20% average were concentrated in the "hospital ward" section and referred to patients own medication, food rating, food choice and hydration during admission. Actions monitored through Patient Experience Strategy action plan, including improved choice of food for longer length stay patients, robust communication processes relating to varied menus		
QAC/19 /09/136	High Level Briefing – End of Life Steering Group	The Committee particularly noted the following matters: • National Audit to be undertaken of EoL, findings to be reported in November 2019.	The Committee received moderate assurance. Further updates to be presented at next meeting	**QAC November 2019**
QAC/19 /09/137	High Level Briefing Infection Control Sub Committee	The following key points were noted by the Committee: • Escalated, above trajectory for E-Coli, 15 hospital onset cases in Q1, 5% reduction target in place. • MRSA Nil return for MRSA bacteraemia cases in Q1, 2 report in August. • Public Health England attended the Trust in July, positive recognition on the Chairing of the Infection Control Sub Committee. • There will be an investigation following these two incidents with a report to November QAC.	The Committee received moderate assurance. Further updates to be presented at next meeting and Director of Infection Prevention & Control report on the agenda for this Board Meeting	**QAC November 2019 & Trust Board Sept 2019**
QAC/19 /09/139	High Level Briefing U+E Care Committee	The following key points were highlighted for the Committee to note: • Decision to Admit protocol successfully implemented 7.08.201, reduction in average time patients are waiting in ED since implementation.	The Committee received moderate assurance. Further	**QAC November 2019**

		• Test of Change pilot commenced 2.09.2019 for co-location and opening of GPAU 24/7 for medical and surgical assessment which will support improved patient flow and aspiration for Assessment Plaza.	updates to be presented at next meeting	
QAC/19 /09/142	SI Lessons Learned Q1 audit	The report provided Moderate Assurance the following points were highlighted for the Committee to note: • Evidence that learning processes are being embedded to be improved and feedback to Senior Leadership CBU team where improved performance is required. 58% of all actions closed, 22% overdue.	The Committee received moderate assurance. Further updates to be presented at next meeting	**QAC November 2019**
QAC/19 /09/147	Learning From Deaths Q1 report	The following key points were noted by the Committee: • 35 of the 174 deaths that occurred within the Trust met the criteria for a structured judgement review (SJR) through the Mortality Review Group (MRG) • 3 were subject to investigation using root cause analysis (RCA) methodology. • AC explained the Trust is not an outlier for HSMR (109.17) or SHMI (106.97). • Outcome of R Codes review to March Quality Assurance Committee	The Committee received moderate assurance. Further updates to be presented at next meeting and R Codes review in March Committee Meeting	**QAC September 2019 & March 2020**
QAC/19 /09/140	GPDR action plan Information Governance + Corporate Records High Level Briefing	The following key points were noted by the Committee: • Work continues to further mitigate IG /cyber risks including full compliance with IG training for staff. • No IG incidents escalated to the Information Commissioner Officer	The Committee received moderate assurance. Further updates to be presented at next meeting	**QAC November 2019**

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QAC/19 /09/150	GMC Survey Results – safety aspects	• Significant improvements since the last survey, all areas of concern down-graded: 20% reduction in red flags and 30% reduction to pink flags. Reduction in category 1 concerns and no category 2 concerns. • The Trust is waiting for advice from HENW if the Trust is still in enhanced monitoring for medicine. • 100% compliance from trainees to complete survey prior to submission date.	The Committee received moderate assurance. A Further update will be provided at future meeting of SPC, QAC and Trust Board	**QAC November 2019 & Trust Board Sept 2019**
QAC/19 /09/151	Strategic Risk Register & BAF	The Committee received and discussed the Strategic Risk Register & BAF agreeing the following amendments: • There were no new risks that are proposed for addition to the BAF; • There were no proposed amendments to risk ratings; • There were no proposed amendments to risk descriptions. • No risks proposed for de-escalation from the BAF. • The updated Board Assurance Framework will be presented to the Trust Board today. The Committee also received the Corporate Risk Register for the first time and specifically discussed the risk relating to Brexit	The Committee received significant assurance and further updates will be provided to the Board meeting today	**QAC November 2019**
QAC/19 /09/154	Delay of eMPA on quality agenda	The Committee received and discussed implications in delay in implementation of ePMA: • GP records from a number of systems to be available through Lorenzo, validation checks continuing. Information Sharing arrangements to be put in place in Halton + Warrington • TAC cards – solution for Out of Hours Doctors to be resolved.	The Committee received moderate assurance. The Board to receive associated business case as part of the meeting today	**QAC November 2019**

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

QAC/19 /09/156	MIAA CBU Governance Review	The Committee noted the report of Limited Assurance. Areas audited chosen to support and strengthen CBUs governance and administrative processes. A number of processes are now in place to strengthen these processes. Follow-up report to be presented to November Audit Committee	The Committee received a limited assurance report; however, significant improvements had taken place since the audit had been completed.	**Audit Committee 21.11.2019**

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

CHAIR'S KEY ISSUES REPORT

AGENDA REFERENCE:	BM/19/09/83 d	**COMMITTEE OR GROUP:**	Finance & Sustainability Committee	**DATE OF MEETING**	25 September 2019

Date of Meeting	21 August 2019
Name of Meeting + Chair	Finance & Sustainability Committee - Terry Atherton
Was the meeting quorate?	Yes

REF	AGENDA ITEM	ISSUE	Recommendation / Assurance/ mandate to receiving body	Follow up/ Review date
FSC/19/08/103	Pay Assurance Dashboard Monthly Report	• Pay spend is above budget in July • Agency is above the ceiling in July and a breakdown by staff group was reviewed and the data was compared against vacancies. A review by highest ward users has been completed • Centralised agency booking process has commenced with no negative feedback at present • Centralised bank was launched on 1 August 2019 • Consultation on high earner pensions and the impact on WLI and PAs was discussed • The revised agency rules were discussed and highlighted IM&T and Clinical Coding may be an issue under the new A&C rules.	The Committee reviewed, discussed and noted the report.	FSC Sept 2019
FSC/19/08/104	Risk Register	• Reviewed the report • Noted updates for one to one and Eastern Cancer Hub	The Committee reviewed, discussed and noted the report.	FSC Sept 2019

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FSC/19/08/105	Corporate Performance	• July A&E performance is 82.11% hitting trajectory • Diagnostics, RTT and Cancer targets met for July with exclusion of Breast • Backlog in reporting of diagnostics was a concern and linked to reduction in WLI but is now improving • Successful in a joint bid for rapid access diagnostics • Ambulance handover over 60 minutes is improving	The Committee noted the report.	FSC Sept 2019
FSC/19/08/106	Monthly Finance report	• M4 is on plan and assumes receipt of PSF, FRF and MRET • Discussed the risk in the position including CIP not being achieved, agency expenditure and unfunded cost pressures issues. • Discussed 121 issues • Noted the income risks in the position • Noted and supported the changes to capital plan to support ePMA • Noted that the Trust was not currently anticipating adding to the current loans	The Committee reviewed, discussed and noted the report with the financial risks and supported the changes to the capital plan.	FSC Sept 2019
FSC/19/08/107	CIP and unfunded cost pressures 2019/20	• Reviewed the progress from June Committee on CIP and movement of the UEC target to other CBUs • Cost Pressures progress has been slower • Acknowledged the actions being taken and the risk to the control total if not achieved	The Committee noted the report.	FSC monthly update Sept 2019
FSC/19/08/109	One to one	• Discussed the actions the Trust took following One to One announcing that they were ceasing trading. • Discussed the current financial position. • Wirral CCG commissioned the service and has not replied to a letter send in May 2019. Terry advised the Committee that he will write a follow up letter to the Chair of Wirral CCG.	The Committee noted the paper	FSC as required

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FSC/19/08/110	ePMA	• Reviewed the updated capital and revenue funding requirements for part 1 and 2 of the ePMA project • Discussed 2 week roll out and timing	The Committee supported revised funding requirements	Board September 2019
FSC/19/08/111	Limited Liability Partnership	• Verbal update of the work ongoing regarding the queries raised by the Board	The Committee noted the progress	FSC as required
FSC/19/08/112	Key issues for escalation	• Agency is an on-going challenge • Note the on-going discussions with pensions and WLI • Continued focus on CIP and Unfunded Cost Pressures • Support capital plan changes / ePMA		

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CHAIR'S KEY ISSUES REPORT

AGENDA REFERENCE:	BM 19 09 83d ii	**COMMITTEE OR GROUP:**	Finance & Sustainability Committee	**DATE OF MEETING**	18 September 2019

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

REF	AGENDA ITEM	ISSUE	Recommendation / Assurance/ mandate to receiving body	Follow up/ Review date
FSC/19/09/116	Pay Assurance Dashboard Monthly Report	• Pay spend is above budget in August • Agency is below the ceiling in August and a breakdown by staff group was reviewed, the data was also compared against vacancies and bank staff levels. It was noted that the monthly ceiling reduces in Q3 and Q4. • Annual leave remained similar to other months but bank increase in August (and end of July) linked to sickness. Along with reduction in shift fill rate with NHSP been a difficult month for nursing. • Currently same numbers of nurses recruited are planning on starting end September / October, normally 50% drop out. • Discussion about the alternative to using overtime such as NHSP may be cheaper. • On Call harmonisation review is underway with support from the unions.	The Committee reviewed, discussed and noted the report.	FSC Oct 2019

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FSC/19/09/117	Risk Register	• Reviewed the report • Noted no new risks or changes to the ratings or titles on BAF strategic objective 3 risks. • Some changes on the corporate risk register in particular BREXIT risk 701	The Committee reviewed, discussed and noted the report.	FSC Oct 2019
FSC/19/09/118	Changes in Cancer indicators	• Discussed the pilot indicators and what to include in IPR, it was suggested rather than just removing the old indicators a narrative should be added "Information not here as we are part of a pilot but should you require this information contact the Trust under FOI"	The Committee reviewed, discussed, noted the report and requested further discussion at Trust Board.	Board September 2019
FSC/19/09/119	Corporate Performance	• August A&E performance is 85.03% hitting trajectory • Diagnostics, RTT and Cancer targets met for August with exclusion of Breast • No 52 week breach patients • Ambulance handover over 60 minutes and 30-60 is improving • Discussion around 6 October deadline to make pension decisions and impact on WLIs	The Committee noted the report.	FSC Oct 2019
FSC/19/09/120	Monthly Finance report	• M5 is on plan and assumes receipt of PSF, FRF and MRET • Discussed the risk in the position including CIP not being achieved, agency expenditure and unfunded cost pressures issues • Noted the target for CIP increases in Q3 and Q4 and level on non recurrent CIP and the impact on the following year • Discussed 121 issues and the Administrators Report • Noted the income risks in the position • The suggested changes to capital plan were discussed and requested further discussion took place at the Private Board • Noted the emergency capital request approved by the Deputy	The Committee reviewed, discussed and noted the report with the financial risks and requested the suggested changes to the capital plan were discussed further at Private Board.	FSC Oct 2019.

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		Director of Finance on 22 August 2019 for £11k		
FSC/19/09/121	CIP and unfunded cost pressures 2019/20	• Reviewed the progress from August Committee on CIP and movement of the UEC target to other CBUs • Cost Pressures progress has been slower • Acknowledged the actions being taken and the risk to the control total if not achieved	The Committee noted the report.	FSC Oct 2019
FSC/19/09/122	Reference Costs	• The reference cost data was submitted in line with the guidance	The Committee noted the paper	FSC Dec 2019
FSC/19/09/123	Key issues for escalation	• Board discussion required regarding the narrative in the IPR for the cancer KPIs • Note the on-going discussions with pensions and WLI • Continued focus on Agency, CIP and Unfunded Cost Pressures • Private Board to discuss the current position with 121 and the Administrators Report • Private Board discussion required on suggested changes to the capital plan		

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CHAIRS KEY ISSUES REPORT

AGENDA REF	BM 19 09 83e	COMMITTEE OR GROUP:	Trust Board	DATE OF MEETING	25th September 2019

Date of Meeting	**Thursday 1st August 2019**
Name of Meeting + Chair	**Audit Committee – Ian Jones, Chair**
Was the meeting quorate?	**Yes**

REF	AGENDA ITEM	ISSUE	Recommendation / Assurance/ Action/Decision	Follow up/ Review date
AC/19/08 /59	Update from Chairs of Quality Assurance (QAC), Strategic People (SPC) and Finance + Sustainability (FSC) Committees	• Finance & Sustainability Committee – Challenges relating to CIP, cost pressures and agency spend were highlighted. • Strategic People Committee – Challenges relating to HMRC tax and pension changes were highlighted.	The Audit Committee noted the update	**n/a**
AC/19/08 /60	Changes or updates to the BAF	The Committee received the following update: • no new risks escalated to the BAF; • risk rating of two risks currently on the BAF to be reduced; • description of one risk amended; • five risks de-escalated from the BAF • Impact of any risk relating to HMRC tax and pension changes to be reviewed and scoped for addition to the BAF.	Further review to take place in the Quality Assurance Committee	**Quality Assurance Committee September 2019**

AC/19/08 /61	Internal Audit Progress Report	The Committee noted that: • 4 reports had been issued; • Information Standards (Discharge Summaries) (18/19) – Substantial Assurance; • Freedom to Speak Up Review – Substantial Assurance; • CBU and Specialities Governance Review (18/19) – Limited Assurance; • Follow Up Review It was noted in relation to the limited assurance received in the CBU and Specialities Governance Review (18/19) there had been a deep dive in to three CBUs and 3 Specialties. There was a framework in place; however, some meetings had been rearranged at the last minute, papers sometimes missing from packs circulated. Detailed action in place and leads assigned.	The Committee noted and discussed the report and progress against actions will be reported at the next meeting	**Audit Committee November 2019.**
AC/19/08 /62	Progress Report on Internal Audit Follow-Up Actions	The Committee particularly noted: • A total of 15 reviews (52 recommendations) were followed up. • At 22 July, 2 reviews had been fully implemented and 2 reviews been superseded. Remaining reviews contain recommendations that were overdue. • Recommendations relating to bank and agency staff progressing, supported by implementation of further enhanced checks in the systems 1 July 2019. • In relation to Cyber Security, the Committee had requested an update report from the CIO to the November meeting.	The Committee noted and discussed the report and requested that updates cyber security should be brought to the November meeting	**Audit Committee November 2019.**

AC/19/08 /65	Counter Fraud Progress Report 2018-19	The Committee particularly noted the following: • Counter Fraud plan is on trajectory for delivery, Theatres and stock review to be progressed. • Evidence collated for submission for consideration to the CPS for 1 on-going investigation. • Second investigation relating to over-payment, final cost to be agreed.	The Audit Committee noted the update	**Audit Committee November 2019.**
AC/19/08 /66	Review Losses and Special Payments Period 1 April 2019 - 30 June 2019	The Committee received the following update: • Value of Losses and Special Payments for the year to date after recovery of monies from NHS Resolution amounted to £91,096 • Increase in losses due to part compensatory payment of £45k for tribunal case, provision in accounts for £150k for full cost. • Stock losses £32,409, reduction compared to same period for 2017-18; pharmacy stock losses and gains £21,475 and theatre stock losses of £10,934. Sign-off had been completed in line with the Trust SORD/SFIs.	The Audit Committee noted the update	**Audit Committee November 2019.**
AC/19/08 /67	Review of Quotation and Tender Waivers	The Committee particularly noted: • In the quarter there had been 24 waivers at a value of £838,673 which is an increase of 6 (33%) compared to the number for the same period last year, the value has reduced by £431,131 (34%) • There were 12 retrospective waivers which is increase of 5 compared to same quarter last year. • 50% of the waivers were retrospective which is an increase compared to 39% for the same quarter last year.	The Chair of the Audit Committee to be provided with information on whether a procurement exercises could have been undertaken in advance of the Audit Committee to determine if individual Directors/Heads of Department should	**Audit Committee November 2019.**

			attend Committee meeting.	
AC/19/08 /68	Progress Report on Internal Audit Follow-up Actions	The Committee particularly noted the following: • At 30 June 2019, 4 audits have 6 outstanding management actions recorded. • one action over 12 months, relates to Cyber Security, CIO had provided assurance this is low risk, estates work is awaited and mitigations are in place until the recommendation can be completed.	The Audit Committee reviewed and noted the report	**Audit Committee November 2019**
AC/19/08 /69	On-Call Harmonisation Annual update	The Committee received the report that highlighted the following key points: • Terms and Conditions and Policy had been ratified in January 2019 • Phase 1 Radiology is in progress, formal consultation to recommence August 2019 with implementation scheduled for October 2019. • Phase 1 Senior Managers On-Call example rotas being scoped for discussion with affected staff, consultation to commence August 2019 with planned implementation October/November 2019. • Monitoring and exception reporting is through the Premium Pay Spend Revie Group. • The Committee discussed potential implications of Pharmacy in Phase 2 due to anticipated roll-out of 7 day working and CQC actions within Pharmacy	The Audit Committee noted the updates on the on-call harmonisation project.	
AC/19/08 /70	MIAA Overtime Audit – interim position statement on implementation of action plan.	The Committee was advised that following an internal audit in 2018 of the process of implementation of the overtime policy and how this was implemented in the Trust that received limited assurance, a remedial plan was developed for action by the Operational and HR teams.	The Committee noted the report and progress against recommendations	**Ongoing review in Audit Committee**

		The Committee noted progress on the following recommendations: • Recommendation 1, Trust Policy - 2 elements, 1st element for staff to adhere to Trust Policy had been completed 15 March 2019, with a letter sent to all Departments. Second element, regular departmental audits is in progress, mini-audit to be undertaken October 2019 to check implementation of the Policy. • Recommendation 2, Departmental Procedures – completed, letter sent to all departments (as above). • Recommendation 4, AFS testing – 2 elements, audit trail of documentation and pre-approval of over-time during annual leave. Policy checks, implementation to be part of the mini audits and prior approval of over-time during annual leave must be signed off by the Chief Nurse and COO. Policy had been ratified, will be published and disseminated through HR Business Partners	following the MIAA Audit	
AC/19/08 /71	Risk Management Strategy Annual Report + Revised Strategy	The Committee received the Risk Management Annual report and an update on the risk management strategy. The following aspects were of particular note. • embedding of DATIX risk module Trust-wide • Ward to Board risk monitoring through CBU/departmental risk registers, monitored through Risk Review Group; • The Trust had been able to provide evidence and examples for 2019 CQC inspection where risks had been escalated and mitigations put in place. • the development of Corporate Risk Registers for Sub Committee is near completion and will embed further the risk management processes	The Committee reviewed, discussed and noted the Annual Report and revised Risk Management Strategy	**Trust Board – September 2019**

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REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/19/09/84**	
SUBJECT:	**Learning from Experience Report - Q1 2019/20**	
DATE OF MEETING:	September 2019	
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	
	Choose an item.	
	Choose an item.	
STRATEGIC CONTEXT	The following report relates to implementation of the Trust's Learning Framework.	
EXECUTIVE SUMMARY (KEY ISSUES):	This is the quarterly integrated "Learning from Experience" (LFE) report. It focuses on the learning from incidents, complaints, claims and inquests over Quarter 1, 2019/20 (April - June).	
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	September 2019
	Summary of Outcome	Assurance provided
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

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NHS Warrington and Halton Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

SUBJECT	Learning from Experience Report Q1	AGENDA REF:	BM/19/05/42

1. BACKGROUND/CONTEXT

This report relates to the period 1st April 2019 to end June 2019. 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 Q1 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. KEY ELEMENTS

2.1 Assurance to the Board of Directors

2.1.1 Incidents

- There was a slight decrease in incident reporting within the Trust in Q1 when compared to Q4 (2651 vs 2594 in Q1) in terms of both number and level of harm

- The 'Reporting to Improve' campaign continues across the Trust and will continue to be highlighted in 19/20
- There has been a significant increase in the number of slips, trips and falls reported on wards B18, A4 and B14; this does not correlate with staffing incidents across these areas and the Falls Quality Improvement Collaborative is underway
- Incidents related to clinical care, pressure ulcers/ skin damage have slightly increased, with the Pressure Ulcer collaborative underway.

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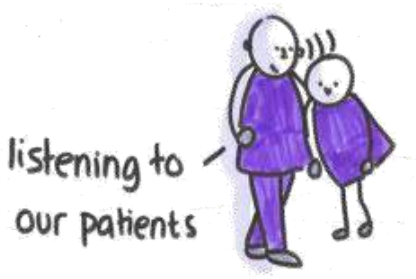
2.1.2 Complaints and PALS

- There has been a decrease in the number of complaints received Trust wide in Q1 (101 Vs 122) and the number of complaints closed within specified timeframes has improved (118 vs 93). There has been a reduction in PHSO referrals.
- The Trust currently has no complaints over 6 months old.
- Themes identified in complaints mirror those found across PALS and incident reporting; delay in appointments and co-ordination of treatment, poor communication and diagnostics.
- Actions from complaints are monitored via the speciality governance dashboards and the Clinical Governance Department, reporting to the Complaints Quality Assurance Group.



2.1.3 Mortality

- As part of the mortality review process the majority of Structure Judgement Reviews (SJR) conducted in Q1 have concluded an overall standard of care as 'Good, adequate' or 'Excellent'. 2 SJRs were reported as 'poor'.
- The absence of DNACPR, DoLs and under 55 reviews are the most common triggers for conducting SJRs

2.1.4 Clinical Audit

- There are a number of audits ongoing across the Trust. For Q1 this briefing makes reference to National Prostate Cancer Audit and Effectiveness of Rectus Sheath Catheters in Laparotomy Patients. Recommendations for which can be seen in the attached slide pack.

2.2 Items escalated in Q1

2.2.1. Clinical Incidents

- There was a slight decrease in incident reporting within the Trust in Q1 when compared to Q4 (2651 in Q4 vs 2594 in Q1) in terms of both number and level of harm

- Q1 reports a significant increase in open incidents; 337 Vs 216 the majority of which are attributed to Urgent and Emergency. The number of incidents breached over 40 days was 23 and over 20 days was 65. Whilst further work is required to close incidents in a more timely manner, the number received is not disproportionate given the complex nature of the department.
- Medical care, digestive diseases, diagnostics and outpatients, Women's and Children's, integrated medicine and community also have a relatively high number of incidents open.
- A total of 1532 incidents were reported across 4 CBUs in Q1 indicating a slight decrease when compared to Q4. The top 5 categories reported in Q1 remain the same as in Q4 (clinical care, communication, pressure ulcers and security) with the exception that medication incidents have been replaced by slips, trips and falls. Of the categories previously reported clinical care, pressure ulcers/ skin damage have slightly increased whilst incidents linked to communication and security have slightly decreased. With regards to security incidents, a Task and Finish Group has been established to look at supporting patients and staff when there is clinically challenging behaviour. This is being reported to Quality Committee in November 2019.
- Q1 has also reported a marginal increase in infection control incidents. Whilst this is minimal this should be closely monitored particularly given the slight increase in incidents relating to pressure area care, considering the potential consequence of those factors combined. The most common theme reported in the SI cause group for Q1 relates to unstageable pressure sores. The Trust have launched the Pressure Ulcer Collaborative, which is being reported to the Quality Committee at this meeting.
- Acute Cardiac Care reported a significant increase in 'staffing incidents'. This has been the result of staff movement, sickness, vacancies and improved reporting. The need for enhanced levels of observations is also reflected in this data. This is being monitored by the CBU.
- In terms of incidents with harm, Q1 has reported 3 moderate and 1 major incident; 2 relate to neonatal death. These investigations concluded no harm caused by the care delivered at the Trust.

- Whilst falls incidents in Q1 have not been linked to harm there has been an increase in reporting on ward B14, A4 and B18. B18 reported the most significant increase and whilst falls within these speciality areas (stroke, gastroenterology and elderly care) are not uncommon further support in these areas may be required. There is no correlation with the number of staffing incidents reported in Q1 to suggest significant staffing deficits in these areas.

2.2.2 Non clinical incidents

- Q1 reports 381 non clinical incidents, 13 of which were sharp related incidents posing potential risk of harm to staff. With regards to sharps prevention, the Health & Safety Sub Committee is overseeing a safer sharps awareness and auditing programme.

2.2.3 Complaints

- Women's & Children's, MSK and Integrated Medicine and Community have improved performance responding to complaints within the specified time. The remaining CBUs performance has decreased in terms of performance and timeframes.
- The Parliamentary and Health Service Ombudsman (PHSO) commenced 1 investigation into the Trust in Q1.

2.2.4 Claims

- 44 claims were received in Q1 and payments for claims settled with damages totalled £152,000.00
- There were 4 Serious Incidents logged as a claim all of which were reported to NHSR.

2.2.5. Mortality and Morbidity

- The Summary Hospital Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratios (HSMR) are within expected range though data has shown an upward trend. This will continue to be monitored. Nationally, NHS digital will release SHMI data monthly rather than quarterly to enable more timely reporting.
- Medical Care, Integrated Medicine and Community and Urgent and Emergency Care report the highest number of mortalities, though this is not disproportionate when considering the type and number of patients cared for in these areas.
- Whilst Q1 reported 2 'poor' ratings in relation to SJRs the overall standard was reported as 'good' or 'adequate' with some evidence of excellent care within the reviews. DNACPR continues to be one of the largest triggers for SJR. With regard to End of Life, the Trust has approved the End of Life Strategy and has appointed two Palliative Care Consultants who are due to take up post in the next few months.

3. Recommendation

Trust Board are asked to discuss and note this highlight report and accompanying slides.

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And together we

make a difference

Learning From Experience Q1 Report

Ursula Martin

Director of Integrated Governance & Quality

July 2019

Overview

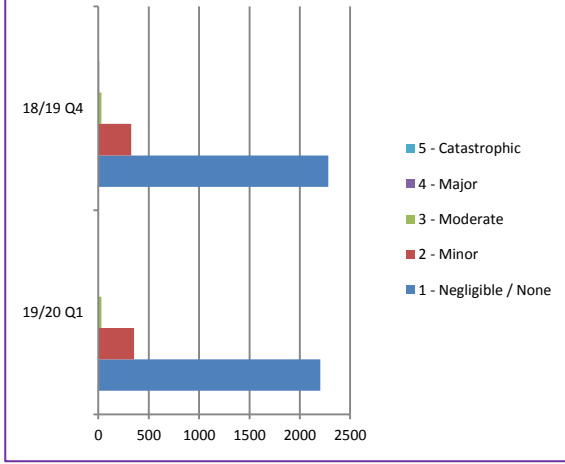
The following slides provide an overview of the information extracted from the Datix system and other clinical governance reports for Incidents, Complaints, Claims, Health & Safety, Mortality and Clinical Audit related to Quarter 1, 2019/12. They should be viewed in conjunction with the High Level Briefing Report.

Incident Headlines

Warrington and Halton Hospitals NHS
NHS Foundation Trust

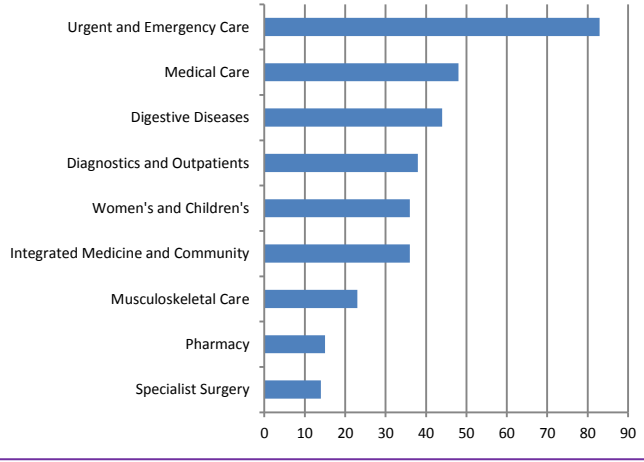
How many staff are raising incidents Q4 vs Q1?

- There was a slight **decrease** in incident reporting within the Trust in Q1 (2651 in Q4 vs 2594 in Q1).
- There was a **decrease** in incidents causing Moderate to Catastrophic harm in Q1 (42 in Q4 vs 36 in Q1).
- The number of minor harm incidents increased slightly in Q1.



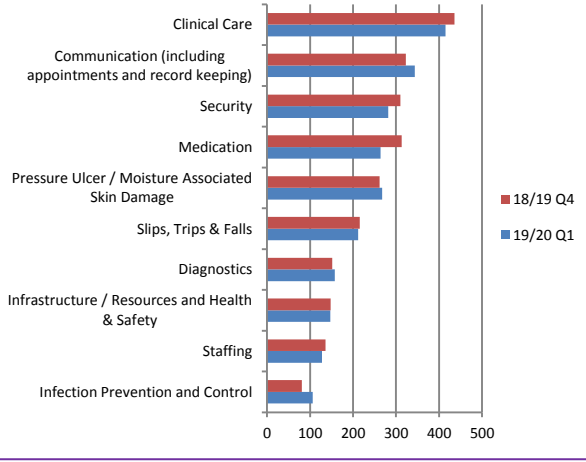
How many incidents are open Q4 vs Q1?

- The Trust reported 216 incidents open in CBUs in the Q4 LFE. To date that has increased to 337. The graph below shows 9 CBUs with open incidents.
- Providing feedback and closing incidents in a timely manner remains an important focus and work will continue to ensure that performance improves.
- Work continues in the Trust to monitor open incidents closely and ensure incident reviews are completed efficiently across the organisation.



What type of incidents are we reporting Q4 vs Q1?

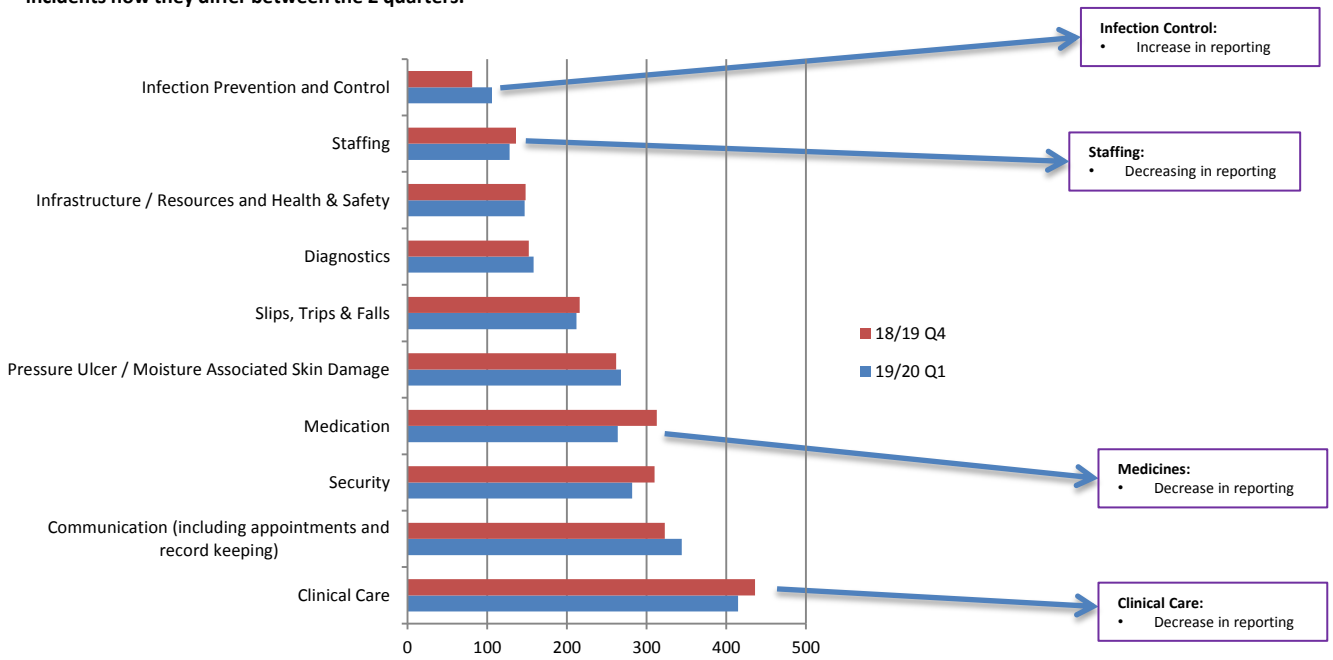
- As stated there was a decrease in the amount of indents reported. Incidents relating to clinical care, medication, falls and staffing decreased in Q4; however, issues relating to pressure ulcers, infection control and diagnostics increased.



Incident Category Analysis Q4 vs Q1

Warrington and Halton Hospitals NHS
NHS Foundation Trust

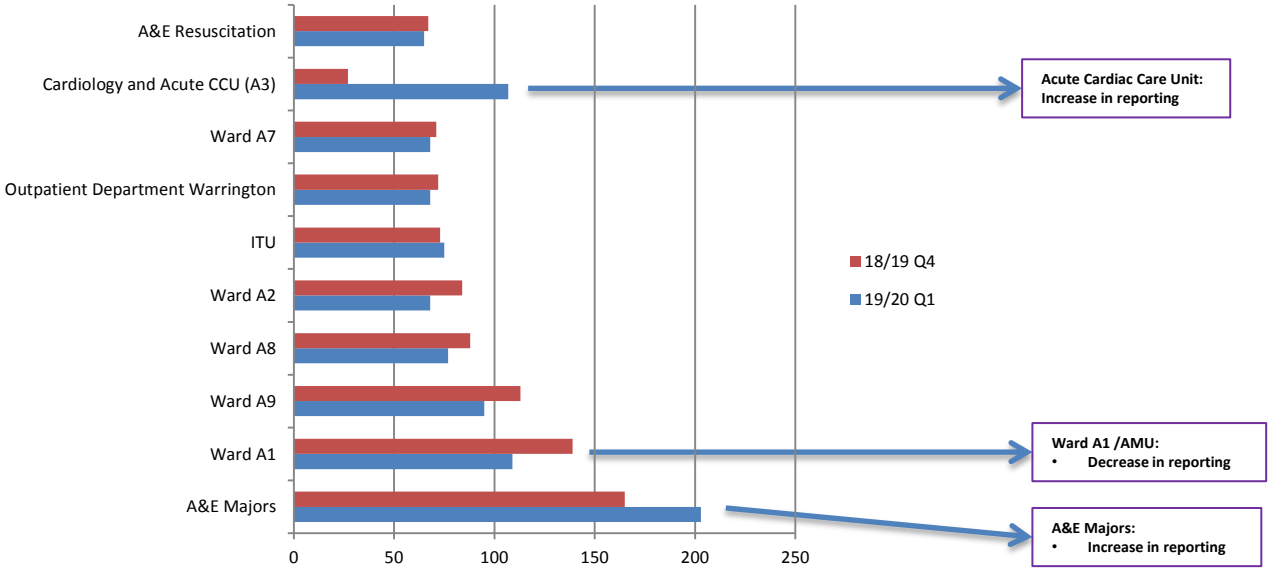
The information shows the top categories reported incidents how they differ between the 2 quarters.



Incident Location Analysis Q4 vs Q1

Warrington and Halton Hospitals NHS
NHS Foundation Trust

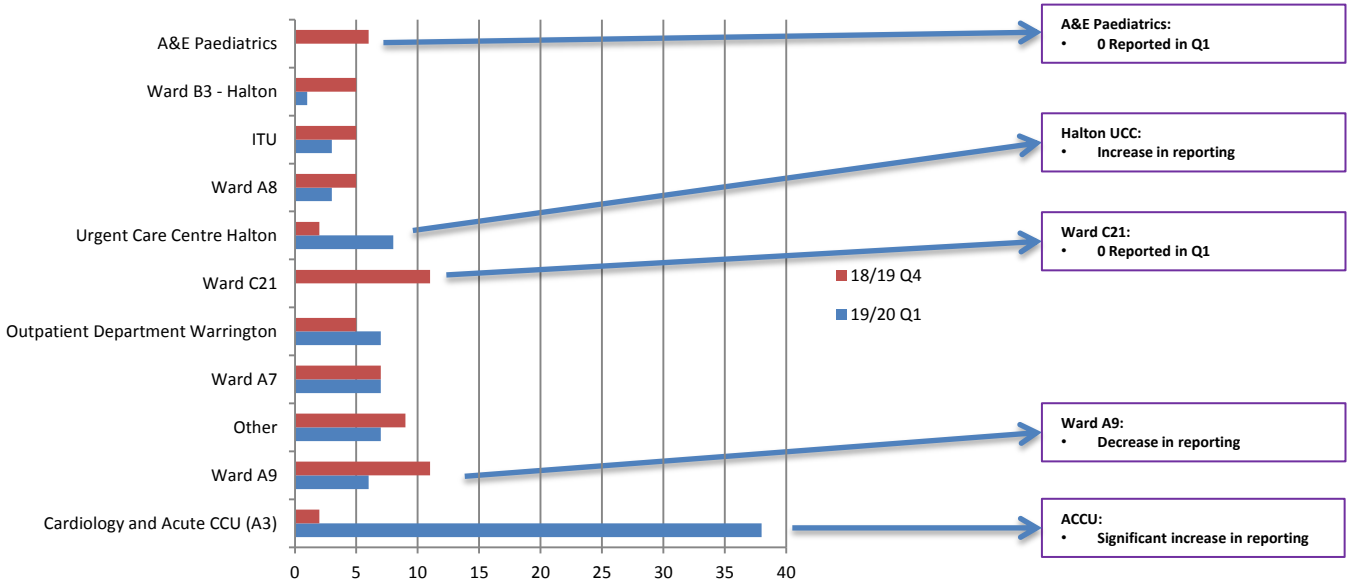
The information shows the top reporting locations and how they differ between the 2 quarters.



Staffing Incidents Location Analysis Q4 vs Q1

Warrington and Halton Hospitals NHS
NHS Foundation Trust

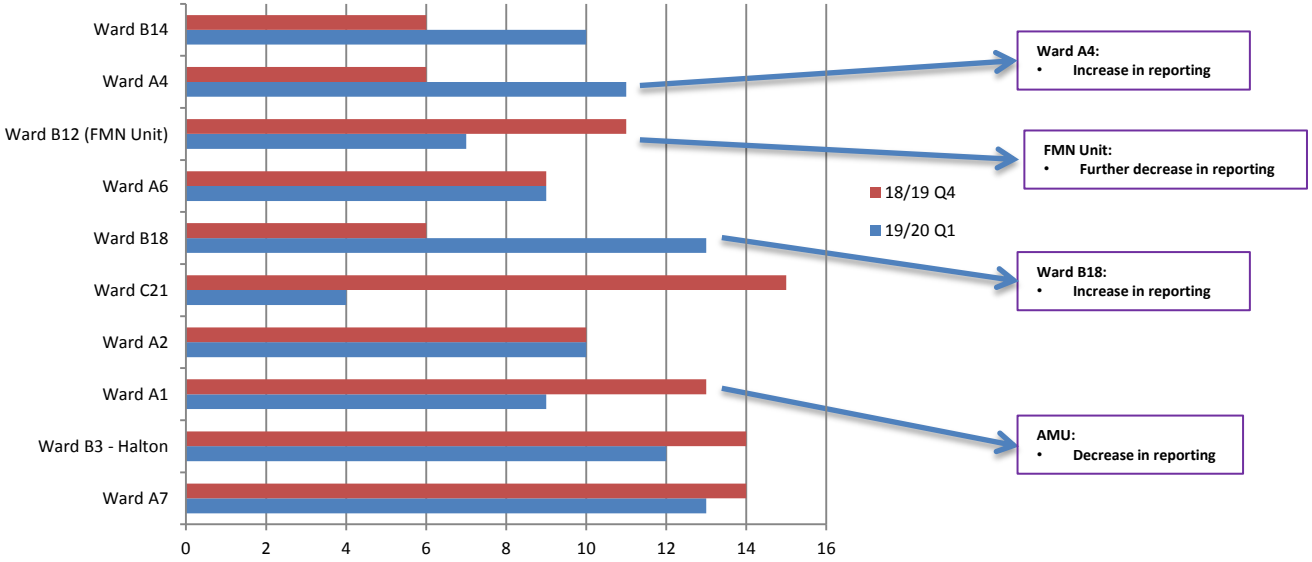
The information shows the top reporting locations in relation to staffing incidents and how they differ between the 2 quarters.



Patient Falls Location Analysis Q4 vs Q1

Warrington and Halton Hospitals NHS
NHS Foundation Trust

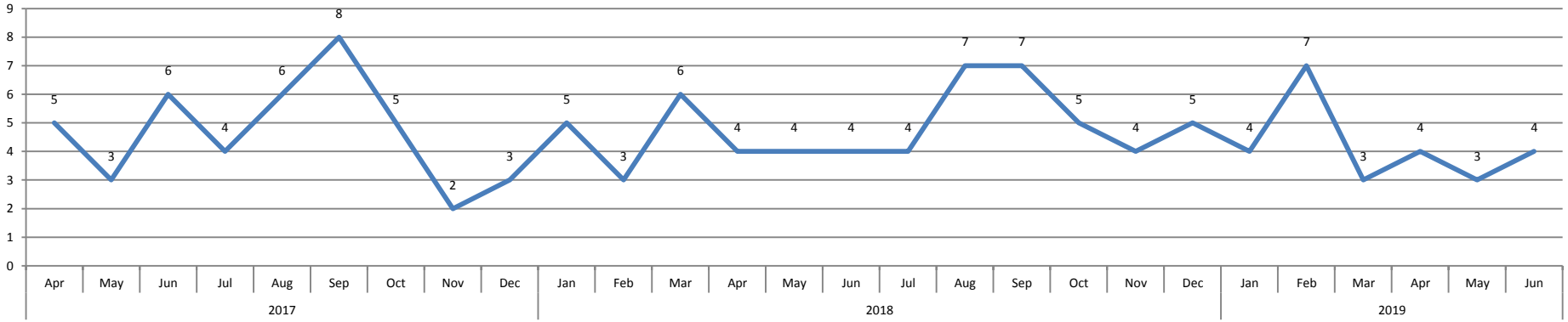
The information shows the top reporting locations in relation to patient falls and how they differ between the 2 quarters.



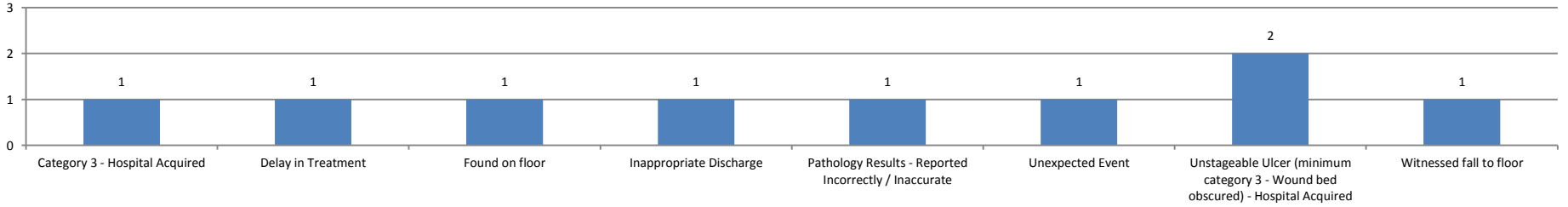
Serious Incident (SI) Reporting

Warrington and Halton Hospitals NHS
NHS Foundation Trust

SIs reported by Month



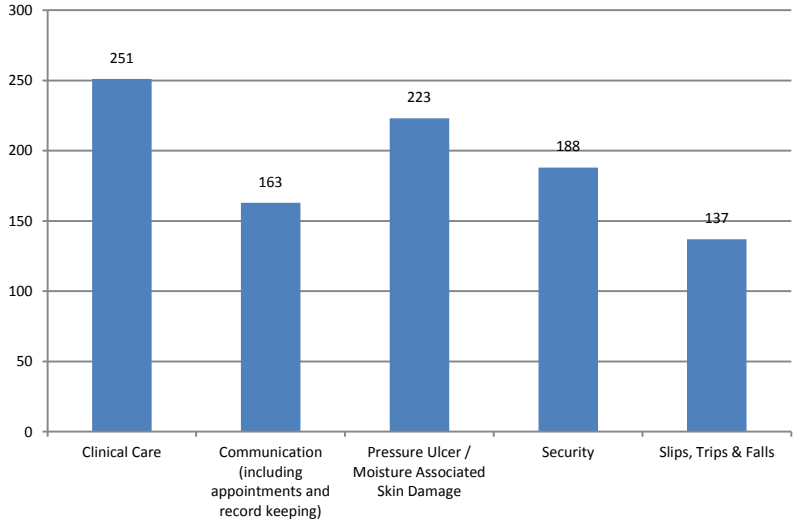
SI Cause Groups Q1

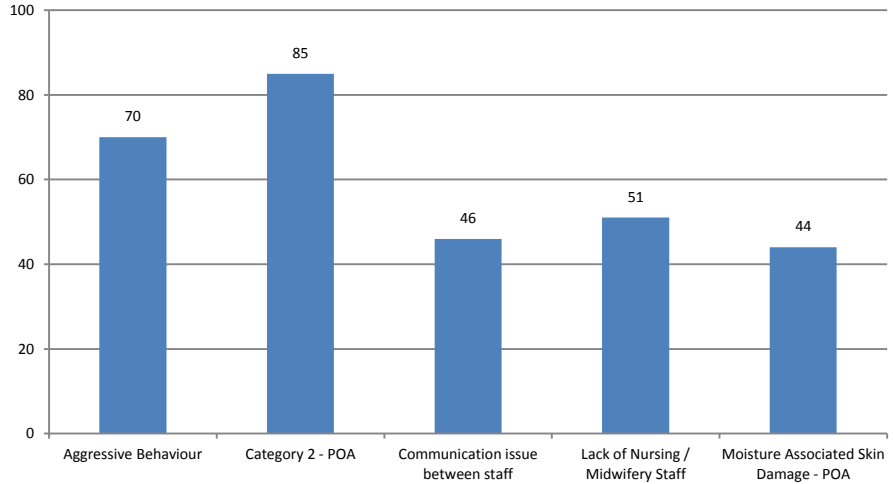


Urgent & Emergency Care, Medical Care, Diagnostics & Outpatients and Integrated Medicine & Community Incidents for Q1 (April to June 2019)

Warrington and Halton Hospitals NHS
NHS Foundation Trust

A total of 1532 incidents were reported across the 4 CBUs in Q1, this has decreased slightly from 1564 from Q4 . The top 5 categories and subcategories were reported as follows:

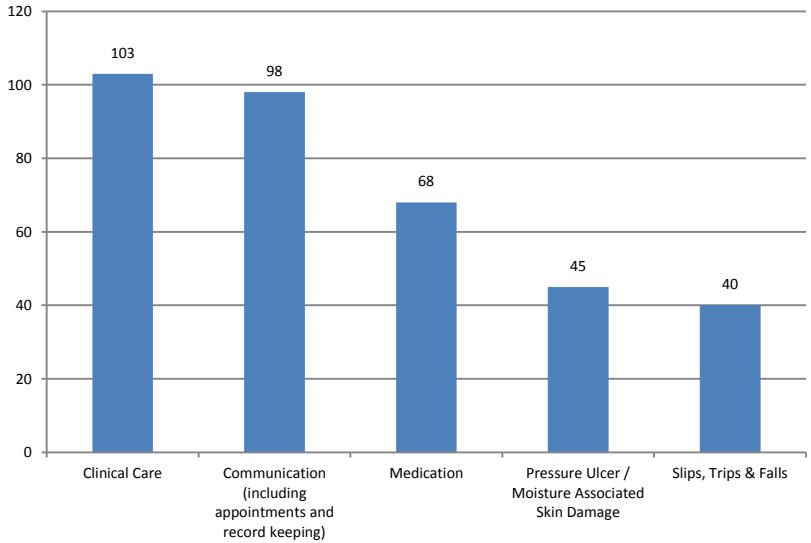


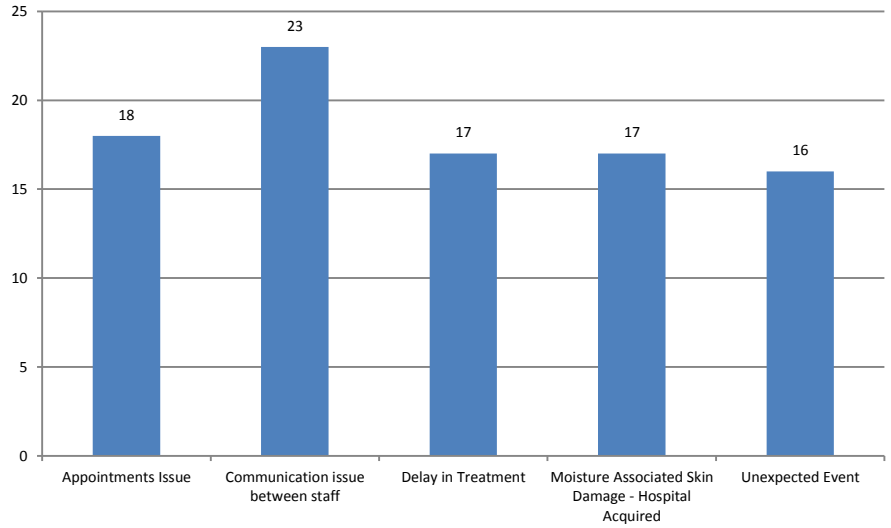


Digestive Diseases, Musculoskeletal Care and Specialist Surgery Incidents for Q1 (April to June 2019)

Warrington and Halton Hospitals NHS
NHS Foundation Trust

A total of 509 incidents were reported across the 3 CBUs, this has decreased slightly from 523 from Q4. The top 5 categories and subcategories were reported as follows:

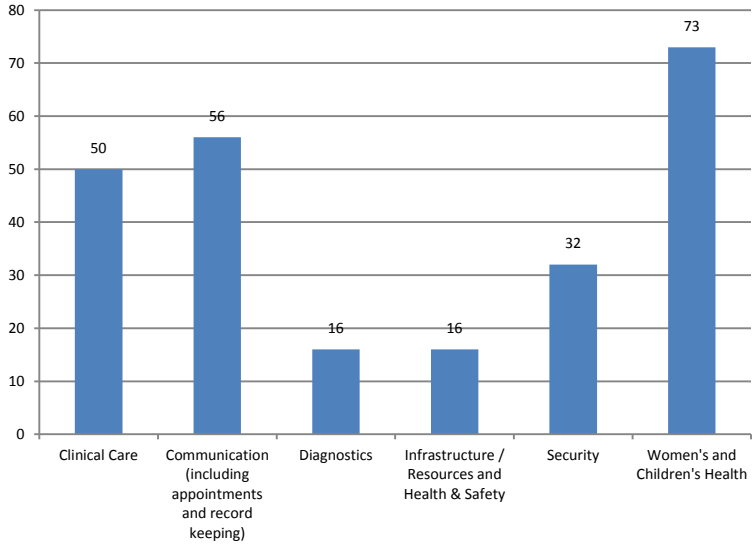


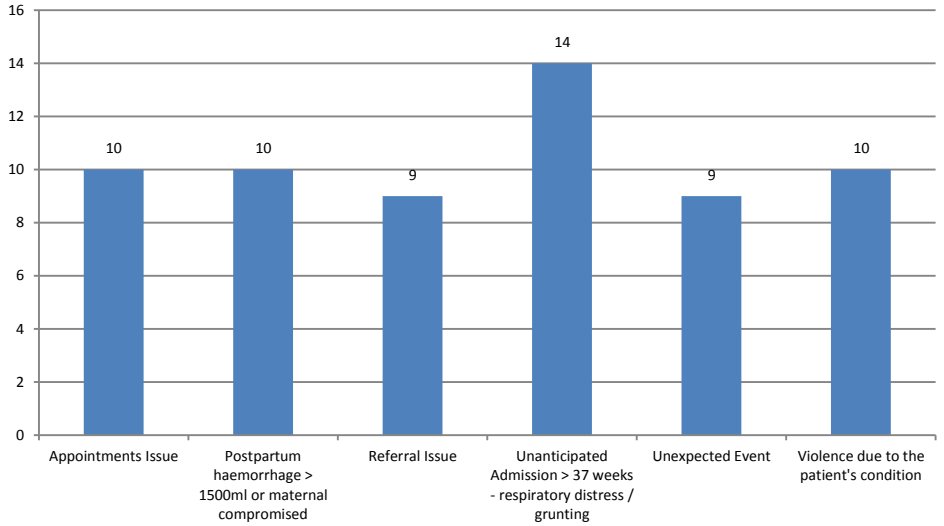


Women's and Children's Health Incidents for Q1 (April to June 2019)

Warrington and Halton Hospitals NHS
NHS Foundation Trust

A total of 312 incidents were reported in the CBU, this has decreased slightly from 323 from Q4. The top 5 categories and subcategories were reported as follows:





Learning from Incidents

What staff told us…….	Actions taken/Lessons Learned
Patient had an MRI scan which identified gall stones. The clinician who reviewed the MRI scan documented no gall stones and the patient was discharged. The patient had several admission with the same symptoms and each clinician reviewed previous documentations without reviewing the MRI scan and gave advice of no gall stones in their management plans. A consultant reviewed at another admission, reviewed the scan, informed the patient of the gall stone, booked a repeat MRI and a management plan was made for treatment.	Clinical results should be reviewed by the requesting clinician. Patient with multiple admissions and the same symptoms should be reviewed by a senior clinician.
Patient was diagnosed with hypokalemia and weighed <18kgs was prescribed 3 Sando K tablets 3 times a day which was given. The next day following administration the patient was hyperkaelemic and commenced on insulin therapy at a regime not suitable for the patient and this resulted in unstable blood sugars over a 48 hour period. Referral was made to the diabetic team who reviewed and made a management plan. The blood sugar became stable following involvement of the diabetic team.	Prescribers to consider the patient's clinical presentation when prescribing medication. Consider the relevant pathway when prescribing and contact the relevant specialist for advice. In this case the pharmacy team could have been contacted for advise on the prescription for Sando K.
Elderly patient was having rehabilitation on the ward, medical treatment and used a Zimmer frame to mobilise. Dosage of diuretic medication was increased. The patient used the Zimmer frame to stand, fell and sustained a fractured neck of femur.	There should be a clear management plan in place for patients at high risk of falls who have been prescribed increased doses of diuretics e.g. regular toileting on care and comfort rounds. The use of urinals for male patients should be considered in the care plan.

Learning from Incidents

What staff told us…….	Actions taken/Lessons Learned
Patient sustained a bowel perforation which is a rare but known complication of Colonoscopy and the patient sadly passed away. Advice was given to the primary team for CT colonoscopy prior to the procedure and this did not take place due to miscommunication.	Colonoscopy could have been avoided by better communication between endoscopy and the referring medical team. Advice requested from another specialty must be taken into consideration, when planning further management for a patient.
A very rare lesion was missed on MRI scan. The lesion was identified five months later when the MRI scan was repeated.	Awareness of rare pathologies as a cause of common presentations such as low back pain. Escalation to specialist clinical teams if no improvement of symptoms after standard care.
A surgical high risk patient attended for procedure. Lengthy discussion with patient and family regarding the risks of surgery. Surgery was required to give patient quality of life. The patient sadly passed away following the procedure.	The pre-operative discussion with patient and family were well documented in Lorenzo by the anaesthetist; this resulted in a much easier discussion with the family when the patient died and is excellent practice. It is good practice to include medical complications and death as risks when completing consent forms in high risk patients.

Learning from Incidents

Urgent and Emergency Care

Patient Safety

Background

- A patient was extracted from the bottom of a quarry and transferred to Warrington Emergency Department at the recommendation of the Trauma Cell.
- The patient was booked in with the presenting condition of hypothermia.
- Patient disclosed the mechanism of injury (fall from 30-60ft) 15-20 minutes after arrival. This was not escalated at the time and the trauma team was not activated. Bloods were taken and escalated to the ED Consultant in view of the elevated lactate.
- The patient required an urgent chest drain and was transferred to CT which showed significant, serious injuries the patient was transferred to a Major Trauma Centre.
- Arriving at the Major Trauma Unit in a stable condition at 16.40, the patient deteriorated at 21.00 and was taken to theatre twice for haemorrhage control from a liver laceration. The patient had a further intra-abdominal bleed resulting in cardiac arrest. The patient is reported to have hypoxic brain injury and is listed for a rehabilitation unit.

Lessons Learned

- If a patient meets the Trauma Team activation criteria a Trauma Call should be made
- Trauma patients requiring CT scan should be scanned within 1 hour.
- Patients should be triaged within 15 minutes
- Ambulance handover must be supported by written documentation at the time of handover of patient.
- Trauma patients requiring transfer are to be escorted by an anaesthetist

Learning from Incidents

Urgent and Emergency Care

Sharing Outcomes

Background

A patient was admitted from a Nursing home following a fall.

Ambulance paperwork notes GCS of 7/15.

No Neurological observations were taken by nursing or medical team, AVPU was noted.

Clinical examination refers to ambulance assessments of pupil reaction , pupil reaction not checked on initial nursing or medical review.

CT showed a large subdural hemorrhage, with midline shift. The patient was managed conservatively and died on the ward

Lessons Learned

Patients admitted with a head injury must receive a full neurological assessment including pupil reaction

Adult patients with head injuries must be commenced on the head injury fast track

Patients with GCS <14/15 should be transferred to Resus/ Majors

Learning from Incidents - WACH

- There were three moderate and one major incidents reported in Q1.
- 13 Incidents required a 72 hour review.
- Two Incidents were Neonatal deaths, one over 37 weeks gestation which was therefore referred to HSIB.
- Following review one Incident has been declared a concise RCA (currently in progress) and another has been declared a Serious Incident (also in progress)

Background ~ SI

- The patient attended the trust in 2016 and was diagnosed with complex hyperplasia following this should have been under 6 monthly surveillance with endometrial biopsies. This did not happen and the patient has now been diagnosed with endometrial carcinoma.
- The patient was not kept under surveillance as per RCOG guidance. Surveillance may have detected the endometrial cancer earlier. It cannot be said with certainty if earlier detection would have changed her treatment outcome and prognosis.
- Expected completion ~ end of September.

Background ~ RCA

- The patient had a total abdominal hysterectomy:
- The patient's uterus was removed with both ovaries and tubes but the cervix was removed separately.
- Later revealed that part of the cervix still remains
- Possible cervical cancer

Learning from Incidents - Paediatrics

We found….	We Acted….
A known high risk CAMHS patient, refused routine observations by the carer providing 1: 1 care and pulled blanket over her head. Another member of staff was called to assist, noted the patients face was very flushed. The blanket was removed to reveal a ligature had been applied this was removed with a ligature cutter. No loss of consciousness or cyanosis at this time. Observations recorded , saturations 99%.	Appropriate nursing and medical intervention with no further medical input required at the time. The ligature applied was the headband from a doll; all equipment, belongings and furniture was removed from the room to minimise the risk whilst awaiting an alternative more appropriate placement. 1:1 observation continued and the daily ward safety huddles increased to communicate escalating concerns and to provide staff support.
A young male, deemed vulnerable absconded from the ward, on return it was confirmed he was carrying a small piece of glass. which was surrendered to staff, though it was believed he may still have retained some.	Police, Social Services, Parents and Site Manager informed. The Absconsion checklist was completed and the risk assessment adhered to. The checklist which is completed on admission will be amended to include informing both the safeguarding children team: for information only initially and the security team - to enable them to have a contingency plan in place if additional staffing is required when there is a high risk admission. CAMHS will be invited to any future 72 hour reviews to provide some valuable advice and input. The officers who escorted Daniel back to the ward did not perform a handover or provide their badge numbers to the ward as would have been expected – this was be fed back to the police.
Patient had 10mg of oral oramorph in PED at 06.00 and a further 2mg of IV morphine administered in theatre at approximately 08.20. Dose reported to have been given too soon . Child was monitored appropriately and there was no adverse effect. Parents informed of possible drug error.	Discussed with Pharmacy and is not an overdose. Discussed with anaesthetist who reported the morphine was given IV in theatre based upon clinical judgment for pain relief and did not exceed safe doses. Nursing staff advised that any questions regarding drugs or doses given should be discussed directly with the anaesthetist in question before speaking to the family.

Learning from Incidents - Women's Health

Warrington and Halton Hospitals NHS
NHS Foundation Trust

We found….	We Acted….
Patient 24 weeks pregnant, had a Fit/Seizure on ward C23. Known to have a history of non-epileptic seizures not on any medication. Emergency measures were triggered; appropriate assistance required patient safety ensured, iv access, bloods and blood sugar obtained, observations completed and Fetal heart auscultated.	Appeared like a Grand Mal seizure due to patient rigidity and behaviour there was no evidence of pre eclampsia or eclampsia. So following Obstetric and medical review the patient was transferred to ward C20 for nursing care.
Term baby admitted from labour ward following traumatic delivery, shoulder dystocia, Baby weighed, placed in incubator in ambient oxygen. Cannula sited bloods obtained. X-ray revealed showed fractured clavicle.	Shoulder dystocia is a known risk of vaginal delivery but was not documented as having been discussed when induction of labour was booked. This is not current practice but may be advisable to consider changing policy, to be discussed with senior staff. Induction was booked for 38 not 39 weeks as per the policy but induction occurred earlier due to development of PIH, the Governance lead will remind other clinicians.
Patient on C20, in a bay of 6 people including one pregnant lady has tested positive for mumps, Patient had not been isolated despite the associate nurse recording that screening for mumps had been sent.	No harm caused to the patient with mumps as appropriate treatment was given. The Pregnant woman was advised of signs and symptoms of mumps and to report any signs of illness. No antenatal action was required as she did not have any direct prolonged contact with the infected woman. The Screening midwife was informed of the incident and no further action was required. The occupational health department was also informed.
A patient was admitted, with three carers, to the ward from a local a secure mental health facility wearing handcuffs. Once the handcuffs were removed the patients wrists were noted to be very red with a blister present on the right wrist. The blister was dressed appropriately and a barrier cream was applied to the left wrist.	Carers from the secure facility were advised of the concerns regarding the skin integrity and advised that the handcuffs may need to be left off to ensure healing but the decision is theirs and needs to be discussed with their managers and the three carers would need to remain at all times.

Learning from Incidents - Radiology

Warrington and Halton Hospitals NHS
NHS Foundation Trust

We found….	We are doing….
An outpatient had a cardiac arrest in the waiting room whilst waiting for an MRI scan. A number of areas for learning were identified during the event, such as the confidence of the staff in managing the situation, locating and using the equipment.	• Amended the process for daily oxygen checks so that the cylinder is now turned on to check the oxygen flows rather than just observe the gauge. • Radiographers who work in CT and MRI now undertake intermediate life support (as opposed to basic life support) training as they did previously to ensure they feel capable and confident to manage a resus situation. • Reviewing the the procedure for the management of a cardiac arrest in the unique MRI environment and introducing a ‘practice drill’ for the procedure.
A patient from A&E had a cardiac arrest and died on the CT scanner outside normal working hours. The incident raised a number of concerns about the handling of patients who pass away outside of the ward/A&E environment such as in diagnostic areas.	• Developing a written procedure to cover the management of deceased patients in diagnostic and other outlying areas by putting together a working group including representation from A&E, ITU, theatre and Radiology. • Plans to share the completed procedure with all relevant staff to ensure awareness for all groups of staff potentially involved. • Radiology to keep a greater amount of items for re-stocking the resus trolley, to ensure it can be re-stocked without having to access stores.

Learning from Medication Incidents

Warrington and Halton Hospitals NHS
NHS Foundation Trust

We found….	We Acted….
The number of diabetic incidents being reported on Datix each month for the Trust was increasing. An analysis of the diabetic incidents was completed and it was identified a significant number of the incidents were due to a patient's insulin dose being omitted or delayed.	Taken to the Trust Safety Huddle, Pharmacy Safety Huddle and Medical Handover to highlight: • Insulin is a critical medicine and should be administered as prescribed. • The importance of prescribing insulin on the white prescription chart. • If a patient is prescribed an IV insulin infusion and normally takes background long acting insulin (E.g. Lantus, Levemir, Toujeo), this should be continued at the usual dose and time. • Guideline on the Extranet: Short-term Management of Patients with Diabetes when Treatment Regimen Unknown.
An adult patient with cerebral palsy who only weighed 17 kg was hypokalaemic with a potassium level of 2.8. They were prescribed Sando K at a dose of 3 tablets TDS, higher than the usual dose for a full size adult. Next day potassium levels were 7.6 and an insulin and glucose infusion was administered to treat the hyperkalaemia. The patient subsequently experienced a number of hypoglycaemic episodes which required treatment and frequent monitoring.	Learning and actions from the 72 hour review included: • Prescribers to consider the patient's clinical presentation when prescribing medication. • The incident to be discussed at the next M&M meeting. • To consider implementing a hypokalaemia guideline. A concise root cause analysis is now being completed for the incident to identify further learning and actions. Taken to Medical Handover to advise when prescribing a medication to always consider the weight of the patient to ensure the dose is appropriate.
IV medications were made up for multiple patients at the same time. This resulted in one patient receiving IV co-amoxiclav which was intended for another patient. The patient had a documented allergy to penicillin, however did not experience a reaction to the co-amoxiclav administered.	A Safety Alert with recommendations on preparing and administering intravenous medications was sent across the Trust, as there was a concern that this practice of preparing IV medication for multiple patients at the same time may be happening in other wards/clinical areas. **This practice increases the risk to patients and is not safe.**

Learning from Incidents

Pressure Ulcers

Actions taken/Lessons Learned
Patients in ED at risk of pressure ulcers should be nursed on Repose trolley topper or dynamic mattress and hospital bed
Patients with orthopaedic devices to receive regular input from orthopaedic team
Dynamic mattress stores to be used out of hours if mattress required urgently
Accurate waterlow assessment will lead to the appropriate mattress being put in place from admission
All risk assessment should be completed within six hours of admission as per the Trust guideline
Education on correct fitting and care of NIV masks
Patients at risk of heel pressure ulcers to have heels floated to alleviate pressure

Learning from Incidents

Information Governance

Radiology referral for patient A included in error in a letter sent to patient B

Action Taken

- Incident reported locally and escalated to NHSX
- Patient A contacted and given details of data items included in the referral
- Patient B initial complaint processed
- SIRO and Caldicott Guardian briefed

Lessons Learned

- A review of printing arrangements in Radiology has been conducted
- The re-siting of printers in Radiology will be considered in order to limit the possibility of re-occurrence
- Radiology staff awareness increased around the use of communal printers
- Review of IG incidents with a specific focus letters sent from the Trust at Information Governance and Corporate Records Sub-Committee scheduled for August 2019

Coroners referral forms containing person identifiable data became available on the hub.

Action Taken

- Documents removed from Hub
- Guidance to prevent re-occurrence of incident issued to users on the referral form

Lessons Learned

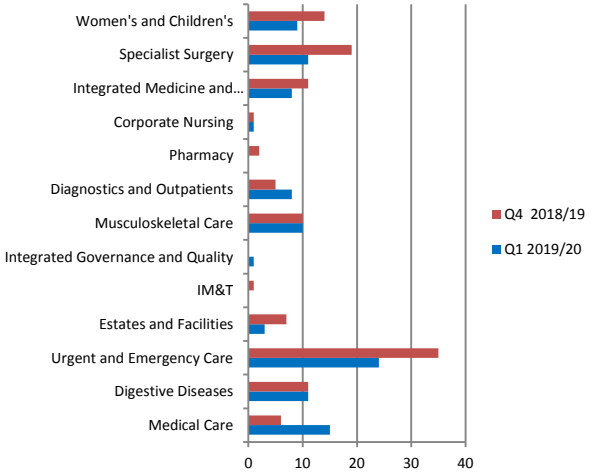
- The process has been changed so that the bereavement team will monitor all documents saved. The documents will now be saved a local temporary file of the individual user and sent to the coroner. This eliminates the possibility of re-occurrence.
- Processes changed in order to prevent further occurrences as a result of developing systems in-house. Robust arrangements to review all project documentation and the specification of systems developed in-house will be routinely adhered to via the Solutions Design Group.

Complaints Headlines Q4 vs Q1

Warrington and Halton Hospitals NHS
NHS Foundation Trust

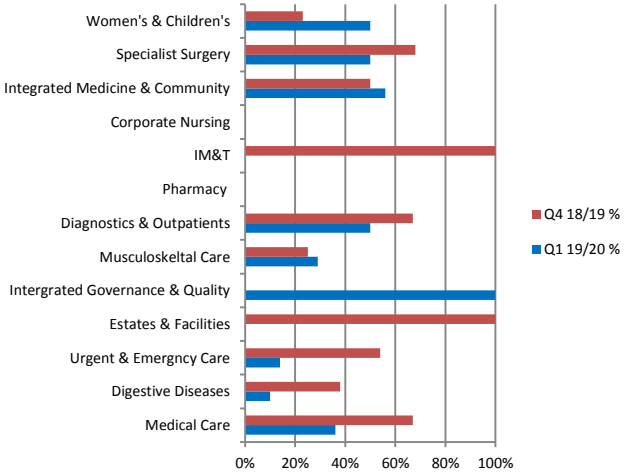
How many people are raising complaints Q4 vs Q1?

- There was an **increase** in complaints opened Trust wide in Q1 (101 versus 122 in Q4).
- Some CBU's saw an increase in the number of complaints received in Q1 (Medical Care and Diagnostics and Outpatients). Urgent and Emergency Care, Women's and Children's, Specialist Surgery, Integrated medicine and Community and Estates and Facilities saw a decrease in the number of complaints received in Q1.



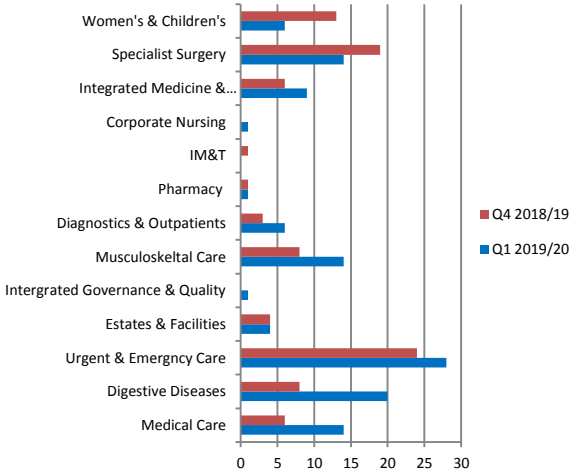
Are we Responsive Q4 vs Q1?

- Women's and Children's , MSK and Integrated Medicine and Community increased their performance for responding to complaints on time. Remaining CBU performance was decreased.
- The Trust currently has 10 breached complaints
- There are no complaints over 6 months old
- There is a plan in place to complete all the breached complaints.



How many complaints has the Trust closed Q4 vs Q1?

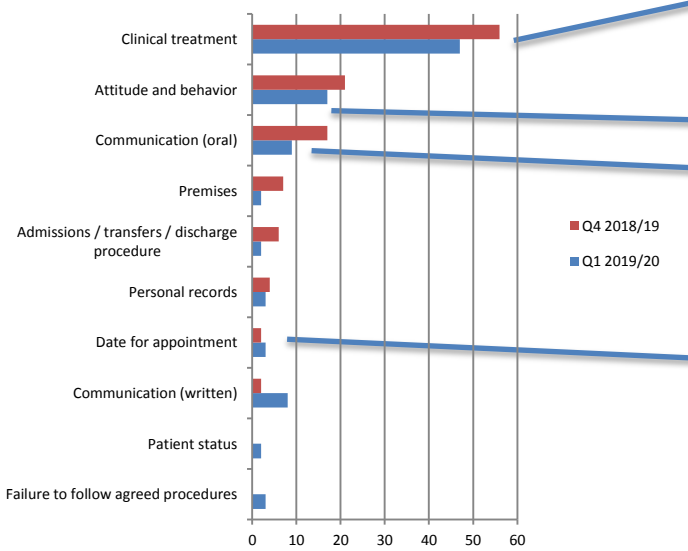
- There was an **increase** in complaints closed in the Trust in Q1 (118 in Q1 versus 93 in Q4).
- Medical Care, Digestive Diseases, MSK and Diagnostic and Outpatients have increased the amount of complaints they have closed. Specialist Surgery and Women's and Children's have decreased the amount of complaints they have closed.



Complaints Analysis Q4 vs Q1

Warrington and Halton Hospitals NHS
NHS Foundation Trust

The information shows the top subjects in complaints in Q4 vs Q1. Note: Complaints can have more than one subject.



Clinical treatment:

- There was a decrease in the number of complaints received in Q1 compared to Q4 regarding clinical treatment. Concerns include delay in treatment, co-ordination of medical treatment, treatment did not have expected outcome, staff attitude and wrong diagnosis.
- A lack of communication in relation to on going clinical treatment makes a perception that the treatment is incorrect.
- Theses issues can also be linked to when the Trust is on full capacity.

Communication and Attitude and Behaviour:

- Poor communication and staff attitude and behaviour has decreased in Q1 in line
- Training on First Impressions and Customer Care continues to be rolled out across the Trust.

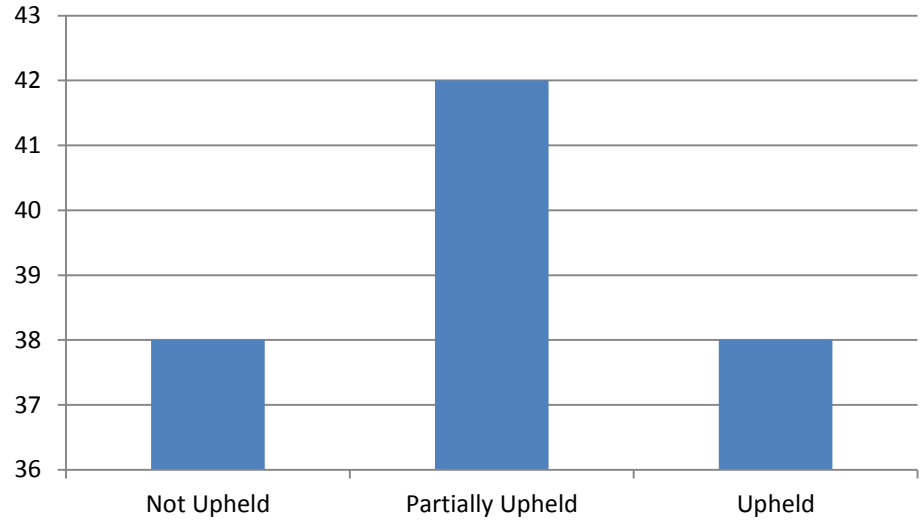
Date for an appointment:

- Occurs when Out-patient Clinics are at full capacity, and appointments cannot be brought forward.
- Cancellation of appointments

Complaints Outcomes Q1

Warrington and Halton Hospitals NHS
NHS Foundation Trust

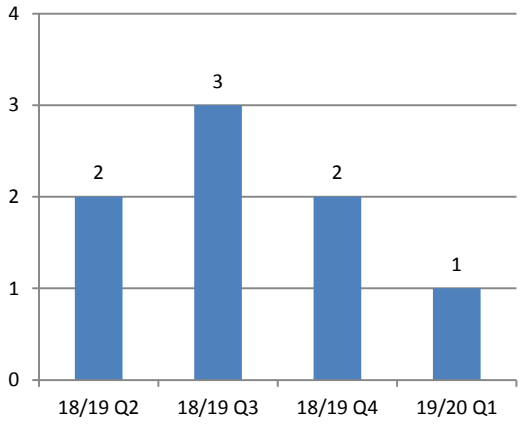
Once a complaint has concluded (either following a local resolution meeting or once a formal written response has been sent) the outcome will be recorded in line with the findings of the investigation. A complaint will be “upheld”, “upheld in part” or “not upheld”.



PHSO Q1

So how many complaints do they investigate?

The PHSO has commenced 1 investigation into the Trust in Q1. The PHSO closed 4 investigations during Q1

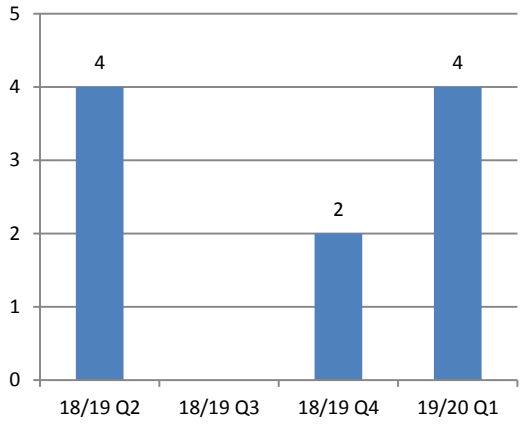


Complainants dissatisfied with the Trust's response have the right to ask the Parliamentary Health Service Ombudsman (PHSO) to consider their complaint. The PHSO will consider the complaint file, medical records and any other relevant information as necessary. The PHSO may decide not to investigate further and no further action will be required from the Trust. Alternatively, recommendations might be made for the Trust to consider. The PHSO may decide to conduct a full investigation which might result in the Trust being required to make an apology, pay compensation and / or produce an action plan to describe what actions are planned to rectify the situation and prevent further occurrences.

NOTE: The PHSO have changed how they investigate complaints and when investigations start; therefore previous graphical data may have changed in this report.

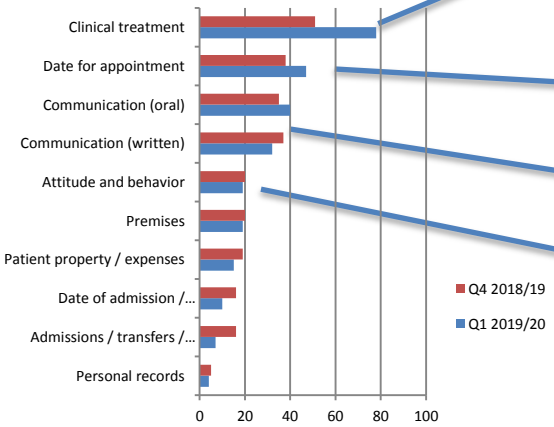
And what are the outcomes?

The Trust currently has 5 open PHSO cases. The PHSO finalised 4 investigations during Q1, 3 were not upheld and 1 was partially upheld with an action plans drafted and implemented.



PALS Analysis Q1

The information shows the top subjects in PALS. Note: PALS can have more than one subject.



Clinical Treatment:
- Co-ordination of medical treatment
- Treatment did not have expected outcome
- Delay in treatment
- This is also mirrored in the complaints analysis.

Date for appointment:
- Unacceptable time to wait for an appointment
- Cancellation of appointment
- Appointment date continues to be rescheduled
- Too short notice given for appointment

Communication:
- Lack of clear explanation
- Patient has been sent no communication
- Test results not communicated to patient

Attitude and Behaviour:
- Issues in relation to communication have increased - may be linked to when the Trust is on full capacity
- Training on First Impressions and Customer Care continues to be rolled out across the Trust.
- This is mirrored in the complaints analysis.

The average response time for a PALS concern of those closed:

Q4	Q1
6 days	5 days

PALS to complaints:

Q4	Q1
7	3

Learning from Complaints and PALS

Warrington and Halton Hospitals NHS
NHS Foundation Trust

You Said….	We Did….
Patient felt uncomfortable during an echo cardiogram appointment as she was not offered a chaperone whilst being treated by a male Cardiology Nurse.	The appointment letters have been amended to include the advice that “your test may be carried out by a female or male physiologist; please contact the department if you require a chaperone” to respect patients privacy and dignity.
Patient was concerned that there was a delay in the Pharmacy Service in dispensing medication for cancer treatments.	The Chemotherapy Pharmacist will ensure that the clinical checks are carried out in advance of the day of collection and new paperwork has been produced so that staff can track the medication when it is being transported between hospital sites.
Patient experienced poor communication during the management of her miscarriage which added to her distress.	The Ward Manager has held a teaching forum to share her experience and discuss pregnancy loss and the impact this has on families. Staff will provide telephone support and ensure communication is consistent and understood.

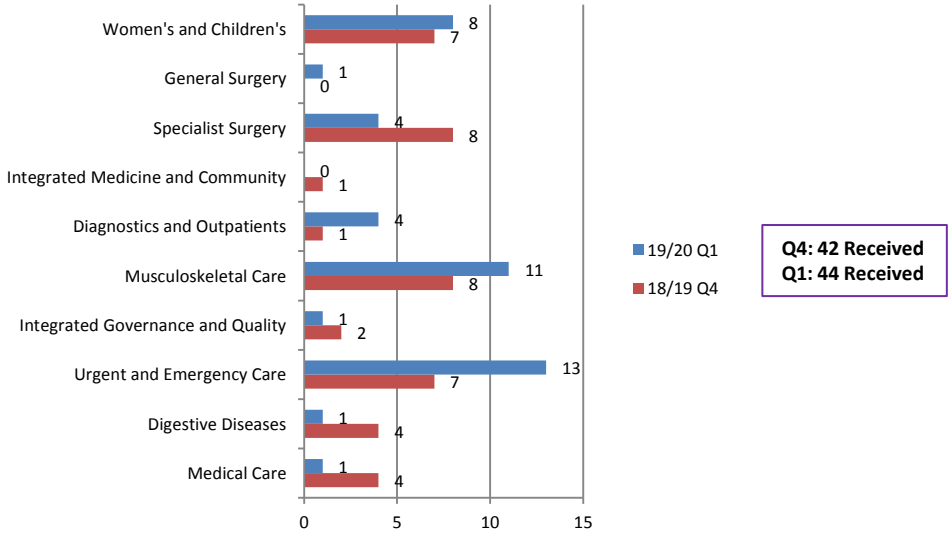
Complaints Headlines

- There was an decrease in the number of complaints the Trust received in Q1 compared to Q4.
- There was an increase in complaints closed in the Trust in Q1.
- There is now a complaints meeting room where patients/families can meet with staff to resolve their concerns.
- Many of the issue raised with the PALS relate to delays in treatment and prolonged periods of waiting for appointments and cancellation of appointments. There has been an increase in timeliness of responding to concerns during Q1 compared to Q4.
- There is continued improvement in the Trust culture to resolve complaints locally and rapidly.
- Reporting on actions from complaints to ensure compliance. CBU staff are continuing to complete actions as they have access through Datix Web.
- Auditing of actions from complaints takes place to ensure that they have made the desired change.
- The CBU staff and managers have access to Governance dashboards to review their live data and meetings are held with the CBU to discuss the current positions and to plan responses.
- There has been a decrease in PHSO referrals and Trust continues to try and resolve all concerns locally at the Trust.
- There is a focus on learning in order to reduce the amount of complaints the Trust received.
- The main focus is to increase the timeliness of response and this is part of a QI project.

Claims Received Analysis

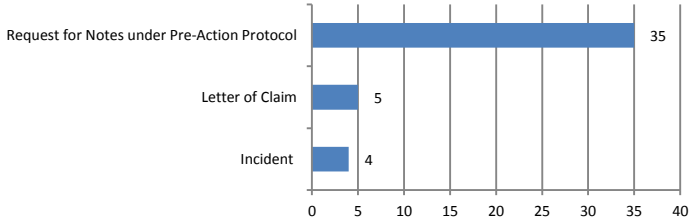
Warrington and Halton Hospitals NHS
NHS Foundation Trust

Clinical Claims Received Q4 2018/19 vs Q1 2019/20



Q4: 42 Received
Q1: 44 Received

Analysis of Clinical Claims Received Qt1 2019/2020



- 33 of the claims were received as a request for notes under the preaction protocol for clinical disputes, of which 10 of them had previously been investigated as a complaint
- 5 Letter of Claim, 1 of which had previously been investigated as a complaint , 2 previously investigated as an incident and 1 previously investigated as an incident and coroners inquest
- 4 Incident *, 1 of which was initially reported to the NHSR because of risks identified during the SI investigation, this has subsequently become Request for notes and 3 were reported to NHSR under the Early Resolution Scheme

* We report all SIs which identify a risk to the NHSR for their consideration whether they are a claim or not.

None Clinical Claims Q4 2018/19 vs Q4 2019/20 – 7 (3 the previous quarter)

Row Labels	Acute Medicine	Catering	General Surgery	Outpatients	Trust Escalation
Assault	1				
Accident by other means		1	1	1	
Needlesick	1				
Slip/Falls				1	1

Claims Closed

Clinical Claims Closed Q1:

20 Withdrawn 1 closed with payment

CBU	Settled with Damages	Withdrawn
Diagnostics and Outpatients		2
Medical Care		3
Musculoskeletal Care		4
Specialist Surgery	1	5
Urgent and Emergency Care		4
Women's and Children's		1

Payments for claims settled with damages totalled £152,000.00 including costs

No Non-Clinical Claims closed Q1

Claims – Action Taken

Specialist Surgery What did we do?

Inappropriate management of PEG feed	Standard operating policy on the insertion and care of PEGS updated

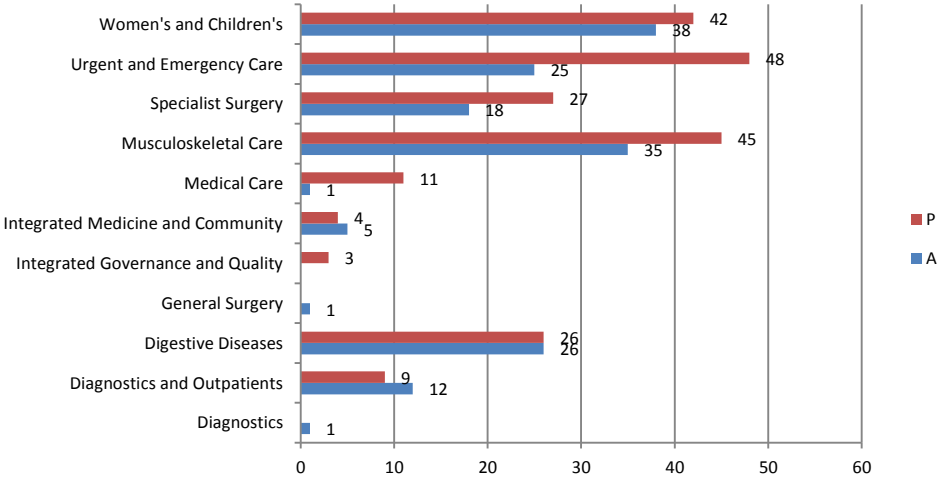
Radiology– What did we do?

Sub-standard reporting	Fed back to individual to learning and self reflection, also discussed at monthly discrepancies meeting for review.

Open Claims

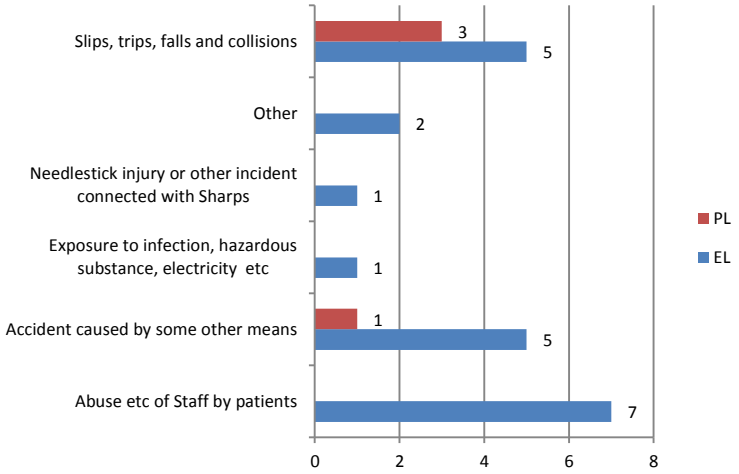
Warrington and Halton Hospitals NHS
NHS Foundation Trust

Number of Open Claims as of 30 June 2019
Actual 162 | Potential 215



Potential = Request for notes
Actual = Formal claim, Letter of Claim / Proceedings

Number of Open Non-Clinical Claims as of 30 June 2019: Public 3 | Employer 21

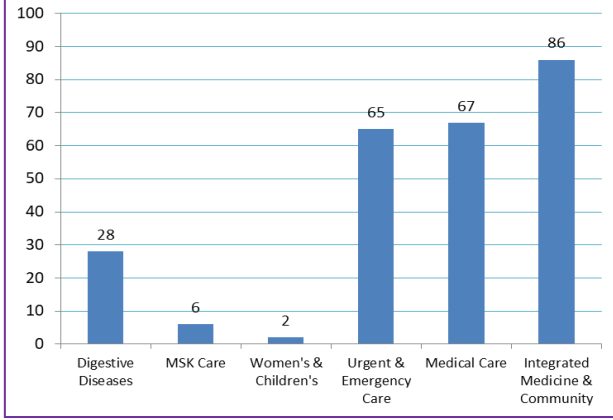


Mortality Headlines

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Q1 CBU Mortalities

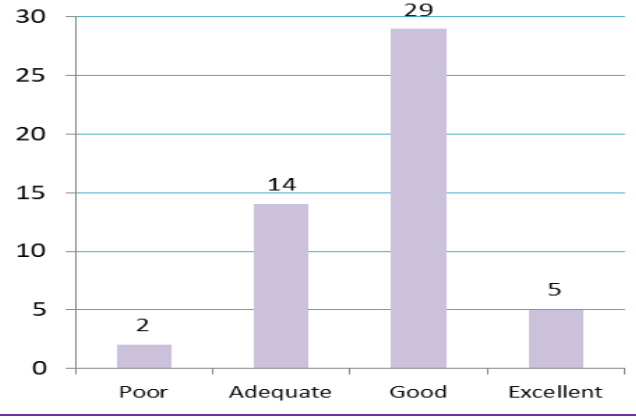
As expected, the three CBUs with the most mortalities are the ones with the greatest throughput and largest number of patients with multiple comorbidities: Medical Care, Integrated Medicine & Community and Urgent & Emergency Care.



Q1 SJRs – Overall Care Grading

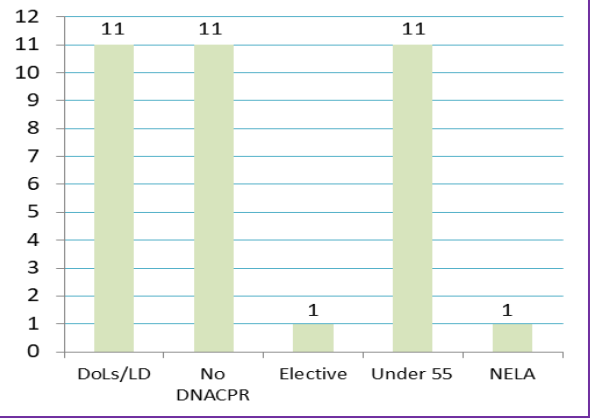
The majority of SJRs conducted have found that our overall standard of care is rated as “Good” or “Adequate”, although evidence of “Excellent” care was also evident within the reviews.

There were 2 “Poor” ratings for Quarter 1 to date; these are discussed at MRG.



Q1 Triggers for SJRs

The below chart displays the triggers for conducting SJRs across Quarter 1. Comparing to Quarter 4, no DNACPR continues to be one of the largest triggers for an SJR. However, there has been an increase of DoLs/LD (of which 1 was an LD) and Under 55 reviews.



Learning from Deaths

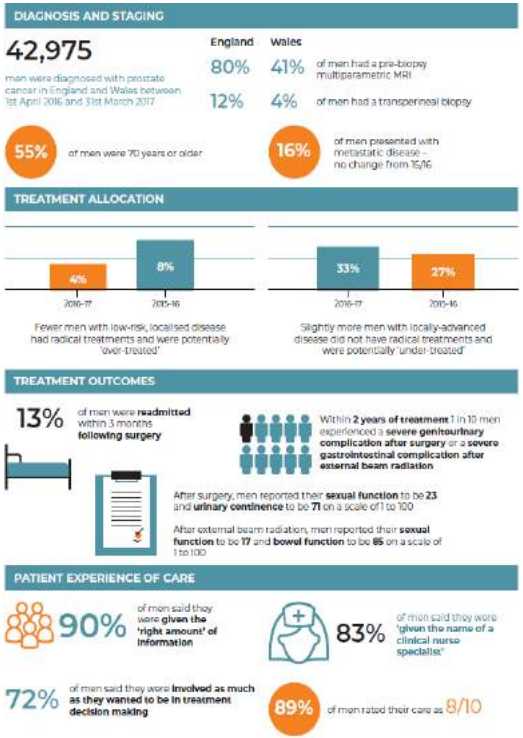
Warrington and Halton Hospitals NHS
NHS Foundation Trust

We found….	We are doing….
We are showing as an outlier for deaths with R-codes and Chronic Obstructive Pulmonary Disease & Bronchiectasis	As these areas are outliers we will establish which patients were involved and conduct focussed reviews, using the SJR template, to see if there is any learning from these deaths.
M&M meetings to be improved/standardised. 	A new template has been developed which includes the deaths by specialty for each CBU and will also include learning from MRG. Each CBU will be responsible for returning a HLBP from their M&M (Mortality & Morbidity) meetings to provide assurance that learning is being disseminated.
SHMI/HSMR further deterioration.	Processes of FCEs and documentation need to be rapidly managed, a task and finish group is in the process of being established to review this further, led by the Trust Mortality Lead.
Trauma cases were presented to MRG and we found that the main lesson was in relation to following the thoracic injuries pathway.	The thoracic injuries pathway was highlighted at the joint ED and medical team meeting to cascade to all relevant staff.
We found evidence of good practice in relation to the documentation of discussions on ITU. 	We have asked the SJR reviewer to highlight the learning so that this can be disseminated Trust wide through the M&M meetings.

Headlines of Learning from Deaths

- Mortality & Morbidity Meetings (M&M) are underway with feedback being provided back to MRG.
- SHMI and HSMR, although within the expected range, are both showing signs of deterioration.
- The SHMI was reviewed as it has been selected as an indicator to be audited as part of the Trust's annual Quality Account. Based on the results the auditors did not identify any material issues in relation to the calculation of this indicator or the six dimensions of data quality.
- A task and finish group is in the process of being established to review FCEs (first consultant episode) further, led by the Trust Mortality Lead.
- We continue our work with the Coding Team to identify improvements that can be made with documentation.

Learning from National Audits



NPCA
National Prostate Cancer Audit

Recommendations

For prostate cancer teams (local and specialist MDTs) within NHS Trusts/Health Boards

1. Increase the use of pre-biopsy multiparametric MRI and avoid its use post biopsy.
2. Increase the use of transperineal prostate biopsy where necessary to reduce the risk of post-biopsy sepsis and to maximise diagnostic accuracy and risk stratification.
3. Advocate active surveillance in the first instance for men with low risk prostate cancer.
4. Investigate why men with locally advanced disease are not considered for radical local treatment.
5. Use data on side effect prevalence from this report to ensure appropriate counselling and management for all patients.
6. When outlying performance is confirmed, engage with partners, including the NPCA, to review practice urgently and instigate quality improvement measures.
7. Engage with the NPCA Quality Improvement initiatives planned for 2019 (see Future Plans).
8. Review and improve data completeness focussing particularly on performance status, use of multiparametric MRI and biopsy route.

Learning from Local Audits

Effectiveness of Rectus Sheath Catheters in Laparotomy Patients

Background:

Quality improvement action plan following Laparotomy Audit of 2015 recommended implementation of use of Rectus sheath catheters delivering continuous infusion of local anaesthetic for acute pain management following Laparotomy.

Key Findings:

- Pain scores have significantly improved with the use of the rectus sheath catheter infusion (RSCI)
- There appears to be approx. 50% less use of the PCA morphine with RSCI on day 1 compared to the laparotomy audit of 2015
- 68% of patients were able to deep breath easily on day of surgery with the use of RSCI
- By day 1, 50% of the patients with RSCI were comfortable enough to at least transfer out of the bed

Recommendations:

- Continue with data collection and possibly adapt to reflect discharge date to enable length of stay of patients to be determined
- Continue to support all members of the multidisciplinary team
- Look at other uses for these types of catheter in relation to pain control e.g Local anaesthetic infusion blocks for those suffering rib fractures

Assurance:

Significant	There is a good system of internal control designed to meet the system objectives, and that controls are generally being consistently applied.

Non Clinical Incidents

From 1st April to 30th June 2019, there were 381 non clinical incidents. The top 2 categories were:

Security incidents = 116	Infrastructure/Health and Safety incidents = 110
The top sub-categories are: • Aggressive Behaviour • Violence due to patients condition • Doors not locked • Loss	The top sub-categories are: • Injury to staff • Equipment Malfunction • Sharps Injury • Hit by an object

During this Quarter, there were 13 sharp related incidents. 5 were during a clinical procedure such as suturing/during surgery/giving an injection. All other incidents occurred during the disposal process. These included re-sheathing needles, a used cannula found in a breakfast bowl, a domestic cleaning a cubicle and received a sharps injury, taking black waste bags out and felt a sharp through the bag and when closing up a black waste bag, found items such as venepuncture equipment, a cannulation pack, blood culture bottles, gloves etc inside. The patient where this equipment had originated from was Hep C+

Following health and safety inspections, it was disappointing to see a number of ward areas had items protruding from the sharp bin lids. On one ward, there was plastic tubing hanging out and on another, blood stained gauze. Other hazards identified were temporary lids were left open, sharp bin lids loose and numerous labels not being completed upon assembly. Some bins were even blood stained on the outside.

Learning from Non Clinical Incidents

Warrington and Halton Hospitals NHS
NHS Foundation Trust

We found….	We Acted….
 When carrying out a health and safety inspection at Halton Hospital we found sharps bins that had been wall mounted too high for staff to use safely.	The health and safety department contacted the Estates Department direct and made arrangements for these to be lowered to a safe height.
A patient attended the Ophthalmology Department for an appointment. He had drops in his eyes to dilate the pupils. Whilst waiting, his wife went out to the car which was parked in a disabled bay, the patient decided to following. The patient was also blind in one eye. As he walked towards his wife, he tripped over a curb.	The gardeners added more shrubbery to the borders as a visual effect. The border is required to segregate cars from a pedestrian area therefore this was the best option to highlight the curbed area. 
 Linen continues to be left on beds that are stored along the Warrington Hospital corridors. This occurs when a patient arrives on a ward already in bed and the spare bed is taken off the ward	Regular reminders are sent to staff enforcing information that all beds and patient trolleys must be stripped of all bed linen and pillows before leaving them on Hospital corridors. This is an infection control issue, there is no-where to leave the linen and is a poor image to portray to patients and visitors who attend the site.
 When a member of staff entered a store room, they tripped over due to the amount of items being stored in a small area. Store rooms that are not managed regularly can become a hazardous area. They can become overwhelming and unmanageable. They can also become dangerous and cause accidents	 A wall mounted electrical heater was disconnected and removed to prevent a fire hazard. With a little effort and organisation, the area was cleared. Emails were circulated and unwanted files etc were collected and recycled. Regular monitoring to prevent this from getting out of hand again

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Warrington and Halton Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/19/09/85**	
SUBJECT:	**CQC Action Plan and Update**	
DATE OF MEETING:	September 2019	
ACTION REQUIRED	**Review, Discuss and approve**	
AUTHOR(S):	Ursula Martin, Director of Governance & Quality	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse Choose an item.	
LINK TO STRATEGIC OBJECTIVES:	All	
EXECUTIVE SUMMARY (KEY ISSUES):	The following are key issues to highlight within the report: • The Trust action plan following receipt of the CQC report from the 2019 inspection is shown in Appendix 1. • All actions and timeframes have been agreed by Executive leads and core service leads • There are 60 actions across 35 recommendations in the CQC action plan • The Urgent and Emergency Care improvement plan is being delivered and overseen by the Chief Operating Officer. Progress has been made; evidence is requested against 6 actions and 8 dates have been amended. The Moving to Outstanding Steering group have asked for an expedited position against some of the actions. • Moving to Outstanding Steering Group has been reconvened to ensure the action plan is delivered and monitored with a revise governance structure to deliver the next steps of Moving to Outstanding • In addition to the CQC action plan in response to the report, a Moving to Outstanding framework is in development	
RECOMMENDATION:	Assurance can be offered to the Board that an action plan has been developed in response to the CQC action plan and is being implemented. In addition it is recommended that the Board review the Moving to Outstanding framework which is in development.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Committee

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Warrington and Halton Hospitals NHS Foundation Trust

	Date of meeting	September 2019
	Summary of Outcome	Noted the development of the action plan which was approved by Executive and core service leads.
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

BOARD OF DIRECTORS

SUBJECT **CQC Update Report** **AGENDA REF:**

1. BACKGROUND/CONTEXT

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

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

In addition to the CQC action plan, there is a Moving to Outstanding Framework in development, which will self assess the Trust against the Key Lines of Enquiry (KLoE) outstanding characteristics, and develop actions to progress the Trust to outstanding. This will be considered by the Board of Directors at a future meeting.

2. KEY ELEMENTS

2.1 CQC action plan

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

- There are 60 actions across 35 recommendations made by CQC
- There are no 'Must Do' actions or regulatory breaches – there are 53 actions relating to 'Should Do' recommendations
- Current compliance of the CQC action plan is as follows.

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Action Status by Type

Row Labels	Report completed - Compliant	Report completed - further evidence requested	On Track	Amended date agreed	Action closed-merged with another	Grand Total
HOWEVER	1	1	5			7
SHOULD	11	1	39	1	1	53
Grand Total	**12**	**2**	**44**	**1**	**1**	**60**

This can be further shown broken down by core service.

	HOWEVER	SHOULD	Grand Total
Surgery	**2**	**15**	**17**
On Track	2	13	15
Report completed - further evidence requested		1	1
Action closed-merged with another		1	1
Trustwide		**11**	**11**
Amended date agreed		1	1
On Track		7	7
Report completed - Compliant		3	3
Critical Care	**3**	**5**	**8**
On Track	1	3	4
Report completed - Compliant	1	2	3
Report completed - further evidence requested	1		1
Maternity	**1**	**2**	**3**
On Track	1	1	2
Report completed - Compliant		1	1
Medical Care	**1**	**19**	**20**
On Track	1	14	15
Report completed - Compliant		5	5
Outpatients		**1**	**1**
On Track		1	1
Grand Total	**7**	**53**	**60**

Progress is underway to deliver the action plan – 27 actions are due for delivery by end October 2019.

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Warrington and Halton Hospitals NHS Foundation Trust

2.2 Urgent & Emergency care Improvement action plan

Compliance with the Urgent and Emergency Care action plan, following the 2019 focused inspection by the CQC, is as follows:

	On Track	Amended date agreed	Complete	further evidence requested	Completed - further action added	Grand Total
MUST	3	2	4	3	1	13
SHOULD	1	1	2			4
Trust action		5	8	3		17
Grand Total	**4**	**7**	**14**	**6**	**1**	**35**

There are 13 actions against 4 regulatory breaches

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

Progress has been made in the following areas

- The new Decision to Admit (DTA) protocol was implemented on 7th August 2019 to coincide with the changeover date of the junior doctors. This gives admitting rights to Emergency Department Consultants, with the aim to support a prompt review by speciality doctors.
- Test of Change to be undertaken with the opening of GPAU 24hrs to commence 2nd Sept for two weeks, with the plan to take surgical referrals once SAU is closed for the day.
- A half day workshop has been held on 31st August with estates and operational staff to look at how we could develop the estate. The second workshop is planned for September and will include review of current right-size footprint and future Assessment Plaza.

The action plan will continue to be monitored and overseen by the Chief Operating Office, who chairs the Urgent & Emergency Care Improvement Group. Progress has been made; evidence is requested against 6 actions and 8 dates have been amended. The Moving to Outstanding Steering group have asked for an expedited position against some of the actions.

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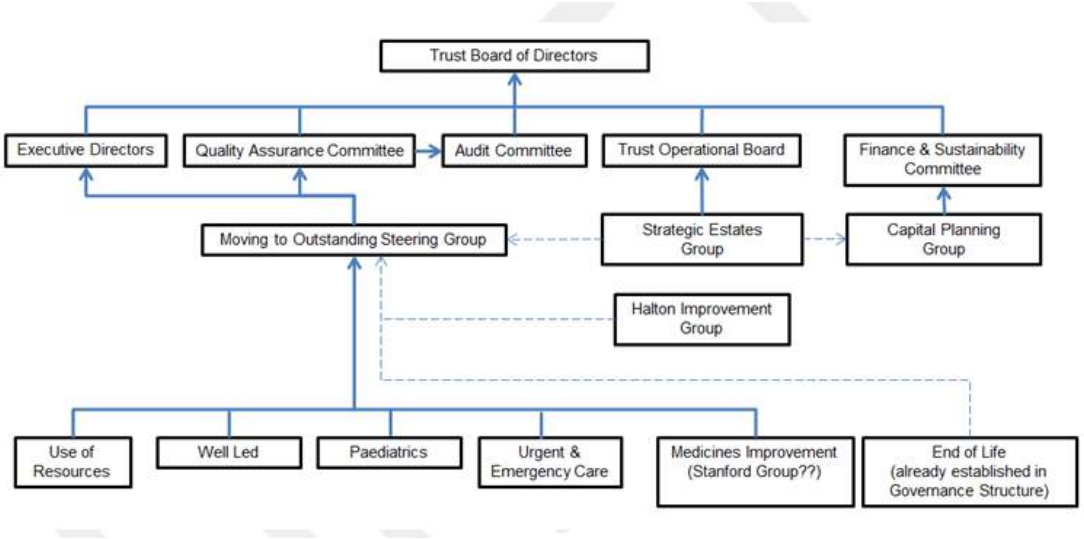
Warrington and Halton Hospitals NHS Foundation Trust

2.3 Governance and oversight structure of CQC action plan

The Trust Moving to Outstanding Steering Group has been reconvened and the governance structure has been agreed as outlined below



A new Task and Finish Group for paediatrics and Medicines Improvement will be convened.

Existing Executive led groups for Use of Resources, Well Led, Urgent and emergency Care and End of Life will monitor the CQC action plan.

3 RECOMMENDATIONS

Trust Board are asked to discuss and note the

- CQC action plan progress and update
- Urgent and Emergency Care action plan progress
- Revised governance structure for CQC Moving to Outstanding

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

Appendix 1 – CQC Action plan

Reference	Core service	Domain	Areas for Review	Action	Type	Exec Lead	Lead Person	Target date for completion
CC01a	**Critical Care**	**Effective**	The trust should consider increasing the number of isolation rooms with negative and positive ventilation, in accordance with Department of Health guidelines. The unit only had two isolation rooms with negative and positive ventilation. This was below the recommended number in national guidance.	Ensure capital bid is developed and timeframe agreed Provide an option paper to enable decision on what can be done 19/20 or 20/21 to share with CQC with risk appraisal	SHOULD	Chris Evans	Mark Carmichael	31/10/19
CC01b	**Critical Care**	**Effective**	The trust should consider increasing the number of isolation rooms with negative and positive ventilation, in accordance with Department of Health guidelines. The unit only had two isolation rooms with negative and positive ventilation. This was below the recommended number in national guidance.	Check with network and regulators what the specification is for regulation	SHOULD	Chris Evans	Mark Carmichael	31/08/19

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

Reference	Core service	Domain	Areas for Review	Action	Type	Exec Lead	Lead Person	Target date for completion
CC02a	**Critical Care**	**Safe**	The trust should review the process for fridge checks so they are completed daily, in line with the trust's medicines management policy. Fridge checks were not always completed daily, in line with the medicines management policy. This had been an issue raised at the previous inspection.	Implement a daily fridge check process to give assurance that the process is fully embedded in to practice	SHOULD	Alex Crowe	Sarah Brennan	31/08/19
CC02b	**Critical Care**	**Safe**	The trust should review the process for fridge checks so they are completed daily, in line with the trust's medicines management policy. Fridge checks were not always completed daily, in line with the medicines management policy. This had been an issue raised at the previous inspection.	Audit of effectiveness of daily fridge checks in 6 months - Sarah Brennan	SHOULD	Alex Crowe	Sarah Brennan	29/02/20
CC03	**Critical Care**	**Responsive**	The trust should continue to review the number and occurrence of patients nursed in a recovery area while they await a critical care bed.	Audit in December 19 and present to January Patient Safety & Effectiveness Sub Committee	SHOULD	Chris Evans	Jerome McCann	31/12/19
CC04	**Critical Care**	**Responsive**	At the time of the inspection there was not a dedicated critical care pharmacist for the unit, although this was being addressed in the weeks following the	Ensure a dedicated pharmacist is allocated to the critical care unit	HOWEVER	Chris Evans	Natalie Crosby	

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

Reference	Core service	Domain	Areas for Review	Action	Type	Exec Lead	Lead Person	Target date for completion
			inspection.					
CC05a	**Critical Care**	**Safe**	Not all prescriptions had review of stop dates documented; the indication for the antibiotic was not always recorded. A medicines reconciliation had been completed for most of the records reviewed.	Standardise where information will be documented - Jerome - 31/8/19	HOWEVER	Alex Crowe	Jerome McCann	31/08/19
CC05b	**Critical Care**	**Safe**	Not all prescriptions had review of stop dates documented; the indication for the antibiotic was not always recorded. A medicines reconciliation had been completed for most of the records reviewed.	Audit in 3 months for effectiveness - Jerome	HOWEVER	Alex Crowe	Jerome McCann	30/11/19
M01	**Maternity**	**Safe**	The trust should ensure that all midwives complete adult safeguarding training level three. Midwifery staff compliance for adult safeguarding level three was below the trust target. Following implementation of updated guidance, compliance for midwives for safeguarding adults level three was 58% at time of inspection, although the service always had someone who was level three trained on each shift..	Provide an assurance report to confirm that all band 7 staff are trained to adult safeguarding level 3 give assurance for training compliance going forward	SHOULD	Kimberley Salmon-Jamieson	Tracey Cooper	30/09/19

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

Reference	Core service	Domain	Areas for Review	Action	Type	Exec Lead	Lead Person	Target date for completion
M02	**Maternity**	**Safe**	The trust should review the availability of nets in case of a pool evacuation. There were two birthing pools, however, only one net in the event of an emergency.	Give assurance that additional nets (1 net for each of the 2 pools) are available.	SHOULD	Kimberley Salmon-Jamieson	Tracey Cooper	31/08/19
M03	**Maternity**	**Responsive**	There was no information available in formats other than standard English. There was no information available in languages other than English or alternative formats such as easy read.	Present the Accessible Information Standards Programme Plan to M2O September 2019 meeting	HOWEVER	Pat McLaren	Gina Coldrick	31/08/19
MC01a	**Medical Care**	**Safe**	The trust should continue to monitor staffing levels and follow escalation plans to ensure levels of nursing and medical staff are sufficient to provide safe care and treatment. In medical care there were not always enough staff to meet planned staffing levels, although there were processes to review staff shortages and take action to keep people safe. The service did not always have enough staff with the right qualifications, skills, training and experience to meet planned staffing levels, although it had processes to review staff shortages and take action to keep people safe.	Reconfiguration of medicine ward management relating to medical staffing	SHOULD	Alex Crowe/ Kimberley Salmon-Jamieson	Fraser Gordon	31/10/19

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

Reference	Core service	Domain	Areas for Review	Action	Type	Exec Lead	Lead Person	Target date for completion
MC01b	**Medical Care**	**Safe**	The trust should continue to monitor staffing levels and follow escalation plans to ensure levels of nursing and medical staff are sufficient to provide safe care and treatment. In medical care there were not always enough staff to meet planned staffing levels, although there were processes to review staff shortages and take action to keep people safe. The service did not always have enough staff with the right qualifications, skills, training and experience to meet planned staffing levels, although it had processes to review staff shortages and take action to keep people safe.	Reconfiguration of management of outlying patients	SHOULD	Alex Crowe/ Kimberley Salmon-Jamieson	Fraser Gordon	31/12/19

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

Reference	Core service	Domain	Areas for Review	Action	Type	Exec Lead	Lead Person	Target date for completion
MC01c	**Medical Care**	**Safe**	The trust should continue to monitor staffing levels and follow escalation plans to ensure levels of nursing and medical staff are sufficient to provide safe care and treatment. In medical care there were not always enough staff to meet planned staffing levels, although there were processes to review staff shortages and take action to keep people safe. The service did not always have enough staff with the right qualifications, skills, training and experience to meet planned staffing levels, although it had processes to review staff shortages and take action to keep people safe.	Implementation of electronic rostering	SHOULD	Alex Crowe/ Kimberley Salmon-Jamieson	May Moonan	31/03/20

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

Reference	Core service	Domain	Areas for Review	Action	Type	Exec Lead	Lead Person	Target date for completion
MC01d	**Medical Care**	**Safe**	The trust should continue to monitor staffing levels and follow escalation plans to ensure levels of nursing and medical staff are sufficient to provide safe care and treatment. In medical care there were not always enough staff to meet planned staffing levels, although there were processes to review staff shortages and take action to keep people safe. The service did not always have enough staff with the right qualifications, skills, training and experience to meet planned staffing levels, although it had processes to review staff shortages and take action to keep people safe.	Review escalation processes for medical staff and develop a Standard Operating procedure	SHOULD	Alex Crowe/ Kimberley Salmon-Jamieson	Mark Forrest	31/10/19

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

Reference	Core service	Domain	Areas for Review	Action	Type	Exec Lead	Lead Person	Target date for completion
MC01e	**Medical Care**	**Safe**	The trust should continue to monitor staffing levels and follow escalation plans to ensure levels of nursing and medical staff are sufficient to provide safe care and treatment. In medical care there were not always enough staff to meet planned staffing levels, although there were processes to review staff shortages and take action to keep people safe. The service did not always have enough staff with the right qualifications, skills, training and experience to meet planned staffing levels, although it had processes to review staff shortages and take action to keep people safe.	Review nurse staffing and develop plans as appropriate	SHOULD	Alex Crowe/ Kimberley Salmon-Jamieson	Judith Burgess/ Sarah Coppell	30/09/19

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

Reference	Core service	Domain	Areas for Review	Action	Type	Exec Lead	Lead Person	Target date for completion
MC01f	**Medical Care**	**Safe**	The trust should continue to monitor staffing levels and follow escalation plans to ensure levels of nursing and medical staff are sufficient to provide safe care and treatment. In medical care there were not always enough staff to meet planned staffing levels, although there were processes to review staff shortages and take action to keep people safe. The service did not always have enough staff with the right qualifications, skills, training and experience to meet planned staffing levels, although it had processes to review staff shortages and take action to keep people safe.	A7 tracheostomy competencies – ensure that all staff have achieved and there is a process of review in place	SHOULD	Alex Crowe/ Kimberley Salmon-Jamieson	Sarah Coppell	30/09/19

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

Reference	Core service	Domain	Areas for Review	Action	Type	Exec Lead	Lead Person	Target date for completion
MC01g	**Medical Care**	**Safe**	The trust should continue to monitor staffing levels and follow escalation plans to ensure levels of nursing and medical staff are sufficient to provide safe care and treatment. In medical care there were not always enough staff to meet planned staffing levels, although there were processes to review staff shortages and take action to keep people safe. The service did not always have enough staff with the right qualifications, skills, training and experience to meet planned staffing levels, although it had processes to review staff shortages and take action to keep people safe.	Explore other wards re capacity to manage patients with tracheostomies in the Trust	SHOULD	Alex Crowe/ Kimberley Salmon-Jamieson	Mark Carmichael/ Kate Brizell	31/10/19

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

Reference	Core service	Domain	Areas for Review	Action	Type	Exec Lead	Lead Person	Target date for completion
MC01h	**Medical Care**	**Safe**	The trust should continue to monitor staffing levels and follow escalation plans to ensure levels of nursing and medical staff are sufficient to provide safe care and treatment. In medical care there were not always enough staff to meet planned staffing levels, although there were processes to review staff shortages and take action to keep people safe. The service did not always have enough staff with the right qualifications, skills, training and experience to meet planned staffing levels, although it had processes to review staff shortages and take action to keep people safe.	Develop and implement a speciality specific Competency training framework in medicine for nursing staff	SHOULD	Alex Crowe/ Kimberley Salmon-Jamieson	Judith Burgess/ Sarah Coppell	31/03/20
MC02a	**Medical Care**	**Safe**	The trust should continue to monitor audit performance to identify further potential improvements.	Ensure monthly reporting to Patient Safety & Effectiveness Sub Committee outlines remedial actions where performance needs to be improved and tracks the performance improvement.	SHOULD	Alex Crowe	Louisa Connolly	30/09/19

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

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

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

Reference	Core service	Domain	Areas for Review	Action	Type	Exec Lead	Lead Person	Target date for completion
MC04a	**Medical Care**	**Responsive**	The trust should continue work to reduce delays in patient discharges where possible. In medical care, there were delays in discharge for patients. Delays in discharge were a frequent issue for patients, particularly in elderly care and dementia ward.	Co location of Health and Social Care Discharge Team - opening day 12/7/19	SHOULD	Chris Evans	Caroline Williams	12/07/19
MC04b	**Medical Care**	**Responsive**	The trust should continue work to reduce delays in patient discharges where possible. In medical care, there were delays in discharge for patients. Delays in discharge were a frequent issue for patients, particularly in elderly care and dementia ward.	Agree a trajectory for improvement in long length of stay with NHSE	SHOULD	Chris Evans	Caroline Williams	01/05/19

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

Reference	Core service	Domain	Areas for Review	Action	Type	Exec Lead	Lead Person	Target date for completion
MC04c	**Medical Care**	**Responsive**	The trust should continue work to reduce delays in patient discharges where possible. In medical care, there were delays in discharge for patients. Delays in discharge were a frequent issue for patients, particularly in elderly care and dementia ward.	Development of discharge patient tracking list to further understand reasons for delays in discharge	SHOULD	Chris Evans	Caroline Williams	05/07/19
MC04d	**Medical Care**	**Responsive**	The trust should continue work to reduce delays in patient discharges where possible. In medical care, there were delays in discharge for patients. Delays in discharge were a frequent issue for patients, particularly in elderly care and dementia ward.	Work with system partners to review and agree actions from Venn Consultants system capacity and demand exercise undertaken in 2018	SHOULD	Chris Evans	Caroline Williams	01/08/19

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

Reference	Core service	Domain	Areas for Review	Action	Type	Exec Lead	Lead Person	Target date for completion
MC04e	**Medical Care**	**Responsive**	The trust should continue work to reduce delays in patient discharges where possible. In medical care, there were delays in discharge for patients. Delays in discharge were a frequent issue for patients, particularly in elderly care and dementia ward.	Develop a plan to reconfigure Care of the Elderly workforce	SHOULD	Chris Evans	Caroline Williams	29/07/19
MC04f	**Medical Care**	**Responsive**	The trust should continue work to reduce delays in patient discharges where possible. In medical care, there were delays in discharge for patients. Delays in discharge were a frequent issue for patients, particularly in elderly care and dementia ward.	Continuation of ECIST long length of stay/safer collaborative - 3 out of 4 events completed, 4th event due September 2019	SHOULD	Chris Evans	May Moonan	30/09/19

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

Reference	Core service	Domain	Areas for Review	Action	Type	Exec Lead	Lead Person	Target date for completion
MC04g	**Medical Care**	**Responsive**	The trust should continue work to reduce delays in patient discharges where possible. In medical care, there were delays in discharge for patients. Delays in discharge were a frequent issue for patients, particularly in elderly care and dementia ward.	Ward Round accreditation participation for medicine - Development of a ward round accreditation scheme to support reduction in delays in discharges	SHOULD	Simon Constable	Alex Crowe	31/12/19

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

Reference	Core service	Domain	Areas for Review	Action	Type	Exec Lead	Lead Person	Target date for completion
MC04i	**Medical Care**	**Responsive**	The trust should continue work to reduce delays in patient discharges where possible. In medical care, there were delays in discharge for patients. Delays in discharge were a frequent issue for patients, particularly in elderly care and dementia ward.	Development of the Trust Frailty pathway	SHOULD	Chris Evans	Fraser Gordon	31/03/20
OP01	**Outpatients**	**Safe**	The trust should review the training available for staff on updating patients' risk assessment records. Although staff assessed risks to patients, staff had not received specific training to be able to update the patient's risk record.	provide assurance to confirm that staff are trained to be able to update the patient's risk record and give assurance for training compliance going forward	SHOULD	Kimberley Salmon-Jamieson	Deb Hatton	30/09/19

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

Reference	Core service	Domain	Areas for Review	Action	Type	Exec Lead	Lead Person	Target date for completion
S01	**Surgery**	**Safe**	The trust should consider needs such as safeguarding and deprivation of liberty are highlighted. Although records were clear, there was no system to quickly highlight issues such as whether there were any safeguarding concerns, or patients were subject to a deprivation of liberty.	Ensure the trust patient alerts policy is reviewed including alerts on Safeguarding and DoLS. This policy to be presented with an implementation plan to PSESC 8th October meeting	SHOULD	Kimberley Salmon-Jamieson	John Goodenough	30/09/19
S02a	**Surgery**	**Effective**	The trust should make sure that all care plans in paper records are filled in consistently. Care records were not always filled in consistently in the paper records, for example the cognitive impairment and dementia section in the fractured hip pathway. This was important as relevant information may be missed.	Confirm timeframe for paper records to be transferred from paper to an electronic version following demonstration (taking place 8/8/19)	SHOULD	Phill James	Cheryl Finney	31/08/19
S02b	**Surgery**	**Effective**	The trust should make sure that all care plans in paper records are filled in consistently. Care records were not always filled in consistently in the paper records, for example the cognitive impairment and dementia section in the fractured hip pathway. This was important as relevant information may be missed.	Audit to be conducted to give baseline and set further trajectories - will be added to the ward quality improvement metrics.	SHOULD	Kimberley Salmon-Jamieson	Cheryl Finney	30/09/19

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

Reference	Core service	Domain	Areas for Review	Action	Type	Exec Lead	Lead Person	Target date for completion
S02c	**Surgery**	**Effective**	The trust should make sure that all care plans in paper records are filled in consistently. Care records were not always filled in consistently in the paper records, for example the cognitive impairment and dementia section in the fractured hip pathway. This was important as relevant information may be missed.	Ensure that an audit of hip fracture pathway is undertaken and present to the Patient Safety & Effectiveness Sub Committee	SHOULD	Alex Crowe	Rajiv Sanger	31/03/20
S03	**Surgery**	**Safe**	The trust should review the monitoring of expiry dates of sepsis bags. We found that blood cultures stored in sepsis bags had expired, which was important for testing the presence of sepsis in a patient.	Ensure the process for monitoring of sepsis bag expiry is reviewed	SHOULD	Kimberley Salmon-Jamieson	Alison Kennah	30/09/19
S04a	**Surgery**	**Responsive**	The trust should ensure that mental capacity assessments and best interest decisions are recorded consistently in records. In surgery, we saw an example of mental capacity assessment not in line with current guidance and trust policy.	Ensure staff attend Safeguarding/DoLS Masterclasses being put in place	SHOULD	Kimberley Salmon-Jamieson	Cathy Johnson	31/12/19

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

Reference	Core service	Domain	Areas for Review	Action	Type	Exec Lead	Lead Person	Target date for completion
S04b	**Surgery**	**Responsive**	The trust should ensure that mental capacity assessments and best interest decisions are recorded consistently in records. In surgery, we saw an example of mental capacity assessment not in line with current guidance and trust policy.	Ensure an audit of mental capacity/best interest is undertaken	SHOULD	Kimberley Salmon-Jamieson	Cathy Johnson	31/03/20

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

Reference	Core service	Domain	Areas for Review	Action	Type	Exec Lead	Lead Person	Target date for completion
S05	**Surgery**	**Effective**	The trust should continue to look at ways to reduce the risk of readmission for elective admissions. From September 2018 to August 2019, all patients at Warrington Hospital had a higher than expected risk of readmission for elective admissions when compared to the England Average. Surgical leads have put measures in place to address this and have seen improvements in readmission rates.	Clarity of governance arrangements and monitoring/scrutiny - clarify where readmissions are being recorded and monitored within the trust and put a process in place to understand the reasons for readmissions develop a SOP around performance monitoring and process of local specialty deep dive, and report to KPI meeting and escalation if we are an outlier for any specialty for readmissions	SHOULD	Chris Evans	Val Doyle	31/10/19

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

Reference	Core service	Domain	Areas for Review	Action	Type	Exec Lead	Lead Person	Target date for completion
S06	**Surgery**	**Effective**	The trust should continue to look at ways to improve outcomes on the national hip fracture database. The service performed lower than other trusts in the national hip fracture database 2018. Surgical leads had recognised this and put an action plan in to place to address.	Ensure that the hip fracture action plan is received at Patient Safety & Effectiveness Sub Committee on a quarterly basis	SHOULD	Alex Crowe	Paul Scott	30/09/19
S07a	**Surgery**	**Safe**	The trust should ensure that controlled drugs are stored securely at all times in theatres. In surgery, we observed on instance of a controlled drug being left unattended in the operating theatres and found some consumables that were past their use by dates.	Controlled Drugs- Immediate actions were taken at the time of the inspection. Pharmacy to conduct bi-monthly spot check audits and report to Theatre Manager - assurance to be given to Moving to Outstanding regarding this process	SHOULD	Alex Crowe	Mark Rigby	30/09/19

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

Reference	Core service	Domain	Areas for Review	Action	Type	Exec Lead	Lead Person	Target date for completion
S07b	**Surgery**	**Safe**	The trust should ensure that controlled drugs are stored securely at all times in theatres. In surgery, we observed on instance of a controlled drug being left unattended in the operating theatres and found some consumables that were past their use by dates.	Consumables- Weekly check list to be developed on each of the 3 trolleys to check expiry dates for replacement, managed by the Housekeeper, which ward manager oversees.	SHOULD	Kimberley Salmon-Jamieson	Cheryl Finney	30/09/19
S08	**Surgery**	**Safe**	The trust should review the levels of safeguarding training with reference to the intercollegiate documents on safeguarding.	Ensure a revised Training Needs Analysis is developed for Safeguarding training aligned to the intercollegiate document and that ESR is updated with these training requirements	SHOULD	Kimberley Salmon-Jamieson	John Goodenough	31/12/19
S09	**Surgery**	**Safe**	The trust should review the process for monitoring consumables so they remain in date and fit for use.	see action S07b - Day Case Ward- MERGE	SHOULD	Kimberley Salmon-Jamieson	Cheryl Finney	

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

Reference	Core service	Domain	Areas for Review	Action	Type	Exec Lead	Lead Person	Target date for completion
S10	**Surgery**	**Safe**	The trust should review the process for monitoring maintenance of patient trolleys. Some patient trolleys in Cheshire and Merseyside Treatment Centre also had not had annual maintenance.	Ensure an audit is undertaken of the asset register and that all trolleys are included	SHOULD	Chris Evans	Cheryl Finney	31/03/20
S11	**Surgery**	**Safe**	The trust should continue the work around safer surgery and the pre-operative briefing and documentation. In surgery, some processes around the pre-operative briefing were not thorough, but work was in progress to improve this.	Revised process put in place from 1st June 2019. Ensure this process is audited across all theatres (observational audit) and reported to Patient Safety & Effectiveness Sub Committee	SHOULD	Alex Crowe	Mark Rigby	31/12/19
S12	**Surgery**	**Safe**	The hospital was below the England averages for audits for hip fractures. The trust had plans to improve performance.	Provide assurance paper to Patient Safety & Effectiveness Sub Committee regarding remedial actions required in relation to hip fracture national audits	HOWEVER	Alex Crowe	Paul Scott	31/10/19

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

Reference	Core service	Domain	Areas for Review	Action	Type	Exec Lead	Lead Person	Target date for completion
S13	**Surgery**	**Safe**	Whilst staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005 and knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care; we saw an example of the application of such processes not in line with current guidance and trust policy.	Increased support via Masterclasses for staff in surgery	HOWEVER	Kimberley Salmon-Jamieson	Wendy Turner	31/12/19
TW01	**Trustwide**	**Well Led**	The trust should review the fit and proper persons processes so all the required information is retained for all directors.	Head of Corporate Affairs to give written assurance that there is a central electronic system held by the Trust for capturing all required information relating to fit and proper persons. The Head of Corporate Affairs will retain copies of all of this information within the Foundation Trust Office and updated as necessary.	SHOULD	Simon Constable	John Culshaw	12/09/19

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

Reference	Core service	Domain	Areas for Review	Action	Type	Exec Lead	Lead Person	Target date for completion
TW02	**Trustwide**	**Well Led**	The trust should consider how it records the delivery plans for the enabling strategies.	Ensure a timetable is developed for key enabling strategy review in the Trust	SHOULD	Simon Constable	Lucy Gardner	30/09/19
TW03a	**Trustwide**	**Well Led**	The trust should review the progress of the implementation of strategies for patients living with dementia and with a learning disability and consider the implementation of a strategy for patients with mental health needs. The trust did not currently have strategies to support patients living with dementia, learning disabilities or mental health illness. Some of the enabling strategies lacked clear delivery plans.	Ensure there is a strategy and implementation plan for patients living with dementia	SHOULD	Kimberley Salmon-Jamieson	John Goodenough	30/11/19

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

Reference	Core service	Domain	Areas for Review	Action	Type	Exec Lead	Lead Person	Target date for completion
TW03b	**Trustwide**	**Well Led**	The trust should review the progress of the implementation of strategies for patients living with dementia and with a learning disability and consider the implementation of a strategy for patients with mental health needs. The trust did not currently have strategies to support patients living with dementia, learning disabilities or mental health illness. Some of the enabling strategies lacked clear delivery plans.	Ensure there is a strategy and implementation plan for patients living with Learning Disabilities	SHOULD	Kimberley Salmon-Jamieson	John Goodenough	30/11/19
TW03c	**Trustwide**	**Well Led**	The trust should review the progress of the implementation of strategies for patients living with dementia and with a learning disability and consider the implementation of a strategy for patients with mental health needs. The trust did not currently have strategies to support patients living with dementia, learning disabilities or mental health illness. Some of the enabling strategies lacked clear delivery plans.	Ensure there is a strategy and implementation plan for patients living with Mental Health needs	SHOULD	Kimberley Salmon-Jamieson	John Goodenough	30/11/19

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

Reference	Core service	Domain	Areas for Review	Action	Type	Exec Lead	Lead Person	Target date for completion
TW04	**Trustwide**	**Use of Resources**	The trust should continue to review the plans to achieve financial sustainability and the action required to deliver financial plan for 2019-20. The trust had not yet fully addressed the plans to break even in 2019-20 which were predicated by the delivery of a cost improvement programme of £7.5million and the resolution of £5million of cost pressures.	Work collaboratively on the 2019/20 Recovery Plan with Bridgewater, Warrington CCG and Halton CCG, and present a High Level Recovery Plan to NHSI in August (6.8.19)	SHOULD	Andrea McGee	Jane Hurst	31/08/19
TW05	**Trustwide**	**Use of Resources**	The trust should review the information reported in the finance report to consider including remedial action on the financial position, risk-based forecasting and the level of recurrent cost improvement plans.	Provide robust forecast reporting, including risk and mitigation on financial position and in year and recurrent cost improvement programme to Finance & Sustainability Committee, including monthly CBU cost improvement and forecast updates at Financial Resources Group.	SHOULD	Andrea McGee	Jane Hurst	31/08/19

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

Reference	Core service	Domain	Areas for Review	Action	Type	Exec Lead	Lead Person	Target date for completion
TW06	**Trustwide**	**Safe**	The trust should review the processes for identifying, reporting and investigation of missed doses for critical medicines across the trust. The service prescribed, gave, and stored medicines well. Although not all medicines prescribed had a signature or appropriate code to indicate if the medicines had been administered and some medicines were not available.	Ensure a review of missed doses and critical meds is undertaken and reported to Patient Safety & Effectiveness Sub Committee Review of Process – D Matthew Review of Datix missed doses – D Matthew Audit of missed doses and missed doses of critical meds – A Kennah	SHOULD	Alex Crowe	Diane Matthew	31/10/19

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

Reference	Core service	Domain	Areas for Review	Action	Type	Exec Lead	Lead Person	Target date for completion
TW07	**Trustwide**	**Safe**	The trust should consider further development and investment in systems to improve medicines reconciliation rates across the trust. While medicines optimisation within the trust was well-led medicines reconciliation rates for the whole trust were currently at 33% of medicines reconciled within 24 hours; this is well below National Institute for Health and Care Excellence guidelines of 90% within 24 hours. The hospital was not following best practice for medicines reconciliation and in medical care and critical care medicines were not always properly recorded or available.	Ensure a plan is developed of how to meet the Trust trajectory to be 80% compliant with Medicines reconciliation within 24 hours by end March 2020 and present to Moving to Outstanding Steering Group	SHOULD	Alex Crowe	Diane Matthew	30/09/19

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

Reference	Core service	Domain	Areas for Review	Action	Type	Exec Lead	Lead Person	Target date for completion
TW08	**Trustwide**	**Safe**	We saw examples where the trust did not properly record the best interest decisions or capacity assessments for patients who lacked capacity. The trust should review the root cause analysis form for serious incidents to consider how information about safeguarding, capacity, patient involvement is included. In Surgery, we saw two cases where mental capacity assessments and best interests decisions were not fully recorded in patient records.	Review the route cause analysis report templates to ensure safeguarding information is recorded appropriately	SHOULD	Kimberley Salmon-Jamieson	Layla Alani	30/09/19

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

Reference	Core service	Domain	Areas for Review	Action	Type	Exec Lead	Lead Person	Target date for completion
TW09	**Trustwide**	**Safe**	The trust should review the process for senior clinician input into structured judgement reviews.	Undertake quarterly review of a random selection of SJRs across the board to assess the outcome reached by the reviewer (senior clinician), and give assurance to the Quality Assurance Committee that all issues are being identified following higher risk deaths. Commence October onwards with a review of the 2nd quarter reviews undertaken.	SHOULD	Alex Crowe	Phil Cantrell	31/10/19

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/19/09/86**
SUBJECT:	**Infection Prevention and Control**
DATE OF MEETING:	25 September 2019
AUTHOR(S):	Lesley McKay Associate Chief Nurse for Infection Prevention and Control/Associate DIPC
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse/DIPC Choose an item.
LINK TO STRATEGIC OBJECTIVES:	SO1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience
	SO2: We will .. Be the best place to work with a diverse, engaged workforce that is fit for the future
	SO3: We will .. Work in partnership to design and provide high quality, financially sustainable services
EXECUTIVE SUMMARY (KEY ISSUES):	This report provides a summary of infection prevention and control activity for Quarter 1 (Q1) of the 2019/20 financial year and highlights the Trust's progress against infection prevention and control key performance indicators. The Trust reported:- • Nil return for MRSA bacteraemia in Q1 • 1 MSSA bacteraemia cases in Q1. There is no national reduction target • 8 Clostridium difficile cases in Q1. 3 cases were reviewed by the CCG and 2 agreed to have no lapses in care. The Trust is on trajectory • 15 E. coli bacteraemia cases in Q1. The Trust is above the planned trajectory Discussion with Care Quality Commission inspectors highlighted the national challenge with reduction of Gram Negative Bacteraemia. National end of year data for 2018/19 showed 67 Trusts with an increase in case and 9 Trusts with no change in case numbers out of 147 organisations. Due to the rise in E. coli bacteraemia cases, a 5% reduction target has been set as a priority in the Quality Strategy for 2019/20. Action plans, which focus on learning from GNBSI incidents, are in place to manage and monitor these infections. Norovirus affected 10 wards in April and May: 4 wards were fully closed and 6 wards were partially closed. The Infection Prevention and Control Team worked closely with the DIPC and Operational Teams to manage the cases. Nationally there is a rise in Measles, Mumps and Pertussis (Whooping Cough) cases. Public Health England alerts have been circulated in the Trust and 2 healthcare workers have been diagnosed with Pertussis. The Infection Prevention and Control Team are working with Public Health

	England to manage this situation. There were 2 decontamination incidents (NNU and CMTC) which were concluded as no harm to patients. Actions are in place to reduce the risk of these incidents occurring again. The Trust commissioned a mobile ward to support operational activity and ward upgrade work. Water testing identified growth of Pseudomonas and the Estates Team has carried out appropriate action including chemical and thermal disinfection and replacement of pipework. There are ongoing concerns and a meeting has been scheduled with the mobile ward company to determine next actions. The Infection Prevention and Control Team have carried out a lot of promotional activity to support reductions in healthcare associated infections. Overall compliance for attendance at mandatory infection control training is 89%. Urgent and Emergency Care, Integrated Medicine and Community and Digestive Diseases CBUs are just below the 85% compliance threshold and have plans in place to improve compliance. The Infection Prevention and Control Strategy is being revised this year and a survey will be launched in Q2 to gain feedback on how the service can be improved and to support changes to the way healthcare is delivered.			
PURPOSE: (please select as appropriate)	Information √	Approval	To note √	Decision
RECOMMENDATION:	The Trust Board is asked to note the contents of the report, exceptions highlighted and progress made.			
PREVIOUSLY CONSIDERED BY:	**Committee**		Quality Assurance Committee	
	Agenda Ref.		QAC/19/09/144	
	Date of meeting		03.09.2019	
	Summary of Outcome		Noted	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None			

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

SUBJECT	Infection Prevention and Control	AGENDA REF:	BM/19/09/86

1. BACKGROUND/CONTEXT

This report provides an overview of infection prevention and control activity for Quarter 1 (Q1) of the 2019/20 financial year (FY). The report highlights the Trust's progress against Healthcare Associated Infection (HCAI) reduction targets, learning from incidents and an update on activity for audit, education, surveillance and policy reviews.

NHSI use Clostridium difficile infection rates as one of a number of metrics to assess Trust performance. Both avoidable and unavoidable cases are taken into account for regulatory purposes. The Trust is assessed for breaches of the Clostridium difficile objective using a cumulative YTD trajectory.

The zero tolerance threshold for avoidable cases of Meticillin resistant Staphylococcus aureus (MRSA) bacteraemia remains in place.

There is a national ambition to halve gram-negative bloodstream infections (GNBSIs). The Antimicrobial resistance 5 year plan provide a revised timescale to meet this objective and advises a systematic approach is required to deliver a 25% reduction by 2021-2022 with the full 50% by 2023-2024.

2. KEY ELEMENTS

HCAI data

RAG rating of Trust performance for HCAIs by month is as shown in Table 1.

Table 1: HCAI data by month

Indicator	Target	Position	A	M	J	Total
C. difficile	≤44	On trajectory	3	1	4	**8**
MRSA bacteraemia	Zero tolerance	On trajectory	0	0	0	**0**
MSSA bacteraemia	No target	No target	0	0	1	**1**
E. coli bacteraemia	5% reduction ≤46	Above trajectory	4	6	5	**15**
Klebsiella spp. bacteraemia	5% reduction ≤13	On trajectory	1	1	1	**3**
P. aeruginosa bacteraemia	5% reduction ≤4	On trajectory	0	0	1	**1**

Breakdown by ward is included at appendix 1.

Clostridium difficile

- 8 cases reported in Q1 (6 hospital onset/ healthcare associated: 2 community onset/ healthcare associated). The trust is on trajectory against the annual threshold
- 3 cases from April were assessed for lapses in care by the CCG review panel who concluded: 2 unavoidable, 1 avoidable
- Plan in place to review the other cases from Q1 at the next CCG review panel meeting
- 1 period of increased incidence noted on B19 in April (2 cases). Ribotyping results were only available for 1 case therefore cross infection could not be ruled out as the patients were cared for in the same bay. The bay was decanted and hydrogen peroxide vapour disinfection completed

All hospital apportioned cases undergo post infection review. Action plans for care improvements are aligned to findings from the reviews and include documentation of stool type, timely sampling and isolation.

The Chief Nurse/DIPC chairs a meeting weekly, where healthcare associated infection investigation reports are reviewed. Learning from these meetings is shared with clinical teams via CBU Governance meetings.

Bacteraemia Cases

Gram positive bacteraemia

Meticillin resistant Staphylococcus aureus (MRSA) bacteraemia

- A nil return was submitted for Q1

Meticillin sensitive Staphylococcus aureus MSSA bacteraemia

- 1 hospital onset case in Q1 – Post infection review in progress
- No national reduction target/threshold

Gram negative bacteraemia (GNBSI)

E coli bacteraemia

- 15 hospital onset cases in Q1

Klebsiella Spp.

- 3 hospital onset cases in Q1

Pseudomonas aeruginosa

- 1 hospital onset case in Q1

Compared to the 2018/19 Q1 period there is an increase in E. coli cases by 3; reduction in Klebsiella spp. by 1 case and reduction in Pseudomonas by 2 cases. All E.coli bacteraemia cases undergo post infection review. Action plans for care improvements are aligned to findings from the reviews and include urinary catheter care, timely blood culture sampling and education on the UTI pathway. These work streams are in progress.

National data for 2018/19 showed 67 Trusts with an increase in E. coli bacteraemia cases and 9 Trusts with no change in case numbers out of 147 organisations. Benchmarking is in progress with Trusts with higher numbers of case reductions to identify any additional actions.

A review of the latest Safety Thermometer data has highlighted the Trust remains above the national average (by 5%) for the proportion of patients with a urinary catheter in situ. This has been discussed at Trust Wide Safety Brief, Ward Manager's meetings and surgical audit meetings. Additional work is in progress with theatres to ensure catheters are only inserted for surgical procedures when necessary and these are removed timely.

Comparative data on HCAI cases and rates over the last 12 months across the Northwest is included in appendix 2. Appropriate comparison with other similar Trusts (local delivery system partners), shows similar case numbers and for C. difficile and MRSA and a significantly lower number of cases for E.coli and Klebsiella spp. than one of our Local Delivery System partners.

Outbreaks - Norovirus

The Trust was significantly affected by Norovirus during April and May. In total 110 patients were reported with symptoms; 91 samples processed and 33 cases confirmed. Ten wards were affected with 4 full ward closures and 6 partial closures.

Rapid testing was used for 18 single patient reported cases with 6 confirmed norovirus. These patients were effectively isolated. The single case testing approach was useful in preventing further transmission.

Table 2: Norovirus incidents by month

	Apr	May	Jun
Outbreaks	6	4	0

Incidents

Decontamination - NNU

The NNU reported an incident whereby eye examination instruments were reused on an infant without decontamination. The risk to the second infant was concluded as low. Duty of Candour was completed by the Ophthalmology Consultant. A Local Safety Standard for this procedure is being developed by the Lead Nurse for Paediatrics to prevent incidents with this equipment from happening again.

Decontamination - CMTC

Theatre staff at CMTC reported an incident relating to a single use needle being left loaded into an instrument that was reprocessed and returned for use with the needle in place. This was identified mid surgical procedure and the needle replaced with a sterile needle. The risk to the patient was concluded as low. The Theatre Manager has arranged retraining on the device and the process for counting these supplementary instruments has been made more robust.

Pertussis

Workplace Health and Wellbeing reported a confirmed case of Pertussis in a member of staff. The case was reported at the time the results were available. Following this a second case has been confirmed and a further suspected case is being investigated. The affected members of staff have been absent from work and the cases were all reported after the infectious period had ended. The cases have been reported to Public Health England and a review meeting will be held to identify any additional actions required.

K25 Water Safety

A mobile ward was commissioned by the Trust to support ward upgrades. Since the installation of the facility there have been water safety issues with high colony counts and Pseudomonas detected. The Estates Team has carried out a vast amount of work including: replacing pipework, thermal and chemical disinfection and installation of point of use filters. In spite of this there are ongoing concerns about water quality. A meeting has been scheduled with the mobile ward company to determine next actions.

Surveillance

A Registered Nurse with a Specialist Interest (RNSI) in infection control has been seconded to the Infection Control Team. The RNSI will be undertaking data collection on surgical site infection for large bowel surgery. Recruitment is in progress to appoint a full time surveillance nurse.

Work continues to make improvements in surveillance via use of computer software and a demonstration is being planned. There are a number of control measures currently in place to provide surveillance data including: local databases for alert organisms (those microorganisms with a potential to cause outbreaks of infection) and HCAI cases and functionality to undertake a retrospective review of microbiology results.

Infection Prevention and Control Training

Overall compliance with mandatory infection control training is above the 85% threshold and has remained around 90% for the last 8 months.

Table 3 Infection Control Training compliance

Infection Control Training	Apr-19	May-19	Jun-19
Overall % of staff trained	91%	91%	89%

The Infection Prevention and Control Nurses have been providing additional training sessions to support CBUs to meet the required attendance targets.

Infection Prevention and Control Audits

A total of 13 audits were completed in Q1. Findings are shown in Appendix 3.

Areas for care improvement include: the environment, Ward Kitchens, handling and disposal of linen and short term urinary catheter management.

- Environmental concerns have been discussed at the IPC operational group and action taken by the Estates Department to implement improvements.
- Ward kitchens have been added to the capital programme. Two kitchens per annum will be upgraded over the forthcoming years
- A single point lesson has been developed to support improvements in compliance with handling linen
- Work is in progress to improve care of urinary catheters as part of the GNBSI reduction activity.

Audit reports are returned to Ward Mangers who are responsible for developing action plans to address areas requiring improvement. Action plans are monitored at the Infection Control Operational Group Meetings.

Environmental Hygiene

- Cleanliness monitoring is carried out by the Facilities team
- Overall cleanliness score for Very high risk areas in Warrington was 97%
- Overall cleanliness score for Very high risk areas in Halton was 96%

Infection Control Policies

The Multi-drug resistant Organisms Policy was approved by the Infection Control Sub-Committee in May.

Antimicrobial Stewardship

- Quarterly point prevalence audit (May) showed overall compliance of 91% with the Trust's Antibiotic Formulary
- 4 wards had less than 90% compliance (A4, A5, A6 and C23). The audit results are reported directly to Consultants' in charge of patients', the Executive Medical Director for action
- Additional challenge has been implemented by the Chief Nurse/DIPC in response to findings from HCAI review meetings and areas where compliance at point prevalence audits has remained lower than 90%

A single point lesson (appendix 4) has been developed on the more common prescribing non-compliances. This has been circulated to all areas to further strengthen antimicrobial stewardship by supporting staff administering medicines to raise queries with prescribers.

Awareness raising events

The Infection Prevention and Control Team have been very proactive during Q1 and carried out a number of activities including:-

- Revision to the blood culture training package
- Revision to E-Learning packages
- Hand hygiene and glove awareness campaign in May
- Delivering Hot Topic sessions at Trust Wide Safety Brief including: Urinary catheter care; revised documentation forms for urinary catheter insertion and monitoring; Trial Without Catheters, choice of drainage bag and supporting patients being discharged with catheters in situ
- Desk top messages for GNBSI reduction
- Presentation at Surgical audit
- Provision of a Masterclass on GNBSI incident investigation to Ward Managers Meeting

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

- Work continues to meet the recommendations of the external review of Infection Prevention and Control reported in 2018
- Aseptic Non-Touch Technique (ANTT) assessor training is scheduled to commence in Q2 and a programme of annual competency assessments for staff undertaking procedures requiring ANTT will be put in place
- The Infection Prevention and Control Strategy is due to be revised and work is in progress to engage staff, patients, carers, the public and stakeholders to produce and deliver a clear and agreed strategy aligned to the Trust's Mission, Values and aims and objectives
- A Survey will be launched in July to gain feedback from Stakeholders and to inform the review of the IPC Strategy

4. IMPACT ON QPS

Q: A reduction in HCAIs will demonstrate a positive impact on patient outcomes.

P: Improved attendance at training assists staff in fulfilling mandatory training requirements.

S: Reduction in HCAIs supports sustainability by avoidance of contractual financial penalties.

5. MEASUREMENTS/EVALUATIONS

- Mandatory reporting of healthcare associated infection (HCAI) to Public Health England
- The Infection Prevention and Control Team meet fortnightly to monitor cases of HCAI. Action is implemented in response to increased incidences of HCAIs and infection control related incidents
- The Infection Control Sub-Committee meets bi-monthly (6 times per annum) and discusses HCAI surveillance data and learning from HCAI incidents
- Meetings take place weekly with the DIPC to review HCAI incident investigation reports and actions are agreed to support care improvements

6. TRAJECTORIES/OBJECTIVES AGREED

- The Clostridium difficile threshold for 2019/20 is ≤44 cases

The apportionment algorithm has changed (reduction in one day from admission i.e. samples taken from 3rd day of admission onwards will be apportioned to the Trust – previously this was from 4th day). Any cases arising within 28 days of a patient discharged will be classified as community onset/ healthcare associated and will also be apportioned to the Trust

- The zero tolerance to avoidable MRSA bacteraemia cases remains in place
- GNBSI 5% reduction target has been set as a priority within the Quality Strategy

Work streams will continue to:-

- Progress GNBSI reduction
- Reduce the incidence of Clostridium difficile infection
- Promote Antimicrobial Stewardship and challenge inappropriate prescribing
- Partnership working with Urgent and Emergency Care CBU to support timely blood culture sampling
- Monitor invasive device management/bacteraemia reduction
- Roll out ANTT competency assessor training
- Review infection control surveillance systems
- Support staff training in Infection Prevention and Control where CBU compliance is lower than 85%
- Promote excellent standards in uniform/workwear and the Bare Below the Elbows campaign
- Support assessment of decontamination standards
- Complete actions from the external review
- Set up a surgical site infection surveillance programme linked to Getting It Right First Time

7. MONITORING/REPORTING ROUTES

High level briefing papers from the Infection Control Sub-Committee are submitted to:-

- Quality and Assurance Committee
- Health and Safety Sub-Committee
- Patient Safety and Clinical Effectiveness Committee

DIPC reports are submitted quarterly to the Quality and Assurance Committee and Trust Board.

Verbal updates are provided to Trust Board monthly as part of the IPR (in full) report.

A Director of Infection Prevention and Control Report is submitted to Trust Board annually.

Exception reports will be submitted to the Quality and Assurance Committee when increased incidences of infection are identified.

8. TIMELINES

2019/20 Financial Year

9. ASSURANCE COMMITTEE

- Infection Control Sub-Committee

10. RECOMMENDATIONS

The Trust Board is asked to note the content of the report, the exceptions reported and the progress made.

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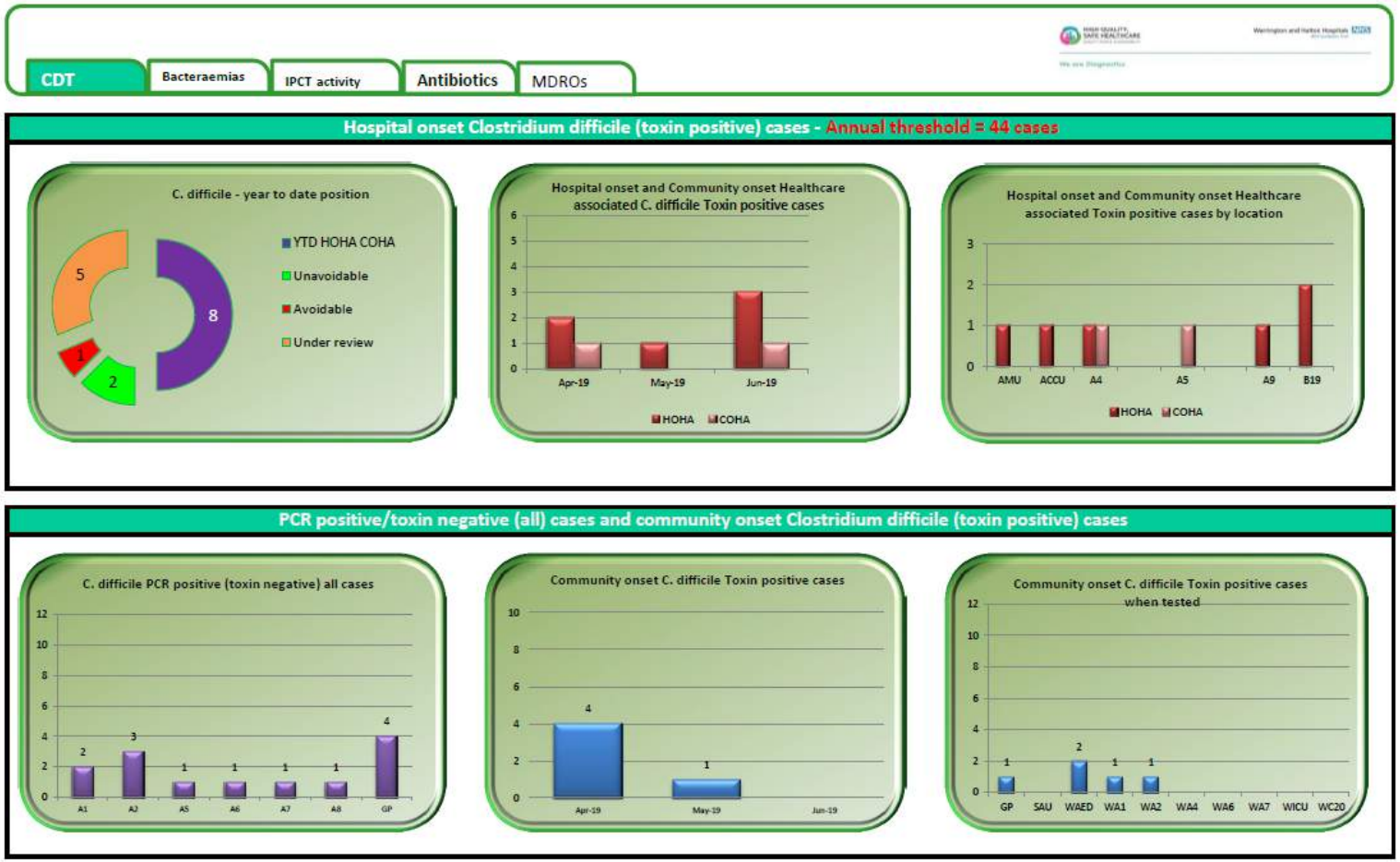
APPENDIX 1 HEALTHCARE ASSOCIATED INFECTION DATA 2019/20

Clostridium difficile Cases



Hospital onset/Healthcare associated = HOHA
Community onset/Healthcare assocaiated = COHA
Community onset/Healthcare associated cases are linked to the ward the patient was most recently discharged from

April - June 2019

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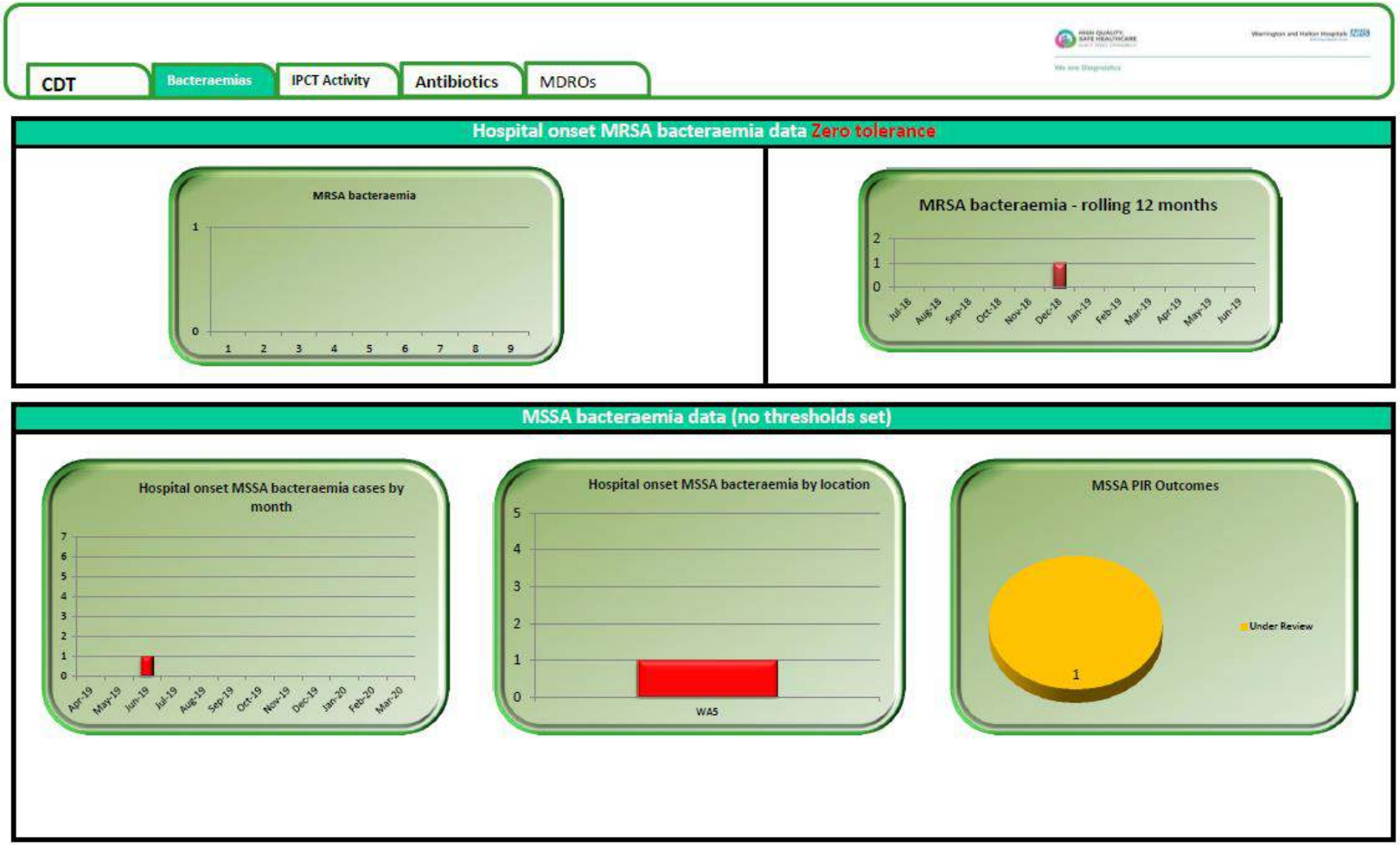
Gram Positive Bacteraemia Cases



April - June 2019

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Gram Negative Bacteraemia Cases

April - June 2019

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APPENDIX 2 COMPARISION OF HEALTHCARE ASSOCIATED INFECTION DATA ACROSS THE NORTHWEST

Public Health England

C. difficile annual tables: Trust cases & rates (hospital onset)

***C. difficile* : Hospital Onset Cases**

	June 2018 to May 2019	
Organisation Name	Counts	Rates per 100,000
AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	39	15.5
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	1	1.4
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	40	15.5
BOLTON NHS FOUNDATION TRUST	25	12.2
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	26	13.8
EAST CHESHIRE NHS TRUST	12	11.1
EAST LANCASHIRE HOSPITALS NHS TRUST	26	8.3
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	55	18.6
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	5	10.6
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	0	0.0
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	112	17.1
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	28	16.3
NORTH CUMBRIA UNIVERSITY HOSPITALS NHS TRUST	20	11.1
PENNINE ACUTE HOSPITALS NHS TRUST	50	12.8
ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TR	35	13.1
SALFORD ROYAL NHS FOUNDATION TRUST	27	10.5
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	14	10.7
ST HELENS AND KNOWSLEY HOSPITAL SERVICES NHS TRUST	28	11.4
STOCKPORT NHS FOUNDATION TRUST	36	15.9
TAMESIDE HOSPITAL NHS FOUNDATION TRUST	24	15.7
THE CHRISTIE NHS FOUNDATION TRUST	15	26.2
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	4	19.7
THE WALTON CENTRE NHS FOUNDATION TRUST	8	15.3
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	30	14.1
WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST	26	14.3
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	89	36.2
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	15	9.7
North West	790	14.7

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Public Health England

MRSA annual tables: Trust cases & rates

MRSA: Trust Cases

Organisation Name	June 2018 to May 2019 Counts	Rates per 100,000
AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	2	0.8
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	0	0.0
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	1	0.4
BOLTON NHS FOUNDATION TRUST	1	0.5
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	3	1.6
EAST CHESHIRE NHS TRUST	1	0.9
EAST LANCASHIRE HOSPITALS NHS TRUST	1	0.3
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	0	0.0
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	0	0.0
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	0	0.0
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	5	0.8
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	3	1.7
NORTH CUMBRIA UNIVERSITY HOSPITALS NHS TRUST	1	0.6
PENNINE ACUTE HOSPITALS NHS TRUST	3	0.8
ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TR	3	1.1
SALFORD ROYAL NHS FOUNDATION TRUST	4	1.6
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	0	0.0
ST HELENS AND KNOWSLEY HOSPITAL SERVICES NHS TRUST	1	0.4
STOCKPORT NHS FOUNDATION TRUST	0	0.0
TAMESIDE HOSPITAL NHS FOUNDATION TRUST	6	3.9
THE CHRISTIE NHS FOUNDATION TRUST	1	1.7
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	0	0.0
THE WALTON CENTRE NHS FOUNDATION TRUST	0	0.0
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	0	0.0
WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST	1	0.5
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	4	1.6
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	2	1.3
North West	43	0.8

Public Health England

MSSA annual tables: Trust cases & rates (hospital onset)

MSSA: Hospital Onset Cases

Organisation Name	May 2018 to April 2019 Counts	Rates per 100,000
AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	29	11.5
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	15	21.6
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	24	9.3
BOLTON NHS FOUNDATION TRUST	19	9.3
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	11	5.8
EAST CHESHIRE NHS TRUST	10	9.2
EAST LANCASHIRE HOSPITALS NHS TRUST	34	10.9
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	22	7.4
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	10	21.3
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	1	3.7
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	83	12.7
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	12	7.0
NORTH CUMBRIA UNIVERSITY HOSPITALS NHS TRUST	20	11.1
PENNINE ACUTE HOSPITALS NHS TRUST	23	5.9
ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TR	33	12.4
SALFORD ROYAL NHS FOUNDATION TRUST	21	8.2
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	14	10.7
ST HELENS AND KNOWSLEY HOSPITAL SERVICES NHS TRUST	33	13.5
STOCKPORT NHS FOUNDATION TRUST	10	4.4
TAMESIDE HOSPITAL NHS FOUNDATION TRUST	12	7.8
THE CHRISTIE NHS FOUNDATION TRUST	13	22.7
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	3	14.7
THE WALTON CENTRE NHS FOUNDATION TRUST	13	24.8
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	29	13.7
WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST	13	7.1
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	24	9.8
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	21	13.5
North West	552	10.3

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Public Health England

E. coli annual tables: Trust cases & rates (hospital onset)

***E. coli* : Hospital Onset Cases by Trust**

Organisation Name	June 2018 to May 2019 Counts	Rates per 100,000
AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	83	32.9
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	6	8.6
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	58	22.4
BOLTON NHS FOUNDATION TRUST	41	20.0
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	30	15.9
EAST CHESHIRE NHS TRUST	14	12.9
EAST LANCASHIRE HOSPITALS NHS TRUST	72	23.0
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	63	21.3
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	7	14.9
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	9	33.0
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	154	23.5
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	34	19.8
NORTH CUMBRIA UNIVERSITY HOSPITALS NHS TRUST	27	14.9
PENNINE ACUTE HOSPITALS NHS TRUST	53	13.6
ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TR	73	27.4
SALFORD ROYAL NHS FOUNDATION TRUST	59	22.9
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	31	23.6
ST HELENS AND KNOWSLEY HOSPITAL SERVICES NHS TRUST	62	25.3
STOCKPORT NHS FOUNDATION TRUST	41	18.1
TAMESIDE HOSPITAL NHS FOUNDATION TRUST	22	14.4
THE CHRISTIE NHS FOUNDATION TRUST	37	64.6
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	6	29.5
THE WALTON CENTRE NHS FOUNDATION TRUST	9	17.2
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	42	19.8
WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST	51	28.0
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	54	22.0
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	30	19.3
North West	1168	21.8

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Public Health England

Klebsiella annual tables: Trust cases & rates (hospital onset)

***Klebsiella* species: Hospital Onset Cases**

Organisation Name	June 2018 to May 2019 Counts	Rates per 100,000
AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	30	11.9
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	7	10.1
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	22	8.5
BOLTON NHS FOUNDATION TRUST	10	4.9
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	8	4.2
EAST CHESHIRE NHS TRUST	12	11.1
EAST LANCASHIRE HOSPITALS NHS TRUST	23	7.3
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	8	2.7
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	5	10.6
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	0	0.0
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	96	14.7
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	11	6.4
NORTH CUMBRIA UNIVERSITY HOSPITALS NHS TRUST	7	3.9
PENNINE ACUTE HOSPITALS NHS TRUST	32	8.2
ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TR	24	9.0
SALFORD ROYAL NHS FOUNDATION TRUST	26	10.1
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	10	7.6
ST HELENS AND KNOWSLEY HOSPITAL SERVICES NHS TRUST	23	9.4
STOCKPORT NHS FOUNDATION TRUST	18	8.0
TAMESIDE HOSPITAL NHS FOUNDATION TRUST	12	7.8
THE CHRISTIE NHS FOUNDATION TRUST	13	22.7
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	0	0.0
THE WALTON CENTRE NHS FOUNDATION TRUST	2	3.8
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	19	9.0
WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST	14	7.7
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	21	8.5
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	10	6.4
North West	463	8.6

Public Health England

Pseudomonas aeruginosa annual tables: Trust cases & rates (hospital onset)

***Pseudomonas aeruginosa* : Hospital Onset Cases**

Organisation Name	June 2018 to May 2019 Counts	Rates per 100,000
AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	12	4.8
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	1	1.4
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	7	2.7
BOLTON NHS FOUNDATION TRUST	2	1.0
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	6	3.2
EAST CHESHIRE NHS TRUST	5	4.6
EAST LANCASHIRE HOSPITALS NHS TRUST	8	2.6
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	11	3.7
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	1	2.1
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	1	3.7
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	27	4.1
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	2	1.2
NORTH CUMBRIA UNIVERSITY HOSPITALS NHS TRUST	6	3.3
PENNINE ACUTE HOSPITALS NHS TRUST	3	0.8
ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TR	1	0.4
SALFORD ROYAL NHS FOUNDATION TRUST	8	3.1
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	7	5.3
ST HELENS AND KNOWSLEY HOSPITAL SERVICES NHS TRUST	11	4.5
STOCKPORT NHS FOUNDATION TRUST	4	1.8
TAMESIDE HOSPITAL NHS FOUNDATION TRUST	3	2.0
THE CHRISTIE NHS FOUNDATION TRUST	9	15.7
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	1	4.9
THE WALTON CENTRE NHS FOUNDATION TRUST	1	1.9
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	9	4.2
WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST	3	1.6
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	8	3.3
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	2	1.3
North West	159	3.0

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Appendix 3 Infection Control Audits

Ward	B1	B3	B4	PIU	Halton OPD	CMTC OPD	Halton UCC	B19	B18	CMTC	AMU	A4	ACCU	Total
Environment	90%	91%	91%	93%	80%	90%	98%	87%	72%	90%	78%	78%	97%	87%
Ward Kitchens	93%	89%	N/A	90%	N/A	N/A	N/A	83%	N/A	100%	82%	73%	100%	88%
Handling/Disposal of Linen	100%	100%	100%	94%	100%	100%	100%	100%	94%	89%	89%	89%	100%	96%
Departmental Waste	100%	100%	100%	100%	100%	94%	100%	100%	100%	100%	100%	95%	100%	99%
Safe Handling Disposal of Sharps	100%	100%	96%	100%	100%	100%	100%	100%	100%	96%	100%	92%	100%	99%
Patient Equipment (General)	98%	100%	100%	94%	94%	90%	97%	98%	95%	97%	95%	78%	100%	95%
Patient Equipment (Specialist)	100%	100%	100%	100%	100%	100%	100%	100%	N/A	N/A	100%	N/A	N/A	100%
Personal Protective Equipment	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	80%	**100%**	99%
Short Term Catheter Management	100%	100%	100%	N/A	N/A	N/A	100%	100%	87%	100%	89%	100%	100%	98%
Enteral Feeding	N/A	80%	N/A	N/A	N/A	N/A	N/A	82%	N/A	N/A	100%	100%	N/A	92%
Care of Peripheral Intravenous Lines	100%	100%	91%	100%	N/A	N/A	N/A	100%	91%	100%	100%	91%	91%	96%
Non-Tunnelled Central Venous Catheters	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	n/a	N/A	N/A	N/A	N/A	N/A
Isolation Precautions	100%	100%	100%	N/A	N/A	N/A	100%	100%	100%	100%	100%	100%	100%	100%
Hand Hygiene	97%	97%	97%	97%	100%	97%	100%	94%	94%	100%	84%	90%	97%	96%
Overall Compliance	98%	97%	98%	97%	97%	96%	99%	96%	93%	97%	94%	89%	99%	96%

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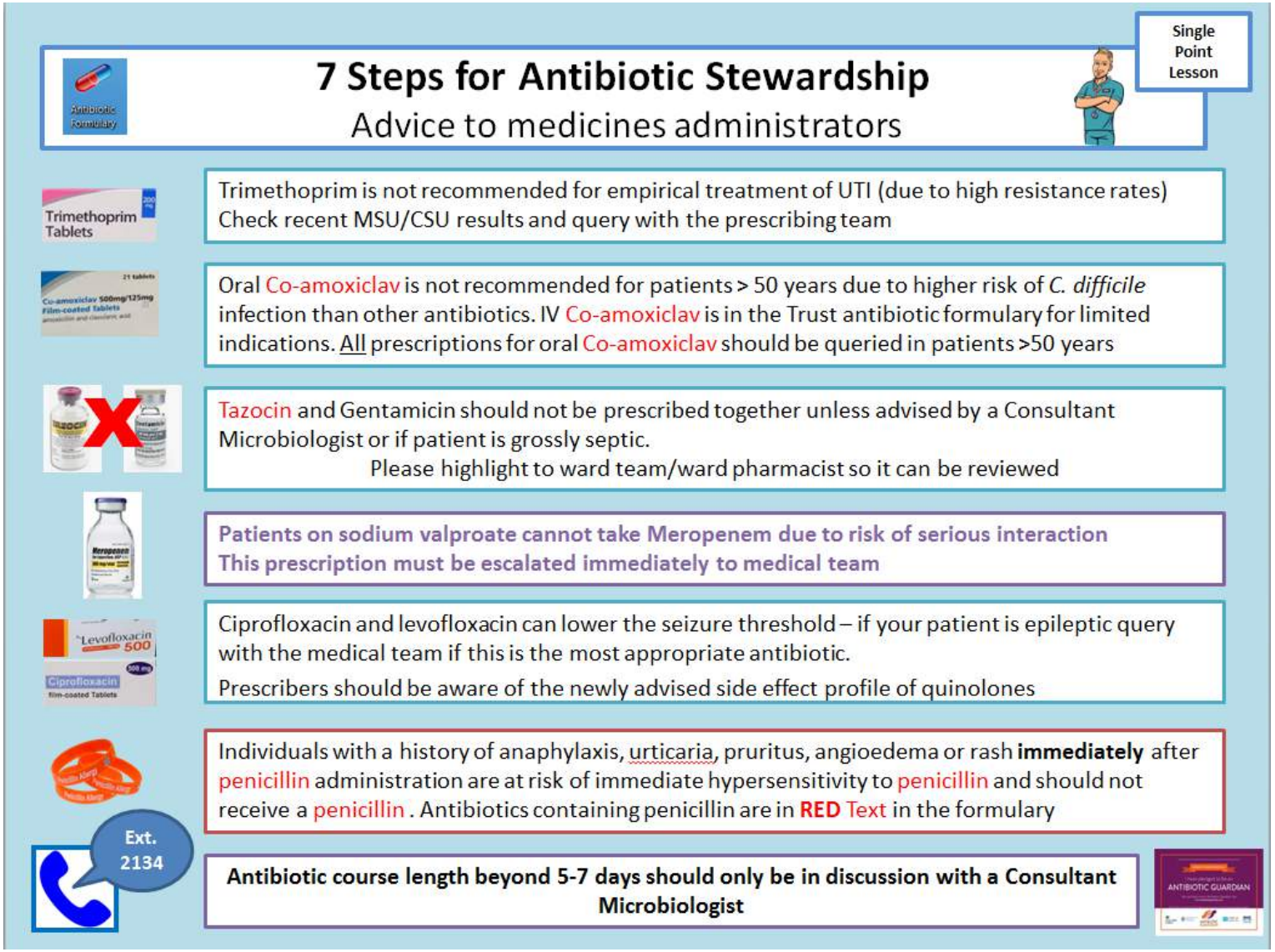
APPENDIX 4 Single Point Lesson Antimicrobial Stewardship



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Warrington and Halton Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/19/09/87**
SUBJECT:	**Learning From Deaths Report Quarter 1 2019-20**
DATE OF MEETING:	25th September 2019
AUTHOR(S):	Dr P. Cantrell, Lead Clinician for Mortality H. McCaffrey, Head of Clinical Effectiveness & Quality
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Executive Medical Director/Deputy CEO
LINK TO STRATEGIC OBJECTIVES:	SO1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience
EXECUTIVE SUMMARY (KEY ISSUES):	This briefing paper overviews Trust mortality data, including; • total number of deaths of patients; • number of reviews of deaths; • number of investigations of deaths; • lessons learned, actions taken, improvements made During Quarter 1, 2019/20; • 174 deaths that occurred within the Trust. • 35 have met the criteria to be subject to a structured judgement review (SJR) through the Mortality Review Group • 3 were to subject to investigation using root cause analysis (RCA) methodology. We are not an outlier for HSMR or SHMI. However, the Mortality Review Group analyses data in relation to Mortality and it is indicated that we have an excess number of deaths in the following diagnosis groups; • R Codes • Chronic Obstructive Pulmonary Disease & Bronchiectasis MRG have requested that Focused Reviews be undertaken to obtain any learning.

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

	Assurance Statement: We would like to provide the Board with the following assurance for learning from deaths; **Moderate** - There is an adequate system of internal control, however, in some areas weaknesses in design and/or inconsistent application of controls puts the achievement of some aspects of the system objectives at risk.			
PURPOSE: (please select as appropriate)	Information	Approval	To note ✓	Decision
RECOMMENDATION:	The Board is asked to note the contents of the briefing paper.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.	**QAC/19/09/147**		
	Date of meeting	3rd September 2019		
	Summary of Outcome	The Committee reviewed, discussed + noted the report and internal control systems.		
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

REPORT TO BOARD OF DIRECTORS

SUBJECT	Learning From Deaths Report Quarter 1 2019-20	AGENDA REF:	BM/19/09/87

1. BACKGROUND/CONTEXT

The National Quality Board report published in March 2017 - National Guidance on Learning from Deaths; A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care stated that,
"Following events in Mid Staffordshire, a review of 14 hospitals with the highest mortality noted that the focus on aggregate mortality rates was distracting Trust boards "from the very practical steps that can be taken to reduce genuinely avoidable deaths in our hospitals".

This report followed the findings of the CQC report published in December 2016 - Learning, Candour and Accountability: A review of the way NHS trusts review and investigate the deaths of patients in England. This found that none of the Trusts the CQC contacted were able to demonstrate best practice across every aspect of identifying, reviewing and investigating deaths and ensuring that learning is implemented. The purpose of this publication was *'to help initiate a standardised approach, which will evolve as we learn'*.

All Trusts were tasked with reviewing their processes and to implement systems to review, understand and learn from deaths that occurred and the National Guidance set the requirements of this:

- governance and capability;
- improved data collection and reporting;
- death certification, case record review and investigation;
- engaging and supporting bereaved Families and carers

This report follows on from the October 2017 report to the Board which outlined the proposed process for the Trust to ensure there are systems in place to review deaths which occur and the content of this report provides an overview of this process.

2. KEY ELEMENTS

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

Using both the HED and Datix Risk Management system to obtain data, this report will include;

- total number of deaths of patients;
- number of reviews of deaths;
- number of investigations of deaths;

- themes identified from reviews and investigations;
- lessons learned, actions taken, improvements made

3. MEASUREMENTS/EVALUATIONS

3.1 Total number of deaths
During Quarter 1, 2019/20, the following occurred;

Total number of deaths	Structured judgement reviews (SJR)*	Root cause analysis (RCA)*	Structured judgement review (SJR) completed from the previous quarter
174	35	3	14

*Details of the SJRs and RCAs can be seen later within this report.

3.2 Investigations of deaths
Structured Judgement Reviews of deaths - Structured Judgement 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. Particular groups of patients are reviewed at the MRG:

- All deaths of patients subject to care interventions with elective procedures. These will be identified using the electronic patient record which provides a daily update as to patients that have died.
- Patients undergoing an emergency laparotomy.
- SHMI/HSMR outliers identified using the HED system.
- Deaths where learning will inform our existing or planned improvement work, for example if work is planned on improving sepsis care, relevant deaths should be reviewed, as determined by the Trust;
- Death of a patient with mental health needs (this covers Inpatients who are detained under the Mental Health Act) identified via the Trust Patient Safety Manager. If the death may have been due to, or partly due, to problems in care including suspected self-inflicted death it will be investigated as a serious incident.
- Trauma deaths will be reviewed and presented at MRG on a quarterly basis.
- Patients who have died aged between 18 and 55 years.
- Patients who have died with no DNACPR in place.
- Once a quarter, a further sample of other deaths will be selected that do not fit the above identified categories, to ensure we take an overview of where learning and improvement is needed most overall.
- All Coroners' reports received post-inquest will be triangulated with the SJR to enhance the learning.
- Any concern that a member of staff may have in relation to a patient death will be reviewed through the mortality process.
- At the request of the Medical Director or Chief Nurse.

During Quarter 1, 49 Structured Judgement Reviews were completed by member of the MRG between April 1st 2019 and June 30th 2019 (14 of which were from the previous quarter). The table below details their overall care rating;

Apr / May / Jun 19	Overall Assessment Care Rating Following SJR					Total
	1: Very Poor	2: Poor	3: Adequate	4: Good	5:Excellent	
	0	2	14	28	5	49

Cases rated as *1: Very Poor* or *2: Poor* are reviewed by MRG and then referred to Governance for further discussion in case they require further investigation and external reporting via StEIS. Cases rated as *3: Adequate* are referred to MRG for further discussion and cases rated as *4: Good* and *5: Excellent* are disseminated for learning through the Mortality & Morbidity Meetings.

Focused Reviews - The Mortality Review Group analyses data in relation to Mortality and where is it indicated that there is a high SHMI/HSMR (i.e. greater than expected number of deaths) in a diagnosis group, we request that a Focused Review be undertaken. The table below details the current Focused Reviews that are underway at present;

Diagnosis Group	Trigger	Observed deaths/ expected deaths	Date due for completion	Learning Identified
R Codes	SHMI	33/18.75	September 2019	Full report to be presented to Mortality Review Group in October 19.
Chronic Obstructive Pulmonary Disease & Bronchiectasis	SHMI	41/31.29	September 2019	Full report to be presented to Mortality Review Group in October 19.

Cases subject to Root Cause Analysis investigation - The following data outlines those deaths that have been deemed by the Trust to be having problems in care which may contribute to death, which are subject to Root Cause Analysis investigation. Some cases may be referred from Mortality Review Group to ensure a Root Cause Analysis investigation is undertaken. The majority of cases are identified through incident and complaint processes.

To note all Root Cause Analysis investigations are shared with patients/families, commissioners and where applicable HM Coroners and regulators/external agencies such as NHS Resolutions.

The following table provides an update on outstanding cases from 2018/19 and also from Quarter 1 2019/20 that were deemed to be due to having problems in care which may contribute to death or are still outstanding;

STEIS Reference	INC Description	Deemed as having problems in care
2018/19 - Q3		
2018/19771	The patient was found collapsed with breathing difficulties. The patient was transferred from the Halton ward to the Warrington Emergency Department (ED). The patient was reviewed on arrival to ED by the consultant. Initial tests showed respiratory failure and appropriate treatment were commenced despite a poor prognosis for the patient. The patient was kept comfortable and sadly passed away in the department. Whilst an inpatient on the ward at Halton, it is thought that the patient had potentially been taking illegal substances on several occasions. On transfer to Warrington, it was noted that the patient had illegal substances on his possession. *This case was not subject to an SJR as a 72 hour review was already underway.	*Subject to inquest – being heard on 15th August 2019
2018/19 - Q4 - There were no cases of harm due to having problems in care to date. However, 2 are awaiting Inquest.		
2018/26921	The patient had a past medical history of Alzheimer's disease, COPD, myeloma, hypothyroidism and a 6 month history of weight loss and was admitted through WHH ED under GP referral for overnight delirium suffering from hallucinations on 12/09/18 the patient was transferred to Halton with a plan for discharge. On the morning of 04/11/18, the staff nurse in charge of the patient's care identified that the patient appeared drowsier. Medication had been taken, however the patient struggled to eat and began coughing when attempting to eat. On the afternoon of 04/11/18, an NHS Professionals (NHSP) Health Care Assistant (HCA) arrived on the ward to begin a shift and received handover and induction. The HCA was asked to assist the patient with eating. The patient was observed being assisted with feeding by the HCA, but when staff went into the bay (approximately 1-2 minutes later), the patient was found to have died and food was seen inside and around their mouth. The patient was DNACPR. *This case was not subject to an SJR as a 72 hour review was already underway.	*Subject to inquest – no date set as yet
2018/23091	The patient was found collapsed at home by his wife having fallen down the stairs after developing chest pain. An ambulance was called and the patient had a cardiac arrest in the ambulance. Resuscitation commenced and the NWAS team diverted to WHH Emergency Department (ED). On arrival at ED the Consultant made the decision that the patient needed to be transferred immediately to Liverpool Heart and Chest Hospital (LHCH) for Percutaneous transluminal coronary angioplasty (PPCI.) The patient was the taken to LHCH, but sadly died. *This case was not subject to an SJR as it did not meet the criteria for a review.	Subject to inquest heard on 8th July 19 – Unavoidable
2019/20 – Q1 TBC		
2019/8122	The patient was admitted to Warrington Hospital on 31/03/2019 after a fall at home, shortness of breath and increased confusion. The patient was admitted to AMU. On 02/04/2019 the patient had an unwitnessed fall and was found on the floor at the end of the bed. Following a brief loss of consciousness the patient displayed acute confusion, pain to right shoulder, laceration to right arm and hematoma to right temporal region. The x-ray confirmed the patient also sustained a fractured clavicle. The CT scan showed a large right hemispheral, falcine and left tentorial subdural haematoma which had progressed since the previous imaging. In the right frontoparietal region there was an impression of extension of	*Investigation in Progress

	haemorrhage. The CT results however were not documented in the patient's records until 04/04/2019. The patient's condition deteriorated and the patient sadly passed away on 08/04/2019. *This case was not subject to an SJR as a 72 hour review was already underway.	
2019/11932	Patient care reviewed in MRG. A brief summary of the issues found; The patient died of Sepsis and Pneumonia following a fall Relatively little medical input for 3 days Went for 3 days without repeated bloods Problems with pain management Considered for discharge but she had an overwhelming infection No IV access for 3-4 days *This case was subject to an SJR and MRG requested that this be reviewed by Governance. This was subsequently deemed to be a Serious Incident.	*Investigation in Progress
2019/13089	In July 2015, an ultrasound scan was completed and reported seeing a probable haemangioma in the right lobe of the liver. The patient attended both her own GP and out of hours GP numerous times, before attending the Spire for a privately funded scan on 28th January 2016. This revealed multiple liver metastases and Histology later confirmed neuroendocrine carcinoma. The review, following this incident being raised following a claim, concluded that it could not be assured that the original probable haemangioma was not actually metastases, as there was one later noted in exactly the same location on the later scan. The patient sadly died on 16th May 2016. *This case is historical and before we undertook SJRs.	*Investigation in Progress

3.3 SHMI / HSMR Summary

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, it is the SHMI which is being used and evaluated nationally as the mortality indicator.

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.

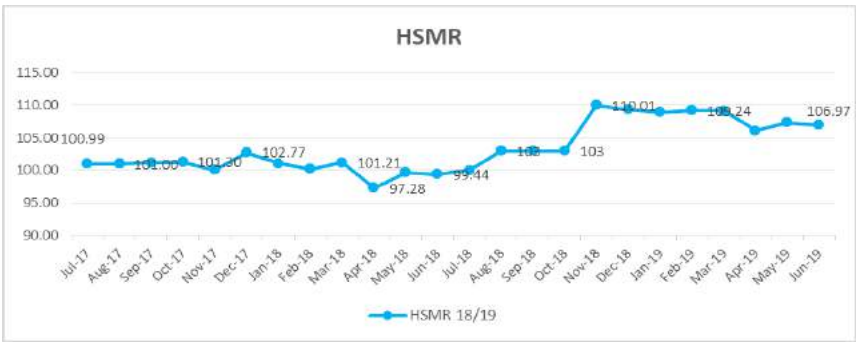
The table below shows the Trust position since July 2017 and demonstrates our current position as 109.97. Our peers' average is 102.06 and we are 16th out of the 20 hospitals in our peer group.

The work being undertaken in relation to the Focussed Reviews should provide us with learning that we can implement to positively impact on SHMI going forwards.

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.

The table below shows the Trust position since July 2017 and demonstrates our current position as 106.97. Our peers' average is 101.20 and we are 15th out of the 20 hospitals in our peer group.



We are not showing as an outlier in any of the diagnosis groups that are monitored by HSMR.

3.4 Learning from deaths

We found....	We are doing....
We are showing as an outlier for deaths with R-codes and Chronic Obstructive Pulmonary Disease & Bronchiectasis	As these areas are outliers we will establish which patients were involved and conduct focussed reviews, using the SJR template, to see if there is any learning from these deaths.
M&M meetings to be improved/standardised. 	A new template has been developed which includes the deaths by specialty for each CBU and will also include learning from MRG. Each CBU will be responsible for returning a HLBP from their M&M (Mortality & Morbidity) meetings to provide assurance that learning is being disseminated.
SHMI/HSMR further deterioration. 	Processes of FCEs and documentation need to be rapidly managed, a task and finish group is in the process of being established to review this further, led by the Trust Mortality Lead.
Trauma cases were presented to MRG and we found that the main lesson was in relation to following the thoracic injuries pathway.	The thoracic injuries pathway was highlighted at the joint ED and medical team meeting to cascade to all relevant staff.
We found evidence of good practice in relation to the documentation of discussions on ITU. 	We have asked the SJR reviewer to highlight the learning so that this can be disseminated Trust wide through the M&M meetings.

4. SUMMARY

During Quarter 1, 2019/20;

- 174 deaths that occurred within the Trust.
- 35 have met the criteria to be subject to a structured judgement review (SJR) through the Mortality Review Group
- 3 were to subject to investigation using root cause analysis (RCA) methodology.

We are not an outlier for HSMR or SHMI. However, the Mortality Review Group analyses data in relation to Mortality and it is indicated that there is an unusual pattern to Mortality in the following diagnosis groups;

- R Codes
- Chronic Obstructive Pulmonary Disease & Bronchiectasis

MRG have requested that Focused Reviews be undertaken to obtain any learning.

Learning is now being disseminated to the CBUs and Specialties through the form of a high level briefing paper. This form provides them with the deaths for their area and also Trustwide learning from MRG to disseminate to staff. This process is still under development and we aim to provide some examples of what good looks like so that we receive meaningful responses back from the leads.

Assurance Statement: We would like to provide the committee with the following assurance for learning from deaths; **Moderate -** There is an adequate system of internal control, however, in some

areas weaknesses in design and/or inconsistent application of controls puts the achievement of some aspects of the system objectives at risk.

5. RECOMMENDATIONS

The Board is asked to note the contents of the briefing paper.

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	BM/19/09/88			
SUBJECT:	**Progress on Lord Carter Report Recommendations & Use of Resource Assessment (UoRA)**			
DATE OF MEETING:	25th September 2019			
AUTHOR(S):	Marie Garnett, Head of Contracts & Performance			
EXECUTIVE DIRECTOR SPONSOR:	Andrea McGee, Director of Finance + Commercial Development			
LINK TO STRATEGIC OBJECTIVES:	All			
EXECUTIVE SUMMARY (KEY ISSUES):	The Trust continues to develop and improve its Use of Resources both internally and in collaboration with system wide partners. The Use of Resources group is developing a work plan which will feed into the Trust's Moving to Outstanding Agenda. The Trust has received a UoRA rating of "Requires Improvement". The report highlighted a number of areas where improvement can be made including; Sickness Absence, Corporate Service Costs, Agency Ceiling, DNA rate and Financial Balance. However, the report noted positive areas including; Clinical productivity, Delayed transfers of care, Pathology, Pharmacy, Non-pay costs, Collaboration and Use of technology.			
PURPOSE: (please select as appropriate)	Information	Approval	To note X	Decision
RECOMMENDATION:	The Board of Directors is requested to note the contents of the report.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

PROGRESS ON THE CARTER REPORT RECOMMENDATIONS & USE OF RESOURCE ASSESSMENT

1. BACKGROUND/CONTEXT

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

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

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

Collaboration at Scale

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

2. KEY ELEMENTS

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

The Trust volunteered to be part of the 2019/20 corporate benchmarking pilot. The Trust submitted benchmarking data in June 2019 and submitted final benchmarking data in July 2019 and is awaiting the final report.

The Trust has received a UoRA rating of "Requires Improvement". The CQC report noted the Trust deficit position, Reliance of working capital loans, Agency Ceiling, Staff Sickness, DNA, Corporate Costs as areas for improvement. The report noted positive areas including; Clinical productivity, Delayed transferred of care, Pathology, Pharmacy, Non-pay costs, Collaboration and outstanding practice for Use of Technology.

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

3. RECOMMENDATIONS

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

Andrea McGee
Director of Finance and Commercial Development
18th September 2019

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

Appendix 1 – Benchmarking Performance against the National Median

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

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

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Use of Resource Graph Key
Trust Position
National Median
Peer Median

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

UoR Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 1 2019/20

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

Lead Director: Director of Human Resources & Organisational Development

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Development and Approval of People Strategy and Dashboard	• The refreshed People Strategy was signed off by the Trust board in Q2 2018/19. Quarterly reports will be presented to the Strategic People Committee.	• Ongoing monitoring and management of the dashboard.	Trust Board, TOB, Strategic People Committee	Complete
Restructure of HR Directorate	• The HR department restructure is complete and key posts in the Senior Management Team have been recruited to.		Trust Board, Strategic People Committee	Complete
HR Polices reviewed to ensure they are clear, simple and transparent	• The Human Resources & Organisational Development (HR&OD) Directorate has a policies and procedures group with management and staff side members. All HR policies are taken through this group and then progressed to JNCC. • Policies reviewed and ratified to date include; the Disciplinary Policy, the Relationships at Work Policy, Special Leave Policy, Secondment Policy and Annual Leave Policy. • A review and refresh of the essential managers training was undertaken during Q1 2019/20. The new training has been rolled out including Difficult Conversations and Equality & Diversity training.	• The Trust is undertaking a programme to review, and where required, simplify HR policies. This is monitored by the Strategic People Committee. Policies to be reviewed in Q2 2019/20 include; the Equality in Employment Policy, Temporary Staffing Policy and Professional Clinical Registration.	Strategic People Committee	Ongoing Monitoring
"Fit to Care" Heath & Wellbeing Programme	• The Trust has a wide range of wellbeing approaches aimed at supporting staff back into work which has included; a Weight management clinic, Healthy Topics, Drop in sessions for healthy hearts and Wellbeing clinics. • The Trust launched its Mental Health first aid courses which aims to help managers spot the signs of mental health and signpost colleagues to support. • The rollout of the refreshed fit to care programme was completed during Q1 2019/20. The Trust is building on the previous approach of educational/informative campaigns, to adopt an impact based approach e.g. Know Your Heart Age event in April 2019, where staff was offered a range of screening tests and access to a Consultant Cardiologist where appropriate. The new programme has now been introduced and will reviewed annually.	• Wellbeing initiatives will continue to be offered and monitored for effectiveness.	Strategic People Committee	Complete

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Use of Resource Graph Key
Trust Position
National Median
Peer Median

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

UoR Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 1 2019/20

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Development of Workforce Streaming Programme across the North West	• The Trust has worked with colleagues across the North West to agree unified ways or working and to reduce bureaucracy. • Key actions included: o Implementation of factual references. o Streamlining of notice periods for new starters. o Agreed honorary contract process and streamlining of mandatory training across the region. o Values based recruitment. • Region wide TUPE guidelines have been implemented. • The streamlining programme is now complete with benefits realisation signed off by Operational Peoples Committee in May 2019 and a summary provided to Strategic People Committee.		Operational People Committee	Complete
Staff Opinion Survey	• Themes from the staff survey were used to develop the refreshed People Strategy. • A staff engagement event "The Perfect Day" took place in May 2018 and outputs are linked to Listening in to Action (LIA). • The Trust achieved a very positive response rate of 50.6% in 2018, a 4.6% improvement on the previous year. The Trust achieved average or above average score for 9/10 of the key themes as well as statistically significant improvements in safety culture and staff engagement. The CBU level results have been shared for local implementation and the Trust level results will be mapped to the delivery of key strategies such as the People Strategy and EDI Strategy.	• A detailed analysis has been undertaken around EDI by protected characteristics. This is being reviewed by the EDI sub-committee in Q2. The committee will seek assurances that any issues highlighted in the results are being addressed through the EDI strategy delivery plan.	Trust Board, TOB, Strategic People Committee	Rolling Programme
Reduction in the high rates of bullying and harassment with a sustained campaign led personally by each trust Chief Executive	• The Freedom to Speak Up Guardian has a network of champions to support staff to raise concerns. • The Trust performed in the upper quartile in the 2017 & 2018 staff surveys in relation to bullying and harassment in comparison with other Acute Trusts. • The Trust has reviewed the SOS results against other employee relations metrics around bullying and harassment and has analysed the areas where we are doing well to look how learning can be shared across other areas. This was focused specifically around; managers training, standards, policy implementation and reward. It was identified that the approach in leadership style within these areas was similar. This learning has been incorporated into the essential managers training. • Work was undertaken with the Trust's communications team to ensure staff know who to raise concerns with and how they would go about this. • An Equality, Diversity and Inclusion Strategy has been developed and implemented.	• The Trust Board signed off the EDI strategy in March 2019. The Trust has the culture and infrastructure to address bullying and harassment and this is supported by the latest staff survey results.	Strategic People Committee	Ongoing Monitoring

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Use of Resource Graph Key
Trust Position
National Median
Peer Median

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

UoR Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 1 2019/20

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Ensure Staff have regular performance reviews	• The number of staff with a valid PDR is 79.33% (May 2019) against a target of 85%. • The PDR process has been reviewed, with a particular focus on engaging staff and condensing timescales to avoid winter pressures. • The Trust has implemented the Trust new pay progress policy. As per the national policy, this is currently for new starters to the Trust only.	• HR Business Partners will continue to work with the CBU managers to further improve PDR compliance. • Part of the People Strategy focuses on improving the quality of appraisals, the Trust has set up a task and finish group commencing in July to initiate this which will include new documents/system, guidance and training. The appraisal system will be integral to our talent management and succession planning framework.	Trust Board, TOB, Strategic People Committee	Ongoing Monitoring
Improving Sickness Absence	• Sickness absence was 4.6% in May 2019. • An audit has been completed on compliance with the Trust's Attendance Management Policy and a number of recommendations were implemented. • Promotion and improvement of flu vaccination uptake takes place annually. • Mental Health "Train the Trainer" training is complete. • A new clinical supervision framework was rolled out which will help to address some of the stress/anxiety related absences. • An ongoing programme of Mental Health first aid training has been rolled out across the Trust.	• The Trust continues to implement sickness management actions including scoping a sickness absence reduction programme based on the NHSi methodology. • A business case is currently being developed to increase the occupational health nursing and counselling provision to meet the increased demand.	Trust Board, TOB, Strategic People Committee	Ongoing Monitoring

KLOE 2 - People

Sickness Absence Rate

UoR

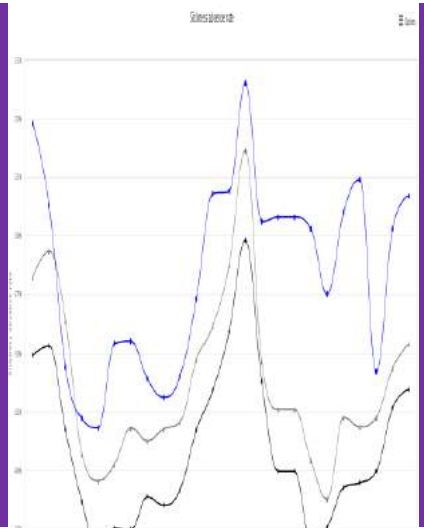
Percentage of staff FTE sick days.

National Median = 4.35% — **November 2018**
Peer Median = 4.48%

1. STHK 3.07%
2. N Lincolnshire 4.14%
3. Mid Cheshire 4.39%
4. Chester 4.44%
5. Bournemouth 4.57%
6. North Tees 4.44%
7. Sunderland 4.70%
8. Gateshead 4.91%
9 Wirral 5.14%
10. WHH 5.17%
11. Southport 6.09%

Current Quartile: **4 (Worse)**
Best Quartile Target: **3.88%**

Source: HSCIC - NHS Digital iView Stability Index
Monitoring - Trust Board, TOB, SPC



Acknowledging that absence rates have remained higher than our peers and therefore there is opportunity to improve, significant strategic and operational work has been undertaken to improve the position and from March 2019 the sickness absence rates have dipped below the 2018/19 rate. This improvement has continued in Q1 2019.

• A case conference protocol is being developed in relation to long term absences.
• The Attendance Management Module of the essential managers training has been reviewed and rolled out.
• A Difficult Conversations Module has been introduced to the essential managers training.
• The Executive Team have supported a proposal to implement a Sickness Absence Reduction Programme, in collaboration with Bridgewater Community NHS Foundation Trust.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

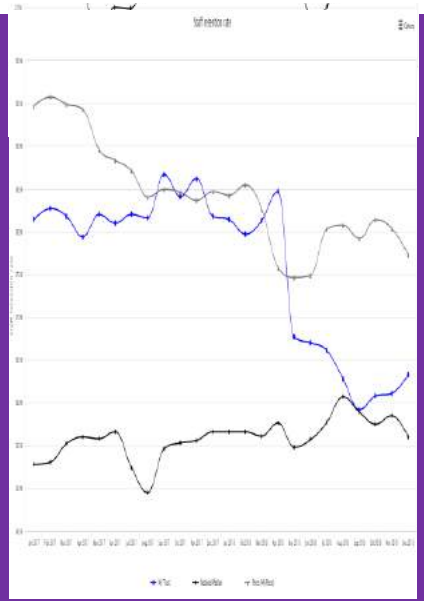
Use of Resource Graph Key
Trust Position
National Median
Peer Median

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

UoR Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 1 2019/20

	Progress/Performance			Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Staff Retention Rate	The percentage of staff that remained stable over 12 months period.	**National Median = 85.6%** Peer Median = 87.7% 1. N Lincolnshire 89.0% 2. Wirral 89.0% 3. Sunderland 88.6% 4. STHK 88.4% 5. Gateshead 87.8% 7. Southport 87.7% **Current Quartile:** **Best Quartile Target:** **Source: HSCIC - NHS Digital iView Stability Index Monitoring - SPC**	**December 2018** 8. Mid Cheshire 87.4% 9. Bournemouth 86.5% 10. North Tees 86.5% 11. WHH 86.3% 12. Chester 85.6% **3 (2nd Best)** **87.50%**		Retention remains above target (positive). This is linked to improved employee engagement (as evidenced by the 2018 Staff Survey results and LIA pulse check survey results) and to the work begun as part of the NHSI Retention Programme.	• A NHSI nursing retention programme is to be rolled out to other staff groups. An action plan is in place following review of all data by NHSI. This includes: o Improve our workforce's ability to achieve a better work life balance o Support our staff to explore and pursue career progression within the Trust o Recognising and Valuing Experience (RAVE) o Develop and empower our Line Manager's to retain their staff • Work has already begun on encouraging experienced staff to remain in our employment - RAVE (recognising and valuing experience) initiative is being explored by the NHSI retention programme delivery group. As part of this a review of the Trust's retire and return policy will be required. • Careers cafés have been set up throughout the year.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Use of Resource Graph Key
Trust Position
National Median
Peer Median

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Progress off track - plans in place to get back on track/Amber on the Model Hospital
Progress significantly off track/Red on Model Hospital
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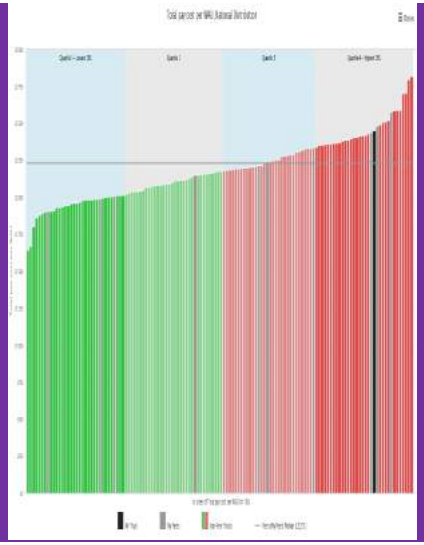
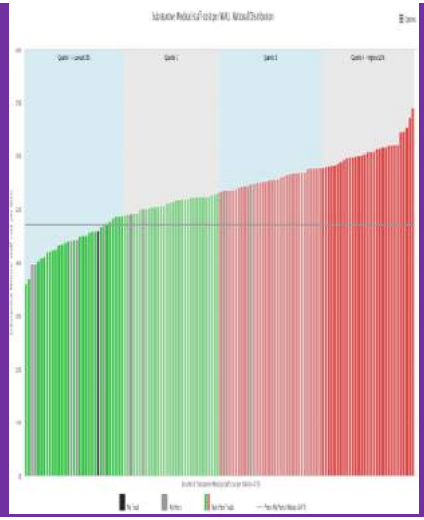
UoR Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 1 2019/20

	Progress/Performance		Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Pay Costs per Weighted Activity Unit	UoR Cost per WAU is the headline productivity metric used within the Model Hospital. It shows the amount spent by a Trust to produce one Weighted Activity Unit (WAU) of clinical output. This metric shows the amount the trust spends on pay per WAU across all areas of NHS clinical activity.	**National Median = £2180** 2017/18 Peer Median = £2312 1. Sunderland £1904 2. STHK £1995 3. Bournemouth £2010 4. Gateshead £2151 5. Wirral £2219 6. North Tees £2242 7. Chester £2336 8. Mid Cheshire £2442 9. WHH £2455 10. N Lincolnshire £2482 11. Southport £2577 **Current Quartile:** 4 (Worse) **Best Quartile Target:** £2,014 **Source: Trust consolidated annual accounts and reference cost data.** **Monitoring - Trust Board, SPC (From March 2019), FSC, TOB.**		Pay Costs per WAU exceeds the Peer and National Medians. The below shows the WAU Staff Costs per staff group and the percentage difference compared to our peers: **Staff Group / Trust / Peer %** Medical £465 -4.5% Nursing £764 -6.2% AHP £188 19.1% Scientists £192 9.4% Corp Supp £413 -3.1% Agency £169 32.0% Non-Sub £183 8.2% When removing AHP costs associated with external SLA, this impacts positively on the overall position.	The key actions focus on reducing reliance and improving value for money for temporary staff (AHP explained below). > The temporary staffing team continue to support the CBUs to improve locum fill and pay rates. > Process medical bank bookings through the Brookson system, improving fill rate and compliance. Premium pay spend review group are placing additional focus on agency usage throughout 2019/20. > Worksteams include; refining central agency booking processes - 1st July 2019, Developing WHH Banks - 1st August 2019, Task & Finish group to renegotiate rates with high rate agencies. Additional scrutiny on high cost bookings.	
Medical Costs per WAU	UoR Cost per WAU is the headline productivity metric used within the Model Hospital. It shows the amount spent by a trust to produce one Weighted Activity Unit (WAU) of clinical output. This metric shows the amount the trust spend on pay for medical staff per WAU across all areas of NHS clinical activity.	**National Median = £533** 2017/18 Peer Median = £471 1. Gateshead £398 2. Mid Cheshire £399 3. Sunderland £442 4. North Tees £444 5. WHH £451 6. Wirral £471 7. Bournemouth £493 8. Chester £502 9. Southport £536 10. N Lincolnshire £548 **Current Quartile:** 1 (Best) **Best Quartile Target:** £488 **Source: ESR, Trust consolidated annual accounts and reference cost.** **Monitoring - SPC**		The Trust is below the national and peer median (positive), however the large number of vacancies within this workforce will have contributed to this. As we seek to recruit to these vacant posts, we could see costs per WAU increase, however this may lead to the reduction in other areas such as agency.	The key actions relate to the Medical Establishment Review include: > Analyse the established medical model and the proposed effective establishment, within the context of RCP Safe Medical Staffing Guide. > Identify the gaps within the Medical Workforce based on the analysis, developing innovative solutions to fill the gaps. > Working with WWL to recruit Drs Internationally.	

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Use of Resource Graph Key
Trust Position
National Median
Peer Median

Key
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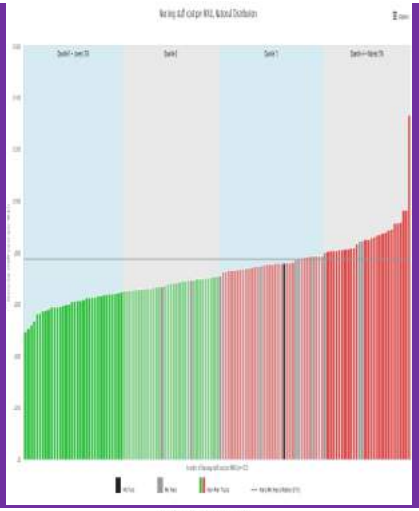
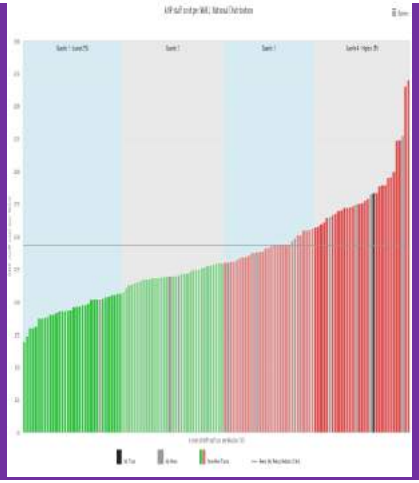
On track for completion
Progress off track - plans in place to get back on track/Amber on the Model Hospital
Progress significantly off track/Red on Model Hospital
Not started/Awaiting further information/New actions parameters to be established

UoR Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 1 2019/20

	Progress/Performance			Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Nursing Cost Per WAU	UoR Total pay costs for nursing staff, adjusted for the % of Trust expenditure reported in reference costs, the MFF, and the % of pay costs that are capitalised, divided by Cost Weighted Output in WAUs.	**National Median = £710** Peer Median = £783 1. Bournemouth £671 2. Sunderland £694 3. STHK £711 4. Gateshead £750 5. WHH £761 6. Wirral £772 **Current Quartile:** **Best Quartile Target:** **Source: ESR, Trust consolidated annual accounts and reference cost.** **Monitoring - SPC**	**2017/18** 7. Chester £778 8. N Lincolnshire £789 9. North Tees £801 10. Southport £845 11. Mid Cheshire £848 **3 (2nd Worse)** **£649**		The Trust is below the peer median for Nursing Costs per WAU which is positive, however again the large number of vacancies will have contributed to this. The Trust seeks to reduce reliance on temporary staffing by offering alternative retention and recruitment solutions with the expansion of the nursing workforce, advanced practice and specialist interest roles.	The key actions are: > Working alongside the WHH Recruitment and Retention group, develop retention strategy and NHSI. > Continue the successful Staff Nurse recruitment open days. The Trust has been in contact with NHSI to look at conflicting data points, which has been escalated to national level within NHSI. The Trust has also been in contact with other Trusts who have the same data issue. The Trust has queried this indicator with NHSI as the data on the model hospital indicators does not triangulate with Trust data. NHSI is visiting the Trust in Q2 2019/20 to review these issues.	
AHP Cost per WAU	UoR Total pay costs for Allied Health Professionals, adjusted for the % of trust expenditure reported in Reference Costs, the MFF, and the % of pay costs that are capitalised, divided by Cost Weighted Output in WAUs.	**National Median = £130** Peer Median = £141 1. STHK £103 2. Wirral £120 3. Bournemouth £121 4. Chester £131 5. Sunderland £138 6. Gateshead £149 **Current Quartile:** **Best Quartile Target:** **Source: ESR, Trust consolidated annual accounts and reference cost.** **Monitoring - SPC**	**2017/18** 7. N Lincolnshire £166 8. Southport £175 9. Mid Cheshire £183 10. WHH £184 11. North Tees £228 **4 (Worse)** **£107**		Across the therapy element of AHP, pay costs for community/other work has been included in the cost per WAU calculation on Model Hospital. This is not our activity - we receive SLA income for these and this should offset against the costs. This means that they should not be included in the pay cost per WAU. • For example, we have Therapists working as 'first point of contact' in GP surgeries. Rather than seeing a GP first, patients with musculoskeletal issues are triaged by a Therapist and either discharged, treated or referred to secondary care. • Finance have used an estimate for this value to produce a revised cost per WAU for AHPs of £123 which would bring the Trust under the national median.		

Warrington and Halton Hospitals NHS
NHS Foundation Trust

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UoR Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 1 2019/20

Recommendation 2 - NHS Improvement should develop and implement measures for analysing staff deployment during 2016, including metrics such as Care Hours Per Patient Day (CHPPD) and consultant job planning analysis, so that the right teams are in the right place at the right time collaborating to deliver high quality, efficient patient care.

Lead Director(s): Medical Director & Chief Nurse

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Care hours per patient day	• The Trust continues to systematically collect and submit Care Hours per Patient Day (CHPPD) data since the national changes in April 2016. • The data is included in the monthly safe staffing and assurance report presented by the Chief Nurse at the Trust Board.	• Care Hours are reviewed each month as part of the Integrated Performance Report (IPR). In 2018/19 this went from 6.2 to 7.6 CHPPD. • Data is submitted monthly to NHSI via the Trust Information team.	Trust Board, TOB	Ongoing Monitoring
Electronic roster and safe care module – six week rosters submitted to NHSI, process for improvement, cultural change and communications	• Implementation of Electronic Roster & Safe Care – all core wards are now live on the system with over 50 wards or departments. • The corporate nursing team has taken over management of the e-roster team. • The E-Rostering team is co-located with the operational management team in a centralised location. • Capacity and demand meetings are held after the bed meetings and the staffing template updated in real time. • The interface between e-roster and NHS(P) is now in place and temporary staff must now be booked via e-roster. • Safe Care acuity is now embedded and the information is used for 6 monthly safe staffing review. • The Trust has shared its achievements with Safe Care and Health Roster products with 4 Trusts in the region and continues to be seen as an exemplar by Allocate for Nurse Rostering & SafeCare.	• Continue to support the Matron daily safe staffing meetings, allows for early identification of hotspots/issues. • Future rollouts for Outpatient Nursing, Administration Staff, Medical Staff and Corporate Functions.	Trust Board	Ongoing development and daily monitoring with Senior Nurse Oversight

Warrington and Halton Hospitals NHS
NHS Foundation Trust

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UoR Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 1 2019/20

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Consultant job planning - improving analysis of consultant job plans and better collaboration within and between specialist teams	• The Trust uses Allocate Software for e-Job planning. • 2019/20 Job planning round was launched in August 2018. There was several consistency panels held to support the process across the eight Clinical Business Units. Of 203 clinicians (both Consultant & SAS doctors in post on 1st April 2019) 182 job plans have been released for review and 126 of these have achieved full sign and implemented on 1st April 2019. Of the 56 still progressing for 2019/20 44 are Consultants and 12 are SAS doctors. • There remain 21 job plans from previous years which are still progressing – 16 being Consultants and 5 are SAS doctors. • The project involving Programmed Activity (PA) corporate budgets for Medical Leadership, Education & Training, Quality & Governance and Appraisal & Revalidation has been completed. The Trust has provided an SOP to detail the revised process for the financial management of PAs. • The renewed Job planning policy for Consultants was agreed with Staff Side via our JLNC and was implemented on 19th June 2018. • The Trust is actively drafting a new Job planning policy for the SAS doctors. • A proposal for reducing sign off levels from 3 to 2 was accepted. • The language used within the e-Job planning software has been improved to allow more effective reporting and easier inputting.	• Job planning progress will continue to be monitored on a regular basis. • Job planning compliance is scrutinised at a fortnightly HR meeting when data is presented to the Head of Medical Staffing & Education and concerns are escalated. • Updates are provided regarding progress to the Trust Joint Local Negotiating Committee. • Mediation meetings continue to be scheduled for outstanding job plans. • Consistency panels will be convened as and when needed. • It has been recognised that earlier escalation is needed in terms of missed deadlines and this is being improved. • A strategic meeting will be held in Q2 2019 which aims to consider 1) advanced planning for future job planning rounds, 2) the NHSI Levels of attainment standards and 3) the current situation and agree any action. • Regular meetings have been put in place at which the Deputy Medical Director, Job Planning & Project Manager, Business Accountant, Head of Management Accounts and the Head of Workforce Systems and Intelligence discuss current progress on Job Planning and related financial aspects.	Operational People Committee	Ongoing development and daily monitoring

Warrington and Halton Hospitals NHS
NHS Foundation Trust

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Progress significantly off track/Red on Model Hospital
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UoR Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 1 2019/20

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
	Recommendation 3 - Trusts should, through a Hospital Pharmacy Transformation Programme (HPTP), develop plans by April 2017 to ensure hospital pharmacies achieve their benchmarks such as increasing pharmacist prescribers, e-prescribing and administration, accurate cost, coding of medicines and consolidating stockholding by April 2020, in agreement with NHS Improvement and NHS England so that their pharmacists and clinical pharmacy technicians spend more time on patient facing medicines optimisation activities.			
	Lead Director(s): Medical Director & Chief Nurse			
Hospital Pharmacy Transformation Programme - developing HPTP plans at a local level	• Developed and approved HPTP Plan, nominated Directors, Board sign off and submission of final plan to NHS Improvement. • The HPTP was completed in May 2017.	• Model hospital metrics are monitored at the Trust's Medicines Governance Committee.	Trust Board	Complete
Moving prescribing and administration from traditional drug cards to Electronic Prescribing and Medicines Administration systems (EPMA)	• Electronic prescribing and medicines administration (ePMA) business case and PID signed off by Trust Board and NHS Digital – the outline business case was approved by the Trust board in October 2017, NHS Digital approved the business case in principle in November 2017. • The ePMA rollout plan was signed off by the Digital Operational Group and the IM&T Committee. • The ePMA pilot commenced on CDU on 5th March 2018. Positive feedback from staff/system users was received. 2nd ePMA pilot at Halton UCC – the pilot was a success and operation of the system has continued post pilot. • ePMA was successfully implemented on the surgical pathway on Ward B4 in December 2018 and within Ward and Theatre orthopaedic pathways at the CMTC in March 2019.	• Planning for rollout across Warrington is now complete. Lessons learned from Halton pilots has been incorporated into the planning stages for Warrington. A desktop exercise has been undertaken to determine implementation and early live support requirements. A number of issues have been identified, the Trust CIO has put together a proposal for the executive team to consider. • Three options (8 week, 4 week and 2 week) for rollout have been proposed. It is anticipated that rollout will take place in early Autumn.	Trust Board/IM&T Committee	Project expected completion – March 2020
Ensuing that coding of medicines are accurately recorded	• The Trust continues to work on improving data quality with workshops held to identify gaps, issues and areas for improvement with plans to address. • PHE SACT data has been reviewed, based on this, the Trust is achieving current data quality targets. • A Blueteq drop-in presentation day held in January 2018 to demonstrate the system and inform clinicians about the contractual requirements to obtain prior approval for the patient pathway before commencing treatment.	• The Trust continues to monitor the contents of the Schedule 6 schema reports to address any data quality issues. • The Trust continues to rollout Blueteq and is further on with implementation than other Trusts in the region.	Medicines Governance Committee	Ongoing Work Programme

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Use of Resource Graph Key

Trust Position
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Peer Median

Key

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UoR Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 1 2019/20

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
80% of trusts' pharmacist resource utilised for direct medicines optimisation activities, medicines governance and safety remits	• The Trust is achieving the recommendation for pharmacists. • All Pharmacy technicians have now been upskilled to carry out medicines reconciliation with new starters being trained as they commence in post. • The ward medicines management technician role has been reviewed with the Associate Directors of Nursing. • Midwifes are screening for regular medication so that pharmacy resources can be focused on those specific patients, this has resulted in an increase in medicines reconciliation within the Women's & Children's CBU.	• The ongoing training program continues to upskill pharmacy technicians on medicines optimisation and administration. • Three wards now have a pharmacy technician administering medicines to patients. Funding has been agreed and recruitment is taking place for the wider rollout, however, the role of the nursing associates is being considered in relation to this project to ensure that wider rollout will be effective.	Quality & Assurance Committee	Ongoing Monitoring
Reduce stockholding days from 20 to 15, deliveries to less than 5 per day and ensure 90% orders and invoices are sent and processed electronically	• The Trust's current stockholding days are 18, which is below the national and peer median. • Average number of deliveries to the Trust per day is 14 which is below the national median. • 97% orders are carried out electronically.	• Reducing stockholding days or number of deliveries to the Trust per day any further would carry an unacceptable level of risk. The Trust continues to monitor performance against our peers.	Medicines Governance	Ongoing Monitoring

Warrington and Halton Hospitals NHS
NHS Foundation Trust

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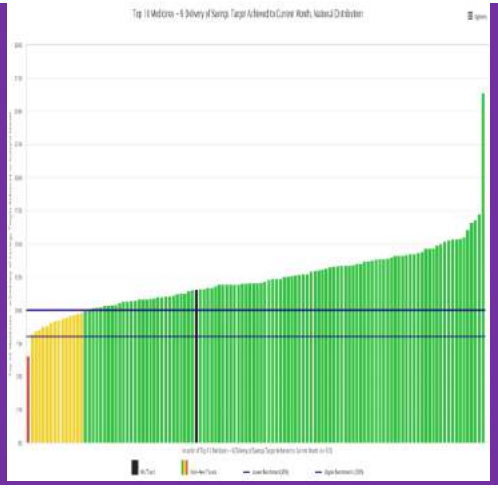
UoR Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 1 2019/20

	Progress/Performance		Actions to Improve Position/Actions for Next Quarter	Assurance	Status
KLOE 3 - Clinical Support Services					
Top 10 Medicines - Percentage Delivery of Savings	UoR This indicator identifies the year to date total % achievement toward the cumulative target saving opportunity.	**National Median = 100%** March 2018 Peer Median = 127% 1. Southport 173% 2. N Lincolnshire 166% 3. Gateshead 129% 4. Wirral 127% 5. STHK 126% 6. Mid-Cheshire 119% 7. WHH 116% **Current Quartile:** N/A **Best Quartile Target:** N/A **Source: Rx-Info Define© (processed by Model Hospital)** **Monitoring - Medicines Governance Committee**		In 2018/19 the Trust achieved savings of £1.05m on Top 10 medicines and high cost drugs.	The Trust will continue to engage with target for Top 10 Savings and will work with system partners to identify opportunities for further savings.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

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UoR Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 1 2019/20

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
	Recommendation 4 - Trusts should ensure their pathology and imaging departments achieve their benchmarks as agreed with NHS Improvement by April 2017, so that there is a consistent approach to the quality and cost of diagnostic services across the NHS. If benchmarks for pathology are unlikely to be achieved, trusts should have agreed plans for consolidation with, or outsourcing to, other providers by January 2017.			
	Lead Director(s): Chief Operating Officer & Director of Strategy			
Establishment of a shared pathology across the local economy	• NHSI has proposed 29 Pathology Networks across the country, with Cheshire & Merseyside being "North 4". An STP wide Pathology Board has been created with a Clinical Director and Pathology Manager from each of the Trusts in the region. • STP Cheshire & Mersey Pathology Board – the CEO of Aintree Hospital NHS Trust has been named Executive lead for the relaunched group. • A Transition Management Team has been established (Wirral Chester, Aintree, Liverpool and Southport & Ormskirk). A project manager has been appointed by the STP. • Branch work stream meetings were established to look at equipment with a view to joint procurement opportunities and contract alignments. • Several drafts of the strategic outline case have been developed. The final case was approved by the Executive Oversight Group on 20th December 2018. • The project appointed a Clinical Director and Director of Operations during Q1 2019/20.	• The strategic business case has been agreed, the first draft of the outline business case is being progressed, Trusts have made comments against this version with further iterations expected during Q2. • Discipline specific groups are being established, it is anticipated these groups will start meeting once the business case has been signed off. These groups include; Workforce, Logistics, Clinical & IT. • LTS has been commissioned by the project to review data to ensure consistency of how it is recorded and reported across all organisations - this will be completed by the end of Q2 2019/20. • During Q2, the Trusts will be asked to score a series of options on how future services will be structured.	Strategic Development and Delivery Committee	Project – expected completion 2021
Development of pathology service specification	• The original plan called for a new specification to be developed, however this has now been superseded by the STP wide pathology board.	N/A	N/A	N/A
Introduce the Pathology Quality Assurance Dashboard (PQAD) by July	• A Pathology Quality Assurance Dashboard (PQAD) has been developed. • PQAD implemented from November 2016.	• Monthly data indicators continue to be submitted. • PQAD data is reviewed monthly at the KPI sub-committee. • The Trust continues to review quarterly and bi-annual indicators, however we understand that the indicators are under review and a new dashboard is under development. A new version is expected during in 2019/20.	KPI Sub-Committee	Rolling Programme

Warrington and Halton Hospitals NHS
NHS Foundation Trust

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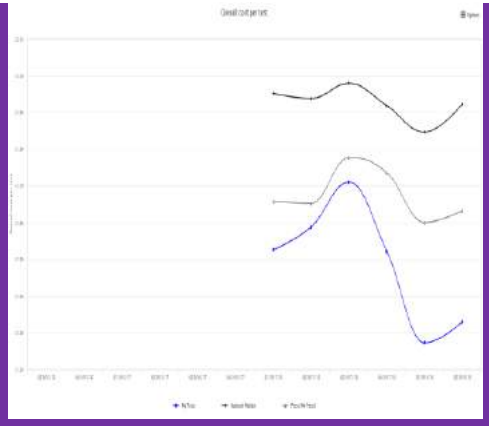
UoR Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 1 2019/20

	Progress/Performance			Actions to Improve Position/Actions for Next Quarter	Assurance	Status
KLOE 3 - Clinical Support Services						
Pathology - Cost Per Test	UoR The cost per test is the average cost of undertaking one pathology test across all disciplines, taking into account all pay and non-pay cost items.	**National Median = £1.92** Peer Median = £1.62 1. North Tees £0.95 2. WHH £1.33 3. Chester £1.57 4. Gateshead £1.70 5. Bournemouth £2.88 **Current Quartile:** **Best Quartile Target:** Source: NHSI Q Pathology Data Collection 18/19 Monitoring - Pathology Business Meeting	**Q2 2018/19** **1 (Best)** **£1.57**		The Trust benchmarks well against the peer and national median and also against Trusts within our STP footprint. Overall the Trust's pathology service is efficient with the use of streamlined processes, technology and procurement opportunities.	The Trust is working with STP partners as part of the Lord Carter recommendations to look at how further efficiencies can be made across the footprint. > The Trust is continuing to engage with the network consolidation, and a number of activities are going to operationalise the new model by 2021.

Warrington and Halton Hospitals NHS
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Use of Resource Graph Key
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UoR Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 1 2019/20

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Recommendation 5 - All trusts should report their procurement information monthly to NHS Improvement to create an NHS Purchasing Price Index commencing April 2016, collaborate with other trusts and NHS Supply Chain with immediate effect, and commit to the Department of Health's NHS Procurement Transformation Programme (PTP), so that there is an increase in transparency and a reduction of at least 10% in non-pay costs is delivered across the NHS by April 2018. **Lead Director(s):** Director of Finance & Commercial Development				
Provide data to NHSi for the NHS purchasing price index benchmarking tool (PPIB)	• The procurement team continues to provide the data to NHSI for the NHS Purchasing Price Index benchmarking tool on a monthly basis. • The Trust continues to review combined PPIB with St Helen's & Knowsley and Southport and Ormskirk NHS Trusts for a collaborative approach to be taken in reviewing and securing lower prices. • The Trust has agreed to run PPIB data on behalf of the Group Purchasing Organisation (GPO) run by HealthTrust Europe which will inform their work plans for driving down costs. • A report of the Top 25 variances has been produced which compares the Trust nationally and against peers. • The Trust has reviewed data for Trusts of a comparable size to look at areas around the Top 100 products for commonality of spend with view to renegotiating on our prices with suppliers, this brought a small saving.	• Where is has been identified that the Trust can obtain a better price for a product or service as a result of the comparison with peers, this will be actioned by the procurement team on an ongoing basis. Examples including; Contrast media injector consumables day set, Celox haemostatic gauze and Laparoscopic clip applier endoclip. • In Q2, a new benchmarking tool will be launched that will replace PPIB.	Finance & Sustainability Committee	Rolling Programme
Developing PTP plans at a local level with each trust board nominating a director to work with their procurement lead to implement changes	• The Procurement Transformation Plan has been drafted and submitted to NHSI. To support this, a procurement dashboard has been established to measure Trust performance against the Carter metrics. The PTP was refreshed using the new NHSI format. • The Director of Finance & Commercial development is the responsible board member and will work with the Associate Director of Procurement to implemented changes around the PTP plan. • A review has been completed for all direct spend (i.e. that not with NHS SC) to determine which products can be transferred to NHS SC to further support the operating model. • All savings identified by Supply Chain Coordination Ltd (SCCL) will be incorporated in the Trust's 2019/20 CIP Plans. Based on 2018/19, 375 lines were transferred into the operating model representing a saving of £0.075m.	• The Trust continues to measure progress against the PTP. • The Procurement Target Operation Model (PTOM) has been finalised. During Q2, the Cheshire & Mersey network will meet, where NHSI will discuss the implementation. • The Trust is working with our SCCL account manager to understand how the potential savings have been calculated and the timetable for delivery, awaiting work plan. • The Trust is working with the category towers to understand how savings can be achieved, each Head of Procurement within the network is taking responsibility for a tower.	Finance & Sustainability Committee	Project Implementation

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Adoption plan for Scan4Safety	• The Trust adoption plan for Scan4Safety (formally the Global Standard: GS1) and pan European Public Procurement Online (PEPPOL) standards was drafted, the procurement lead for the project is the Deputy Head of Procurement. • Scan4Safety was presented to a number of forums throughout the Trust. • A draft PID was developed. The Trust has made progress in a number of areas: • Been allocated our 10,000 GLN's by GS1 as a way to assign a GLN to all of the locations within the Trust. • Agreed in principle that the issue relating to GSRN will be dealt with by replacing all staff ID Badges with a badge which as well as a photograph, will contain a barcode linked to the member of staffs payroll number. • The inventory management systems offered by the main providers in this area have been evaluated. This area along with the associated hardware and software represents the biggest cost to the Trust, so care is required to ensure that the solution selected meets the requirements into the future.	• The Trust's Chief Information Officer has been identified as executive lead for the Scan4Safety project. A project team has also been established. The project team have identified two demonstrator sites to visit during Q2.	Trust Board, Trust Operational Board	Project Implementation
NHS Standards of Procurement - to achieve level 1 by October 2016, develop improvement plan to meet target by March 2017	• The Trust has achieved NHS Standards of Procurement Level 1 accreditation. • The procurement team has identified and collated evidence in order to meet the criteria for Level 2 accreditation. • The Trust submitted the evidence to the Procurement Skills Development Network (FSD) for Level 2.	• The Trust's initial level 2 assessment was completed in June 2019 and the formal assessment is due in Q2 with the assessment panel taking place on 22nd August 2019.	Finance & Sustainability Committee	Project Implementation
Benchmarking – Model Hospital Procurement	• The Trust is currently ranked 31/135 Trusts – placing the Trust in the upper quartile (best). • A review has taken place for each of the model hospital procurement metrics which looks at how far the Trust is from reaching with upper quartile. • The procurement team has produced a strategy to look at the feasibility of the Trust reaching the upper quartile for each metric and actions needed to get there.	• The procurement team will continue to work through actions to improve its position against the Model Hospital metrics as part of a rolling programme. • The procurement team has developed a tracker to review progress against the key metrics. • The main metrics are included on the Trust Procurement Dashboard.	Finance & Sustainability Committee	Ongoing

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Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 1 2019/20

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Key Procurement Metrics	• Target of 80% addressable spend transaction volume on catalogue - Trust currently is at 92% (Q1 2019/20). • Target of 90% addressable spend transaction volume with a purchase order - Trust currently at 97% (Q1 2019/20). • 90% addressable spend by value under contract - Trust currently at 73% (Q1 2019/20). • The procurement team produce monthly reports on all orders raised to ensure the contract register is upto date. The contract registered is reviewed monthly by the Senior Contract Managers with oversight from procurement management meetings.	• Addressable Spend Transaction Volume Even though the target has been achieved, this continues to be monitored on a monthly basis. For suppliers where spend that is not transacted via a PO , these are placed on a 100% PO rule i.e. if they do not have an order number their invoice will be rejected. • Addressable Spend under Contact The procurement team has recently reviewed processes around the Contract Register with a view to improve addressable spend under contract.	Finance & Sustainability Committee	Ongoing Monitoring

KLOE 4 - Corporate Services

Procurement Process Efficiency and Price Performance Score Clinics

UoR

This measure provides an overall view of how efficient and how effective an NHS Provider is in it's procurement process and price performance, respectively, when compared to other NHS providers.

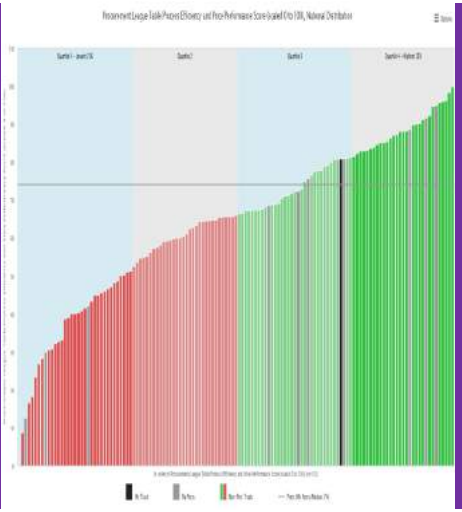
National Median = 66 **Q3 2018/19**
Peer Median = 72

1. Bournemouth 95
2. Southport 92
3. STHK 89
4. Wirral 81
5. WHH 81
6. Chester 72
7. N Lincolnshire 72
8. North Tees 69
9. Mid Cheshire 42
10. Gateshead 30
11. Sunderland 13

Current Quartile: **3 (2nd Best)**
Best Quartile Target: **82**

Source: Purchase Price Index and Benchmark (PPIB) tool

Monitoring: Senior Procurement Meeting



The Trust is above the National Median and peer median. The latest procurement league table has the Trust at a weighted score of 81 (Peer Median 76/National Median 66) which puts the Trust in the best quartile.

The Procurement Team has in place a strategy for improving performance that is reviewed on a monthly basis.

The Trust has undertaken a review of all procurement metrics and track this on a monthly basis. The key actions are as follows:
> Undertake a monthly review of a rolling top 25 by spend to identify and implement any areas of opportunity producing a monthly summary report.
> Undertake an analysis of all non-pay spend to understand what is not applicable to PPIB and why.
> Submitted for Level 2 of the Procurement Standards with the assessment taking place in Q2 2019/20.

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UoR Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 1 2019/20

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Recommendation 6 - All trusts estates and facilities departments should operate at or above the benchmarks for the operational management of their estates and facilities functions by April 2017 (as set by NHS Improvement by April 2016); with all trusts (where appropriate) having a plan to operate with a maximum of 35% of nonclinical floor space and 2.5% of unoccupied or under-used space by April 2017 and delivering this benchmark by April 2020, so that estates and facilities resources are used in a cost effective manner. **Lead Director:** Chief Operating Officer				
Strategic estates strategy inc cost reduction based on benchmarks and in the longer term plan for investment/reconfiguration	• The Trust has an estates strategy in place to meet the overall Trust strategy. The strategy is phased 1, 2, and 3. Phase 1 is to explore immediate options for delivering savings by rationalising part of the estate. Phase 2 is to explore the potential for external and/or better utilised 'on site' accommodation for current service provision and phase 3 is to explore opportunities for wider STP collaborative initiatives. • Phase 1 is being delivered and monitored through Strategic Development and Delivery Committee. The strategy has been refreshed to reflect local clinical strategy and the STP estates strategy. • A draft estates and facilities strategy aligned with the Trusts clinical strategy has been developed and submitted. • The Associate Director of Estates and Facilities has been nominated as co-chair for the One Halton estates enabler sub-group.	• The Trust continues to explore internal and partnership collaboration opportunities for relocation of back office and clinical support functions with Bridgewater Community NHS Trust using a joint executive estates working group to move forward this agenda. During Q2, information around current estates heads, locations and space utilisation for both Trusts will be analysed and next steps will be jointly agreed. A programme of work has been agreed by both executive teams which will be delivered over a series of phases. • A draft estates and facilities strategy was submitted to and agreed in principle by the Trust Operational Board, a final strategy will be submitted to the TOB and Trust Board during Q2. • A 12 month estates and facilities workforce plan is currently in development, an external review of operational estates to enable the delivery of CIP. • The C&M Health & Care Partnership (formally STP) has carried out an audit of 19 Trusts FM contracts, the Trust has signed up to explore collaboration for some key FM services across the partnership.	Estates and Facilities sub-Committee, TOB, Strategic Development and Delivery Committee	Ongoing management and monitoring of the plan

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UoR Use of Resource Assessment Indicator

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Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 1 2019/20

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Investing in energy saving schemes such as LED lighting, combined heat and power units, and smart energy management systems	• The Trust has procured an energy infrastructure upgrade (CHP) which will save carbon, energy, money and future investment, upgrading their facilities using private sector capital repaid through guaranteed savings. • Estates have accessed funding from Carbon Energy Fund (CEF) replacing 4000 halogen bulbs with more cost effective LED. • The Trust has realised saving of £140k from the CHP contract which has been used for the departments CIP target.	• The Trust is exploring options to introduce a carbon reduction lighting. • The Trust is progressing an internal replacement programme for emergency lighting as and when the lighting needs to be replaced.	Estates and Facilities Sub-Committee	Complete
Estates and facilities costs embedded into trusts' patient costing and service line reporting systems.	• Estates and Facilities costs are incorporated into the PLICS system. Quarterly service line reports are provided to CBUs by the financial planning team. The costing teams use the estates system, MICAD, to export floor area and can allocate energy/facilities costs based on m2.		Estates and Facilities Sub-Committee	Complete
Model Hospital & Effectiveness of Estates	• The Trust continues to review the effectiveness of its estate and monitors cost efficiency metrics to ensure it provides value for money and take actions for any deviation from the benchmark values. • Results of the Trust PLACE assessment have been developed into an action plan which is monitored by the estates and facilities operational board and the Quality Assurance Committee.	• The model hospital data shows the Trust favourable when benchmarking against peer and national medians. The Trust's ERIC return is being completed at the end of Q1 with new benchmarking data is expected in October 2019.	Estates and Facilities Sub-Committee/TOB/ Quality Assurance Committee	Ongoing Monitoring

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Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 1 2019/20

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All trusts (where appropriate) have a plan to operate with a maximum of 35% of nonclinical floor space and 2.5% of unoccupied or under-used space by April 2017 and delivering this benchmark by April 2020, so that estates and facilities resources are used in a cost effective manner	• Model hospital data reports the Trust utilises 38.7% of its estate for non-clinical use and has 0.9% of empty space. Whilst every effort to minimise the use of trust accommodation for non-clinical purposes has been made, it is difficult given the complexities of the numerous corporate functions and the estate footprint. • The current estate strategy aims to address the under-utilised space to under 2.5% by rationalising the estate. Better use of under-utilised estate will result in a reduction in the size of the estate and the amount of estate used by non-clinical functions.	• The estates and facilities function is fully involved in the Halton Healthy New Towns and New Hospital for Warrington initiatives. Changes to the estate are centred around patient care. Opportunities to work with Bridgewater should provide better flexibility in terms of estate.	Strategic Development and Delivery Committee	Ongoing Monitoring

KLOE 4 - Corporate Services

Estates & Facilities Costs (£ per m2)

UoR

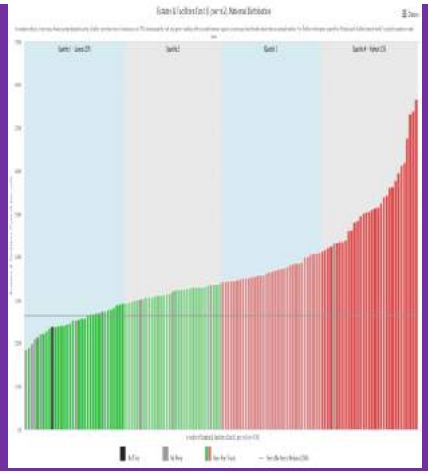
The total estates and facilities running costs is the total cost of running the estate in an NHS trust including, staff and overhead costs. In-house and out-sourced costs, including PFI costs, will be included.

National Median = £342 **2017/18**
Peer Median = £264

1. North Tees £186
2. Sunderland £200
3. Wirral £211
4. Mid Cheshire £221
5. WHH £239
6. N Lincolnshire £253
7. Chester £275
8. Bournemouth £304
9. Southport £321
10. Gateshead £336
11. STHK £432

Current Quartile: **1 (Best)**
Best Quartile Target: **£293**

Source: ERIC 2017-18 Total Estates and Facilities Running Costs Monitoring - Estates and Facilities Operational Group



The Trust benchmarks well against national and peer median for hard facilities costs even with the challenges of maintaining an aging estate. We have invested capital year on year to reduce backlog maintenance, however without a significant increase in investment, the amount of backlog to bring the estate up to appropriate standards will always rise. This in turn has and will continue to have an adverse effect on overall estates and facilities costs.

Estates and facilities costs are continually monitored. Where efficiencies can be made, proposals/business cases produced for consideration by the Trusts Executive Team.

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Recommendation 7 - All trusts corporate and administration functions should rationalise to ensure their costs do not exceed 7% of their income by April 2018 and 6% of their income by 2020 (or have plans in place for shared service consolidation with, or outsourcing to, other providers by January 2017), so that resources are used in a cost effective manner.

Lead Director(s): Director of HR & OD, Director of Finance & Commercial Development and Chief Information Officer

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Rationalisation of corporate and administration functions	• The Trust's corporate and administration functions current costs are 7.5% of income based on planned income as of Q1 2019/20. This includes Finance, HR, IM&T, Communications, Research, Transformational and Executive costs. • The Trust will collaborate with other organisations where appropriate to provide services in a more streamlined way maximizing opportunities to procure and work at scale, reduce waste and support the delivery of clinical services, facilitating change where required. • The NHSI operational productivity team visited the Trust in August 2018 to look at the whole of the model hospital and identify opportunities. • As a follow up to the NHSI productivity session, a specific corporate service session took place in October 2018 which will focus on IM&T, Finance and HR. • Corporate Services are utilising NHSI Corporate Service Productivity Programme to review opportunities around Chart of Accounts, Journal Policy, Budget Holder Support, Accounts Payable Automation, Sharing Ledger Costs, Policies and Procedures and Financial Reporting. The Trust is working with Mid-Cheshire Hospitals NHS Trust to review structures as part of a wider benchmarking exercise.	• The Trust Deputy Directors are leading on a programme of work to review and improve the corporate metrics. • A benchmarking exercise has been undertaken with Mid Cheshire Hospitals NHS Foundation Trust. The first draft is currently being reviewed prior to being shared for comments by the Executive Team. • Improving the consistency of Benchmarking returns was discussed at the Collaboration @ Scale workshop. NHSi is to support work to assess returns and advise on amendments. • The IM&T SLT have reviewed the IM&T Model Hospital metrics and apportioned the costs so that they accurately reflect the work areas for pay and non-pay. Looking at the pure IT areas the department is within national levels however further work is underway to see where tangible improvements can be made.	Strategic Development and Delivery Committee	Rolling Programme
Corporate CIP Targets	• All corporate divisions have been assigned costs savings targets in 2019/20. The targets and the progress to date in identifying schemes to meet the targets are summarised. The cost savings being delivered either reduce costs or increase income, thereby improving their respective percentage cost figures.	• Corporate CIP performance for 2019/20 as at M3 is £0.093m in-year CIP delivered against a M3 target of £0.104m M3 YTD target, the full year target is £1.203m. • Collaboration at Scale activity is now seen as key to future gains and aims to identify future procurement opportunities.	Finance & Sustainability Committee	Rolling Programme

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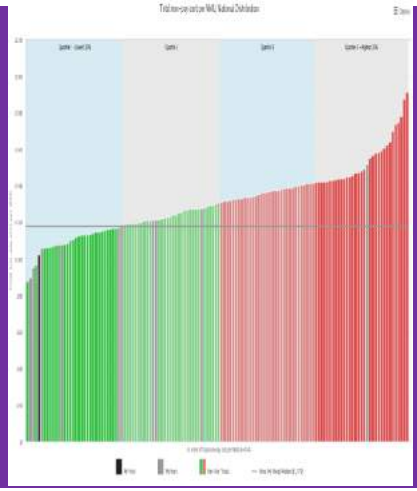
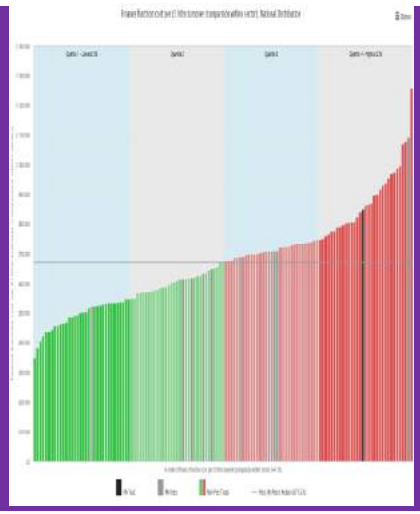
KLOE 4 - Corporate Services						
Non Pay Costs per WAU	UoR Cost per WAU is the headline productivity metric used within the Model Hospital. It shows the amount spent by a trust to produce one Weighted Activity Unit (WAU) of clinical output. This metric show the amount the trust spends on non-pay per WAU across all areas of NHS clinical activity.	**National Median = £1307** Peer Median = £1200 1. Chester £898 2. Mid Cheshire £954 3. WHH £1027 4. Gateshead £1058 5. Wirral £1078 6. Southport £1172 7. N Lincolnshire £1187 8. Bournemouth £1213 9. STHK £1218 10. North Tees £1280 11. Sunderland £1518 **Current Quartile:** **1 (Best)** **Best Quartile Target:** **£1172** **Source: HSCIC - NHS Digital iView Stability Index**	**2017/18**		The Trust is performing in the upper quartile (best) nationally. The Trust continues to review opportunities to reduce non-pay costs whilst maintaining quality.	All departments across the Trust are continuously looking at ways to reduce costs as part of day to day business as well as via CIP.
Finance Costs per £100m Turnover	UoR Total finance cost divided by trust turnover multiplied by a £100m	**National Median = £676k** Peer Median = £701k 1. Sunderland £522k 2. Chester £617k 3. STHK £621k 4. N Lincolnshire £636k 5. Mid-Cheshire £651k 6. Wirral £652k 7. Bournemouth £710k 8. Gateshead £711k 9. North Tees £711k 10. WHH £852k 11. Southport £1.1m **Current Quartile:** **4 (Worst)** **Best Quartile Target:** **£550k** **Source: Trust consolidated annual accounts and NHSI improvement 17/18 data collection template.**	**2017/18**		The Trust has submitted benchmarking data for 2019/20 and is awaiting the publication to understand the current position.	As part of the Lord Carter recommendations, each Corporate service will carry out a review to look at potential opportunities as identified within the model hospital and the national benchmarking exercise.

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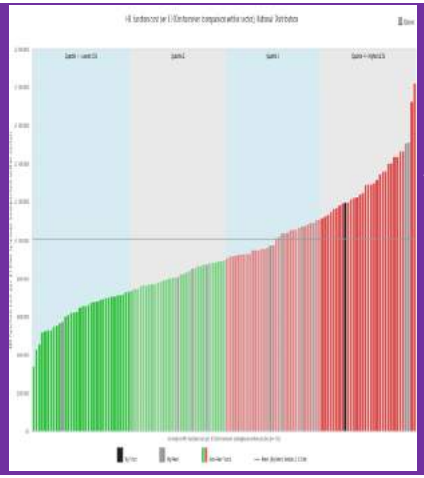
Human Resource Costs per £100m Turnover	UoR HR is made up of a number of sub compartments taken into consideration when considering total HR costs per £100m turnover.	**National Median = £898k** **2017/18** Peer Median = £1.06m 1. Sunderland £575k 2. STHK £812k 3. Chester £854k 4. Bournemouth £875k 5. Wirral £974k 6. Mid Cheshire £1.04m 7. Gateshead £1.07m 8. North Tees £1.09m 9. WHH £1.2m 10. Southport £1.5m 11. N Lincolnshire £1.5m **Current Quartile: 4 (Worst)** **Best Quartile Target: £732k** **Source: Trust consolidated annual accounts and NHSI improvement 17/18 data collection template.**		The Trust has submitted benchmarking data for 2019/20 and is awaiting the publication to understand the current position.	As part of the Lord Carter recommendations, each Corporate service will carry out a review to look at potential opportunities as identified within the model hospital and the national benchmarking exercise.

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	Recommendation 8 - NHS Improvement and NHS England should establish joint clinical governance by April 2016 to set standards of best practice for all specialties, which will analyse and produce assessments of clinical variation, so that unwarranted variation is reduced, quality outcomes improve, the performance of specialist medical teams is assessed according to how well they meet the needs of patients and efficiency and productivity increase along the entire care pathway. **Lead Director(s):** Chief Operating Officer and Director of Strategy			
Variation in Theatres and Outpatients	• A new theatre scheduling process was launched and is designed to provide improved visibility and forward planning around utilising theatre and anaesthetic capacity. • Theatre listing meetings immediately follow '6-4-2' scheduling meetings and examine the patients on each individual list for the following week. • Theatre '6-4-2' scheduling meetings are now fully established. Theatre sessions are now 'locked down' at two weeks. • A list planning process was launched with the aim of formally introducing expected list timings into the discussion to ensure all scheduled lists are planned to run at or close to maximum operating time available. • Demand and Capacity work is complete and the model is now fully functional. Clinic templates for all specialties are being validated to ensure the accuracy of all outcomes. • The KPI Sub-Committee continue to monitor Theatre utilisation, Late starts and Cancellations. • A Theatre Transformation Board chaired by the CBU Manager for Digestive Diseases has been established. • The Transformation Team have developed a capacity and demand summary which CBU managers will monitor. • A programme of work around improving Theatre Utilisation and Late Starts has commenced. Full analysis and benchmarking with peers has been undertaken regarding late starts and improvements have been made. • The Theatre productivity group has been established with a sub-group focusing specifically on cancellations with a view to address the number of cancelled sessions.	• The Associate Director of Elective Care Performance has established a project around pre-operations and will present findings during Q2. • Options and plans around the co-location of Breast Screening and Orthopaedics are being finalised.	Trust Operational Board	Ongoing

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Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 1 2019/20

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Emergency Care Improvement Programme	• An improvement programme for patient flow agreed a number of key work streams across mid Mersey following a system review, these work streams feed into the Mid-Mersey A&E delivery board. • The Trust has its own internal flow board which focuses on 9 key work streams to support improvements in flow. • Red 2 Green patient data is collected on all wards through daily board rounds and a process to share the data around patient delays with partner organisations is in place with partner organisations expected to respond with actions in place to reduce the delays. • Frailty work stream – the frailty assessment unit is operational. • The Emergency Care Improvement Programme visited the Trust. There was an NWAS challenge for all conveyances and a walk through of the urgent/emergency care system. Positive informal feedback was received. • As a result on the system wide capacity and demand review carried out by the Venn Group, the Trust has agreed with partners to approve capacity and flow in the short term. • ED Ambulatory Care opened January 2019. This has resulted in increased assessment throughput and a reduction in direct admissions from ED. • The Trust will continue to focus on Super Stranded Patients with system partners the trajectory for 2019/20 is > 95 patients. • Ambulance Handovers over 30 and 60 minutes continues to reduce month on month. • The Trusts dedicated discharge lounge opened in March 2019. • The Integrated Care team is now co-located from June 2019.	• The Trust will continue to work with One Halton and Warrington Together to ensure proposals are developed consistently with an integrated approach. • The Trust is working with NHSI around SAFER/LLOS Collaboration to run until September 2019. • An Urgent & Emergency Care review meeting chaired by the COO has been established. • A new ward round accreditation process is being developed.	A&E Delivery Board Flow Board	Ongoing

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Use of Resource Graph Key

Trust Position
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Peer Median

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UoR Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 1 2019/20

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Specialty level reviews across local delivery system	• The Trust is participating in a series of specialty level reviews across the Local Delivery System (LDS). • Implementation of plans to reduce variation within pathways across the LDS. • Specialty reviews have now been held in urology, trauma & orthopaedics and ophthalmology. • A programme of workshops across priority specialties has been agreed, led by the LDS Director of Service Redesign. • A new clinical strategy was developed and launched. • Work to re-invigorate the DTOC process to include daily validation with weekly reviews and a weekly corporate flow meeting has been completed. • The Trust is working with Cheshire and Mersey Cancer Alliance to develop optimal pathways beginning with Colorectal, the Trust is supported by Aqua. A one stop show has been launched. • A new clinical model around the Stroke Pathway has been agreed, implementation took place in April 2019. • An Integrated Discharge Manager has been recruited who will manage both Health & Social Care Teams.	• GIRFT reviews continue to take place within a number of specialities across the Cheshire & Mersey footprint, with each speciality developing an action plan. • The Trust has signed up with NHSI to carry out a length of stay evaluation programme, this is included in the SAFER collaboration to run until September 2019. • All 33 clinical services now have 3-5 year clinical strategies agreed and prioritised. The Clinical strategies seek to address variation and target improvement.	QPS, Strategic Development and Delivery Committee	Ongoing

Warrington and Halton Hospitals NHS
NHS Foundation Trust

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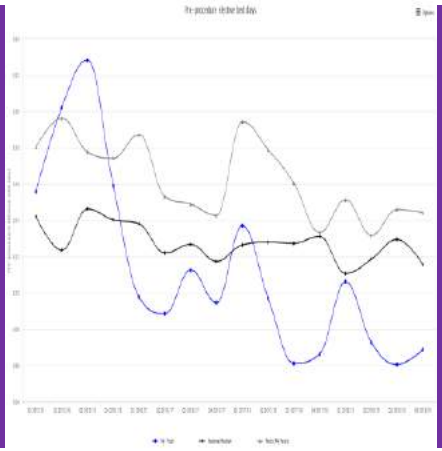
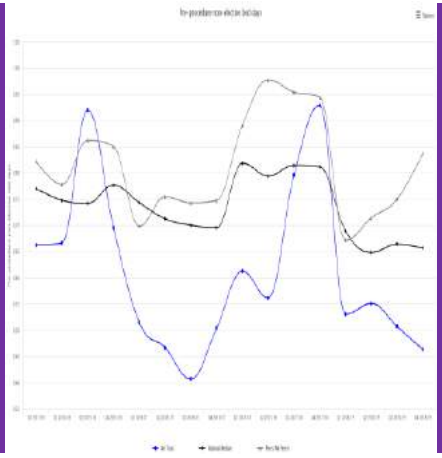
UoR Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 1 2019/20

	Progress/Performance			Actions to Improve Position/Actions for Next Quarter	Assurance	Status
KLOE 1 - Clinical						
Pre Procedure Elective Bed Days	UoR The number of bed days between the elective admission date and the date that the procedure taken place.	**National Median = 0.12** Peer Median = 0.11 1. North Tees 0.02 2. Bournemouth 0.04 3. Mid Cheshire 0.06 4. WHH 0.07 5. Wirral 0.09 6. Sunderland 0.12 **Current Quartile:** **Best Quartile Target:** **Monitoring : KPI Sub-Committee** **Source: Hospital Episode Statistics**	**Q4 2018/19** 7. STHK 0.16 8. N Lincolnshire 0.25 9. Southport 0.27 10.Chester 0.32 11. Gateshead 0.35 **2 (2nd Best)** **0.06 days**		The Trust continually reviews opportunities to provide same day admission. The surgical transformation programme is supporting the reduction in theatre cancellations and improving productivity and efficiency.	Theatre productivity and efficiency remains a focus for the surgical theatre transformation in 2019/20. Performance against this metric is further monitored via the Theatre Performance Dashboard.
Pre Procedure Non Elective Bed Days	UoR The number of bed days between an emergency admission date and the date the procedure taken place.	**National Median = 0.66** Peer Median = 0.73 1. Bournemouth 0.26 2. WHH 0.46 3. North Tees 0.53 4. Wirral 0.66 5. Sunderland 0.70 6. Mid Cheshire 0.76 **Current Quartile:** **Best Quartile Target:** **Monitoring: KPI Sub-Committee** **Source: Hospital Episode Statistics**	**Q4 2018/19** 7. Chester 0.91 8. STHK 0.93 9. N Lincolnshire 0.99 10. Gateshead 1.03 11. Southport 1.12 **1 (Best)** **0.52 days**		The Trust continually reviews opportunities to improve efficiency around emergency and non elective procedures. The surgical transformation programme is supporting the reduction in theatre cancellations and improving productivity and efficiency.	Theatre productivity and efficiency remains a focus for the surgical theatre transformation in 2019/20. Performance against this metric is further monitored via the Theatre Performance Dashboard.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

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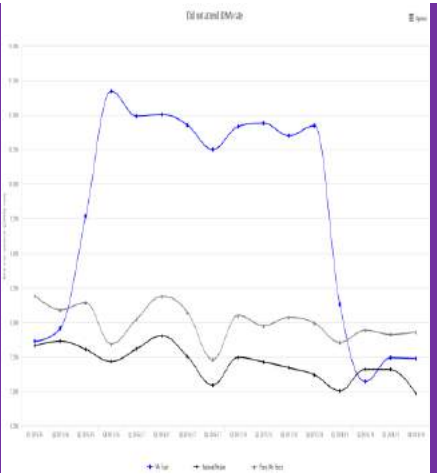
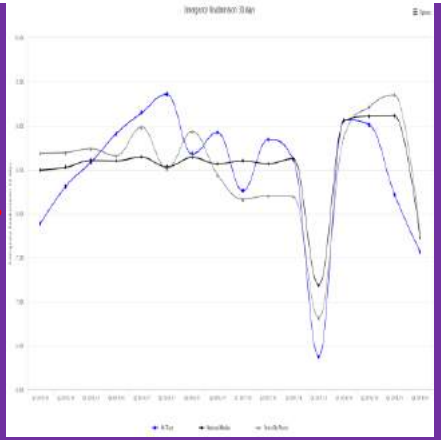
UoR Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 1 2019/20

	Progress/Performance			Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Did Not Attend (DNA) Rate	UoR Rate of patients not attending their outpatient appointment.	**National Median = 6.96%** Peer Median = 7.68% 1. Chester 5.66% 2. Mid-Cheshire 5.73% 3. Southport 6.84% 4. N Lincolnshire 6.89% 5. WHH 7.47% 6. Bournemouth 7.80% **Current Quartile:** **Best Quartile Target:** **Monitoring: KPI Sub-Committee** **Source: Hospital Episode Statistics**	**Q4 2018/19** 7. Gateshead 7.92% 8. North Tees 8.35% 9. Sunderland 8.46% 10. Wirral 8.55% 11. STHK 9.42% **3 (2nd Worst)** **5.96%**		In May 2018, the Trust reintroduced a text reminder service which has resulted in a significant improvement in the DNA rate. The Trust has dipped below the national median in Q3 2018/19, however we continue to focus on how the DNA rate can be improved.	The Trust has continued to implement improvements in the interface with patients. Further improvements in the interface are being implemented via the Outpatient Steering group, which is intended to improve the position further.
Emergency Readmission (30 Days)	UoR This indicator measures the percentage of admissions of people who returned to hospital as an emergency within 30 days of the last time they left hospital after a stay. Admissions for cancer and obstetrics are excluded as they may be part of the patient's care plan.	**National Median = 7.73%** Peer Median = 7.58% 1. N Lincolnshire 6.31% 2. Chester 6.50% 3. Bournemouth 7.34% 4. Wirral 7.35% 5. WHH 7.57% 6. Sunderland 7.57% **Current Quartile:** **Best Quartile Target:** **Monitoring: KPI Sub-Committee** **Source: Hospital Episode Statistics**	**Q4 2018/19** 7. Gateshead 8.00% 8. STHK 8.20% 9. Southport 8.81% 10. Mid Cheshire 8.90% 11. North Tees 9.71% **2 (2nd Best)** **7.73%**		Every effort is made when discharging patients to ensure that the discharge is appropriate. Readmissions are reviewed by the clinical directors to review any inappropriate discharges and ensure lessons are learned.	The Trust will continue to review the improvement through the Trust clinical governance processes to ascertain if there is a need to review discharge procedures.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

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UoR Use of Resource Assessment Indicator

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Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 1 2019/20

Recommendation 9 - All trusts should have the key digital information systems in place, fully integrated and utilised by October 2018, and NHS Improvement should ensure this happens through the use of 'meaningful use' standards and incentives.

Lead Director: Chief Information Officer

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Electronic Patient Record & Structured Clinical Notes	• The Trust implemented Lorenzo EPR in December 2015. • The Trust continues to optimise Lorenzo functionality to ensure that it meets with developing business and clinical needs. This project is monitored by the Digital Board. • The Trust continues to upgrade Lorenzo in line with the development roadmap. • The Trust has been selected as a Digital Exemplar for work relating to the use of the Electronic Patient Record. This project is making excellent progress. The team is pulling together conceptual designs to support future state for the selected pathways ' Head Trauma and Diabetes'. • Electronic Maternity Nursing Observations (MEWS) went live during Q4 2018/19. • The Trust was successful in their bid to HLSI to support implementation of Inpatient nursing observations.	• The Trust in collaboration with the C&M H&SCP Digital Programme is developing two delivery plans to demonstrate viability of the preferred option. • Lorenzo Digital Exemplar – Diabetes future state is agreed in principle subject to detailed plans being approved in July. Head Trauma future state is on target for completion end of Q2 • Warrington Care Record - A strategic options appraisal is complete and is going through STP Governance arrangements for assurance and recommendation to implement STP solution. • Work continues with GP viewer which will give Trust clinicians access to Warrington GP records via Lorenzo. Following testing it is now anticipated this functionality will be available during Q2. • The first of type for NHS Digital GP Connect project has commenced, to enable patient medications from GP systems to be integrated to Lorenzo. High level designs are being drafted. It is anticipated testing will take place during Q2 2019/20.	IM&T Sub-Committee/ Trust Board	Project Implementation – expected completion – Plan up to 2020 on track.
Electronic Document Management System	• A review of requirements now Lorenzo has been live for 3 years has been undertaken to ensure any investment required is for the right solution.	• The Trust Digital Strategy will be refreshed during Q2 to ensure a fit with the EPR and paperless strategy. • A revised EDMS/Paperless 2020 business case will be developed followed by a procurement process in order to achieve a paperless Trust by 2020.	IM&T Sub-Committee	Project Implementation – Initiation

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UoR Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 1 2019/20

	Progress/Performance	Actions to Improve Position/Actions for Next Quarter	Assurance	Status
ePMA	• Electronic prescribing and medicines administration (ePMA) business case and PID signed off by Trust Board and NHS Digital – the outline business case was approved by the Trust board in October 2017, NHS Digital approved the business case in principle in November 2017. • The ePMA rollout plan was signed off by the Digital Operational Group and the IM&T Committee. • The ePMA pilot commenced on CDU on 5th March 2018. Positive feedback from staff/system users was received. 2nd ePMA pilot at Halton UCC – the pilot was a success and operation of the system has continued post pilot. • ePMA was successfully implemented on the surgical pathway on Ward B4 in December 2018 and within Ward and Theatre orthopaedic pathways at the CMTC in March 2019.	• Planning for rollout across Warrington is now complete. Lessons learned from Halton pilots has been incorporated into the planning stages for Warrington. A desktop exercise has been undertaken to determine implementation and early live support requirements. A number of issues have been identified, the Trust CIO has put together a proposal for the executive team to consider. • Three options (8 week, 4 week and 2 week) for rollout have been proposed. It is anticipated that rollout will take place in early Autumn.	IM&T Sub-Committee	Project Implementation

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Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 1 2019/20

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

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UoR Use of Resource Assessment Indicator

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Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 1 2019/20

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

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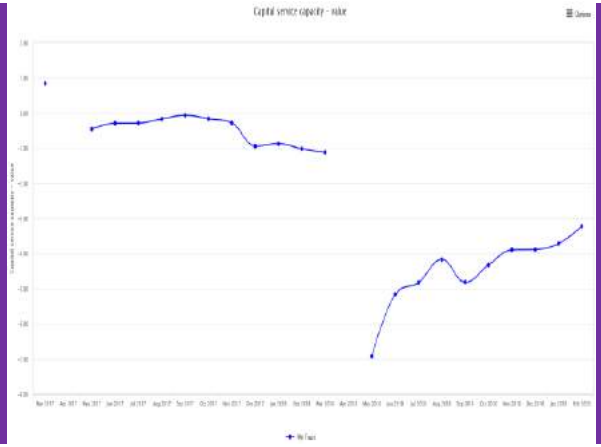
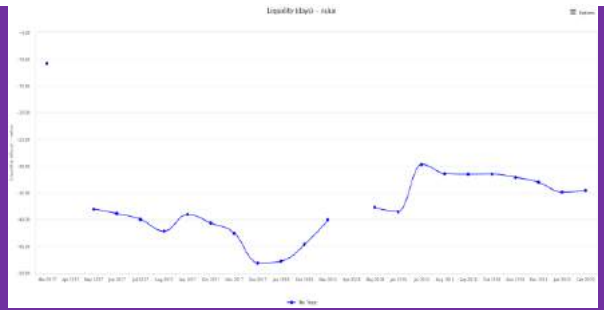
Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 1 2019/20

	Progress/Performance		Actions to Improve Position/Actions for Next Quarter	Assurance	Status
KLOE 5 - Finance					
Capital Services Capacity	UoR **WHH Model = -1.92 (March 2019)** **WHH Current = -0.67 (June 2019)** The degree to which the provider's generated income covers its financial obligations **Source: Provider returns** **Monitoring: FSC/Trust Board**		The operating performance of the Trust results in an operating deficit so the Trust is focussing on improving its operating performance through income increase and cost reduction whilst maintaining the quality of healthcare.	> CBUs and Corporate Divisions continue to explore all opportunities to identify cost savings, increase activity at minimal cost, reduce cooperating costs. > The Trust continues to work with commissioners on the current and future sustainability of services. > The new Trust Financial Resource Group (FRG) continues to review performance though SLR, Benchmarking and the Model Hospital.	
Liquidity (Days)	UoR **WHH Model = -44.22 days (March 2019)** **WHH Current = -46.70 days (June 2019)** Days of operating costs held in cash or cash-equivalent forms, including wholly committed lines of credit available for drawdown. **Monitoring: FSC/Trust Board** **Source: Provider returns**		The historic and current operating and financial performance has resulted in reduced cash and the need for additional working capital loans. The Trust manages the cash position very closely to maintain liquidity and meet its financial obligations.	The Trust is working to improve liquidity in a number of ways including the strengthening of treasury management, reduction in aged debt, management of capital programme and access to working capital loans.	

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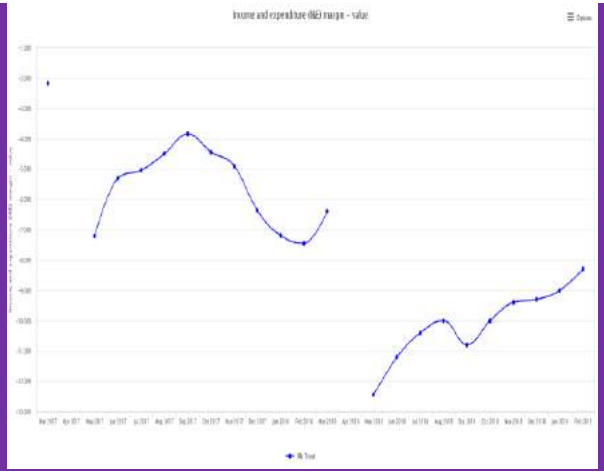
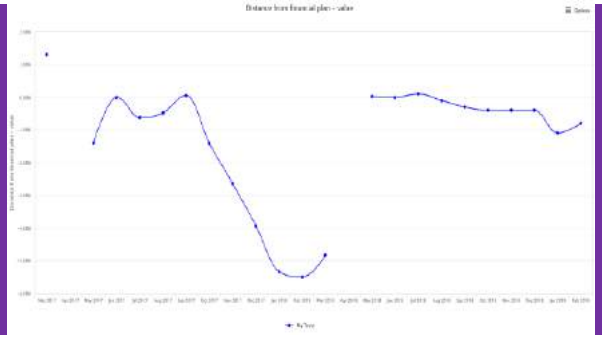
Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 1 2019/20

	Progress/Performance		Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Income & Expenditure Margin	UoR The income and expenditure surplus or deficit, divided by total revenue.	**WHH Model = -6.20% (March 2019)** **WHH Current = - 4.96% (June 2019)** **Monitoring: FSC/Trust Board** **Source: Provider returns**		The operating performance of the Trust results in an operating deficit so the Trust is focussing on improving its operating performance through income increase and cost reduction whilst maintaining the quality of healthcare.	> CBUs and Corporate Divisions continue to explore all opportunities to identify cost savings, increase activity at minimal cost and reduce operating costs. > The Trust continues to work with commissioners on the current and future sustainability of services. > The Financial Resource Group (FRG) continues to review performance through SLR, Benchmarking and the Model Hospital.
Distance from Financial Plan	UoR Year-to-date actual I&E margin in comparison to year-to-date plan I&E margin. I&E margin calculated on a control total basis. Measure is in percentage points.	**WHH Model = -0.70% (March 2019)** **WHH Current = 0.45% (June 2019)** **Monitoring: FSC/Trust Board** **Source: Provider returns**		The Trust is marginally ahead of the planned deficit but is focussing on improving its operating performance through income increase and cost reduction whilst maintaining the quality of healthcare.	The Trust achieved the plan and control total in 2018/19 and continues to monitor and manage the plan.

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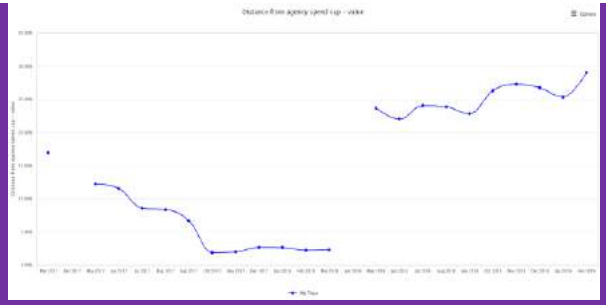
UoR Use of Resource Assessment Indicator

Appendix 2

Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 1 2019/20

	Progress/Performance		Actions to Improve Position/Actions for Next Quarter	Assurance	Status
Agency Spend - Cap Value	UoR The extent to which the trust is meeting the target for the amount spend on agency workers for the financial year.	**WHH Model = 30.39% (March 2019)** **WHH Current = -1.93 (June 2019)** **Monitoring: FSC/Trust Board** **Source: Provider returns**		The Trust is marginally below the agency ceiling with a continued reliance of agency staff to cover gaps from vacancies.	The Trust continues to explore all opportunities to reduce its reliance on agency by recruiting to substantive roles, focusing on retention, innovative workforce models and international recruitment.

Warrington and Halton NHS Foundation Trust

Use of Resources assessment report

Address
Lovely Lane
Warrington
WA5 1QG
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Date of publication:
24 July 2019

This report describes our judgement of the Use of Resources and our combined rating for quality and resources for the trust.

Ratings

Overall quality rating for this trust	**Good** ●
Are services safe?	**Good** ●
Are services effective?	**Good** ●
Are services caring?	**Good** ●
Are services responsive?	**Good** ●
Are services well-led?	**Good** ●

Our overall quality rating combines our five trust-level quality ratings of safe, effective, caring, responsive and well-led. These ratings are based on what we found when we inspected, and other information available to us. You can find information about these ratings in our inspection report for this trust and in the related evidence appendix. (See www.cqc.org.uk/provider/RWW/reports)

Are resources used productively?	**Requires improvement** ●

Combined rating for quality and use of resources	**Good** ●

We award the Use of Resources rating based on an assessment carried out by NHS Improvement.

Our combined rating for Quality and Use of Resources summarises the performance of the trust taking into account the quality of services as well as the trust's productivity and sustainability. This rating combines our

five trust-level quality ratings of safe, effective, caring, responsive and well-led with the Use of Resources rating.

Use of Resources assessment and rating

NHS Improvement are currently planning to assess all non-specialist acute NHS trusts and foundation trusts for their Use of Resources assessments.

The aim of the assessment is to improve understanding of how productively trusts are using their resources to provide high quality and sustainable care for patients. The assessment includes an analysis of trust performance against a selection of initial metrics, using local intelligence, and other evidence. This analysis is followed by a qualitative assessment by a team from NHS Improvement during a one-day site visit to the trust.

Combined rating for Quality and Use of Resources

Our combined rating for Quality and Use of Resources is awarded by combining our five trust-level quality ratings of safe, effective, caring, responsive and well-led with the Use of Resources rating, using the ratings principles included in our guidance for NHS trusts.

This is the first time that we have awarded a combined rating for Quality and Use of Resources at this trust. The combined rating for Quality and Use of Resources for this trust was good, because:

- We rated safe, effective, caring, responsive and well-led as good. All five core services we inspected during this inspection we rated as good. In rating the trust, we took into account the current ratings of the six services not inspected this time.
- We rated well-led for the trust overall as good.
- Our rating for Warrington Hospital and Halton General Hospital were both good which was an improvement since the last inspection.
- Our ratings for medical care and critical care at Warrington Hospital were both good which was an improvement from the last inspection. Our ratings for surgery at Warrington Hospital and Halton General Hospital were both good which was the same rating as the last inspection.
- We rated maternity at Warrington Hospital as good. We previously inspected maternity jointly with gynaecology so we cannot compare our new ratings directly with previous ratings. We rated outpatients at Halton General Hospital as good. We previously inspected outpatients with diagnostic imaging so we cannot compare our new ratings directly with previous ratings.
- The trust was rated Requires Improvement for use of resources. Full details of the assessment can be found on the following pages.

NHS Improvement

Warrington and Halton NHS Foundation Trust

Use of Resources assessment report

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Date of site visit:
02 April 2019

Date of NHS publication:

This report describes NHS Improvement's assessment of how effectively this trust uses its resources. It is based on a combination of data on the trust's performance over the previous 12 months, our local intelligence, the trust's commentary on its performance, and qualitative evidence collected during a site visit comprised of a series of structured conversations with the trust's leadership team.

Are resources used productively?	**Requires improvement** ●

How we carried out this assessment

The aim of Use of Resources assessments is to understand how effectively providers are using their resources to provide high quality, efficient and sustainable care for patients. The assessment team has, according to the published framework, examined the trust's performance against a set of initial metrics alongside local intelligence from NHS Improvement's day-to-day interactions with the trust, and the trust's own commentary of its performance. The team conducted a dedicated site visit to engage with key staff using agreed key lines of enquiry (KLOEs) and prompts in the areas of clinical services; people; clinical support services; corporate services, procurement, estates and facilities; and finance. All KLOEs, initial metrics and prompts can be found in the Use of Resources assessment framework.

We visited the trust on 02 April 2019 and met the trust's leadership team including the chief executive and the chair, as well as relevant senior management responsible for the areas under this assessment's KLOEs.

Findings

Is the trust using its resources productively to maximise patient benefit?	Requires improvement

- We rated the trust's use of resources as Requires Improvement.
- The trust did not balance its budget in 2017/18, reporting a deficit of £15.0m (6.4% of its turnover) against a plan of a £3.7m deficit. The trust delivered a deficit of £15.0m (including Provider Sustainability Funding) in 2018/19 which is 6.2% of turnover and £1.8m better than plan.
- The trust has a cost improvement plan (CIP) of £7m (or 2.6% of its expenditure) in 2018/19 and delivered £5.6m. Of this, c.70% was recurrent.
- The trust is reliant on external loans to meet its financial obligations and deliver its services.
- The trust spends on average the same on pay and other goods and services per weighted unit of activity than most other trusts nationally. For 2017/18, the trust had an overall cost per weighted activity unit (WAU) of £3,482 compared with a national median of £3,486. This indicates that the trust is as productive at delivering services as other trusts by showing that, on average, the trust spends the same to deliver the same number of services.
- For the same period, the trust had a total pay cost per WAU of £2,455 compared with a national median of £2,180, placing the trust in the highest (worst) quartile. However, the trust benchmarked in the lowest (best) quartile for non-pay cost per WAU, at £1,027 compared to a national median of £1,307.
- At the time of the assessment the trust was meeting the constitutional operational performance standards for Referral to Treatment, Cancer and Diagnostics; however, was not meeting the standards for Accident and Emergency (A&E).
- Individual areas where the trust's productivity compared particularly well included clinical productivity, delayed transfers of care, pathology, pharmacy and non pay cost per WAU. Opportunities for improvement were identified in DNA rates, sickness absence, corporate services and agency spend.
- The trust demonstrated it is actively engaged with partners across the local health economy through the Collaborative & Sustainability, Warrington Together and One Halton working groups. In addition, the trust has worked in collaboration with Commissioners and the Lead GP for Warrington CCG to deliver an integrated diagnostics service to provide ECG and 24 hour ECG services in selected Warrington GP practices.
- The trust was able to demonstrate effective use of technology to improve operational productivity such as; virtual clinics, robotic process automation in outpatients and a 'tap on, tap off' system within the Emergency Departments.

How well is the trust using its resources to provide clinical services that operate as productively as possible and thereby maximise patient benefit?

- At the time of the assessment in April 2019, the trust was meeting the constitutional operational performance standards for Referral to Treatment (RTT) and Cancer, but not Accident & Emergency (A&E).

- Patients are less likely to require additional medical treatment for the same condition at this trust compared to other trusts. At 9.04%, emergency readmission rates are slightly below the national median of 9.06% for quarter 2 2018/19.
- Fewer patients are coming into hospital unnecessarily prior to treatment compared to most other hospitals in England.
    - With pre-procedure elective bed days, at 0.06, the trust is performing lowest (best) quartile below the median when compared to the national median of 0.13.
    - With pre-procedure non-elective bed days at 0.05, the trust is performing in the lowest (best) quartile, below the median when compared nationally – the national median is 0.66.
- The trust demonstrated it is actively engaged with partners across the local health economy through the Collaborative & Sustainability, Warrington Together and One Halton working groups. For example; the trust, in conjunction with Bridgewater Community NHS FT, has introduced a Frailty Assessment Unit which provides assessment and intervention for frail or elderly patients with an acute illness allowing them to remain, where possible, in their own residence and avoid hospital attendance or admission. From June 2018 to March 2019, the assessment unit saw a total of 396 attendances with an average direct discharge rate of 89%.
- In addition, the trust has worked in collaboration with commissioners and the lead GP for Warrington CCG to deliver an integrated diagnostics service to provide ECG and 24 hour ECG services in selected Warrington GP practices. The project was introduced in 2018, with an anticipated completion date of June 2019, and aims to improve health outcomes of patients through quick and appropriate diagnostic assessment.
- The Did Not Attend (DNA) rate for the trust is high at 7.47% for quarter 3 2018/19. However, the trust has seen a significant reduction in DNA rates from 10.85% in quarter 4 2017/18 to 7.32% in quarter 2 2018/19. The trust explained this is mostly attributable to the implementation of a text reminder service in May 2018. In addition, the trust have moved to ‘Bookwise’, a computerised booking system to ensure better utilisation of clinic rooms and out of hours capacity.
- At 2.7% in January 2019, the trust reports a delayed transfers of care (DTOC) rate that is lower than average and lower than the trusts own target rate of 3.5%. However, the trust saw an increase in the DTOC rate for October and November 2018 (7.5% and 9.2% respectively). The trust has recently appointed an Associate Director of Integrated Care, a joint post with Warrington Council to review integrated care and improve flow for stranded patients.
- The trust was able to demonstrate good engagement with the Getting it Right First Time (GIRFT) programme with an embedded governance model with ownership through the Clinical Business Units (CBUs) and executive leadership from the Executive Medical Director. GIRFT is used alongside the 7 day services audit and as part of benchmarking exercises to support discussions with clinical teams with coordinated action plans.

How effectively is the trust using its workforce to maximise patient benefit and provide high quality care?

- For 2017/18 the trust had an overall pay cost per WAU of £2,455, compared with a national median of £2,180, placing it in the highest (worst) quartile nationally. This means that it spends more on staff per unit of activity than most trusts.

- The trust is in the highest (worst) quartile for Allied Health Professional (AHP) cost per WAU, at £184 compared to a national median of £130 for 2017/18. The trust noted this is in part due to the provision of community services and the use of innovative, alternative staffing roles to support nursing and medical vacancies.
- The trust benchmarks in the second highest (worst) quartile for nursing cost per WAU, at £761 compared to a national median of £710. However, the trust explained a nursing staff review was undertaken in 2018 in order to stabilise the substantive workforce and reduce the reliance on temporary and non-substantive staff, therefore increasing the nursing pay cost. This included, where appropriate, over recruitment to the workforce. The trust has also introduced a number of alternative roles, including 28 advanced care practitioners and 4 nurse Consultants. This ensures the workforce is adaptable and assists in covering hard to fill roles, as well as providing innovative career pathways. There is an Advanced Nurse Practitioner Strategy in place.
- For medical staff, the trust benchmark in the lowest (best) quartile with a cost per WAU of £461 compared to a national median of £533. However, the trust noted this is as a result of vacancies within the medical workforce, particularly in hard to recruit to specialities, and recognise as these vacancies are recruited to the medical cost per WAU will increase. The trust has appointed to 6 Training Fellows in conjunction with Wrightington, Wigan and Leigh FT.
- The trust did not meet its agency ceiling as set by NHS Improvement for 2018 and is forecasting to miss the ceiling in 2019. It is spending more than the national average on agency as a proportion of total pay spend (6.1% of total pay bill compared to a national average of 4.4%). The trust explained the higher than average sickness and vacancy rates within the trust has led to the requirement of additional agency staff and noted it is expecting to see a reduction in agency spend following appointments into hard to recruit to specialties.
- At £145, agency staff cost per WAU was above the national median of £107 for 2017/18. The trust noted a premium pay spend review group has been introduced to identify high priority areas and individually meet with teams to resolve issues where possible. In addition, approval from the Director of Nursing is required for any price cap overrides.
- With regards to collaboration, the trust is involved in the Temporary Staffing Steering group (for medical locums) which brings together all trusts in the Cheshire and Merseyside footprint and has led to a reduction in commission rates, the development of management information visible by all members and the introduction of a supplier review programme. This should result in reductions in agency costs in 2019/20.
- The trust has introduced an innovative approach to its internal bank whereby a bidding system for shifts is used. Emails are sent to all applicable staff and the first response is allocated the shift.
- The trust has implemented e-rostering for nurses, healthcare assistants, midwives and consultants and is on track to roll e-rostering out to AHPs and other departments. Key performance indicators (KPIs) are in place for nursing staff and a lead nurse is allocated for staffing reviews each day to match staff with daily demand. The trust have also introduced CLWRota (by Rotamap) e-rostering for anaesthetics, allowing the trust to plan, operate and report on anaesthetic activity using online tools for departmental communication and coordination.
- As of April 2019, 97% of consultants have a job plan and job planning is recorded electronically using Allocate software. The trust has also undertaken job planning for specialist nurses and advance nurse practitioners, together with developing job plans for AHPs.

- Staff retention at the trust is good, with a retention rate of 86.1% in October 2018 against a national median of 85.8%.
- At 5.03% in October 2018, staff sickness rates are worse than the national average of 4.27%. The trust identified the highest areas of sickness are musculoskeletal and mental health related illnesses. However, the trust noted a reduction in musculoskeletal related sickness which was attributed to bringing physiotherapy as part of the Health and Wellbeing service. This, together with the Health and Safety team, provides targeted support. The trust has also introduced Occupational Health drop in sessions within the hotspot areas, however, the full impact of this has not yet been evaluated.

How effectively is the trust using its clinical support services to deliver high quality, sustainable services for patients?

- At £1.72, the overall cost per test at the trust benchmarks in the second lowest (best) quartile and above the national median of £1.86. The trust was able to provide evidence of working collaboratively with the Cheshire and Mersey Pathology Network, with a Memorandum of Understanding (MOU) in place, to continue to implement the recommendations from the Carter Review into operational productivity in the NHS of a hub and spoke delivery model at scale.
- For imaging, the trust benchmarks in the second highest (worst) quartile for cost per report at £54.59 compared with a national median of £49.93. The trust was able to demonstrate engagement and collaboration with the Cheshire and Mersey radiology network, in particular, through the standardisation of protocols and shifts. Through the collaboration a centralised hub has been introduced which covers out of hours reporting across Cheshire and Merseyside, ensuring the most cost effective use of on call resources for urgent reporting. The trust also noted they do not lose a registrar each day due to on call commitments as a result of this.
- The trust's medicines cost per WAU, at £234, is relatively low when compared to a national median of £320. As part of the Top Ten Medicines programme, it is making good progress in delivering on nationally identified savings opportunities, achieving 116% of the savings target against a lower benchmark of 80% and an upper benchmark of 100% (as of March 2018). The trust has made good progress in implementing switching opportunities for biosimilars, with the exception of Rituximab (52%). However, the trust were able to demonstrate ongoing work with NHS England to address the issues arisen regarding implementation.
- The trust was able to demonstrate it is using technology to improve operational productivity. Examples include virtual clinics and electronic whiteboards. In addition, the trust has developed a number of projects including:
    - A 'tap on, tap off' system in the Emergency Department whereby users use Smartcards to move from one device to another with a "tap" of the card reader. The user, in moving to another device picks up the "session" from where they previously left it. The trust demonstrated the system, as it is quicker and more productive, has resulted in releasing additional time for clinicians to spend patient facing.
    - Use of robotic process automation software in outpatients which replicates user inputting of appointments. The trust noted this has reduced the clinical risk of delays to and waiting times for testing and treatment and avoided an increase in DNA rates, together with releasing staff time for other tasks.

How effectively is the trust managing its corporate services, procurement, estates and facilities to maximise productivity to the benefit of patients?

- For 2017/18 the trust had an overall non-pay cost per WAU of £1,027, compared with a national median of £1,307, placing it in the lowest (best) nationally. The indicates the trust are spending less on other goods and services per unit of activity than most other trusts nationally. The trust attributed this in part to the Clinical Business Unit (CBU) structure which allows an integrated approach to planning and prioritisation of resources.
- The cost of running its Finance and Human Resources departments are higher than the national average. For 2017/18, the finance function cost per £100m turnover was £852,330 against a national median of £676,480, placing the trust in the highest (worst) quartile.
- The trust also benchmarks in the highest (worst) quartile for its HR function cost per £100m turnover, at £1.2m compared with a national median of £898,020. Within this function, the trust recognised it was an outlier for its medical staffing costs and was able to demonstrate a service review of this has commenced with the aim of reviewing service options and staffing models. In addition to the service review, the trust is working with local organisations to identify and implement opportunities for collaboration, including the appointment of shared HR and Organisation Development Director.
- The trust has an IM&T function cost per £100m turnover of £2.55m compared with a national median of £2.47m placing it in the highest (worst) quartile. The trust was able to evidence collaboration with local organisations through the appointment of shared Chief Information Officer.
- The trust is working with the Cheshire and Merseyside Health and Care Partnership through the Collaboration at Scale (CaS) Board and have agreed a corporate Collaboration at Scale MOU as a key enabler. Developments include ambition for a single payroll provider and common finance ledger, as well as developing a programme to be mobilised across corporate and clinical support services. The trust's procurement processes are relatively efficient and tend to successfully drive down costs on the products it buys. This is reflected in the trust's Procurement Process Efficiency and Price Performance Score of 81 (Q3 2018/19). The trusts supplies and services cost per WAU, at £316, is below the national median of £365.
- With regards to collaboration, the trust played a leading role in the Cheshire & Merseyside Collaborative procurement for a Direct Engagement model that resulted in savings estimated across the region of c£1.4m. Plans and service proposals are also in place for the trust to provide procurement services to 3 neighbouring trusts.
- The trust was able to demonstrate an embedded structure for procurement with senior procurement managers aligned to the Clinical Business Units and a clinical and innovation lead identified for each procurement project.
- At £239 per square metre for 2017/18, the trust's estates and facilities costs benchmark significantly below the national average of £342. The trust also benchmarks below the national median for Hard Facilities Management (FM) costs per metre squared (£54 compared to a national median of £80) and Soft FM costs per square metre (£104 compared to a national median of £127.)
- The trust has a total backlog maintenance figure of £182 per square metre (level with the national median) and a critical infrastructure risk of £101 per square metre compared to a national median of £81 per square metre. The trust demonstrated an understanding of the estates and maintenance costs and noted there was a focus on tackling these with available capital investment.

How effectively is the trust managing its financial resources to deliver high quality, sustainable services for patients?

- The trust is in deficit and has an inconsistent track record of managing spending within available resources and in line with plans.
- In 2017/18 the trust reported a deficit of £15.0m against a control total and plan of a £3.7m deficit (6.4% of its turnover). For 2018/19 the trust had a control total and plan of £16.9m deficit and delivered a deficit of £15.0m (6.19% of turnover), £1.9m better than plan.
- The trust had a cost improvement plan (CIP) of £7m (or 2.6% of its expenditure) in 2018/19 and delivered 80% of the plan at £5.6m, of which 70% was recurrent. In 2017/18 the trust delivered £5.1m, which was 49% of the planned £10.5m. Of this, 40% was recurrent.
- The trust has reduced its reliance on non recurrent CIP in 2018/19 to 30%. However, the trust did plan for 25% of their CIP to be delivered non recurrently in 2018/19, unlike the previous year where it all materialised in year.
- The trust has low cash reserves and is not able to consistently meet its financial obligations and pay its staff and suppliers in the immediate term, as reflected by its capital service and liquidity metrics. The trust is reliant on short-term loans to maintain positive cash balances.
- The trust used SLR to identify a loss making service which was under a local tariff and used their evidence to negotiate an uplift in the tariff over a number of years which results in an additional £4m for the trust.

Outstanding practice

- The trust was able to demonstrate it is using technology to improve operational productivity through a number of projects including:
    - A ‘tap on, tap off’ system in the Emergency Department whereby users use Smartcards to move from one device to another with a “tap” of the card reader. The user, in moving to another device picks up the “session” from where they previously left it. The trust demonstrated the system, as it is quicker and more productive, has resulted in releasing additional time for clinicians to spend patient facing.
    - Use of robotic process automation software in outpatients which replicates user inputting of appointments. The trust noted this has reduced the clinical risk of delays to and waiting times for testing and treatment and avoided an increase in DNA rates, together with releasing staff time for other tasks.

Areas for improvement

- At 5.03% in October 2018, sickness absence rates are above the national average. Although some initiatives are already in place, the trust should consider further analysis and develop further actions to address sickness rates.
- The trust benchmarks above the national average for the majority of corporate services, including HR, Finance and IM&T cost per £100m turnover.
- The trust did not meet its agency ceiling as set by NHS Improvement for 2018 and is forecasting to miss the ceiling in 2019. At £145, agency staff cost per WAU was above the national median of £107 for 2017/18.
- Despite improvements, the DNA rate for the trust is high at 7.47% for quarter 3 2018/19, and therefore the trust would benefit from further work in this area.
- The trust need to develop a plan to return to financial balance and remove the requirement for borrowing to meet its financial obligations.

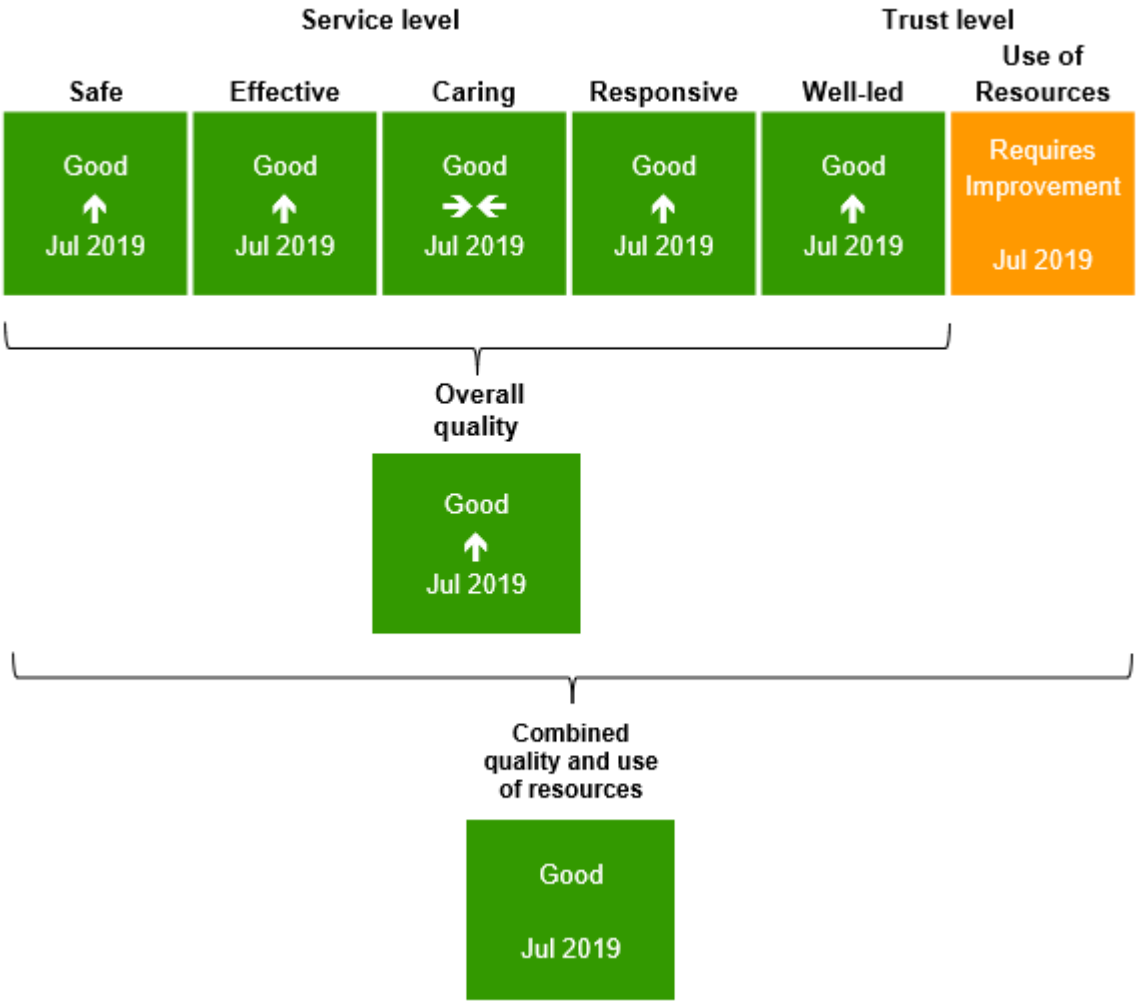
Ratings tables

Key to tables					
Ratings	**Inadequate**	**Requires improvement**	**Good**		**Outstanding**
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔➔	↑	↑↑	↓	↓↓
Month Year = date key question inspected					

***** Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust



Use of Resources report glossary

Term	Definition
18-week referral to treatment target	According to this national target, over 92% of patients should wait no longer than 18 weeks from GP referral to treatment.
4-hour A&E target	According to this national target, over 95% of patients should spend four hours or less in A&E from arrival to transfer, admission or discharge.
Agency spend	Over reliance on agency staff can significantly increase costs without increasing productivity. Organisations should aim to reduce the proportion of their pay bill spent on agency staff.
Allied health professional (AHP)	The term ‘allied health professional’ encompasses practitioners from 12 diverse groups, including podiatrists, dietitians, osteopaths, physiotherapists, diagnostic radiographers, and speech and language therapists.
AHP cost per WAU	This is an AHP specific version of the pay cost per WAU metric. This allows trusts to query why their AHP pay is higher or lower than national peers. Consideration should be given to clinical staff mix and clinical staff skill mix when using this metric.
Biosimilar medicine	A biosimilar medicine is a biological medicine which has been shown not to have any clinically meaningful differences from the originator medicine in terms of quality, safety and efficacy.
Cancer 62-day wait target	According to this national target, 85% of patients should begin their first definitive treatment for cancer within 62 days following an urgent GP referral for suspected cancer. The target is 90% for NHS cancer screening service referrals.
Capital service capacity	This metric assesses the degree to which the organisation’s generated income covers its financing obligations.
Care hours per patient day (CHPPD)	CHPPD measures the combined number of hours of care provided to a patient over a 24 hour period by both nurses and healthcare support workers. It can be used to identify unwarranted variation in productivity between wards that have similar speciality, length of stay, layout and patient acuity and dependency.
Cost improvement programme (CIP)	CIPs are identified schemes to increase efficiency or reduce expenditure. These can include recurrent (year on year) and non-recurrent (one-off) savings. CIPs are integral to all trusts’ financial planning and require good, sustained performance to be achieved.
Control total	Control totals represent the minimum level of financial performance required for the year, against which trust boards, governing bodies and chief executives of trusts are held accountable.
Diagnostic 6-week wait target	According to this national target, at least 99% of patients should wait no longer than 6 weeks for a diagnostic procedure.

Did not attend (DNA) rate	A high level of DNAs indicates a system that might be making unnecessary outpatient appointments or failing to communicate clearly with patients. It also might mean the hospital has made appointments at inappropriate times, eg school closing hour. Patients might not be clear how to rearrange an appointment. Lowering this rate would help the trust save costs on unconfirmed appointments and increase system efficiency.
Distance from financial plan	This metric measures the variance between the trust's annual financial plan and its actual performance. Trusts are expected to be on, or ahead, of financial plan, to ensure the sector achieves, or exceeds, its annual forecast. Being behind plan may be the result of poor financial management, poor financial planning or both.
Doctors cost per WAU	This is a doctor specific version of the pay cost per WAU metric. This allows trusts to query why their doctor pay is higher or lower than national peers. Consideration should be given to clinical staff mix and clinical staff skill mix when using this metric.
Delayed transfers of care (DTOC)	A DTOC from acute or non-acute care occurs when a patient is ready to depart from such care is still occupying a bed. This happens for a number of reasons, such as awaiting completion of assessment, public funding, further non-acute NHS care, residential home placement or availability, or care package in own home, or due to patient or family choice.
EBITDA	Earnings Before Interest, Tax, Depreciation and Amortisation divided by total revenue. This is a measurement of an organisation's operating profitability as a percentage of its total revenue.
Emergency readmissions	This metric looks at the number of emergency readmissions within 30 days of the original procedure/stay, and the associated financial opportunity of reducing this number. The percentage of patients readmitted to hospital within 30 days of discharge can be an indicator of the quality of care received during the first admission and how appropriate the original decision made to discharge was.
Electronic staff record (ESR)	ESR is an electronic human resources and payroll database system used by the NHS to manage its staff.
Estates cost per square metre	This metric examines the overall cost-effectiveness of the trust's estates, looking at the cost per square metre. The aim is to reduce property costs relative to those paid by peers over time.
Finance cost per £100 million turnover	This metric shows the annual cost of the finance department for each £100 million of trust turnover. A low value is preferable to a high value but the quality and efficiency of the department's services should also be considered.
Getting It Right First Time (GIRFT) programme	GIRFT is a national programme designed to improve medical care within the NHS by reducing unwarranted variations.
Human Resources (HR)	This metric shows the annual cost of the trust's HR department for each £100 million of trust turnover. A low value is preferable to a high value but the quality and efficiency of the department's services should also be considered.

cost per £100 million turnover	
Income and expenditure (I&E) margin	This metric measures the degree to which an organisation is operating at a surplus or deficit. Operating at a sustained deficit indicates that a provider may not be financially viable or sustainable.
Key line of enquiry (KLOE)	KLOEs are high-level questions around which the Use of Resources assessment framework is based and the lens through which trust performance on Use of Resources should be seen.
Liquidity (days)	This metric measures the days of operating costs held in cash or cash equivalent forms. This reflects the provider's ability to pay staff and suppliers in the immediate term. Providers should maintain a positive number of days of liquidity.
Model Hospital	The Model Hospital is a digital tool designed to help NHS providers improve their productivity and efficiency. It gives trusts information on key performance metrics, from board to ward, advises them on the most efficient allocation of resources and allows them to measure performance against one another using data, benchmarks and good practice to identify what good looks like.
Non-pay cost per WAU	This metric shows the non-staff element of trust cost to produce one WAU across all areas of clinical activity. A lower than average figure is preferable as it suggests the trust spends less per standardised unit of activity than other trusts. This allows trusts to investigate why their non-pay spend is higher or lower than national peers.
Nurses cost per WAU	This is a nurse specific version of the pay cost per WAU metric. This allows trusts to query why their nurse pay is higher or lower than national peers. Consideration should be given to clinical staff mix and clinical staff skill mix when using this metric.
Overall cost per test	The cost per test is the average cost of undertaking one pathology test across all disciplines, taking into account all pay and non-pay cost items. Low value is preferable to a high value but the mix of tests across disciplines and the specialist nature of work undertaken should be considered. This should be done by selecting the appropriate peer group ('Pathology') on the Model Hospital. Other metrics to consider are discipline level cost per test.
Pay cost per WAU	This metric shows the staff element of trust cost to produce one WAU across all areas of clinical activity. A lower than average figure is preferable as it suggests the trust spends less on staff per standardised unit of activity than other trusts. This allows trusts to investigate why their pay is higher or lower than national peers.
Peer group	Peer group is defined by the trust's size according to spend for benchmarking purposes.
Private Finance Initiative (PFI)	PFI is a procurement method which uses private sector investment in order to deliver infrastructure and/or services for the public sector.
Patient-level costs	Patient-level costs are calculated by tracing resources actually used by a patient and associated costs

Pre-procedure elective bed days	This metric looks at the length of stay between admission and an elective procedure being carried out – the aim being to minimise it – and the associated financial productivity opportunity of reducing this. Better performers will have a lower number of bed days.
Pre-procedure non-elective bed days	This metric looks at the length of stay between admission and an emergency procedure being carried out – the aim being to minimise it – and the associated financial productivity opportunity of reducing this. Better performers will have a lower number of bed days.
Procurement Process Efficiency and Price Performance Score	This metric provides an indication of the operational efficiency and price performance of the trust's procurement process. It provides a combined score of 5 individual metrics which assess both engagement with price benchmarking (the process element) and the prices secured for the goods purchased compared to other trusts (the performance element). A high score indicates that the procurement function of the trust is efficient and is performing well in securing the best prices.
Sickness absence	High levels of staff sickness absence can have a negative impact on organisational performance and productivity. Organisations should aim to reduce the number of days lost through sickness absence over time.
Service line reporting (SLR)	SLR brings together the income generated by services and the costs associated with providing that service to patients for each operational unit. Management of service lines enables trusts to better understand the combined view of resources, costs and income, and hence profit and loss, by service line or speciality rather than at trust or directorate level.
Supporting Professional Activities (SPA)	Activities that underpin direct clinical care, such as training, medical education, continuing professional development, formal teaching, audit, job planning, appraisal, research, clinical management and local clinical governance activities.
Staff retention rate	This metric considers the stability of the workforce. Some turnover in an organisation is acceptable and healthy, but a high level can have a negative impact on organisational performance (eg through loss of capacity, skills and knowledge). In most circumstances organisations should seek to reduce the percentage of leavers over time.
Top Ten Medicines	Top Ten Medicines, linked with the Medicines Value Programme, sets trusts specific monthly savings targets related to their choice of medicines. This includes the uptake of biosimilar medicines, the use of new generic medicines and choice of product for clinical reasons. These metrics report trusts' % achievement against these targets. Trusts can assess their success in pursuing these savings (relative to national peers).
Weighted activity unit (WAU)	The weighted activity unit is a measure of activity where one WAU is a unit of hospital activity equivalent to an average elective inpatient stay.

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Warrington and Halton Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/19/09/89**
SUBJECT:	**Electronic Prescribing & Medicines Administration (ePMA) Business Case Update**
DATE OF MEETING:	25th September 2019
AUTHOR(S):	Phillip James, Chief Information Officer
EXECUTIVE DIRECTOR SPONSOR:	Phillip James, Chief Information Officer
LINK TO STRATEGIC OBJECTIVES:	SO1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience
EXECUTIVE SUMMARY (KEY ISSUES):	An amendment to the ePMA business case (**Appendix A**) was presented to and supported by the Executive Team on 15th August 2019 and the Finance And Sustainability Committee on 21st August 2019 to continue the implementation of ePMA on the Warrington Hospital site. The business case outlines a proposal for a 2 week rapid deployment window in November 2019. The plan has since been amended to a 4 week window with no change to the documented resource and investment. The project team is working towards a target start date of 4th November 2019 with the 4 week deployment window fixed. As a result, additional Capital funding of £65k has been requested for 2019/20 and additional Capital funding of £20k is requested in 2021/22. Revenue funding requested relating to the capital charges has increased by £11k in 2019/20 and £14k in 2020/21. • The funding requested for 2019/20 is available from within the capital contingency. The funding requested for 2020/21 will be ring fenced within the capital programme for 2020/21.

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

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Warrington and Halton Hospitals NHS Foundation Trust

RECOMMENDATION:	The Board is recommended to approve the additional investment in the ePMA scheme.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Finance and Sustainability Committee
	Agenda Ref.	FSC/19/08/110
	Date of meeting	21st August 2019
	Summary of Outcome	Business Case Supported
FREEDOM OF INFORMATION STATUS (FOIA):	Whole FOIA Exemption	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Section 43 – prejudice to commercial interests	

Appendix A

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Warrington and Halton Hospitals NHS Foundation Trust

BUSINESS CASE

Area: IM&T	**Author: Phill James**
	Executive Lead: Phill James / Alex Crowe

Project: Electronic Prescribing Position – Executive Update	**Date: August 2019**

Quality & Safety	✓	**Business Development**	✕	**Capital**	✓

1.0 Purpose

This business case is to propose an updated plan for the electronic prescribing and medicines administration **(**ePMA) parts 1 & 2 roll out for the Warrington Hospital site and request associated capital funding.

2.0 Background

On the 6th June 2019 an ePMA position paper was presented to Executive Team (attached as appendix 1) to clarify the project background and status following lessons learnt from the Halton deployment of Parts 1 & 2 (of 4) to deliver enhanced prescribing and administration (see HPTP below).

The Executive Team approved delaying the planned June 2019 Warrington site deployment and requested the Head of EPR and Programmes to return and present a way forward.

The current ePMA activity aims to deploy parts 1 and 2 of the NHS Digital agreement. The Trust should also deploy part 3 (Dose Range Checking) and part 4 (Closed Loop Administration) prior to April 2020 to benefit from the investment made directly to the supplier by NHS Digital on behalf of the Trust. A delay to parts 1 & 2 will mean parts 3 & 4 will have to be delivered in 20/21 without NHS Digital funded support. Parts 3 and 4 remain to be proven by the supplier, accepted by the Trust, and irrespective of timing, subject to a further Trust business case to prove the costs versus benefits.

A safe deployment plan must incorporate lessons learned in respect of commissioning support and project management resource to deploy the solution at the proposed pace, acknowledge competition for finite Lorenzo resources and allocate the necessary time to resolve two key dependencies prior to deployment:

- Embedded Temporary Access Card (NHS Registration Authority cards referred to as TACs) process for Nurses and Doctors respectively, with the latter unable to prescribe
- Assured Pharmacy processes and support.

3.0 Proposed Service Development

ePMA remains a key enabler for safe patient care as recognised by the Lord Carter Hospital Pharmacy Transformation Programme (HPTP) in 2017 and NHS England Long Term Plan in 2019, the former requiring e-prescribing and administration functionality deployment by April 2020.To safely and effectively build upon the Halton ePMA Parts 1 & 2 pilot, an 8 week Warrington plan to deploy the solution in June 2019 was consulted upon.

3.1 Amended Deployment Plan

The original plan was an 8 week deployment making use of incumbent resources alone. Assurance has been sought by comparing to the plans of other Lorenzo ePMA Trusts. Whilst those Trusts took 10 weeks plus to deploy, none were operating at full escalation, all had more BAU resources available to provide support in hours and some reached a tipping point that led to acceleration of activities prior to the planned completion date.

Consultation with IM&T, clinical and management colleagues (Clinical Practitioners / Medical Cabinet / Medicines Governance) gleaned professional opinion regarding lack of resilience to lost capacity (i.e. staff numbers too finely tuned), unrealistic expectations of staff working a number of weekends without a break and the risks of operating parallel paper & electronic processes for long periods exacerbated by service pressures.

The formal outcome of the stakeholder consultation was a 2 week Warrington deployment plan justified by the following rationale:

- avoids staff fatigue of long shifts over a number of weeks
- limits the risk of medication errors as patients are moved between paper/electronic locations
- limits operational disruption whilst operating at full escalation
- greater likelihood to benefit from ad-hoc support of other Lorenzo NHS trusts (i.e. loaning of short term resource)
- Demonstrates the project is listening to key clinical decision makers (i.e. plan credibility) and engenders stakeholders ownership.

The project team also considered:

- lessons learnt from the recent Halton deployment including safe speed of change, typical staff queries, commissioning support measures and Pharmacy support measures
- lessons learnt from Morecambe Bay and Sheffield Lorenzo ePMA Trusts
- the opportunity the delay to ePMA presents to re-allocate the Trust's finite Lorenzo change management expertise to progress competing Lorenzo work (including the (high profile) Digital Exemplar Programme).

The project team subsequently re-assessed the time and effort required to resolve two key dependencies:

- embedded Temporary Access Card (NHS Registration Authority cards referred to as TACs) process for Nurses and Doctors respectively, with the latter unable to prescribe
- Assured Pharmacy processes and support.

And concluded a delay to November 2019 or March 2020 was necessary and after further discussion, November 2019 was the preferred date. This timing also realizes other benefits:

- more readily allows Lorenzo enhancements to compete within the non-negotiable NHS Digital funding window (i.e. known as the "innovation fund", inclusive of A&E medicines reconciliation and effective and accurate management of GP referrals)
- avoids a clash with the challenging doctors rotation period.

Note the A&E medicines reconciliation scheme mitigates some risk of the proposed ePMA delay.

The 2 week plan requires high numbers of short term resource. NHS resources "loaned" from other ePMA Trusts in the North West (i.e. Stockport, Morecambe Bay and Sheffield) have been requested however their availability is restricted to core working hours and a maximum of 3 days. The plans have therefore been costed on the assumption that no loaning is possible and only short term contractor resources will complement incumbent personnel to avoid operational difficulties.

Additional Considerations

- All personnel will be required to understand the risks of a mixed paper / electronic environment for the duration of the deployment period
- all personnel are required to understand the impact of the removal of prescribing rights from doctors TAC cards once ePMA is live
- all personnel will be required to understand the business continuity processes in their immediate work areas for instances when ePMA is not available, to assure safe continuity of care
- the Pharmacy Department will be required to resource the ongoing management of the ePMA configuration within Lorenzo to maintain safe prescribing methods (i.e. recruit the ePMA IT Pharmacy Manager)
- investment in part time Chief Pharmacist support, ring fenced from business as usual, has been delayed to 20/21 to provide expertise post deployment whilst also supporting consideration of parts 3 & 4
- Existing Lorenzo out of hours support will support ePMA functionality out of hours.

3.2 Detail Of Dependencies

Temporary Access Cards – Nurse Process and Dr Prescribing Rights
There has been a legacy issue with use of Temporary Access Cards (TACs) by staff/agency where personal issue SMART cards have not been available. A pilot to improve TAC card behaviours, practice and resilience is underway on several Warrington wards. Successful embedding of these new practices prior to the ePMA deployment is necessary due to the use of SMART Cards for ePMA prescribing in and out of hours.

Nurse TAC Process:
Since 13th May, 2019, the Trust Clinical and Registration Authority staff have been piloting a different approach to issuing TACs. This involves giving the Ward Manager responsibility for managing the TACs for their small number of Wards.

The Standard Operating Process (SOP) has been signed off by the pilot wards A1/A9 and is ready for implementation across the Trust. Meetings to endorse the SOP have been held with Chief Nurse/Deputy Chief Nurse, Ward Managers meeting 11th July and CBU meeting 12th July.

The status of the nursing SOP was discussed at TOB on 29th July 2019 with no issues raised.

Doctor TAC Process:
On 16th May 2019 the Trust received confirmation of the legal position on inpatient prescribing using a Temporary Access Card (TACs), with the Trust's legal advisors directing that this should be prohibited. This is due to the inability to readily identify the prescriber using the TAC and the lack of an advanced electronic signature for each prescription. As a result of this advice, prescribing rights will be removed from TACs.

The SOP has been discussed at the weekly CBU management meetings in July and a CBU manager is currently exploring the process requirements following difficulties experienced on a recent weekend shift.

Options to resolve this SOP remain in development.

Pharmacy Processes

The configuration of medications within the ePMA deployment unit to deliver safe, effective prescribing is an ongoing organic interactive process for the lifetime of the system but prescribing efficiency relies upon a robust starting position, i.e. fit for purpose formulary to make for safe inpatient prescribing.

Resources available to focus on the formulary and system configuration have been limited and unsustainable to this point.

A number of Pharmacy staffing agreements are now in place to support ePMA deployment and BAU:

- Back fill and release of Chief Pharmacy for full time project support
- Recruitment of an incumbent Pharmacy IT Manager to fulfil ePMA administration responsibilities and complement incumbent ePMA Pharmacy resource

A successful deployment relies upon timely access to these resources. Current time estimate for recruitment of resources is autumn 2019.

4.0 Financial Appraisal
Capital funding of £65k is requested in 2019/20 to manage changes from planned expenditure including commissioning support, ePMA project manager, consultant PA's, Consultancy costs and floor walkers (further detail in Appendix 4). Capital funding of £20k is requested in 2020/21 for ePMA project manager pay costs. The ePMA IT Pharmacy Manager role is to be funded as a substantive position within existing Pharmacy department budgets.

The revenue funding requested relating to capital charges has increased by £11k in 2019/20 and £14k in 2020/21.

Table 1 provides a summary of the capital and revenue additional requirements

Table 1 Additional capital and revenue required

Capital	2019/20 £000	2020/21 £000
Original Budget	479	0
Slippage 2018/19	69	0
Revised Budget	548	0
Expenses/Costs	(613)	(20)
Additional Capital Budget	65	20
Additional Revenue	**2019/20 £000**	**2020/21 £000**
Depreciation	9	11
PDC dividends	2	3
Total additional revenue for capital charges	11	14

EPMA CAPITAL INVESTMENT

Table 2 outlines the proposed 2 week deployment plan to deploy parts 1 and 2 across all Surgical, Specialist Medicine and Acute Medicine departments on the Warrington site in November 2019, to be completed by 31st December 2019.

Table 2 Deployment Plan

Support Criteria	Description	Capital Cost
Short Term Commissioning Support	**Short Term Commissioning Support to allocated Wards.** 76 different supporters need to cover gaps in shifts. Incumbent IMT staff are additional to this and have been included in the rota. At its peak 84 Go Live support workers are required to cover day shifts on any one day, with 3 out of hours in addition to this (referred to below). This is based on a Project Teams table top exercise, covering the 22 areas in scope, and allocated resources in order to manage risk at go live. As a result the total number of shifts was identified, and known incumbent IMT resources used to populate the shifts. Based on this, gaps were identified and outstanding resources calculated: For example, on day 1 there are 84 day shifts in total and 3 shifts to be covered out of hours to manage risk. By allocating available IMT resources, this would leave a gap of 73 shifts. Over the course of the 2 week roll out plan (ensuring all individuals work 5 days out of 7 and have the necessary breaks) there is the potential need for 76 different individuals. This is based on a best estimate and on the assumption that all would only work 5 days out of the 7. Across the 2 Weeks: • a total of 754 day shifts • 42 out of hours • Overall total of 796.	£166,250

	Based on the attempt at populating this rota, there is a gap of 665 shifts to resource. Please refer to Appendix 3 for the worked example of the roll out structure for the 2 week plan. (Resources are phased in and out to mitigate risk). *Calculation is based on:* • *665 shifts* • *a day rate of £250 per person (agency comparable to AfC band 4)* • *inclusive of VAT* • *Inclusive of agency commission.* *Work will be conducted to attempt to reduce this rate at the time of final planning.*	
Short Term Commissioning Support and Out of Hours Support	**Familiarisation provided to external supporters and Out of Hours supporters (approximately 79 floor walkers / go live support people)** *This is based on each individual having:* • *1 day familiarisation opportunity (76 Floor Walkers and 3 Out of Hours).* • *ePrescribing training provided face to face by the ePR Training Team and Product Specialists already familiar with the system and methodology.* • *Pharmacy input will also be included.* *Calculation is based on:* • *79 shifts* • *a day rate of £250 per person (not comparable to AfC bands for this purpose)* • *inclusive of VAT* • *inclusive of agency commission.* *Work will be conducted to attempt to reduce this rate at the time of final planning.*	£19,750
Pharmacy	**Pharmacy Support allocated throughout the Trust** *Based upon the use of incumbent resource of 1 Pharmacist per area, hence no additional investment required*	NIL
Cut Over	**5 Prescribers and 5 Checkers of Prescriptions prior to Go Live for 3 days across 15 Wards** *This is to ensure paper prescription charts are transferred over to Lorenzo in time for Go Live and require medical expertise to do so.* • Day 1 = 5 Prescribers and 5 Checkers of Prescriptions • Day 2 = 5 Prescribers and 5 Checkers of Prescriptions • Day 3 = 5 Prescribers and 5 Checkers of Prescriptions *Calculation is based on:* • *30 shifts*	£7,500

	• *a day rate of £250 per person (not comparable to AfC bands for this purpose)* • *inclusive of VAT* • *inclusive of agency commission.* *Work will be conducted to attempt to reduce this rate at the time of final planning.*	
Out of Hours	**3 Commissioning Supporters per night (14 of) to provide support when required** *Calculation is based on:* • *42 shifts* • *a day rate of £250 per person (not comparable to AfC bands for this purpose)* • *inclusive of VAT* • *inclusive of agency commission.* *Work will be conducted to attempt to reduce this rate at the time of final planning.*	£10,500
Grand Total		**£204,000**

The detailed ePMA financial profile can be found in Appendix 4.

5.0 Risks

Two related Datix risks are currently registered and will benefit from the resolution of the TAC card dependency:

- 202 – Failure to prevent unauthorised access to electronic person identifiable data caused by smartcard and password sharing resulting in invalidation of electronic clinical systems audit trail data – Rating of 12
- 834 - Failure to add prescribing rights to (TAC) smartcards resulting in doctors inability to prescribe drugs and perform discharge medication TTOs – **Rating of 9**

The following Datix risk has been recorded to capture the impact and mitigation of the proposed March 2020 timing of the deployment:

- 980 - Failure to comply with regulatory requirements caused by not implementing electronic prescribing and medicines administration (ePMA Parts 1-4) as a quality and safety medication prescribing and administration improvement and resulting in a failure to reduce EPMA preventable medication incidents – **Initial rating of 16.**

  The following Quality & Safety mitigations have been actioned by the Pharmacy Department:

  - staff training
  - incident reporting
  - Policy and Standard Operating Procedures

The risks associated with delaying the deployment to March 2020 are:

- staff perceptions of the ability of Digital to deliver
- extension of the existing medication risk scenarios
- parts 3 & 4 remain subject to a further business case, non-deployment in 2019/20 may result in additional costs to offset lost NHS Digital funded support

As a result of these risks the implementation date has been recommended as November 2019. Note the deployment of GP Connect to deliver Lorenzo medicines reconciliation within the current calendar year provides some clinical mitigation to the risks of an ePMA delay.

6.0 Recommendations

The Executive Team is recommended to support:

- the proposed 2 week deployment plan for Warrington parts 1 & 2 in November 2019, to complete by 31st December 2019
- the request for additional capital funding of £65k in 2019/20 and £20k in 2020/21 to the Capital Planning Group
- provision of a fixed term ePMA Project Manager for 12 month period to initially deploy current ePMA parts 1 & 2 and subsequent develop the ePMA parts 3 & 4 business case

The Executive Team is recommended to note:

- the review and consultation that has informed the 2 week plan
- the requirement to successful embed nurse and doctor TAC card processes in advance of the target deployment timescales
- the time required to recruit project management and pharmacy resources for a safe deployment

Amendment History

Issue	Date	Author	Reason
Version1	16.07.19	Sue Caisley	Initial Business Case
Version2	22.07.19	Phill James	Inclusion of comments and advice
Version 3	25.07.19	Denise Corcoran	Review of costs and income.

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Appendix 1 - Executive Team Update Position Paper – June 2019

1.0 BACKGROUND

WHH's current system for prescribing and administration of inpatient medicines is predominantly paper based. Problems associated with the current system include the potential to cause harm due to:

1. Transcription, dose calculation or recording errors
2. Incomplete or inappropriate prescribed medication
3. Prescription or administration of the wrong drug, strength, dose or frequency of medication
4. Omitted or delayed medication doses
5. Illegible hand writing
6. Lost, misplaced or inaccessible prescription charts
7. Time wasted in transferring prescription charts between wards and the dispensary

Following the deployment of the Lorenzo Electronic Patient Record (EPR) System across Warrington and Halton Hospitals NHS Foundation Trust in 2015, the Trust approved the implementation of Electronic Prescribing Part 1 (of 4) across all departments to deliver the benefits detailed in the business case and reduce the risks highlighted above.

Following delivery of first go live prototype, a delay of 18/19 plans to deploy ePMA into Warrington is proposed based upon recent lessons learned. The value of this investment and risks associated with non-delivery require Executive Management Team approval.

1.1 Timeline of Events

NHS Digital (NHS X) require all Trusts to implement ePMA fully by 2020, an expectation shared by the Care Quality Commission and NHS Improvement. In October 2017 the Trust was presented with the opportunity to begin implementing e-Prescribing through the funded Lorenzo programme by March 2018. The Trust Executive subsequently approved the business case for full deployment.

The business case set out the resources required for the first go live prototype in 17/18 and agreed £250k capital resource to increase staffing in 18/19 and 19/20 for subsequent full deployment, namely one Programme Manager, one Product Specialist and a part-time Pharmacist. A number of staffing assumptions were stated for 18/19 and 19/20:

- Additional training support will be provided if required from Trust BAU resources
- No provision for clinical backfill for training as the classroom training will be no more than 2 hours
- 24*7 support will be provided as is; wards will be expected to be self-sufficient. This will be reviewed after the first go-live of the prototype.

2.0 CURRENT POSITION

To date the ePMA Project Team has deployed electronic prescribing in the following first go-live areas:

Area	Implementation Date
Runcorn Urgent Care Centre (ED functionality)	March 2018
Halton Ward B1 (medical functionality)	July 2018
Halton Ward B4 & Theatres (surgical & theatre functionality)	December 2019
CMTC Ward & Theatres (orthopaedics & theatre functionality)	April 2019

Having utilised a 2 week support plan, the Project Team has focussed on the planning required to deploy into the Warrington site including:

- reviewing first go live lessons learned
- consulting with staff
- consulting with Pharmacy.

E.g. A blend of e-learning and one to one and group training was successful during the surgical ward deployments and deemed suitable for the Warrington site with training material (quick reference guides, videos) enhancements.

Full Warrington deployment was planned for June/July 2019 to benefit from doctors with the greatest familiarity with Lorenzo (in advance of the changeover of junior doctors at the beginning of August) and an operationally quieter time of year but three issues now lead to a proposed delay:

Support Plan Resources

Table top exercises have assessed Support Plan requirements from a clinical, patient safety and resource perspective depending for several speeds of implementation (8, 4 and 2 week periods).

It is now understood that the combination of assumed ward staffing and planned IM&T staffing is insufficient to safely deploy and stabilise ePMA to minimise operational disruption and maintain patient safety.

Temporary Access Cards – TAC Management And Prescribing Rights

On 16th May 2019 the Trust received legal advice regarding inpatient prescribing using a Temporary Access Card (TAC). The Trust's legal advisors directed that this should be prohibited due to the inability to readily identify the prescriber plus the lack of an advanced electronic signature for each prescription. The operational impact of removing doctors prescribing rights requires time to support and manage prior to ePMA deployment.

The Ward Managers Forum has also raised the issue of Temporary Access Cards (TACs) management during recent planning consultation. The on-going TAC pilot (since 13th May) requires time to complete and review with Ward Managers prior to deploying ePMA.

Pharmacy Processes

The configuration of medication within the ePMA deployment unit to deliver safe, effective prescribing is an ongoing organic interactive process for the lifetime of the system. Resources available to focus on the Formulary and system configuration are limited. A delay in the deployment of electronic prescribing provides an opportunity to now focus on updating the Formulary to make it fit for inpatient prescribing and enhancing the safety of the system by extending the medication content, adding prescribing support information, building additional order sets and extending the range of medicines available as Patient Group Directions - electronically.

3.0 RISK

No risk to reflect the failure to deploy ePMA in a timely manner currently exists. In response to approval of the proposed delay a risk will be immediately developed and recorded on Datix.

4.0 RECOMMENDATION

The Executive Management Team is recommended to approve the:

- proposed delay of the Warrington ePMA deployment to the new target date of 16th September 2019, for subsequent noting by the Trust Digital Board on 10th June 2019
- development of costed deployment options for robustly deploying ePMA into the Warrington site with independent review by the NHS Digital (NHS X) ePMA national lead
- submission of an Executive Management Team paper to request funding and provide associated assurance.

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Appendix 2 – Detailed Support Plans

SUMMARY - Gold Standard

76 different resources needed to cover the Floor Walking shifts. This is based on IMT staff only working Monday to Friday (for part time staff, their working days only) during the day. No evenings or weekends.
The 76 resources covers any gaps in the day shifts, weekends and evening shifts. Remote Support is also covered in the numbers required.

Week 1

Days 1 and 2 will require 70 extra resources plus 3 for out of h	140	6
Days 3 and 4 require 45 plus 3 for out of hours	90	6
Day 5 requires 46 plus 3 for out of hours	46	3
Days 6 and 7 require 48 plus 3 for out of hours	96	6
Week 2		
Day 1 will require 32 extra resources plus 3 for out of hours	32	3
Day 2 will require 31 plus 3 for out of hours	31	3
Days 3 will require 32 plus 3 for out of hours	32	3
Days 4 and 5 will require 33 plus 3 for out of hours	66	6
Days 6 and 7 require 45 plus 3 for out of hours	90	6
	623	42

Based on a **£250 day rate** and the extra resources needed each day, the approximate cost is **£155,750 for floor walking supp** 186900

Out of Hours will also need to be accounted for. It is estimated 3 people will be needed per day to cover this. This equates to an additiona 12600

An extra days attendance per person will be required for Training using the £250 day rate and an approximate resource figure of 79 (Floor Walking ar 23700

Cut Over support will be required for 3 days prior to Go Live. Based on 15 Wards and 5 Prescribers and 5 Checkers at an hourly rate of £35 and assuming a working day of 8hrs, the total cost for the 3 d 9450

The Command Centres would follow one of three options : Bronze - IMT staff based in IMT. This will cover 2 shifts, 8am to 16.00pm and 16.00pm to 23.00pm, The Team will consist of IT Technical Support, a Product Specialist,
Overall the Total Cost would equate to: **£196,000** 232650 196000

SUMMARY - Silver Standard

43 different resources needed to cover the Floor Walking shifts. This is based on IMT staff only working Monday to Friday (for part time staff, their working days only) during the day. No evenings or weekends. The 43 resources covers any gaps in the day shifts, weekends and evening shifts. Remote Support is also covered in the numbers required.

Week 1
Days 1 and 2 will require 14 extra resources plus 3 for out of hours
Days 3 and 5 require 10 extra resources plus 3 for out of hours
Days 6 and 7 require 17 extra resources plus 3 for out of hours

Week 2
Days 1 and 2 will require 24 extra resources plus 3 for out of hours
Days 3 and 4 will require 15 plus 3 for out of hours
Days 5 will require 16 plus 3 for out of hours
Days 6 and 7 require 27 plus 3 for out of hours

Week 3
Day 1 require 32 extra resources plus 3 for out of hours
Day 2 requires 31 extra resources plus 3 for out of hours
Days 3 and 5 will require 24 plus 3 for out of hours
Days 5 will require 15 plus 3 for out of hours
Days 6 and 7 require 28 plus 3 for out of hours

Week 4
Days 1 to 5 require 10 extra resources plus 3 for out of hours
Days 6 and 7 require 19 plus 3 for out of hours

Based on a **£250 (inclusive of VAT) day rate** and the extra resources needed each day, the approximate cost is **£129,750 for floor walking support**.

Out of Hours will also need to be accounted for. It is estimated 3 people will be needed per day to cover this. This equates to an additional cost of **£21,000**.

An extra days attendance per person will be required for Training using the £250 day rate and an approximate resource figure of 79 (Floor Walking and Out of Hours) = **£11,500**.

Cut Over support will be required for 3 days prior to Go Live. Based on 15 Wards and 5 Prescribers and 5 Checkers at an hourly rate of £35 and assuming a working day of 8hrs, the total cost for the 3 days would equate to **£10,000**.

The Command Centres would follow one of three options : Bronze - IMT staff based in IMT. This will cover 2 shifts, 8am to 16.00pm and 16.00pm to 23.00pm, The Team will consist of IT Technical Support, a Product Specialist,

Overall the Total Cost would equate to: **£172,250**

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Appendix 3 – Outline Structure of 2 Week Roll out

Surgical Pathway	Theatres	SAU	A6	A5	A4	A9	C20/GAU
Week 1 - Monday	4+4	LD	2+2	2+2	2+2	2+2	1+1
Week 1 - Tuesday	4+4	LD	2+2	2+2	2+2	2+2	1+1
Week 1 - Wednesday	4+4	LD	1+1	1+1	1+1	1+1	1+1
Week 1 - Thursday	4+4	LD	1+1	1+1	1+1	1+1	1+1
Week 1 - Friday	4+4	LD	1+1	1+1	1+1	1+1	1+1
Week 1 - Saturday	3+3	LD	1+1	1+1	1+1	1+1	1+1
Week 1 - Sunday	3+3	LD	1+1	1+1	1+1	1+1	1+1
Week 2 - Monday	2+2	LD	1+1	1+1	1+1	1+1	1+1 [C20/GAU / C22]
Week 2 -Tuesday	2+2	LD	1+1	1+1	1+1	1+1	1+1 [C20/GAU / C22]
Week 2 -Wednesday	2+2	LD	1+1	1+1	1+1	1+1	1+1 [C20/GAU / C22]
Week 2 -Thursday	2+2	LD	1+1	1+1	1+1	1+1	1+1 [C20/GAU / C22]
Week 2 -Friday	2+2	LD	1+1	1+1	1+1	1+1	1+1 [C20/GAU / C22]
Week 2 -Saturday	2+2	LD	1+1	1+1	1+1	1+1	1+1 [C20/GAU / C22]
Week 2 -Sunday	2+2	LD	1+1	1+1	1+1	1+1	1+1 [C20/GAU / C22]

Specialist Medicine	C22	B19	B18	B12	B14	MOD
Week 1 - Monday	2+2	2+2	2+2	2+2	2+2	1+1
Week 1 - Tuesday	2+2	2+2	2+2	2+2	2+2	1+1
Week 1 - Wednesday	1+1	1+1	1+1	1+1	1+1	1+1
Week 1 - Thursday	1+1	1+1	1+1	1+1	1+1	1+1
Week 1 - Friday	1+1	1+1	1+1	1+1	1+1	1+1
Week 1 - Saturday	1+1	1+1	1+1	1+1	1+1	1+1
Week 1 - Sunday	1+1	1+1	1+1	1+1	1+1	1+1
Week 2 - Monday	1+1 [C20/GAU / C22]	1+1 [B18 / B19]	1+1 [B18 / B19]	1+1 [B12 / B14]	1+1 [B12 / B14]	REM
Week 2 -Tuesday	1+1 [C20/GAU / C22]	1+1 [B18 / B19]	1+1 [B18 / B19]	1+1 [B12 / B14]	1+1 [B12 / B14]	REM
Week 2 -Wednesday	1+1 [C20/GAU / C22]	1+1 [B18 / B19]	1+1 [B18 / B19]	1+1 [B12 / B14]	1+1 [B12 / B14]	REM
Week 2 -Thursday	1+1 [C20/GAU / C22]	1+1 [B18 / B19]	1+1 [B18 / B19]	1+1 [B12 / B14]	1+1 [B12 / B14]	REM
Week 2 -Friday	1+1 [C20/GAU / C22]	1+1 [B18 / B19]	1+1 [B18 / B19]	1+1 [B12 / B14]	1+1 [B12 / B14]	REM
Week 2 -Saturday	1+1 [C20/GAU / C22]	1+1 [B18 / B19]	1+1 [B18 / B19]	1+1 [B12 / B14]	1+1 [B12 / B14]	REM
Week 2 -Sunday	1+1 [C20/GAU / C22]	1+1 [B18 / B19]	1+1 [B18 / B19]	1+1 [B12 / B14]	1+1 [B12 / B14]	REM

Acute and Emergency Medicine	GPAU	A7	A8	ACCU	A2	AMU / A1	ED	FAU	DIS LOUNGE
Week 1 - Monday	LD	2+2	2+2	2+2	2+2	4+4	4+4	REM	REM
Week 1 - Tuesday	LD	2+2	2+2	2+2	2+2	4+4	4+4	REM	REM
Week 1 - Wednesday	LD	1+1	1+1	1+1	1+1	4+4	4+4	REM	REM
Week 1 - Thursday	LD	1+1	1+1	1+1	1+1	4+4	4+4	REM	REM
Week 1 - Friday	LD	1+1	1+1	1+1	1+1	4+4	4+4	REM	REM
Week 1 - Saturday	LD	1+1	1+1	1+1	1+1	2+2	2+2	REM	REM
Week 1 - Sunday	LD	1+1	1+1	1+1	1+1	2+2	2+2	REM	REM
Week 2 - Monday	LD	1+1	1+1	1+1	1+1	2+2	2+2	REM	REM
Week 2 -Tuesday	LD	1+1	1+1	1+1	1+1	2+2	2+2	REM	REM
Week 2 -Wednesday	LD	1+1	1+1	1+1	1+1	2+2	2+2	REM	REM
Week 2 -Thursday	LD	1+1	1+1	1+1	1+1	2+2	2+2	REM	REM
Week 2 -Friday	LD	1+1	1+1	1+1	1+1	2+2	2+2	REM	REM
Week 2 -Saturday	LD	1+1	1+1	1+1	1+1	2+2	2+2	REM	REM
Week 2 -Sunday	LD	1+1	1+1	1+1	1+1	2+2	2+2	REM	REM

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Appendix 4 –ePMA Financial Profile

Table 2: 2 Week Deployment Plan Resources

EPMA Capital Investment								
Capital								
Narrative	Period Covered	18/19	19/20	19/20	19/20	20/21	Total	
		Actuals	M1 - M4	M5 - M12	Forecast	Forecast		
		£000's	£000's	£000's	£000's	£000's	£000's	
Budget								
EPMA		250		250	250	0	500	
EPMA Devices		0		229	229	0	229	
Budget Total		**250**		**479**	**479**	**0**	**729**	
Expenditure								
EPMA Project Manager	Sept 19 to Aug 20	0	0	-28	-28	-20	-48	
Commissioning Support	Jul 19 to Mar 20	-12	-17	-26	-43	0	-55	
Consultant PA	Aug 19 to Mar 20	0	0	-8	-8	0	-8	
Consultancy costs	up to sept 2019	-13	-52	-25	-77	0	-90	
Consultancy costs			-24	0	-24		-24	
Short term commissioning support (floor walkers)		0	0	-204	-204	0	-204	**as per table 2**
Chief Pharmacist		0	0	0	0	0	0	
EPMA Devices / Equipment		-156	-192	-37	-229	0	-385	
Total		**-181**	**-285**	**-328**	**-613**	**-20**	**-814**	
					0		0	
Underspend/(Overspend) - annual		69			-134	-20	-85	
Underspend/(Overspend) - cumulative		**69**			**-65**	**-85**		
Narrative		18/19		19/20		20/21		
		£000's		£000's		£000's		
Budget brought forward		0		69		-65		
Budget in year		250		479		0		
Expenditure		-181		-613		-20		
Underspend/(Overspend)		69		-65		-85		
Revenue		18/19		19/20		20/21	21/22 to 24/25	Total
		£000's		£000's		£000's	£000's	£000's
Depreciation		36		159		163	456	814
PDC dividends		6		24		19	22	71
Total		42		183		182	478	885

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/19/09/90**
SUBJECT:	Safe Staffing Report – 6 monthly review (Nov 2018 – May 2019)
DATE OF MEETING:	25 September 2019
ACTION REQUIRED	To discuss, note the contents and actions outlined within the report.
AUTHOR(S):	Rachael Browning – Associate Chief, Nurse Clinical Effectiveness
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse Choose an item.
LINK TO STRATEGIC OBJECTIVES:	SO2: To have a committed, skilled and highly engaged workforce who feel valued, supported and developed and who work togther to care for our patients
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	BAF2.2: Nurse Staffing BAF2.5: Right People, Right Skills in Workforce BAF2.1: Engage Staff, Adopt New Working, New Systems
STRATEGIC CONTEXT	
EXECUTIVE SUMMARY (KEY ISSUES):	This paper details the six monthly review of nurse staffing in line with the commitment requested by the National Quality Board in 2016 and more recently in the Improvement Resource for Adult Inpatient Wards in Acute Hospitals January 2018. • The report provides an overview of the current nurse staffing workforce data, including numbers of staff in post, turnover of staff, and the introduction of the nurse associate role in January 2019. • The report represents the review of a 4 week sample of census data recorded within the SafeCare acuity and dependency system between 22nd April and 19th May 2019. • The data demonstrates that our budgeted nurse staffing WTE (whole time equivalent) is comparable to the safe care data requirements. • Significant improvements have been made in the overall nurse staffing establishments enabling the Trust to meet the SafeCare acuity establishments of 688.37 WTE. The actual number of staff in post is currently 576.74 leaving the number of nurse vacancies across the Trust at 111.63 which is an improvement of 22 WTE from the previous 6 month review. • The ongoing Trust Nursing Recruitment and Retention Plan continues to be delivered at pace. A number of new and innovative approaches have been adopted to support the recruitment campaign, which has resulted in a further 83.4 WTE RNs recruited in the last 12 months. A targeted approach for Health Care Assistant (HCA) recruitment has had a significant

<table>
<tr><td></td><td>impact reducing vacancies from 90 WTE to 25wte in the last 6 months.
• Since the development of The Trust retention plan as part of the NHS Improvement collaborative programme we have seen an improvement in turnover from 14.99% in November 2018 to 12.81% in May 2019
• Care Hours Per Patient Day (CHPPD) is the national reporting metric for safe staffing levels. NHS Choices has recently replaced planned versus actual staffing levels. WHH ended 2018 / 19 with a CHPPD rate of 7.0. Since April 2019 we have consistently maintained a rate of 7.6. CHPPD continues to increase bringing us in line with the national median rate of 8.1 and peer organisations of 7.8.
The report demonstrates the progress that continues to be made across the organisation in Nursing and Midwifery staffing. There are still a number of challenges faced including recruitment to vacant posts and acknowledging the age profile of our current workforce which is a work stream initiative in the NHSI retention plan.</td></tr>
<tr><td>RECOMMENDATION:</td><td>It is recommended that the Trust Board review the progress to date and note the contents of the report.</td></tr>
<tr><td>PREVIOUSLY CONSIDERED BY:</td><td><table>
<tr><td></td><td></td></tr>
<tr><td>Committee</td><td>Quality Assurance Committee</td></tr>
<tr><td>Agenda Ref.</td><td>QAC/19/09/146</td></tr>
<tr><td>Date of meeting</td><td>3 September 2019</td></tr>
<tr><td>Summary of Outcome</td><td>Reviewed and noted</td></tr>
</table></td></tr>
<tr><td>FREEDOM OF INFORMATION STATUS (FOIA):</td><td>Release Document in Full</td></tr>
<tr><td>FOIA EXEMPTIONS APPLIED: (if relevant)</td><td>None</td></tr>
</table>

Contents

1. Introduction

This paper details the six monthly review of nurse and midwifery staffing in line with the commitment requested by the National Quality Board (NQB) document, 'Supporting NHS Providers to deliver the right staff, with the right skills, in the right place at the right time – safe and sustainable staffing ' (2016) in response to the Francis Enquiry (2013). More information on this can be found in Appendix 1. The NQB guidance has been further refreshed, broadened and re issued in January 2018 with the provision of 'An Improvement Resource for Adult In-patient Wards in Acute Hospitals' which recommends that Boards should carry out a strategic staffing review at least annually. At this Trust, the staffing review is carried out twice per year, review meetings are held with the ward managers and Chief Nurse to discuss and sign off all establishments in addition to the bi –annual staffing reviews.

The following report is presented as an expectation of the NQB guidance and represents the outcome of reviewing the acuity and dependency data recorded in the Safe Care system over a four week period from 22nd April 2019 to 19th May 2019 at WHH.

All ward sisters/charge nurses, matrons, lead nurses and the associate chief nurse, clinical effectiveness participate in the acuity and dependency review process.

2. Workforce Information - Warrington and Halton Hospitals (WHH)

There is a growing body of evidence which shows that nurse staffing levels makes a difference to patient outcomes (mortality and adverse events) patient experience, quality of care and the efficiency of care delivery. Short staffing compromises care and recurrent short staffing results in increased stress and reduced staff wellbeing, leading to higher sickness and a higher turnover rate as more staff leave.

2.1. Staff in post

The chart below shows the total number of budgeted registered nursing and midwifery staff in post by month from June 2018 to May 2019. Nurse recruitment remains a priority with targeted recruitment events in place locally and regionally, bespoke recruitment for areas with high number of vacancies supported by enhanced social media campaign. A focused approach for retaining staff includes options available such as ward moves, flexible contracts and continued professional development in order to retain staff.

Chart 1

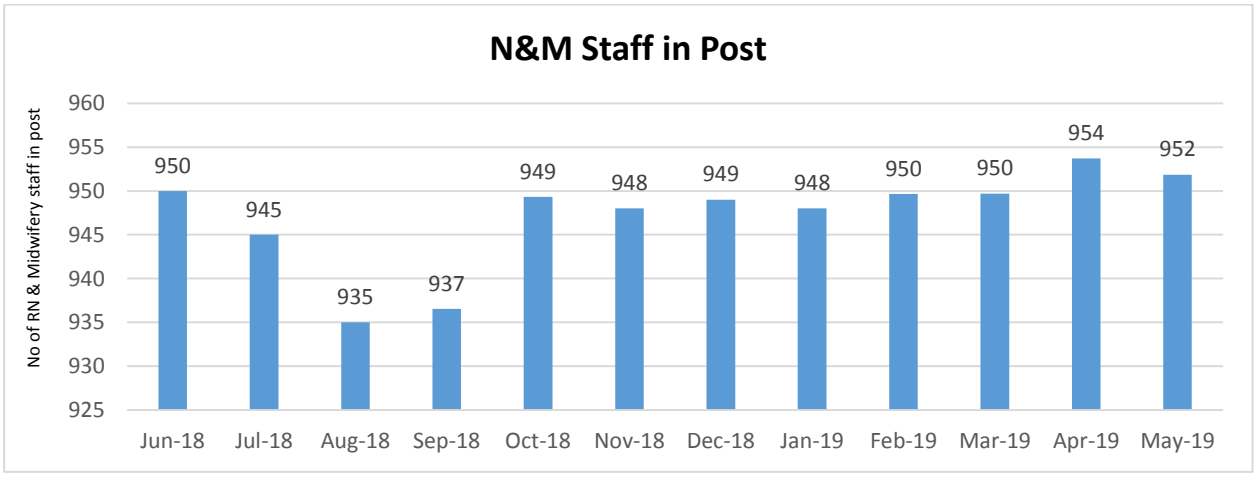
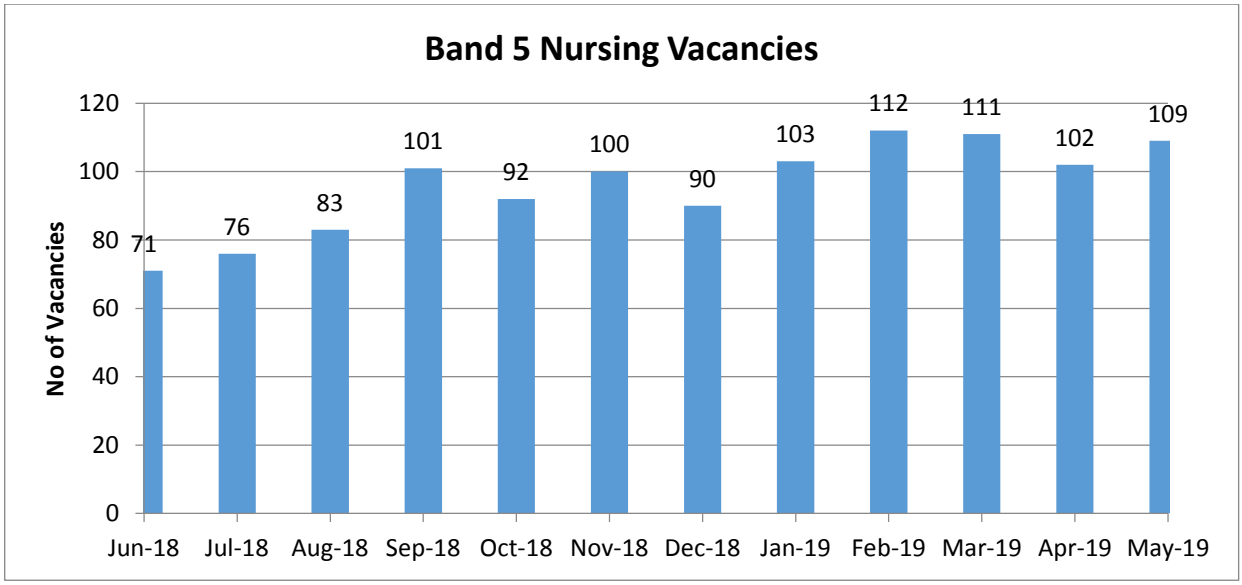


Chart 2 identifies the number of band 5 vacancies based on the funded establishments against the number of staff in post (excluding operating department practitioners in Theatres). We have seen a gradual increase in the number of RN vacancies in the Trust. This increase is associated with the investment in nurse staffing, an increase of 20 WTE RN's and with the Trust opening a number of new facilities to ensure that our patients receive high quality care in the appropriate setting e.g. The Frailty Assessment Unit and Discharge Suite. In May 2019 the number of RN vacancies stands at 109 WTE's however 72 candidates have accepted a position at WHH and are due to commence post in September 2019 as a result of continued recruitment campaigns.

Chart 2



In this report we have included further detailed analysis on band 5 nursing vacancies. In the context of new starters in the last 12 months the Trust has welcomed 83.4 WTE new starters into the Band 5 Nursing roles (41.3 in the last 6 months). However the Trust has an additional 38 WTE vacancies, 20 WTE from the staffing business case and a further 18 to support the opening of our new facilities. The chart below highlights the reasoning behind this.

Chart 1 indicates the number of staff in post remains the same however chart 2 shows an increase in the number of WTE vacancies. In the last 6 months the turnover rate has reduced therefore whilst we are not losing staff, as demonstrated in chart 3 we have seen an increased number of internal promotions and staff reducing their contracted hours

Chart 3

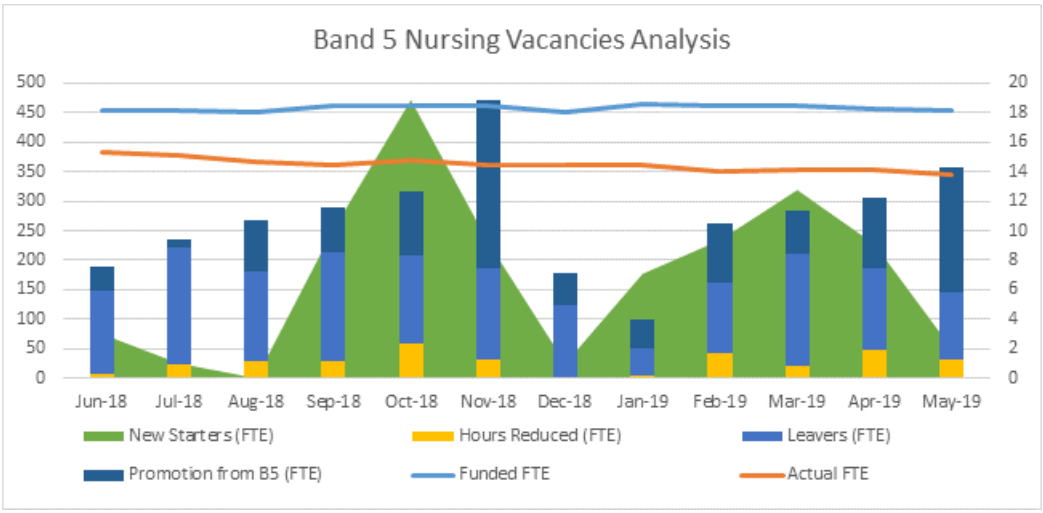
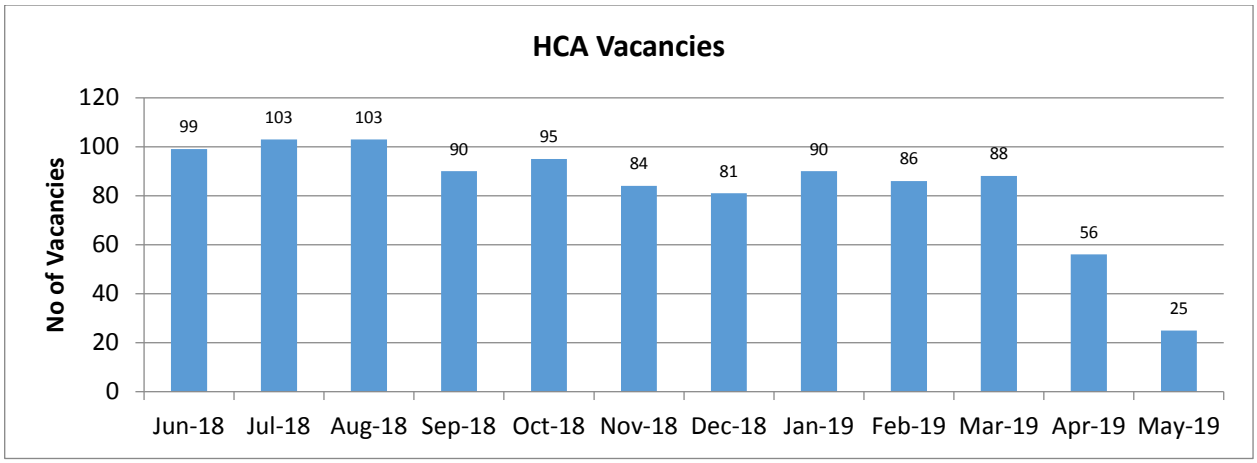


Chart 4 identifies the number of HCA vacancies based on the funded establishments against the number of staff in post. Proactive recruitment campaigns over the last 6 months have reduced the overall number of HCA vacancies in May 2019 to 25 WTE.

Chart 4



2.2. Staff Turnover

Chart 5 illustrates nursing and midwifery turnover which has seen a gradual improvement from November 2018, the current rate in May 2019 is 12.81% against the national average of 11.9%.

The Trust are now part of a national programme with NHS Improvement (NHSI) Retention workforce collaborative, which has enabled access to best practice and exemplar practice from other organisations as well as identifying our retention priorities and plan for 2019.

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

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

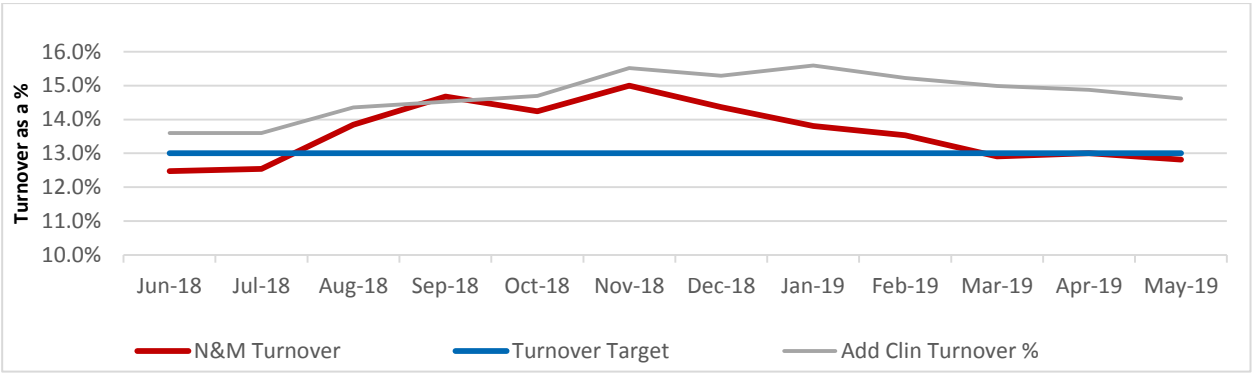
Work is underway in these priority areas to support improvements against a detailed action plan which has been submitted to and endorsed by NHSI in March 2019.

Progress to date includes the development of an internal transfer process to provide flexibility when staff want to gain experience in another area, a series of career café events providing information on development opportunities across our organisation and more recently a targeted health and wellbeing campaign supporting staff in their roles including a menopause clinic and back club.

The aim of the collaborative is to reduce the turnover of our Nursing and Midwifery workforce by 1.5% over the next 12 months from a baseline rate of 14.99% commencing in November 2018. The turnover in May 2019 is 12.81% a reduction of 2.18% to date.

Monthly progress updates on staff turnover reduction will be provided to the recruitment and retention group chaired by the Chief Nurse.

Chart 5



2.3. Recruitment and Retention

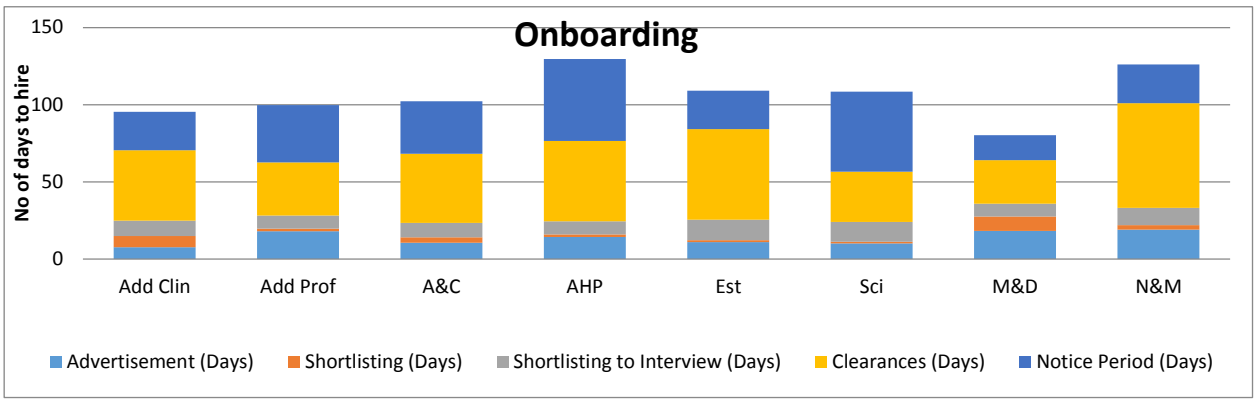
The Nursing Recruitment and Retention Strategy is being delivered alongside the NHSI Retention Collaborative programme. An innovative recruitment campaign continues with flexible working plans and night only contracts. A number of new approaches have been adopted to support the recruitment campaign, including open days. In the last 12 months the Trust has welcomed 83.4 WTE new starters into the Band 5 Nursing roles (41.3 in the last 6 months. and 79 HCA's. We anticipate 72 registered nurses joining the Trust in September 2019 as a result of a series keep in touch events.

It should be noted that whilst we are celebrating some success over the last 12 months in managing to recruit this number of qualified nurses in a competitive market, we must be cognisant that the lead in time for some of the staff to commence in post in September 2019 and continuing attrition rates must also be considered.

Chart 6 illustrates the results of the '*on boarding'* questionnaire, given to new starters on their induction. This details an overwhelming positive response. Managers are reminded about their responsibility to

keep in touch with their successful candidates while the process is under continual review by the recruitment team.

Chart 6



2.4. Workforce Development

WHH first cohort of 8 Nurse Associates registered in January 2019 and commenced posts in the following areas: B3, B4, CMTC, ACCU, A4, A9 and C20. With the introduction of this new role and in line with recommendations outlined within NHS Improvements resource "Safe, sustainable and productive staffing improvement resource for the deployment of nursing associates in secondary care," quality impact assessments have been undertaken. All 8 Nurse Associates have commenced a 12 month preceptorship programme. We continue to support 5 trainee nurse associates in Cohort 2 of the programme. They are due to qualify in March 2020.

In March 2019, we began to pilot a new 2 week induction programme for HCA's which includes a wide range of care activity and clinical skills. Participants will work in a simulated environment following a patient journey. In week 2 of their induction period, each new starter is paired with a buddy within their clinical area and they are supported by a member of the clinical education team. The final day of induction comprises of an afternoon out to review experiences in the first 2 weeks and identify future support requirements. Following an evaluation of the first 2 pilot programmes and approval at Education Governance Committee, the programme has now been fully implemented.

In addition to the new induction programme, a 1 day, 3 yearly refresher training is commencing for Band 2-4 nursing healthcare support staff to refresh and enhance their skills and knowledge and providing an opportunity to reinforce best practice and to share lessons from patient experience feedback, complaints and concerns.

Trust wide role out of Clinical Supervision took place in February 2019 with two launch events. Providing access to clinical supervision to appropriate clinical staff group can support staff in relation to their responsibilities, to enable them to deliver care and treatment to people who use services safely and to an appropriate standard.

Since January 2019 an updated Core Competency Framework has been piloted with new band 5 RN's as part of their Trust Induction. It is pleasing to note initial feedback has been positive with a full evaluation process now underway. Once reviewed, this framework will be rolled out to all band 5 RN's Trust wide.

We currently have 14 qualified advanced care practitioners and 26 of our nursing staff undertaking additional training to become advanced nurse practitioners. We continue to offer the registered nurse with a special interest opportunity to enable staff to gain experience and develop in a specialist area for example tissue viability.

We recently submitted a bid to the joint nursing directorate of NHSI and NHS England to support the development and increase of clinical placements for pre-registration nursing students at WHH. The bid was undertaken in collaboration with Chester University, we are delighted to report that we have received the funding (50k) to support the development of the clinical placement infrastructure in the Trust. Plans are in place to expand the CLIP model of student placements to other wards with an additional practice educator to support the expansion.

A further programme of leadership development has taken place with our ward managers in 2019. This comprised of 6 modules and 3 cohorts have now completed the programme with a total of 34 attendees. The programme has been positively evaluated.

The Lead Nurse Development programme is underway. A Matron Development programme commenced in July 2019.

3. Evidence Based Strategic Workforce Planning

There must be sufficient and appropriate staffing capacity and capability on inpatient wards to provide safe, high quality care to patients at all times. Nurse staffing levels are determined by using a range of metrics. Warrington and Halton Foundation Trust use four factors as follows;

- Using systematic evidenced based acuity data utilising the Safer Nursing Care Tool (SNCT)
- Benchmarking with Peers for example Care Hours per Patient Days (CHPPD) through the Model Hospital.
- NICE Guidance and 1:8 minimum staffing: patient ratios
- Professional judgement

Each of the above methodologies are used to ensure that we have consistent evidence based approach to determining the required establishments for each ward.

3.1. Evidence Based Acuity Data

The Trust operationally utilises the SafeCare function within the Allocate e-rostering system to collect acuity and dependency data twice daily for all wards. SafeCare uses the same dependency scoring as the Safer Nursing Care Tool (SNCT). This is an evidence based tool that enables nurses to assess patient acuity and dependency, incorporating a ‘staffing multiplier’ to ensure that nursing establishments reflect

patient needs in acuity/dependency terms. The data has previously been manually collated for a two week period twice a year; however we are now able to access the information on a daily basis from the SafeCare module in the electronic system. The data is inputted twice daily. The senior nursing team review the data twice daily to ensure appropriate escalation plans are in place to support staffing decisions to meet the needs of the operational demands so that high quality care can be provided on inpatient wards. Any potential care issues associated with staffing are also recorded here using the Red Flag system (See Appendix 2).

3.2. SafeCare Census Results

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

Overall the SafeCare results (summarised in Table 1) demonstrates the acuity of the patients at the time of the survey indicated we required 688.37 WTE against a budgeted nursing staff wte of 681.41. This represents a difference of -6.96 WTE. The survey is an average of the acuity and dependency of the patient group over a four week sampling period (22nd April to 19th May 2019). It is important to note that two wards (K25 & B3 at Halton) which were open at the time of the data collection did not have a funded establishment for nursing staff. Staffing requirements for ward K25 and B3 were achieved by a combination of transferring substantive nurses from other wards as well as the use of temporary staff from NHS Professionals. When factoring in the wards with no budgeted nurses, the comparison would seem to indicate that overall the wards have more staff budgeted than they on average require, however there are a number of other considerations that bring the two figures into line as detailed below.

Table 1 – SafeCare™ Census Results 22nd April – 19th May 2019

	SafeCare Required WTE Nurses vs Nurses in Post*					
Ward	SafeCare Required WTE	Budgeted Nursing Staff WTE	+/- Budget	Nursing Staff in Post WTE	+/- in post *(SafeCare requirements & vacancies)*	Average Daily 1:1s
A1	47.13	59.66	12.53	40.51	-6.62	2.5

A2	38.64	38.14	-0.50	28.69	-9.95	1.29
A4	38.11	38.51	0.40	32.5	-5.61	0.43
A5	35.61	38.61	3.00	29.76	-5.85	2.11
A6	45.26	40.04	-5.22	31.44	-13.82	1.38
A7	52.37	43.47	-8.90	34.5	-17.87	0.04
A8	47.55	43.46	-4.09	32.2	-15.35	1.46
A9	38.72	45.14	6.42	37.68	-1.04	0.85
HICU	34.24	27.92	-6.32	24.19	-10.05	0.00
B3	33.98	0	-33.98	15.51	-18.47	0.38
B4	17.33	22.62	5.30	17.09	-0.23	0.00
B12 FMN	33.44	47.13	13.69	36.29	2.85	0.00
B14	34.80	35.88	1.09	29.77	-5.03	0.04
B18	26.14	38.54	12.40	35.12	8.98	0.95
B19	37.82	33.22	-4.60	30.07	-7.75	1.12
C20	12.41	19.68	7.27	16.72	4.31	0.00
ACCU	36.93	48.71	11.78	43.38	6.45	1.46
C22	27.53	26.76	-0.77	25.33	-2.20	2.04
CMTC	17.73	33.92	16.19	24.17	6.44	0.78
K25	32.65	0	-32.65	11.82	-20.83	0.00
Total	688.37	681.41	-6.96	576.74	-111.63	16.82

* Budgeted Nursing Staff WTE information provided by Finance
Nurses in post information taken from e-rostering system

3.2.1 One to One or Enhanced Care

On average during the census period we had 16.82 patients identified each day across all wards that required enhanced care (1:1s). This is not directly included in the SafeCare requirement; however the wards record the number of patients requiring the direct supervision therefore to directly supervise 16.82 patients 24 hours a day would require a significant nursing resource.

3.2.2 Medical Admissions Ward and Elective / Day Case Surgical Wards

The budgeted nursing staff for A1, CMTC and B4 shows a positive position however throughout the day the daily responsive staffing planning is in line with NICE guidance and 1:8 minimum staffing: patient ratios. SNCT does not adequately quantify the care hours required on a medical admissions ward like A1, and elective day case patients. These areas have a high turnover of patients that cannot be captured in the twice daily census.

3.2.3 SafeCare Requirement Compared to Number of Staff in Post

The SafeCare WTE requirement is 688.37 with 576.74 WTE staff currently in post giving a shortfall of 111.63 WTE which represents the total number of RN and HCA vacancies at the time of the report.

4. Monthly Staffing Return

Nursing and Midwifery staffing data is published on a daily basis at entrances to WHH wards along with submission of data on a monthly basis through the Unify system to NHSE, in addition to publication on

the Trusts website and reporting to the Board of Directors. A review of the 'ward staffing boards' has been undertaken to ensure that staffing levels are displayed on all ward entrances and to support patient understanding of ward staffing.

The Trust is required to submit a monthly staffing return as part of the Strategic Data Collection Service (SDCS) detailing planned v's actual staffing fill rates. In line with recommendations from the NQB (2016) the staffing data return is presented to the Board of Directors on a monthly basis highlighting areas where fill rates fall below 90%. Although the 90% standard has not been constantly achieved during the day time there have been mitigating actions taken with senior nurse escalation, and an increase in HCA fill rates to support the ward teams. Matrons and lead nurses support the ward managers with ward risk assessments and staffing plans to ensure safety is maintained.

4.1. Comparing staffing levels with peers – Care Hours Per Patient Day (CHPPD)

Care Hours per Patient Day (CHPPD) was developed following Lord Carter's review in February 2016, it has been tested and adopted to provide a single, consistent and nationally comparable way of recording and reporting deployment of staff to provide care on inpatients wards. CHPPD monitoring and tracking can be facilitated alongside e-rostering systems and supports the daily assessment of operational staffing requirements. NHS Improvement (NHSI) Model Hospital portal now makes it possible to compare CHPPD metrics with comparable peer Trusts.

Chart 7 and 8 illustrates the reported CHPPD figures for the Trust from April 2019 to June 2019 which gives us an overall CHPPD for the current financial year of 7.6. This is in comparison to the peer median of 7.8 and the national median figure of 8.1 hours over the same period and represents an improvement from 2018 / 19 in which we saw a gradual increase in CHPPD as a result of the significant investment in nurse staffing and ended the year with a rate of 7.0.

This position will continue to improve as we make progress in the Trust wide Recruitment and Retention Strategy.

Chart 7 CHPPD - Model Hospital website

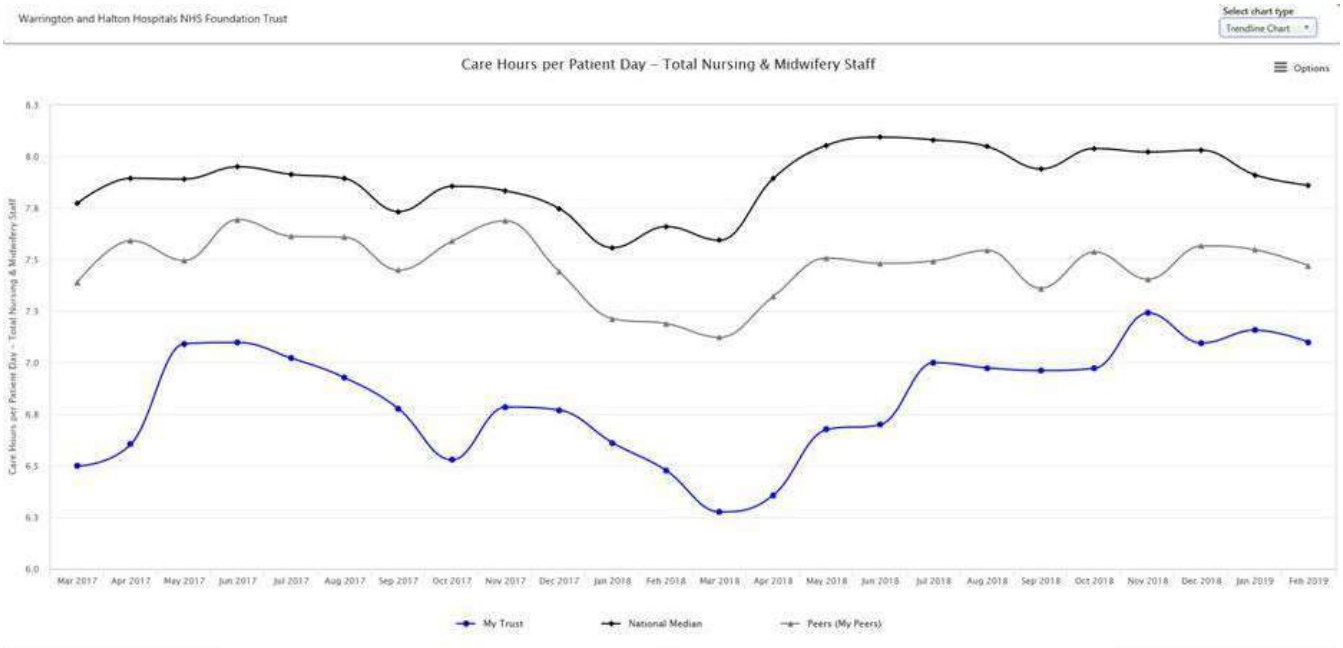


Chart 8 – CHPPD Model Hospital website

Financial year	Month	Cumulative count over the month of patients at 23:59 each day	CHPPD - Registered	CHPPD - Care Staff	CHPPD All
2019/20	April	14008	4.4	3.2	7.6
	May	14623	4.3	3.3	7.6
2019/20 Total		28631	4.4	3.2	7.6

Monitoring arrangements remain in place to review staffing on a daily basis. The number of staff is triangulated with staffing incidents and 'red flag' events. Further information can be found in appendices 2 and 5. This provides greater assurance and a transparency to the governance processes to ensure adequate safe staffing levels and well as indicators of safety and effectiveness across the organisation.

5. Women and Children

5.1. Paediatrics

Nurse staffing levels for Paediatrics are based on Royal College of Nursing (RCN) Standards from the document 'Defining Staffing Levels for Children and Young People's Services: RCN Standards for Clinical Professionals and Service Managers (July 2013)'. This supports assessing acuity with numbers of staff on shift, patient acuity and dependency needs. Paediatrics use an adapted acuity tool. Patient acuity levels are monitored at 3 different time points through a 24 hr period against staffing levels on the main ward B11. Acuity and dependency of the patients on the Paediatric wards was monitored over a 4 week period in May 2019 (appendix 6).

During the 4 week monitoring period there are a number of shortfalls of qualified nursing staff identified on the ward at the specific monitoring times. The majority of the shortfalls were noted at times when the ward had young people admitted for Child and Adolescent Mental Health Services (CAMHS) which increased acuity due to the supervision element of care required; in response to this additional HCA support was utilised. The current escalation tool does not account for HCA's which means the ward had additional resources available to them. Therefore during the monitoring period the paediatric department was safe and had appropriate escalation processes in place to manage the peaks in activity and acuity.

5.2 Neonatal Unit (NNU)

Neonatal Unit (NNU) staffing levels are defined by British Association of Perinatal Medicine (BAPM) guidance. Table 2 below demonstrates the impact of the Trust-wide staffing business case. The NNU staffing establishment ensures compliance with commissioned activity and BAPM guidance making us one of the only units in Cheshire and Merseyside to achieve this standard.

BAPM staffing recommendations are assessed at two points during a 24 hour period and recorded on the Badgernet system. This system is used across the region for all NNU's. An acuity assessment against the BAPM standards utilising the Badgernet system was undertaken over a 4 week period, 4th- 31st May 2019. A robust escalation plan is in place based on BAPM guidance in order to ensure safe quality care delivery is in place on the NNU. The unit, as part of the escalation process, remained open during this period however there was one period on the 23/5/19 between 9am-1900 the unit was only accessible to emergency admissions due to specialised staffing requirements and high acuity, an improved position to previous reports. The findings of a staffing review which were included in the Trust-wide staffing business case has confirmed NNU staffing establishment ensures compliance with commissioned activity and BAPM guidance.

Table 2

	% Shifts staffed to BAPM recommendations		
	2016/17	2017/18	18/19 (This year)
WHH	46.03	57.48	80.31
National average	56.93	61.62	67.91

5.3 -Midwifery Workforce Position

A recent staffing benchmarking tool for maternity services has been provided by the National Quality Board (2018) - Improvement Resource for Maternity Staffing, which recommends using Birthrate Plus for measuring staffing levels in maternity services.

Staffing levels are based on assessment of clinical risk and the needs of the women and their babies during labour, delivery and the immediate postnatal period. A minimum staffing ratio of 1:1 care for women in established labour has been recommended in Safer Childbirth 2007 and is further supported by NICE, 2015. A review of a two week sample of census data recorded of staffing levels to meet acuity was performed between the 11th to the 21st March 2019. The snapshot demonstrated a ratio of 1:28.

The Birthrate Plus Acuity Tool provides staff with a framework to assess the demands within the Labour Ward and the number of staff required to manage these demands. It uses a classification system based upon clinical indicators during labour, birth and the immediate postnatal period. The tool is able to record the fluctuating workload and can give an early indication when demand is greater to ensure adequate staffing levels are in place. WHH Midwives work flexibly between different areas of the Maternity service to ensure each setting is safe. The current Birthrate Plus assessment performed in 2018 gives a ratio of 1:28 (midwife: birth).

The two week census period has provided data on staffing and acuity. This provides limited data as it only reflects capacity and demand over a short period of time. The 3 month period provided for the NQB tool provides a longer period to assess these aspects in terms of midwife to birth ratios and a longer reporting period is more useful to show trends in activity and acuity. This was done for January 2019 to March 2019, when benchmarking against the Improvement Resource for Maternity Staffing by the National Quality Board (2018) tool, which showed a ratio of 1:28 (midwife: birth). It should be noted that The Royal College of Midwives (RCM) recommend a target of 85% staffing levels to meet acuity with clear protocols for escalation. Our acuity tool does show that we escalate to meet acuity demands on a four hourly basis to achieve at least 85% staffing levels. We do have a current escalation policy which has been aligned with a regional escalation policy across Cheshire and Merseyside.

5.4 Maternity Workforce Development

A workforce document produced by HEE England (2019) outlines the challenges to provide improved outcomes for women and babies through Continuity of Carer (CoC) models. To support the development of a CoC model the Trust has received funding via The Local Maternity System over a 6 month period for a midwife to lead on implementation.

Development of an integrated staffing model alongside midwifery led unit, due to open the end of 2019, is currently taking place which incorporates a review of the requirements to provide the CoC model. Developing these types of models can lead to many workforce challenges, such as a change in staff working patterns and a review of on call payments. In return the evidence shows many benefits to women and babies, including reduction in pre-term birth and foetal loss, which would have a positive impact financially.

The document describes how the workforce for maternity will be viewed as a whole Local Maternity System, with the ageing population of midwives being identified as a specific area of concern regionally. With this in mind there is a requirement to increase student placements. As a Trust student placements in Maternity will be increased by 29% for 2019 with a further 10% the following year, above the 25% required.

Strengthening leadership and changing the culture of birth to be woman and family focused is a focus of the document. We have made huge strides at WHH to work on changing the culture using funding

creatively to develop a new Midwifery Led Unit Manager and a second Matron post in order to strengthen leadership and drive change.

The Head of Midwifery is currently reviewing the maternity staffing establishments as determined by birth rate plus (BR+) to include the impact of any increased activity in 2019 / 20 as we move to implement a strengthened marketing strategy.

Ref: Health Education England (2019) Maternity Workforce Strategy. Transforming the Maternity Workforce Phase 1: Delivering the Five Year Forward View for Maternity. www.hee.nhs.uk

6. Use of Temporary Staffing

NHS Professionals (NHSP) is the agreed supplier of temporary staffing to the Trust. During periods of high demand NHSP have been unable to meet the demand which has resulted in the use of agency staff as per table 3 below.

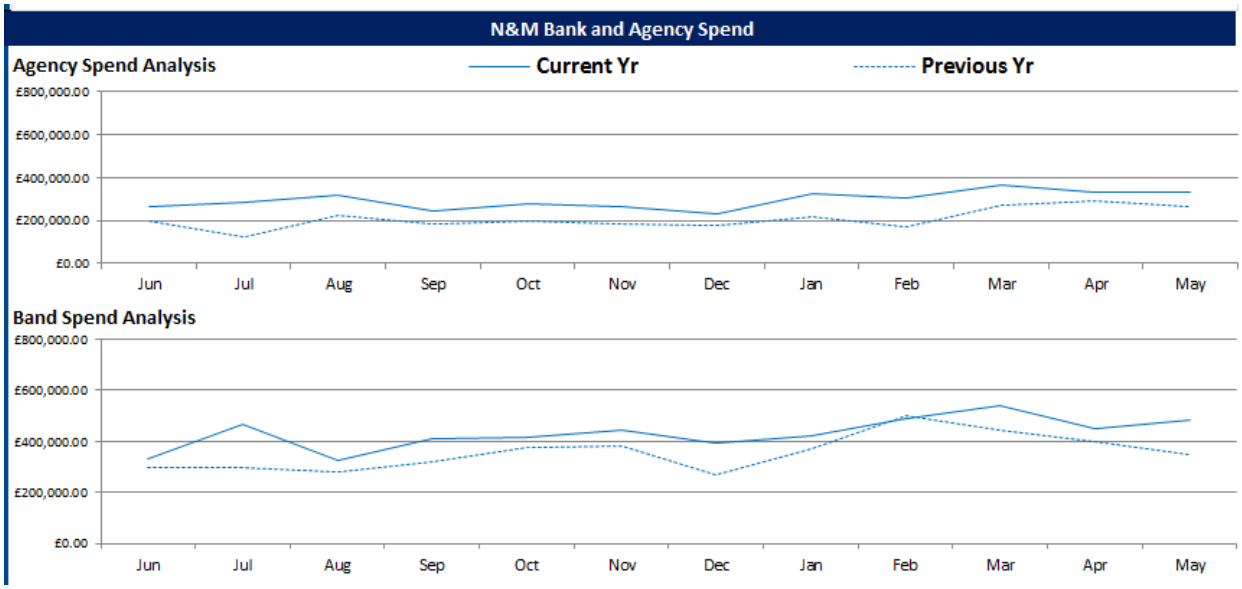
Table 3 Identifies Bank and Agency demand and fill rates from 1st December 2018 to 31st May 2019.

Clinical Business Unit	Agency Filled	Agency Unfilled	Bank Filled	Unfilled	Grand Total
Acute Care Services	30	1	38	3	72
Airway Breathing & Circulation	589	560	2253	691	4093
Child Health		1	34		35
Diagnostics	195	86	634	121	1036
Digestive Diseases	1179	372	2902	406	4859
Discharge/Patient Flow			50		50
Medical Care	90	246	535	155	1026
Musculoskeletal Care	152	143	846	268	1409
Outpatients	8	87	110	61	266
Specialist Medicine	891	671	6299	1555	9416
Specialist Surgery		1	104	13	118
Unscheduled Care	16	59	259	26	360
Urgent & Emergency Care	2076	1357	3353	845	7631
Women's & Children's Health	290	173	2031	328	2822
Grand Total	5516	3757	19448	4472	33193

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

Chart 9 below shows agency use and bank spend analysis for the current financial year. Bank / agency spend remains consistent throughout 2019 which is a similar spend in 2018. Agency reduction is a priority and we have recently introduced a review panel led by the deputy chief nurse for the high spending wards. The aim is to challenge and support these areas to reduce overall spend on temporary staffing. We have a pro-active approach for any WHH staff to join the NHSP bank to enable us to reduce overall high cost agency spend. As we recruit more nurses, we would expect to see a further reduction in this spend.

Chart 9



7. Overall Conclusions

The report provides an overview of the current position in the nursing workforce, including data from the evidence based staffing review (SNCT) and comparative benchmarking data from CHPPD. It is positive to report that the census data recorded within the SafeCare acuity and dependency system in April / May 2019 demonstrates that our budgeted nurse staffing WTE is comparable to the safe care data requirements.

The report recognises that although significant improvements have been made in the overall nurse staffing establishments enabling the Trust to meet the SafeCare acuity establishments of 688.37 WTE's, the actual number of staff in post is currently 576.74 leaving the number of nurse vacancies across the Trust at 111.63 which is an improvement of 22 WTE from the previous 6 month review. Some of these vacancies are as a result to the uplift in establishments following the successful nurse staffing business case, and as a response to the Trust opening a number of new facilities to ensure that our patients receive high quality safe care in an appropriate care setting which include our Frailty Assessment Unit, The Discharge Suite and more recently ED Ambulatory service.

The ongoing Trust Nursing Recruitment and Retention Plan continues to be delivered at pace. A number of new and innovative approaches have been adopted to support the recruitment campaign, which has resulted in a further 83.4 WTE RNs recruited in the last 12 months. A targeted approach for HCA recruitment has had a significant impact reducing vacancies from 90 WTE to 25 WTE in the last 6 months.

Since the development of The Trust retention plan as part of the NHSI collaborative programme we have seen an improvement in turnover from 14.99% in November 2018 to 12.81% in May 2019.

CHPPD is the national reporting metric for safe staffing levels. NHS Choices has recently replaced planned versus actual staffing levels. WHH ended 2018 / 19 with a CHPPD rate of 7.0. Since April 2019 we have consistently maintained a rate of 7.6. CHPPD continues to increase bringing us in line with the national rate of 8.1 and peer organisations rate of 7.8.

The report demonstrates the progress that continues to be made across the organisation in Nursing and Midwifery staffing. There are still a number of challenges faced including recruitment to vacant posts

and acknowledging the age profile of our current workforce which is a work stream initiative in the NHSI retention plan.

8. Recommendations

It is recommended that the Trust Board review the progress to date and note the contents of the report.

Appendix 1

National context and expectations of the National Quality Board

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

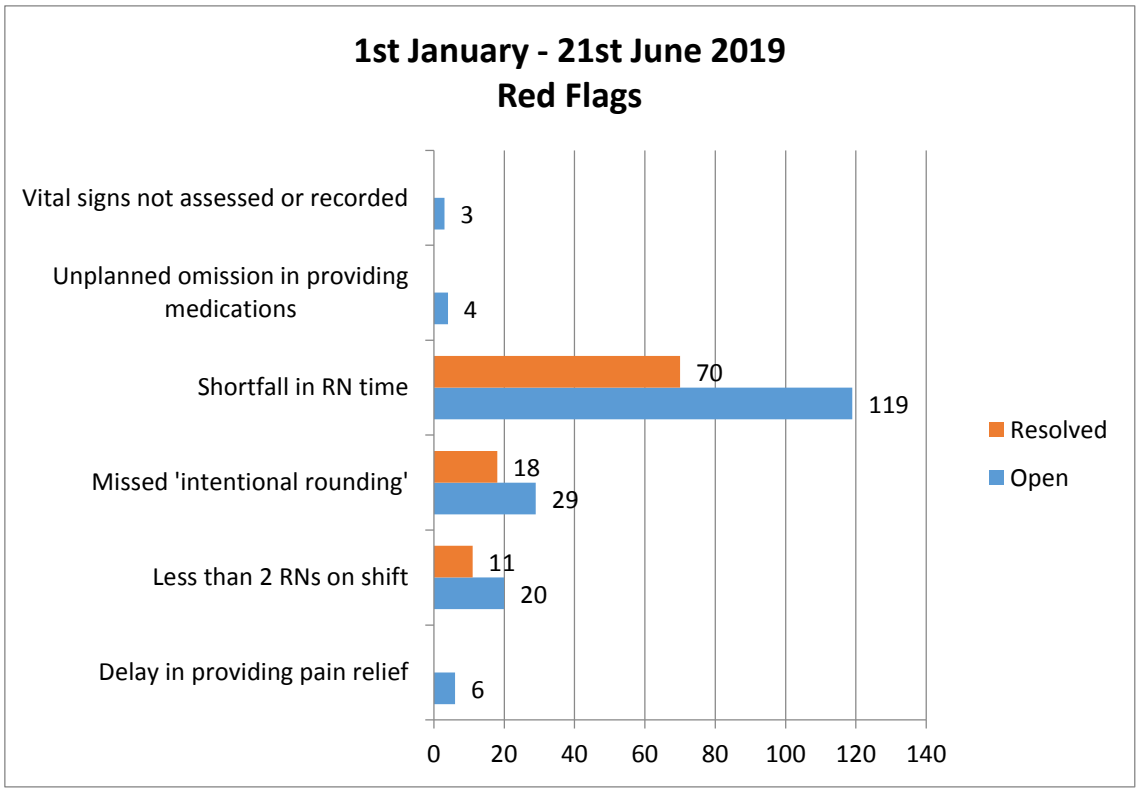
The NQB (2016) described three main expectations of NHS Provider Boards to ensure their organisation has the right culture, leadership and skills in place for safe, sustainable and productive staffing. They are also responsible for ensuring proactive, robust and consistent approaches to measurement and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

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

Appendix 2

NICE Guidance Red Flags

Red flags can be defined as events that prompt immediate response by the registered nurse in charge of the ward on a given shift to ensure there is sufficient staff to meet the needs of patients on the ward. These events are recorded within the SafeCare™ system, there have been 284 raised in the year to date, these are summarised in the chart below. This is a reduction from 309 noted in the previous 6 months. Red Flags are one way for our ward staff to escalate staffing related issues to their Matron. However they can be by passed when wards verbally report the issue directly and it is resolved without cause to record within SafeCare™. A recent audit indicated staff were satisfied with the response when a red flag is raised however the senior nursing team need to ensure the process of closing the red flag on the system is undertaken on each occasion.



Following an audit of the escalation process for nurse staffing it was agreed to check the Red Flag system with a questionnaire sent to all senior nurses including Ward Managers and their deputies. The outcome was that we need red flags that better reflect the frequently occurring issues. With this in mind we have recently reviewed the current red flags with a proposal to include additional metrics going forward. We hope to introduce the new process in September 2019. Contributions came from ward managers as well as senior nurses within the Trust plus examples from elsewhere.

<u>Maternity Red Flags</u>

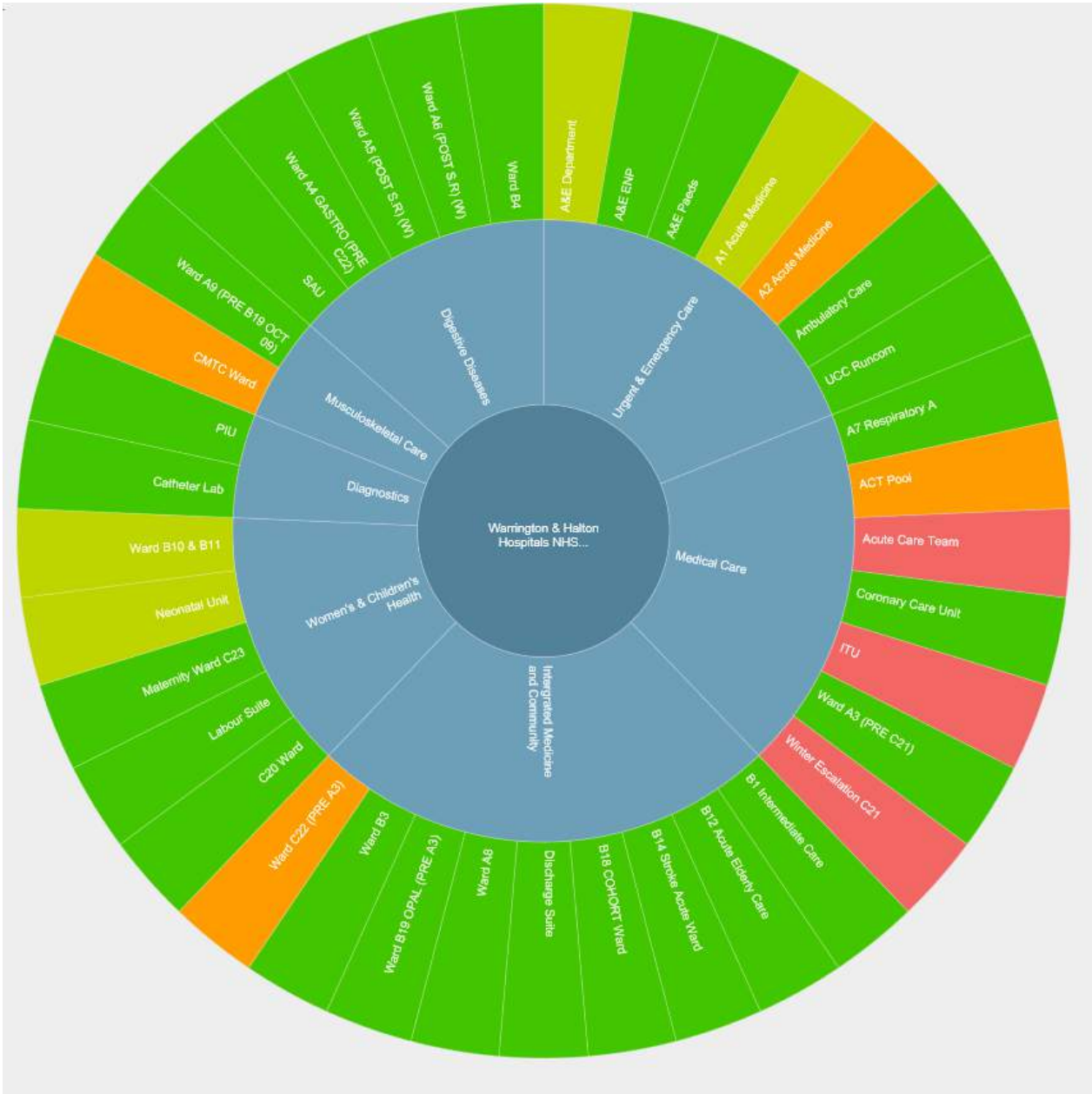
Red flags are reviewed in each area and data collected if red flag is triggered. These have been reviewed January to March 2019.

Each area has its own red flags which are detailed as follows:

Maternity Area	Red Flag
Triage / ANDU	• Delay of more than 60 minutes of review by Doctor - none • Delay of 30 minutes or more between presentation and triage - none
Labour Ward	• Missed or delayed care (e.g. delay of 60 minutes or more in washing and suturing) - none • Delay of two hours or more between admission for induction and start of the process - 2 • Any occasion when one midwife is unable to provide continuous one to one care in labour - none
Maternity Ward	• Missed medication during an admission to hospital (e.g. diabetes medication) - none • Delayed recognition and action on abnormal vital signs (e.g. sepsis or urine output) - none

Appendix 3

Allocate Safe Care "live" output



The above chart is an example of the live report that can, with one click, provide detailed information about staff and patients on all of our wards. Wards highlighted in 'Red' have either got a potential challenge (insufficient staff to provide adequate care) or have not submitted the required patient information.

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

Appendix 4

Establishment Uplift

There is a requirement for an agreed level of contingency for planned and unplanned leave, within the nursing establishments, (this may also referred to as headroom or uplift). Factors included currently within the organisation are long service entitlements in annual leave and alignment with Trust sickness/absence targets along with both mandatory and specific training leave for development. The requirement for this will be greater if there is a higher proportion of part time staff.

It is important that the level of uplift is realistic and reviewed at least annually. In conjunction with the finance team a review has taken place to understand the WHH position against peer organisations in more detail to ensure alignment and parity, particularly with regard to the management of maternity leave which currently does not align with the uplift in establishment. The outcome of the review noted WHH to be both a local and national outlier in regards 'uplift' based at 20% with national recommendations between 22.5% and 25%. As part of the recent financial injection into the nursing staffing budget the establishment uplift, the 23 wards included in the staffing business case have now had their uplift to 23%. The table below illustrated how the 23% uplift has been broken down

	RCN recommended	Current WHH funded uplift	Evidenced WHH actual position	Recommended WHH funded uplift	Comments
Annual Leave	17.0%	15.5%	17.0%	17.0%	17% is sufficient to cover an average of 30 days + 8 bank hol per person.
Sickness / absence	4.5%	3.5%	6.4%	4.2%	Sickness cover should be aligned to the organisational sickness absence target.
Study leave	2.0%	1.0%	1.8%	1.8%	The requirement for study leave cover is 1.8% based upon the current mandatory & essential training demands
Parenting leave	1.0%	0.0%	2.5%	0.0%	On average 18 wte are on parenting leave at any one time, equating to 2.5%. It is proposed that parenting leave is managed within baseline
Other leave	0.5%	0.0%	0.5%	0.0%	4,900 hours lost to special leave during 16/17 across all wards areas, this equates to 0.5%. It is proposed that special leave is managed within baseline.
Total	**25.0%**	**20.0%**	**28.2%**	**23.0%**	

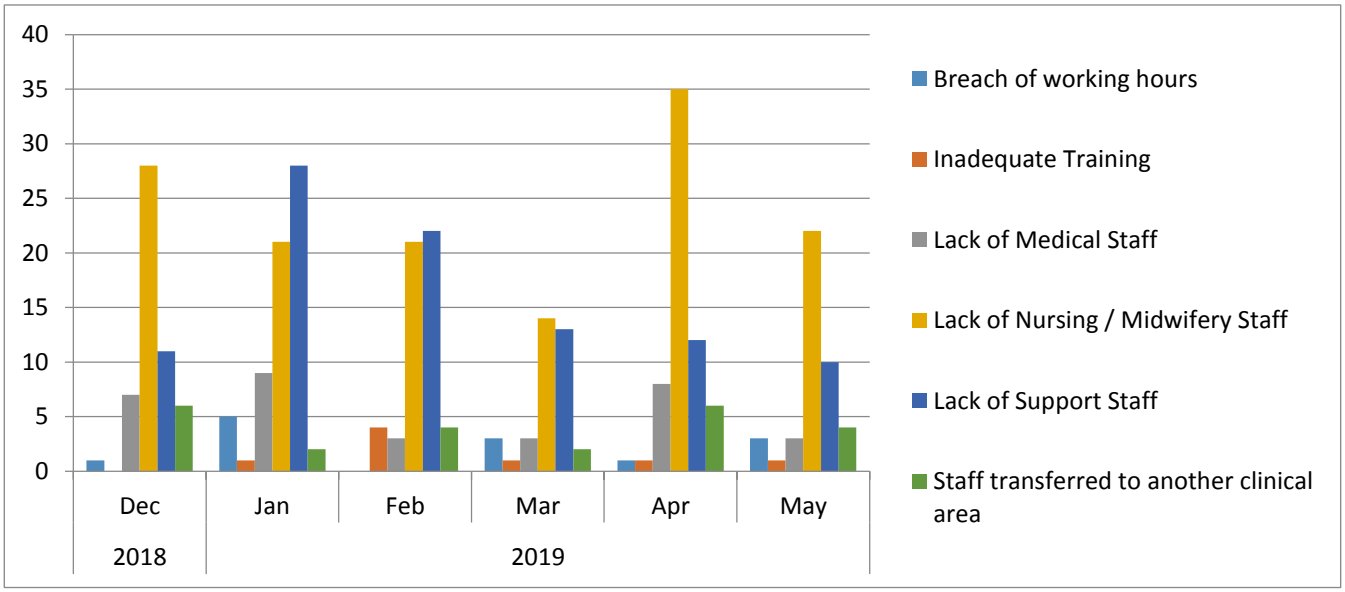
Appendix 5

Reported Staffing Incidents

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

'Lack of Nursing / Midwifery Staff and 'lack of support staff' are highlighted as the largest reason for completing a Datix within this criterion. This does not distinguish between members of the multi-disciplinary team. All incidents are monitored and actioned within the relevant CBU with detail provided in monthly governance reports. Monitoring of staffing incidents takes place on a monthly basis by the senior nursing team.

Number of staffing incidents from December 2018 to May 2019.



This illustrates significant improvement since the previous report. Incidents describing lack of staff/nursing/midwifery staff has reduced by a third. Whilst some of the difference can be explained by the introduction of the Red Flag process and robust staffing escalation planning, there remains a notable improvement in numbers.

Appendix 6

Acuity and dependency levels on the Paediatric wards over a 4 week period May 2019.

May 2019	0700	1400	2200	Mitigation
Sat 4th				
Sun 5th				
Monday 6th				
Tuesday 7th				
Wed 8th				
Thurs 9th				
Fri 10th				
Sat 11th			-0.9 wte	Sickness of RN on night shift just before shift commenced.
Sun 12th	-0.7 WTE			2 x HCA on duty on LD.
Mon 13th				
Tue 14th			-0.8 WTE	HCA on night shift
Wed 15th				
Thurs 16th			-0.8 WTE	HCA on night shift
Fri 17th				
Sat 18th				
Sun 19th				
Mon 20th			-1 wte	HCA on night shift
Tue 21st	-0.7 wte			2 X HCA on duty and band 7 ward manager.
Wed 22nd				
Thurs 23rd				
Fri 24th				
Sat 25th				
Sun 26th				
Mon 27th		-0.1wte		3x HCA on duty
Tue 28th				
Wed 29th				
Thurs 30 th				
Fri 31st				

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REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/19/09/91**			
SUBJECT:	**Freedom to Speak up**			
DATE OF MEETING:	25 September 2019			
AUTHOR(S):	Jane Hurst, Deputy Director of Finance, Strategy			
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse			
LINK TO STRATEGIC OBJECTIVES:	SO1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience			
	SO2: We will .. Be the best place to work with a diverse, engaged workforce that is fit for the future			
	Choose an item.			
EXECUTIVE SUMMARY (KEY ISSUES):	The purpose of this paper is to update the Board on the activity of the Freedom to Speak Up (FTSU) Team.			
PURPOSE: (please select as appropriate)	Information	Approval	To note x	Decision
RECOMMENDATION:				
PREVIOUSLY CONSIDERED BY:	**Committee**	Operational People Committee		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome	noted		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

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Warrington and Halton Hospitals NHS Foundation Trust

TRUST BOARD

SUBJECT	Freedom to Speak Up	AGENDA REF:	

1. BACKGROUND/CONTEXT

The purpose of this paper is to update the Board on the activity of the Freedom to Speak Up (FTSU) Team.

2. DISCLOSURES

In 2019/20 (1 April to 31 August) the FTSU team received the following disclosures.

Table 1 Disclosures in 2019/20

Quarter 1	5
Quarter 2	3
Total	**8**

The cases can be grouped as follows:-

Table 2 Types of disclosures in 2019/20

Behaviour and relationships	6
Patient safety	1
Staffing levels	1
Total	**7**

The issues have been across different operational areas and all have been managed through discussion or support from HR or senior nursing.

The patient safety concern was reviewed and ward manager was made aware of concern of record keeping issue.

There is currently no national data available for Q1 or Q2 2019/20 to compare the Trust data to.

3. ACTIVITY OF THE FTSU TEAM APRIL TO AUGUST

The team continues to attend meetings and training sessions across the Trust but recognises the number of disclosures has dropped. The group is reviewing new ways to promote FTSU service and October is national FTSU month. During October the team plans to have stalls on both sites and to visit the wards.

The self-review tool was completed in August 2018 by individual Board member input and shared with the Trust Board in September 2018. The guide (see Appendix 1) recommends the Board should repeat the self-reflection exercise at least every two years. The guidance and tool has been updated nationally the key expectations include:-

- Behave in a way that encourages workers to speak up
- Demonstrate Commitment – including focus to reduce bullying, effective communication and engagement strategy and consider inviting workers who speak up to present their experiences in person to the Board
- Have a strategy to improve your FTSU culture
- Support your Freedom To Speak Up Guardian (FTSUG)
- Be assured your FTSU culture is healthy and effective – FTSU report in person at least every 6 months but this should not be the only assurance the Board receives. The audit report is another significant piece of assurance
- Be open and transparent with external stakeholders

The supplementary information (see Appendix 2) includes the following:-

- Individual responsibilities – Action each Director should review
- Evaluating FTSUG capacity, wellbeing and capability – Discussed with Non-Executive Lead, Executive Lead and Chair.
- Communication Strategy – Action to be reviewed
- FTSU Strategy – Action to be refreshed
- Triangulating Data – Action to share with HR Lead
- Board Assurance – Includes elements and examples for review
- Guardian Report content guidance – Action to be reviewed
- Audit of FTSU Policy - Completed

4. RECOMMENDATIONS

The Trust Board is asked to note the progress of Freedom To Speak Up.

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NHS Warrington and Halton Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/19/09/92**
SUBJECT:	***Junior Doctor/Trainee Engagement update***
DATE OF MEETING:	**25.09.2019**
AUTHOR(S):	Alex Crowe, Deputy Medical Director/Director Medical Education/CCIO
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Executive Medical Director/Deputy CEO
LINK TO STRATEGIC OBJECTIVES:	SO1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience
	SO2: We will .. Be the best place to work with a diverse, engaged workforce that is fit for the future
	SO3: We will .. Work in partnership to design and provide high quality, financially sustainable services
EXECUTIVE SUMMARY (KEY ISSUES):	▪ 14.01.2019. Deferred to March…. ▪ 27.03.2019. Referred to future BTO…. ▪ 29.05.2019. Update to September Board to include results from GMC survey….. ▪ 6 mth update - GMC NTS Survey Results Presentation by L Sala on the 25th July 2019 WHH GMC Trainee Survey Results for WI Each year the GMC carries out the National Training Survey. This is a very informative comparative tool to highlight areas of good practice in medical education as well as areas that might need further attention or improvements. During the Survey, trainees are provided with the opportunity to record ***free-text comments*** about their training placements. The GMC will filter comments relating specifically to "patient safety" and "bullying and undermining" and share these with directly with HEENW. HEENW has a duty to investigate and respond to the GMC, and share the comments as per each Trust, and request that we investigate and provide an explanation and/or an Action Plan to resolve the problem. WHH responses should indicate whether our governance arrangements have already raised the concern, and if not, whether governance should be developed to encourage direct local reporting.

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	Trainees are reminded to make comments in good faith, and to only record concerns which they feel have been appropriately raised but not been addressed. WHH response should also refer to any evidence (from local surveys, metrics or other sources) that the concern raised has been addressed. Following the GMC NT Survey Results - The comment has been recorded in the HEENW database of Concerns and has been risk-rated at **Level 1** and further advised that they will review the Risk Score in light of our response. WHH received **1 "Bullying and Undermining" Action Plan** for which a response was submitted to HEENW on the 26th July 2019 having been signed-off by the DME – Dr Alex Crowe.			
PURPOSE: (please select as appropriate)	Information ✓	Approval	To note ✓	Decision
RECOMMENDATION:	Following the Grand Round Presentation of the GMC NT Survey Results – every Specialty was provided with a bespoke Action Plan to discuss with their Consultant/Clinical Teams. To further support their responses to their Action Plans, the "GMC Questions" that the Trainees were asked in response to the INDICATOR scores was also provided to help them explore how thy may deliver improvements as we begin to welcome the NEW Trainee Workforce in August 2019, with a deadline for completion of Action Plans by the 13th Sept. 2019.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Strategic People Committee		
	Agenda Ref.	**SPC/19/09/84**		
	Date of meeting	18.09.2019		
	Summary of Outcome	The report was discussed and noted		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None			

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

SUBJECT	Junior Doctor/Trainee Engagement update	AGENDA REF:	BM/19/09/93

1. BACKGROUND/CONTEXT

The Trainee Medical Workforce is required to complete the annual GMC National Trainee Survey around April/May every year and for all Trainees this is a requirement whilst placed on any Foundation Grade or Core/Specialty Grade Training Programme(s).

The Survey is run directly via the GMC portal and HEENW track the completion rates per Trust to ensure a 100% compliance rate prior to closure of the Survey. HEENW then collaboratively advise Trusts of their key findings as well as the GMC "releasing the portal" into the public domain. The GMC Portal allows the Trust to directly extrapolate their Trust's Data by Specialty.

The Results are "nationally benchmarked" and advise that a Trust's results are a valid and reliable way to advise a Trust on its areas of Good/Noteworthy practice (GREEN Indicators) and Areas to address/improve upon (RED Indicators).

It is evident from 2018, following our GMC NT Survey Results combined with the Monitoring Visits from HEENW that improvements were required to be made to offer a more supportive learning environment that provided trainees with a balance in service delivery versus their needs as Trainees on Programme…

With direct support/intervention from the Medical Director combined with NEW leadership in the appointment of a NEW DME, the improved "listening and learning culture" has been very evident in transforming the results that we have been delighted to receive in 2019.

2. KEY ELEMENTS

The Trust secured a 100% completion rate for the GMC National Trainee Survey for those placed in WHH at the time in which the Survey was running. This ensures that even those on rotation – during the time the Survey is running – can offer their opinions of their learning experiences and the environments/specialties in which they are placed.

The Key elements for change began with the Medical Director forming a **"Trainee Experience Group"** with excellent CBU level engagement which immediately demonstrated real commitment in "listening" and "delivering" on the actions needed to address Trainees' concerns. The Trainees also demonstrated that they could also be part of the culture and take on small projects to drive improvements in the Service and the "app" called "Trello" was utilised (led by a Trainee) to track change projects for the Trainees in collaboration with other Trust colleagues.

This then mirrored the Actions agreed from the **Junior Doctor Trainee Forums**; offering a good attendance with discussions about improvements which were also noted in the Action Notes.

The DME/Dep MD chaired the **JD Forums** and demonstrated a commitment to the Trainee Workforce and continued to illicit how the services could improve and hold a strong level of accountability to drive the improvements forward. The efforts from this forum also supported the improved location and facilities for a **new Doctors Mess** which was formally opened in July 2019. Medical Education will now also lead on a new Project to support the **New BMA Facilities Charter** with monies ring-fenced from HEE/BMA funding to deliver on the necessary improvements for our Trainee Workforce.

Following the appointment of the NEW DME/Dep MD; ideas also flourished in the Medical Education Service with the "shared concept from the "**Safety Huddle**" and delivered the weekly "**Med ED Huddle"** coupled with a **NEW Medical Education Newsletter**.

There was also a strong emphasis on recognition for the Medical Workforce. Although we have always held **The Annual Medical Education Excellence Awards** - the DME/DepMD considered the approach of a **"Medical Educator of the Month" Award** – based around the **WHH Values Model** with a Certificate and Letter of Recognition from the DME for their support to the Trainee/Medical Student workforce. These "surprise" ward-based initiatives have also been shared via the Med ED **Twitter Account: @MedEdWHH**

The **Medical Education Quality Committee** continues on a quarterly basis with "Specialty Tutor Reports" to be completed by the Royal College Tutors in providing information regarding the trainees' experiences and to address any areas of concern. The MEQC Minutes are then forwarded onto the Strategic People Committee

We have also set the run of dates for the whole academic year 2019/20 to ensure the **JD Forums** are well attended with a culture of importance around trainee attendance.

3. ACTIONS REQUIRED

Following the Grand Round Presentation of the GMC NT Survey Results – every Specialty was sent a "bespoke Action Plan" to discuss with their Consultant/Medical/Clinical Teams. To further support their responses to their Action Plans, the "GMC Questions" that the Trainees were asked in response to the INDICATOR scores was also provided to help them explore how they may deliver improvements as we begin to welcome the NEW Trainee Workforce in August 2019, with a deadline for completion of their Action Plans by the 13th Sept. 2019.

4. MEASUREMENTS/EVALUATIONS

HEENW have a **"Quality Framework"** that assesses the **Level of Risk** assigned to the Concerns that are raised by Trainees – this is utilised not only when the GMC NT Survey Results are delivered but also following the HEENW Monitoring Visits. As below:

Risk Category	Description
Category 0	NO Concerns - ALL HEE Standards are met
Category 1	**Minor Concerns** – in one or more areas the HEE Standards are not being met, but we are assured by the Action Plans in place to address the concern,
Category 2	**Significant Concerns** – there are a significant number of areas in which the HEE Standards have not been met, and plans are not demonstrating improvements.
Category 3	**Major Concerns** – the placements concerned are well below the standards expected by HEE; the agreed improvements have not been delivered and there is a significant risk to the quality of education and training
Category 4	**Training Suspended** – when all other avenues have been explored, HEE may decide to suspend placements. This decision may only be made after careful consideration, and at the very highest level of the Organisation.

In June 2018

Our Trust's **Overall RISK Score was recorded as Category 2** - with 2 Concerns graded at Category 3 as below:

CAT 3 - Patient Safety Concern – GP - *Referred A&E patients – ensure they are appropriately clerked, reviewed and treated within appropriate timeframes*.
CAT 3 - **Governance and Quality Control** – Trainees' concerns/complaints addressed and resolved and they can be empowered to raise concerns (even in conflict) and to be offered outcomes and solutions/improve feedback.

CAT 2 – HANDOVER – focus required for CMT's – formalised/structured/dedicated room
CAT 2 – ROTAS – Medicine - ALL Grades must factor in learning experience/curricula
CAT 2 – MEDICINE INDUCTION (local) – "on-call arrangements"/Bleep process prior to beginning their placements.
CAT 2 – Clinical Supervisors in Medicine – awareness of their duties and the curricula (esp. for GPST's) – locum consultants' turnover
CAT 2 – Learning experience, particularly for FY's in Medicine – to include Supervision/Assessments and Feedback.

CAT 1 – Role of the CBU's/Structure – alignment to Specialty groupings – rota issues.
CAT 1 – Equality & Diversity –"challenging" intolerance
****HEENW view the "GMC Enhanced Monitoring Status" of the Trust as "Departmental" (focus on Medicine Specialties) rather than "Trust wide" concerns****

In June 2019

HEENW - following release of the GMC National Trainee Survey results for WHH noted the following and **reduced our overall RISK Score to Category 1** based on their "**Quality Framework".** A Letter was submitted to the Chief Executive in July 2019 confirming the following key points**:**

- ✓ Noted many significant improvements within MEDICINE
- ✓ HANDOVER improving by a significant 50 pts from 2018
- ✓ Improving scores for CMT is most noticeable = RISK score reduced from 2 to 1

- ✓ Overall Medical Specialties – Improvements are apparent = RISK score reduced from 2 to 1
- ✓ Monitoring and Reporting Systems (ALL Specialties) = RISK score reduced from 2 to 1
- ✓ Burnout Question – (Gastro – but remains inconclusive) = RISK Score of 1
- ✓ Anaesthetic Trainees - Managing patients in EM = RISK Score of 1
- ✓ GPST's in Paeds – requires some improvements in Experience, Curriculum Coverage, Rota Design and Feedback - RISK Score of 1
- ✓ ***2018 HEENW Quality Framework Results*** = 5@CAT 2, 2@CAT 1, 2@CAT 3, 1 Patient Safety
- ✓ ***2019 HEENW Quality Framework Results*** = 6 CAT 1 – **Reduced Overall RISK SCORE from 2 to 1**

5. TRAJECTORIES/OBJECTIVES AGREED

In collaboration with the Specialties, with responses from their bespoke Action Plans, Medical Education will continue to advocate for the Trainees' experiences and ensure we continue to coordinate our Formal Postgraduate Teaching Programmes following our Inductions.

We will continue to advocate for the Trainees and address issues and concerns as and when they arise and report and escalate accordingly.

6. MONITORING/REPORTING ROUTES

- ✓ The "mirroring" of the Medical Handover Structure and interface with Trust Wide Safety Brief – Medical Education "safety" Huddles – every Wednesday morning with the DME/Dep MD.
- ✓ Medical Education Newsletter - edited and delivered to the Trainee workforce and the "Supervisory" Workforce - every month.
- ✓ Continue to coordinate the Junior Doctor Trainee Forum - Quarterly/MINS/Action Notes – (returning to the Common Room of the Education Centre)
- ✓ Continue to lead and coordinate the Medical Education Quality Committee – MINS/Action Notes/Tutors Reports.
- ✓ Medical Education Faculty Away Day – Chaired by the DME/Dep MD
- ✓ HEENW - strong links as a Regional Centre – e.g. - NEW IMG Induction Programme

For the future:

- ✓ face to face meetings with CBU over GMC National Trainee Survey Action Plans
- ✓ delivering on the Ward "Round" Accreditation Initiative
- ✓ RCP and RCS Educational events at WHH – "regional hub" within HEENW - PACES exams, Educational Events, etc.
- ✓ Development of Primary Care and Secondary Care Medical Education Plan
- ✓ Explore Trainee Fellows aligned with Universities – support ITF's clinical knowledge/academic achievements

7. TIMELINES

- Responses due to the GMC NT Survey Action Plan - 13th Sept 2019
- NO further HEENW Action Plans to be completed or submitted

- NO further date yet received from HEENW for an AAV – Monitoring Visit in 2019.
- Await update from HEENW on our "GMC Enhanced Monitoring Status" for 2019.

8. ASSURANCE COMMITTEE

- ❑ 2018 = **31 REDS**
- ❑ 2018 = **58 PINKS**
- ❑ 2018 HEENW Quality Framework Results = 5@CAT 2, 2@CAT 1, 1@CAT 3
- ❑ 2018 - 1 Patient Safety Concern – Action Plan response was submitted
- ❑ 2018 – Medicine "Action Plans" and "Site Visits" – HEENW Head of School Intervention

- ❑ 2019 - **reduced to 25 REDS in 2019 (19% overall improvement)**
- ❑ 2019 - **reduced to 40 PINKS in 2019 (31% overall improvement)**
- ❑ 2019 HEENW Quality Framework Results = 6@CAT 1
- ❑ 1 Bullying & Undermining Concern – Action Plan response was submitted on the 26th July 2019
- ❑ There were NO Patient Safety Concerns raised.

- ✓ The GMC NT Survey does Influence WHH AAV/Dean's Report/CQC Rating for the Trust
- ✓ Does affect the "GMC Enhanced Monitoring Category/Grade of the Trust - 1,2,3
- ✓ Does affect Medical Workforce Recruitment and Attraction
- ✓ +VE & -VE Outliers - what is Trending? ***(teamwork/local teaching/feedback)***
- ✓ Can access Comparative Results with other Trusts

9. RECOMMENDATIONS

- ✓ Review the **6 CAT 1 Concerns** from the 2019 GMC/HEENW Results:-
  - *Improving scores for CMT is most noticeable = RISK score reduced from 2 to 1*
  - *Overall Medical Specialties – Improvements are apparent = RISK score reduced from 2 to 1*
  - *Monitoring and Reporting Systems (ALL Specialties) = RISK score reduced from 2 to 1*
  - *Burnout Question – (Gastro – but remains inconclusive) = RISK Score of 1*
  - *Anaesthetic Trainees - Managing patients in EM = RISK Score of 1*
  - *GPST's in Paeds – requires some improvements in Experience, Curriculum Coverage, Rota Design and Feedback - RISK Score of 1*

- ✓ Deliver on the Project Plan to improve the **"Facilities and Rest Charter"** for the Trainee Workforce – utilising BMA/HEE ring-fenced monies.

- ✓ Grow and support the **International Trainee Fellow** post holders – supporting their Academic journey via Edge Hill University matched by an excellent clinical placement experience.

- ✓ Continue to advocate our "protected" Formal PG Teaching Programmes and ensure the CBU's reflect this in the balance of service commitment – ***good rota design.***

- ✓ Encourage a culture of **"Local Teaching"** - Trainees utilise all opportunities for learning:
  - *Post Take Ward Round and Handover*
  - *Local/Specialty Specific Training (CBU Seminar Rooms)*
  - *Grand Round*
  - *QI – Quality Academy*
  - *Clinical Skills and Simulation*
  - *Journal Clubs*
  - *MDT Meetings*

- ✓ Deliver and support the **NEW Internal Medicine Curriculum** as this replaces the Core Medical Training which will be phased out.

- ✓ Continue to explore with our partners at **Alder Hey** an improved FY model of Track Rotations for the next Foundation Programme academic year 2020/2012.

- ✓ Collaboration with our current LDA Key Stakeholder at The University of Liverpool following the **NEW 3rd Year Cohorts of Medical Students** arriving at WHH in September 2019. Ensure capacity and the learning experiences for these students and other "learners" are not compromised.

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NHS Warrington and Halton Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/19/09/93**
SUBJECT:	**Flu Programme 2019**
DATE OF MEETING:	25 September 2019
AUTHOR(S):	Deborah Smith, Deputy Director of HR and OD Caroline Eardley, Workplace Health and Wellbeing Lead Nurse
EXECUTIVE DIRECTOR SPONSOR:	Michelle Cloney, Director of HR & OD
LINK TO STRATEGIC OBJECTIVES:	SO2: We will .. Be the best place to work with a diverse, engaged workforce that is fit for the future
	SO1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience
EXECUTIVE SUMMARY (KEY ISSUES):	This paper provides an update to Trust Board on evaluation of the Influenza Vaccination Programme for 2018 and sets out the 2019 Programme. • The 2018 Programme was very successful and achieved an uptake level of 86.7% of frontline staff against a target set by CQUIN of 75%. • The Board are asked to commit to achieving the ambition of 100% of frontline staff receiving the vaccine. • The Board are also asked to commission the establishment of a Flu Support Team for the period of the Flu Programme 2019. • The Board are also asked to appoint a Board Champion for the Flu Programme 2019, as this was successful in the previous year's campaign. • The Communications Team are supporting with the campaign for the Flu Programme 2019 and are in the process of finalising the communications plan. • The Programme delivery plan includes targeting clinical areas and a highly visible presence across the Trust. • The aim is to vaccinate over 50% of staff within the first 4 weeks. The Programme will continue

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	until January 2020 with the option to extend until 31st March 2020 if required. • The CQUIN target this year has been increased from 75% of frontline staff receiving the vaccination, to 80%. • This year the Flu Vaccination Team includes 17 Peer Flu Vaccinators, predominately senior nursing staff trained to give the flu vaccines to their peers. • Monthly returns will be submitted to Public Health England which will set out uptake and benchmark WHH against other trusts. • This year the Trust has not been requested to provide an opt-out feedback, however this could be requested before the campaign commences.			
PURPOSE: (please select as appropriate)	Information X	Approval	To note	Decision X
RECOMMENDATION:	Trust Board are asked to: • Note the evaluation of the Flu Programme 2018; • Commit to achieving the ambition of 100% of healthcare workers receiving the vaccine; • Agree on a Board Champion for the Flu Campaign 2019; • Commission the formation of a Flu Support Team; • Note the outline of the Flu Programme 2019.			
PREVIOUSLY CONSIDERED BY:	**Committee**	1T		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

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NHS Warrington and Halton Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

SUBJECT	Flu Programme 2019	AGENDA REF:	BM/19/09/93

1. BACKGROUND

This paper provides an update to Trust Board on evaluation of the Influenza Vaccination Programme for 2018 and sets out the 2019 Programme.

2. KEY ELEMENTS

2.1. Flu Programme 2018 Evaluation

The Flu Programme 2018 achieved an uptake level of 86.7% of frontline staff against a target set by CQUIN of 75%.

The Programme was very successful. Of particular note was the impact that the visibility of the Workplace Health and Wellbeing Team had on the uptake. The whole team committed to vaccinating staff and were able to build on their good reputation across the Trust to achieve the 86.7% compliance. Vaccinations were available at various times throughout the day and night to accommodate all staff and the team provided targeted mobile clinics on Wards, at training events, and on the corporate induction.

Senior leaders across staff groups (Nursing, Medical, and Allied Health Professionals workforce as well as staff side representatives) supported with the Flu Programme with a consistent message and direction for staff. The Board Champion for the Flu Programme 2018 supported with the Workplace Health and Wellbeing Lead offering leadership to the Programme at the highest level.

2.2. Flu Programme 2019

Leadership

A challenging target was set last year by national clinical and staff side professional leaders to achieve 100% uptake for frontline staff. The Board are asked to commit to achieving the ambition of 100% of frontline staff receiving the vaccine.

The Board are also asked to commission the establishment of a Flu Support Team for the period of the Flu Programme 2019. Guidance suggests that a Flu Support Team is established from senior leaders across staff groups to ensure that there is a consistent message and direction for staff during the Programme. The WHH Flu Support Team should consist of the Occupational Health Lead Nurse and a senior Leader (Band 8a+) from Nursing, Medical and AHP workforce as well as staff side representatives.

The Board are also asked to appoint a Board Champion for the Flu Programme 2019, as this was successful in the previous year's campaign. The Board Champion will work with

the Flu Team, including the Peer Vaccinators, to advocate vaccination to staff and provide leadership to the Programme at the highest level in the organisation.

Communication Plan
The Communications Team are supporting with the campaign for the Flu Programme 2019 and are in the process of finalising the communications plan. The campaign will include myth busters, benefits promotion, and senior leaders as advocates, clinic timetables, posters, email, desktop notifications, social media and weekly celebrations of success.

Delivery
The Programme delivery plan includes targeting clinical areas and a highly visible presence across the Trust. The aim is to vaccinate over 50% of staff within the first 4 weeks. The Programme will continue until January 2020 with the option to extend until 31st March 2020 if required.

The vaccine delivery is staggered this year due to production issues, therefore receipt of the vaccine will be on 3 occasions over a 4 week period.

The CQUIN target this year has been increased from 75% of frontline staff receiving the vaccination, to 80%.

This year the Flu Vaccination Team includes 17 Peer Flu Vaccinators, predominately senior nursing staff trained to give the flu vaccines to their peers.

Monthly returns will be submitted to Public Health England which will set out uptake and benchmark WHH against other trusts.

This year the Trust has not been requested to provide an opt-out feedback, however this could be requested before the campaign commences.

2.3. Vaccines Available for Employees

Quadrivalent influenza vaccine for 16-64 years
Quadrivalent vaccine will be provided to healthcare workers offering protection against four strains of flu. This is the standard egg-grown quadrivalent influenza vaccine (QIVe)

Adjuvanted trivalent influenza vaccine for 65 and over years
Trivalent vaccine continues to be recommended for this age group as it is likely to be a more effective vaccine than the standard dose non-adjuvanted trivalent and egg-based quadrivalent influenza. This vaccine will be given by the Workplace Health and Wellbeing only and will not be delegated to Peer Flu Vaccinators.

3. MEASUREMENTS/EVALUATIONS

Monthly returns will be submitted to Public Health England which will set out uptake and benchmark WHH against other Trusts. A full evaluation of the Flu Programme 2019-20 will be conducted in April 2020.

4. RECOMMENDATIONS

Trust Board are asked to:

- Note the evaluation of the Flu Programme 2018;
- Commit to achieving the ambition of 100% of healthcare workers receiving the vaccine;
- Agree on a Board Champion for the Flu Campaign 2019;
- Commission the formation of a Flu Support Team;
- Note the outline of the Flu Programme 2019.

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Warrington and Halton Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/19/09/94**
SUBJECT:	**Board Assurance Framework and Strategic Risk Register report**
DATE OF MEETING:	25th September 2019
AUTHOR(S):	John Culshaw, Head of Corporate Affairs
EXECUTIVE DIRECTOR SPONSOR:	Mel Pickup, Chief Executive
LINK TO STRATEGIC OBJECTIVES:	All
	Choose an item.
	Choose an item.
EXECUTIVE SUMMARY (KEY ISSUES):	This is an update of strategic risks on the Trust Strategic Risk Register. It has been agreed that the Board receives an update on all strategic risks and any changes that have been made to the strategic risk register, following review at Quality Assurance Committee. A Risk Review Group has been established reporting to Quality Assurance Committee, for oversight and scrutiny of strategic risks and for a rolling programme of review of CBU risks, to ensure risks are being managed and escalated appropriately. Since the last meeting: • It is proposed that on risk is escalated from the Corporate Risk Register to the BAF; • There are no proposed amendments to the ratings of any risks currently on the BAF is reduced; • There are no proposed amendments to risk descriptions. • It is proposed that one risk is de-escalated from the BAF to the Corporate Risk Register Also included in the report are notable updates to existing risks.

PURPOSE: (please select as appropriate)	Information	Approval	To note	Decision
		✓		
RECOMMENDATION:	Discuss and approve the changes and updates to the Board Assurance Framework and Strategic Risk Register			

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Warrington and Halton Hospitals NHS Foundation Trust

PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee
	Agenda Ref.	QAC/19/07/119
	Date of meeting	2nd July 2019
	Summary of Outcome	The Committee reviewed, discussed and approved the amendments
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

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Warrington and Halton Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

SUBJECT	Board Assurance Framework	AGENDA REF:	BM/19/09/93

1. BACKGROUND/CONTEXT

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

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

2. KEY ELEMENTS

2.1 New Risks

There is one new risk that is proposed for escalation to the BAF.

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

This risk rating was previously reduced and subsequently de-escalated from the BAF following the delay in the exit from the EU. However, a regional NHSE/I roadshow took place on the 11th September 2019, attended by Deputy COO, EPRR lead and representatives from Procurement and Pharmacy. NHSE/I reported that overall preparation has improved with national procurement of alternative delivery routes, an express freight channel and national engagement with key suppliers to create a replenishing 6 week buffer stock. The key concern is the planned exit date coinciding with the start of the winter period and the impact on workforce capacity and UEC demand, with the potential challenges of adverse weather, seasonal flu and changes to supply requirements. The clear message from NHSE/I is that the risk remains as high as earlier in the year.

A recommendation was made to, and subsequently supported by, the Risk Review Group meeting on 13th September 2019, to increase the risk rating to 16 (4x4) and re-escalate the risk to the BAF. The proposal was also supported by the Finance & Sustainability Committee that met on 18th September 2019.

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2.2 Amendments to risk ratings

Since the last meeting, there have been no proposed amendments to the ratings of any risks currently on the BAF.

2.2 Amendments to risk titles

Since the last meeting, there have been no proposals to amend the descriptions of any of the risks that are currently on the BAF.

2.4 Removal of Risks

Following a review of the risks at the Risk Review Group, it is proposed that one risk is de-escalated from the BAF to the Corporate Risk Register.

Risk #695: *Failure to meet NHS Cervical screening programme standards for failsafe of backlog of cervical cancer patients screening reviews. Caused by lack of a implementation of a policy for undertaking the invasive cancer audit and disclosure. NHSCSP guidance issued in 2013. Resulting in non-compliance with cervical screening specification 2018/2019 and NHSCSP guidance*

Significant progress has been made in relation to the completion of the actions, details of which are included in section 2.5 below, and substantial assurance has been received.

2.5 Existing Risks - Updates

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

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
115	Failure to provide adequate staffing levels in some specialities and wards, caused by inability to fill vacancies, sickness, resulting in pressure on ward staff, potential impact on patient care and impact on Trust access and financial targets.	• Associate Chief Nurse undertaken 6 month staffing review on all patient areas • Currently a Bank vacancy rate of 106 August - 5 booked for induction Sept – 19 booked for induction Oct – 4 booked for induction Further 15 going through pre-employment checks • HCA – 25 vacancies Aug – 2 booked for induction Sept – 2 booked for induction Oct - 1 booked for induction • Turnover continues to be monitored monthly and as part of the NHSi Collaborative with an overall reduction of RN turnover of 2.44%	No impact on risk rating
134	Risk: Financial Sustainability	• In relation to the aged debt, the	No impact

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Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
	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.	supplier/debtor has gone in to administration; this will avoid further growth of the debt. The Trust will liaise with the Administrators re: the existing debt. • The Trust will write to Wirral CCG in relation to financial support for the existing debt. • The Trust has provided the Administrator with proof of debt. • Submitted System Recovery Plan on 2nd August 2019. • Update on System Recovery Plan to be provided to NHSE/I by 13th September 2019, along with the first draft of the 5 year plan. • CEO / Accountable Officer led Financial System Recovery Group established to oversee the system financial recovery plan • Capital prioritisation process in place • Review of CBU Forecast Outturns has taken place. • Following £1b increase in NHS Capital investment, NHSE/I have instructed Trusts to revert to their original capital plans. Gaps • Mitigated system risk of circa £10m – plans required to address across the system of Warrington & Halton CCGs. WHH NHS FT and Bridgewater Community Healthcare NHS FT. • Risk that capital needs exceed capital funding resources available.	on risk rating
135	Failure to retain medical trainee doctors caused by lack of recruitment resulting in risk to reputation and service provision	• Clinisys (the supplier of the ICE system) have advised a provisional date for the migration of Sunday 15th September. They have indicated that a maximum 9 hour outage of the ICE system will be required. This information has been shared with the EPG held on 20th August. A further meeting is scheduled for Thursday 22nd August with IT, clinicians and CBU leads to discuss the impact of the	No impact on risk rating

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
		downtime and to agree robust contingency plans. • ICE data migration due to new resilient servers is due to commence on 15th September 2019. • MIAA have produced the draft report entitled 'IT Service Continuity & Resilience Review'. The action plan to address findings has been formulated and contains actions to add	
224	Failure to meet the emergency access standard caused by system demands and pressures. Resulting in potential risk to trust reputation, financial impact and below expected Patient experience	• Trajectory achieved in Month 1, Month 2, Month 3, Month 4 and Month 5 (84.97%). • Review of ED footprint with a view of right sizing for the future based on demand trends taking place in Sept 19 • Pilot of a co-located medical and surgical assessment unit taking place between 3 Sept – 10 Sept 2019. A review will then take place to inform the long term strategy for an Assessment Plaza. • Monitoring of utilisation of internal UC system i.e. GPAU, ED Ambulatory throughput – reports monitored via Patient Flow Sub-Committee and Trust Operations Board • Fully embedding actions associated with system wide capacity & demand review undertaken by Venn Consulting – 3 key actions being progressed for Winter 2019 – 8 IMC Beds agreed via IBCF, Rapid Response Service and increased home reablement capacity (c 20 beds worth of capacity total)	No impact on risk rating
125	Failure to maintain an old estate caused by restriction, reduction or unavailability of resources resulting in staff and patient safety issues, increased estates costs and unsuitable accommodation.	• Work completed to main power to Trust Main IT Network Room equipment.	No impact on risk rating
145	Influence within Cheshire & Merseyside a. Failure to deliver our strategic vision, including two new hospitals and vertical & horizontal	• No funding received in latest capital allocation. Additional £1b capital promised but allocation criteria yet tbc. • Positive meeting the Medical	No impact on risk rating

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Warrington and Halton Hospitals NHS Foundation Trust

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
	collaboration, and influence sufficiently within the Cheshire & Merseyside Healthcare Partnership and beyond, may result in an inability to provide high quality sustainable services may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position. b. Failure to fund two new hospitals may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position.	Director and Director of Strategy at Alderhey confirming their intention to work with the Trust to repatriate WHH patients • Pathology – Draft outline business case for pathology reconfiguration across Cheshire & Merseyside. Currently options for further development do not include any option where WHH is a hub. All options proposed include an Essential Services Lab (ESL) at WHH. Currently providing detailed feedback on strategic outline business case to ensure quality standards and turnaround time are sustained for proposed ESL • Updated Pathology outline business case received and will be presented to the Trust Board for feedback. • Confirmation received that there will be a new single lot open tender process to commence to determine the provider for both Runcorn and Widnes UTCs. Intention for the contract to commence 1 April 2020. • Eastern Sector Cancer Hub – Letter received providing feedback following submission, next steps to be decided following Exec Team Meeting. • Letter has been sent from the Trust to the Lead for the Eastern Sector Cancer Hub process requesting details of the public consultation and formal procurement process as well as requests for further information in relation to our submission and the scoring under the evaluation process. • Further Committee in Common with Bridgewater and consensus received on operational model.	
414	Failure to implement best practice information governance and information security policies and procedures caused by increased competing priorities due to an outdated IM&T workforce plan resulting in ineffective information governance advice and guidance	• The draft Digital strategy is currently being consulted on following the publishing of which, the restructure will be based. The structure proposal will now be conducted throughout October with an aim to gain approval late November.	No impact on risk rating

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
	to reduce information breaches.		
695	Failure to meet NHS Cervical screening programme standards for failsafe of backlog of cervical cancer patients screening reviews. Caused by lack of a implementation of a policy for undertaking the invasive cancer audit and disclosure. NHSCSP guidance issued in 2013 Resulting in non-compliance with cervical screening specification 2018/2019 and NHSCSP guidance	SQAS Action Plan: Summary to date: • 50 recommendations in total • 5/50 recommendations are for the CCG to complete. (1 green, 4 amber) No change • Warrington Actions • 27/45 are complete • 16/45 are amber • 2/45 are red. **Update on the Red Rated Actions** Increase number of Registered Nurse and HCA hours to support colposcopy clinics Review the capacity and shared space within the patient gynaecology waiting area to ensure that it meets the specification outlined. **Update on the Amber Rated High Priority Actions** Ensure that there are suitable monitors for image viewing and the availability of image capture. A business case and risk assessment has been completed to support the procurement of the new equipment as part of a capital funding bid. Complete procurement process for cold coagulation to ensure that women with high grade have alternative treatment choices. A business case and risk assessment has been completed to support the procurement of the new equipment as part of a capital funding bid. Progress of the SQAS action plan continues to be monitored at monthly WH Governance Meeting Risk assessments completed to support non-compliance with the SAQA recommendations are monitored as part of the risk register process.	Recommend to de-escalate to the Corporate Risk Register

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

Risk ID	Strategic Risk	Update since last Risk review	Impact of update on risk rating
241	Failure to retain medical trainee doctors caused by lack of recruitment resulting in risk to reputation and service provision	• GMC National Training Survey results received in July 2019, noting 6 Category 1 (minor) risks, no patient safety issues resulting in an overall Trust risk score of Category 1. This is a significant improvement compared to 2018, when the Trust was scored as Category 2. Key areas to note: Decreases in category 1 and 2 risks; significant improvement in GMC training feedback scoring; there is an action plan in place to resolve any concerns. • Currently awaiting feedback in relation to enhanced monitoring. • Review of Digital Strategy on going	No impact on risk rating

2.6 Risk Management Strategy Updates

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

The Corporate Risk Register is now shared at all the Committees of the Board, the Risk Review Group in addition to any additional oversight Committees of Strategic/Corporate risks.

The Corporate risk register is a list of all the risks which may prevent the Trust from achieving its' Corporate objectives and is comprised of all risks on the CBU and corporate risk registers which are identified as likely to affect the organisation at a corporate level.

3 RECOMMENDATIONS

Discuss and approve the changes and updates to the Board Assurance Framework and Strategic Risk Register

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/19/09/95**
SUBJECT:	**Request to change the Foundation Trust's Constitution – Change the Trust's Name**
DATE OF MEETING:	25 September 2019
AUTHOR(S):	Pat McLaren, Director of Community Engagement
EXECUTIVE DIRECTOR SPONSOR:	Mel Pickup, Chief Executive
LINK TO STRATEGIC OBJECTIVES:	All
	Choose an item.
	Choose an item.
EXECUTIVE SUMMARY (KEY ISSUES):	The Foundation Trust has been working to move to Teaching Hospital status for the past two years, following initial approval from the Council of Governors to commence the process. This process, as described by NHS Identity for Foundation Trusts, has now concluded and the final action is to amend the Constitution to reflect the name change to Warrington and Halton Teaching Hospitals NHS Foundation Trust. The Foundation Trust's Constitution states: *45. Amendment of the constitution* *45.1. The Trust may make amendments to its constitution if:* *45.1.1 more than half of the members of the Board of Directors of the Trust voting approve the amendments; and* *45.1.2 more than half of the members of the Council of Governors of the Trust voting approve the amendments.* The paper proposes amendments to the all areas of the Constitution: • Change to the Trust's Name – Recorded in section 1.1 'Name' • Replacement of Warrington and Halton Hospitals NHS Foundation Trust with Warrington and Halton Teaching Hospitals NHS Foundation Trust - 10 occasions in document • Replacement of branding (attached provided by NHS Identity via NHS Improvement North Communications Team)

PURPOSE: (please select as appropriate)	Information	Approval	To note	Decision
		X		
RECOMMENDATION:	That the Trust Board approves the request of the Council of Governors to change the Constitution of the Foundation Trust with immediate effect.			

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

PREVIOUSLY CONSIDERED BY:	**Committee**	Council of Governors
	Agenda Ref.	**CoG /19/08/53**
	Date of meeting	13 August 2019
	Summary of Outcome	Approved by vote
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	Amendments to the Constitution	AGENDA REF	BM/19/09/94

1. BACKGROUND/CONTEXT

The Trust has been working on its status as a Teaching Hospital for the past two years, following initial approval from the Council of Governors to commence the process.

This process has now concluded and the final action is to amend the Constitution to reflect the name change to Warrington and Halton Teaching Hospitals NHS Foundation Trust.

In order to make amendments, the Trust's Constitution states:

> *45. Amendment of the constitution*
>
> *45.1. The Trust may make amendments to its constitution if:*
>
> *45.1.1 more than half of the members of the Board of Directors of the Trust voting approve the amendments; and*
>
> *45.1.2 more than half of the members of the Council of Governors of the Trust voting approve the amendments.*

The proposed amendments are set out below.

- Change to the Trust's Name – Recorded in section 1.1 'Name'
- Replacement of Warrington and Halton Hospitals NHS Foundation Trust with Warrington and Halton Teaching Hospitals NHS Foundation Trust - 10 occasions in document
- Replacement of branding (below brand provided by NHS Identity via NHS Improvement North Communications Team)

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

A full copy of the amended Constitution will be circulated once all name changes, and new branding, have been incorporated.

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2. KEY ELEMENTS

The timeline for the change of status is set out below:

Actions	Materials/Communications format	Timeline	Status
Proposal to change Trust's name	• Trust Board approval • CoG approval • Board decision – option 1 and option 2		April 17 July 17 Feb 19
Branding	1. Draft design for engagement 2. Application to NHS Identity team for new branding 3. Rebrand all digital platforms 4. Rebrand print items only as due for renewal/re-order 5. New signage main entrances	April 17 On approval of constitution change	
Support from the University of Chester	Letter from CEO MP requesting letter of support from Vice Chancellor	Received 20.11.18	
Press release	Name change – local/regional media	On approval of change to constitution	
Change Constitution	Paper to CoG on 13.8.19	Approved	
Stakeholder engagement	1. Trust staff – Team Brief/all staff comms 2. Governors and Members 3. University of Chester 4. Other academic partners 5. Commissioners 6. MPs 7. Warrington Together partners 8. One Halton partners 9. Healthwatch 10. NHSI regional team	Letter from CEO 5.8.19	Staff - complete Governor | Members University of Chester Academics Commissioners MPs elected members WT and One Halton Healthwatch NHSI Regional Team
Formal notification of name change	1. NHS Improvement national team 2. NHS England 3. NHS Digital 4. Care Quality Commission 5. NHS Choices 6. NHS Jobs 7. NHS Employers	Following Board approval of constitution change	

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3. ACTIONS AND RECOMMENDATIONS

The Council of Governors has now approved the proposed amendments to the Trust's Constitution and submits this formal request to the Trust Board for approval.

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BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/19/09/96**
SUBJECT:	**Emergency Preparedness, Resilience and Response (EPRR) Assurance 2019/20**
DATE OF MEETING:	25th September 2019
ACTION REQUIRED	**For assurance**
AUTHOR(S):	Emma Blackwell
EXECUTIVE DIRECTOR SPONSOR:	Chris Evans Chief Operating Officer
LINK TO STRATEGIC OBJECTIVES:	SO1: To ensure that all care is rated amongst the top quartile in the North West of England for patient safety, clinical outcomes and patient experience
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	BAF1.4: Business Continuity
	Choose an item.
	Choose an item.
STRATEGIC CONTEXT	As part of the NHS England Emergency Preparedness, Resilience and Response (EPRR) Framework, providers and commissioners of NHS funded services must show they can effectively respond to major, critical and business continuity incidents whilst maintaining services to patients. The NHS Core Standards for EPRR set out the minimum requirements expected of providers of NHS funded services in respect of EPRR.
EXECUTIVE SUMMARY (KEY ISSUES):	In line with the requirements of the 2019/20 EPRR assurance process, the Trust has undertaken the annual self-assessment against the NHS EPRR core standards. Of the 64 core standards, the Trust is fully compliant with 61, and partially compliant with 3 standards but with evidence of progress towards full compliance. The Trust has achieved an overall compliance level of 'Substantial' which is an improvement from last year's rating. The Trust is required to report the outcome of the 2019/20 EPRR Audit to Board.

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RECOMMENDATION:	The Board is asked to note the 'Substantial' compliance rating achieved by the Trust.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Event Planning Group
	Agenda Ref.	EPG/200819/04
	Date of meeting	20.08.19
	Summary of Outcome	Approved
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

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BOARD OF DIRECTORS

SUBJECT	Emergency Preparedness, Resilience and Response (EPRR) Assurance 2019/20	AGENDA REF:	BM/19/09/95

1. BACKGROUND/CONTEXT

NHS Acute Hospital Trusts are defined as 'Category 1 Responders' by the 2004 Civil Contingencies Act. This carries legal duties to have up to date plans and procedures to underpin the response to a wide range of Major Incidents and Business Continuity challenges.

Under the Act, Acute Trusts must show that they can effectively respond to emergencies and business continuity incidents while maintaining services to patients. This work is referred to as Emergency Preparedness, Resilience and Response (EPRR).

The NHS England EPRR Core Standards are the minimum standards which NHS organisations and providers of NHS funded care must meet. Providers of NHS funded services must complete an assurance self-assessment based on the EPRR core standards. This assurance process is led by NHS England and NHS Improvement via the Local Health Resilience Partnerships (LHRP).

2. KEY ELEMENTS

The EPRR Assurance Process

All providers of NHS funded care are required to undertake an annual self-assessment against the EPRR Core Standards and rate their level of compliance. Once this has been completed organisations must report to their Board, though a statement of compliance.

The Chief Operating Officer as the Trust Accountable Emergency Officer has a responsibility to submit the self-assessment report, compliance rating and action plan to the Regional NHSE/I EPRR Team. The EPRR Team will further assess the submission and supporting evidence, and submit a Regional assessment through to the NHSE/I EPRR National Board.

Warrington and Halton Hospital Statement of Compliance

Following the self-assessment and in line with the definitions of compliance (appendix 1), Warrington and Halton Hospital has declared itself as demonstrating a **Substantial** compliance against the EPRR Core Standards.

The Trust was rated against 64 applicable standards, and reported full compliance with 61 standards. 3 standards were rated as partially compliant but with evidence of progress towards full compliance. No standards were rated as non-compliant.

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	6	0	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	14	13	1	0
Command and control	2	2	0	0
Training and exercising	3	3	0	0
Response	7	7	0	0
Warning and informing	3	3	0	0
Cooperation	4	4	0	0
Business Continuity	9	8	1	0
CBRN	14	13	1	0
Total	64	61	3	0

Last year the Trust reported a partial assurance level with 10 partially compliant standards. The significant improvement in assurance level highlights the work that has been undertaken in the past 12 months specifically around business continuity and EPRR staff training and exercising.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

The 3 partially compliant standards are:-

- Mass Casualty Patient Identification

The Trust Emergency Department has systems in place to record and track unidentified patients arriving from a mass casualty incident, the Lorenzo system will generate a unique identification number until the patient details are known, however this does not follow the current national guidance. DXC are working on this as part of updating the ED Major Incident functionality on Lorenzo.

- Data Protection and Security Toolkit

The Trust's DSP Toolkit submission was published as per NHS Policy in March 2019. Confirmation was received from NHSX that the assessment had been published with the status standards not fully met. An action plan was agreed and is being led by the Information Governance Manager.

- Decontamination Capability available 24/7

Staff training in Chemical Biological Radiological Nuclear (CBRN) decontamination is an area to be progressed and is part of the EPRR work plan for 2019/20. Earlier this year 8 members of the ED team attended the NWAS CBRN training. A training plan is currently being devised to ensure full decontamination training is rolled out within the Emergency Department by the end of March 2020.

Progress against the partially compliant standards will be monitored via the monthly Event Planning Group. The Event Planning Group is chaired by the Chief Operating Officer (Accountable Emergency Officer) or Deputy Chief Operating and reports to the Trust Operational Board.

4. IMPACT ON QPS?

No impact.

5. MEASUREMENTS/EVALUATIONS

The statement of compliance is detailed in appendix 1.

6. TRAJECTORIES/OBJECTIVES AGREED

The action plan is detailed within the core standards audit.

7. MONITORING/REPORTING ROUTES

Progress on actions will be monitored via the monthly Event Planning Group.

8. ASSURANCE COMMITTEE

Trust Event Planning Group
Local Health Resilience Partnership

9. RECOMMENDATIONS

The Board is asked to note the achievement of the 'substantial' compliance rating against the EPRR core standards.

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Appendix 1 – WHH 2019/20 EPRR Statement of Compliance

Cheshire & Merseyside Local Health Resilience Partnership (LHRP) Emergency Preparedness, Resilience and Response (EPRR) assurance 2019-2020

STATEMENT OF COMPLIANCE

Warrington and Halton Hospitals NHS Foundation Trust has undertaken a self-assessment against required areas of the NHS England Core Standards for EPRR

Following assessment, the organisation has been self-assessed as demonstrating the Substantial compliance level (from the four options in the table below) against the core standards.

Compliance Level	Evaluation and Testing Conclusion
Full	Arrangements are in place and the organisation is fully compliant with all core standards that the organisation is expected to achieve. The Board has agreed with this position statement.
Substantial	Arrangements are in place however the organisation is not fully compliant with one to five of the core standards that the organisation is expected to achieve. A work plan is in place that the Board or Governing Body has agreed.
Partial	Arrangements are in place however the organisation is not fully compliant with six to ten of the core standards that the organisation is expected to achieve. A work plan is in place that the Board or Governing Body has agreed.
Non-compliant	Arrangements in place do not appropriately address 11 or more core standards that the organisation is expected to achieve. A work plan has been agreed by the Board or Governing Body and will be monitored on a quarterly basis in order to demonstrate future compliance.

The results of the self-assessment were as follows:

Number of applicable standards (same as last year)	Standards rated as **Red**	Standards rated as **Amber**	Standards rated as **Green**
64	0	3	61
Acute providers: **64** Specialist providers: **55** Community providers: **54** Mental health providers:**54** CCGs: **43**			

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Where areas require further action, this is detailed in the attached core standards improvement plan and will be reviewed in line with the organisation's EPRR governance arrangements.

I confirm that the above level of compliance with the core standards has been agreed by the organisation's board / governing body along with the enclosed action plan.

Sign Name
The organisation's Accountable Emergency Officer

Print Name

25/09/2019
Date of board / governing body meeting

Click here to enter a date.
Date signed

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REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/19/09/97**
SUBJECT:	**EU Exit Preparation Update**
DATE OF MEETING:	25th September 2019
AUTHOR(S):	Emma Blackwell, Resilience Manager
EXECUTIVE DIRECTOR SPONSOR:	Chris Evans, Chief Operating Officer
LINK TO STRATEGIC OBJECTIVES:	SO1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience
	Choose an item.
	Choose an item.
EXECUTIVE SUMMARY (KEY ISSUES):	On 31st October 2019 the UK is scheduled to exit the European Union. Negotiations are ongoing to agree the terms of departure but at this stage NHSE/I have instructed that organisations prepare for a no deal scenario. EU Exit Leads for the Trust attended a regional EU Exit workshop on the 11th September hosted by NHSE/I. The event provided assurance on the planning and contingency arrangements that have been put into place. However, the message was clear that exiting the EU at the start of the winter period presents a significant risk to the NHS. The Trusts EU Exit response has been stood up with an EU Exit team in place consisting of subject matter experts for critical areas including supply/procurement, pharmacy, workforce, overseas visitors and data.

PURPOSE: (please select as appropriate)	Information	Approval	To note √	Decision
	This paper updates the Trust Board on national processes, systems and structures that are involved in preparing for the EU Exit,			

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	and the local preparation and key actions required to ensure the Trust is prepared for a no deal exit on the 31st October.	
RECOMMENDATION:	In view of the challenges the EU Exit will present at the start of the winter period it is recommended that the risk be re-escalated onto the Board Assurance Framework.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	
FREEDOM OF INFORMATION STATUS (FOIA):	Whole FOIA Exemption	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Section 41 – confidentiality	

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NAME OF COMMITTEE

SUBJECT	EU Exit Preparation Update	AGENDA REF:	

1. BACKGROUND/CONTEXT

On 31st October 2019 the UK is scheduled to exit the European Union. Negotiations are ongoing to agree the terms of departure but at this stage NHSE/I have instructed that organisations prepare for a no deal scenario.

The NHS stood up the formal operational response to the EU Exit on the 2nd September and this is again being led by Professor Keith Willett, EU Exit Strategic Commander. Professor Willett is supported by regional control teams who will be the point of escalation for local organisations.

The Trust's Brexit Working Group was re-established at the end of August and members from this group attended a North West Regional NHSE/I EU Exit workshop on the 11th September. Dan Moore, Deputy COO also attended this event on behalf of the Trust's SRO for EU Exit.

Following on from the regional workshop, the purpose of this paper is to update the Trust Board on national processes, systems and structures that are involved in preparing for the EU Exit and the key actions needed locally to ensure the Trust is prepared for a no deal exit on the 31st October.

Whilst overall assurance from NHSE/I is higher than earlier in the year, the scheduled date of the 31st October conflicting with winter pressures provides a significant risk to the NHS and the Trust risk assessment needs to be reviewed and updated accordingly.

2. KEY ELEMENTS

National Context

Continuity of Supplies

The intention of government planning is to avoid any disruption of services to patients or supplies. The NHS has goods entering the UK from the EU across all

methods of transport, 76% of medicines and 56% of devices are imported from or through the EU.

In preparation for the 31st October, the following contingency arrangements have been put into place:-

- National procurement of alternative routes and express freight channels for NHS goods.
- Suppliers to create a replenishing 6 week buffer stock.
- NHS Supply Chain increased stockpile by 35%.
- Additional warehouse capability to store stockpiles.
- Regulatory flexibility so products continue to be placed on UK market.
- National Supply Disruption Response (NSDR) team in place at DHSC.
- Medicines Shortage Response Group (MSRG) has been established.
- Key categories such as food, linen, laundry and lift maintenance are being reassessed with key supplier business continuity plan reviews.
- Flu vaccine – all vaccines needed nationally plus additional vaccines will be in the country by the 31st October.

Co-Ordinating the NHS Response

The Operational model for the EU Exit response is as follows:-

- **Central control and co-ordination** with a single point of contact for each region to escalate any issues.
- **Commercial and Procurement Cell** who will work with NSDR, suppliers and clinicians to support NHS in responding to supplier disruption.
- **EPRR & Shortage Response** to support additional incident management capacity and serious shortage escalation protocols.

Prior to the 31st October the national teams will be available Monday to Friday working extended hours. From the 1st November they will be available 24/7.

Local Preparation

Brexit Working Group

The Trust re-established the Brexit Working Group at the end of August and fortnightly meetings are taking place led by Chris Evans, Chief Operating Officer with representation at senior level from key areas including Finance, Procurement, Pharmacy, HR and IM&T. The group meets formally to update on operational readiness and reviews new information and guidance as it becomes available.

EU Escalation Process

A process on how EU Exit issues will be escalated is being developed for all key areas and will be shared at the next Brexit group.

Operational Readiness Tracker

The operational readiness tracker is updated by key leads and monitored by the Brexit working group.

Business Continuity Plans

Service level business continuity plans are now in place across all clinical business units and are supported by the overarching Trust Business Continuity Plan.

In addition the Trust is well underway with Winter planning arrangements including season flu planning.

Communication

A regional EU Exit communications event is scheduled to take place on the 23rd September. Following this an internal communications plan will be developed to ensure key messages are being delivered to front line staff.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

The regional workshop provided an update on the key areas of activity and the local actions that are required, this is detailed below with the subject matter experts for each area:-

Medicines – Diane Matthews/Maria Keeley

- Prescribe and dispense as normal and reassure patients that extra medication is not required and avoid issuing longer prescriptions.
- Do not stockpile locally.
- Incidences involving over ordering of medicines will be investigated.
- Report any shortages through usual routes and collaborate locally.

Medical Devices and Clinical Consumables – Alison Parker/Brian Burge

- Review existing arrangements and plan for longer lead in times and communicate internally.
- Continue to manage any continuity of supply issues following business as usual routes.
- Ensure arrangements are in place to receive goods out of hours and at weekends.
- No local stockpiling

Adult Social Care

- Arrange system wide meeting to ensure contingency plans are shared on EU Exit and Winter, reviewing risks and workforce pressures and identify mitigations.

Workforce – Amanda Jordan/Tina Jones

- Provide continued reassurance to EU staff.
- Continue to promote the benefits of the EU Settlement scheme
- Keep abreast of immigration/employment developments.

Reciprocal Healthcare – Caroline Thornton/Steve Barrow

- Continue to support current reciprocal healthcare arrangements until further advice from the Government
- In a no deal scenario, amended charging regulations will come into force from exit date. Overseas staff will need to understand new regulations and ensure they can be put into practice.
- DHSC and NHSE/I will provide updates and further information once the position is agreed.

Clinical Trials – Nemonie Marriott

- Continue to recruit patients into clinical trials.
- Ensure staff are familiar with issued guidance and the DHSC technical notices.

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Data – Mark Ashton

To date, the Trust has not identified any IT systems which have a touchpoint in the EU.

- Data Protection Officer to join NHS Digital webinars and review guidance as it becomes available.

Finance – Steve Barrow

- Trusts were asked to continue to record any EU Exit specific spend that has been incurred.

System wide planning

Organisations were requested to work with partners to identify concerns, interdependencies and vulnerabilities in key areas. A meeting will be scheduled with key EU Exit leads from the Trust, Local Authorities, and the CCG.

4. IMPACT ON QPS?

The risk of a no deal EU exit on the 31st October is documented on the Trust risk register.

5. MONITORING/REPORTING ROUTES

Regular updates on EU Exit preparations will be provided to Trust Board.

6. TIMELINES

18th September – Assurance template to be submitted to NHS England
23rd September- Regional communications event
26th September – Brexit Working Group meeting
1st October – SitRep testing commences
21st October – Daily SitRep commences
31st October – Planned EU Exit

7. RECOMMENDATIONS

In view of the challenges the EU Exit will present at the start of the winter period it is recommended that the risk be re-escalated onto the Board Assurance Framework.

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Trust Board

DATES 2019-2020

All meetings to be held in the Trust Conference Room

Date of Meeting	Agenda Settings	Deadline For Receipt of Papers	Papers Due Out
2018			
Wednesday 28th November	Wednesday 7th November	Monday 19th November	**Wednesday 21st November**
2019			
Wednesday 30th January	Wednesday 9th January	Monday 21st January	**Wednesday 23rd January**
Wednesday 27th March	Wednesday 6th March	Monday 18th March	**Wednesday 20th March**
THURSDAY 23 May YR END	Thursday 2 May (EXECS)	Tuesday 14 May	**THURSDAY 16 May**
Wednesday 29 May	Thursday 9 May (EXECS)	Monday 20 May	**Wednesday 22 May**
Wednesday 31 July	Thursday 11 July (EXECS)	Monday 22 July	**Wednesday 24 July**
Wednesday 25 September	Thursday 5 Sept (EXECS)	Monday 16 September	**Wednesday 18 September**
Wednesday 27 November	Thursday 7 Nov (EXECS)	Monday 18 November	**Wednesday 20 November**
2020			
Wednesday 29 January	Thursday 9 January (EXECS)	Monday 20 January	**Wednesday 22 January**
Wednesday 25 March	Thursday 5 March (EXECS)	Monday 16 March	**Wednesday 18 March**