We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

# WHH Board of Directors Meeting Part 1

**Wednesday 28 November 2018**
**09.45am-12.55pm 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 28 November 2018 time 9.45am -12.55pm
Trust Conference Room, Warrington Hospital

BUFFET LUNCH 13.00 – 14.00 to include:

i. Signing Ceremony, Strategic Partnership (MOU) - Warrington & Royal Vale College and WHH NHS Foundation Trust, Mel Pickup, CEO, Steve McGuirk, Chairman, and Nichola Newton (Principal & Chief Executive).
ii. Meeting with Doctors relating to - Partnership with King Edward Memorial Hospital, Mumbai

| REF BM/18 | ITEM | PRESENTER | PURPOSE | TIME | |
|---|---|---|---|---|---|
| | Ward Accreditation | | Presentation | 09.45 | N/A |
| BM/18/11/102 | Welcome, Apologies & Declarations of Interest | Steve McGuirk, Chairman | N/A | 10.15 | Verbal |
| BM/18/11/103 PAGE 4 | Minutes of the previous meeting held on 26 September 2018 | Steve McGuirk, Chairman | Decision | 10:22 | Encl |
| BM/18/11/104 PAGE 13 | Actions & Matters Arising | Steve McGuirk, Chairman | Assurance | 10:25 | Encl |
| BM/18/11/105 PAGGE 15 | Chief Executive's Report<br>(a) NHSI QRM feedback - 15 October 2018<br>(b) Brexit planning and preparedness briefing<br>(c) Summary of NHS Providers Board papers | Mel Pickup, Chief Executive | Assurance | 10:30 | Verbal |
| BM/18/11/106 | Chairman's Report | Steve McGuirk, Chairman | Information | 10:45 | Verbal |

Quality People Sustainability

| | | | | | |
|---|---|---|---|---|---|
| BM/18/11/107 PAGE 29 | Integrated Performance Dashboard M10 and Assurance Committee Reports | All Executive Directors | Assurance | 10.50 | Enc |
| (a) | - Quality Dashboard including PAGE 69<br>○ Monthly Nurse Staffing Report (September, October) | | | | Enc |
| (b) | - Key Issues report Quality and Assurance Committee (6.11.2018) PAGE 83 | Margaret Bamforth, Committee Chair | | | Enc |
| (c ) | - Sustainability Dashboard | | | | Enc |
| | - Finance and Sustainability Committee PG 88<br>- (24.10.2018)+ (21.11.2018 to follow) | Terry Atherton, Committee Chair | | | |
| (d) | - Audit Committee (22.11.2018 to follow) | Ian Jones, Committee Chair | | | |
| (e) | People Dashboard<br>- Strategic People Cttee (21.11.2018) PG 91 | Anita Wainwright, Committee Chair | | | |

| | | | | | |
|---|---|---|---|---|---|
| BM/18/11/108 | Spinal Services Update | Simon Constable<br>Deputy Chief Executive/<br>Executive Medical Director | Assurance | 11.15 | Verbal |

Quality

| | | | | | |
|---|---|---|---|---|---|
| BM/18/11/109<br>PAGE 96 | Learning from Experience Summary Report | Kimberley Salmon-Jamieson<br>Chief Nurse | Assurance | 11.20 | Enc |
| BM/18/11/110<br>PAGE 100 | DIPC Quarterly Report | Kimberley Salmon-Jamieson<br>Chief Nurse | Assurance | 11.25 | Enc |
| BM/18/11/111<br>PAGE 113 | CQC Action Plan Report | Kimberley Salmon-Jamieson<br>Chief Nurse | Assurance | 11.30 | Enc |
| BM/18/11/112<br>PAGE 123 | Safeguarding Adults Annual Report | Kimberley Salmon-Jamieson<br>Chief Nurse | Assurance | 11.40 | Enc |
| BM/18/11/113<br>PAGE 125 | Ward Accreditation Report | Kimberley Salmon-Jamieson<br>Chief Nurse | Assurance | 11.45 | Enc |
| BM/18/11/114 | Quality Academy | Kimberley Salmon-Jamieson<br>Chief Nurse | Assurance | 11.55 | PPT |
| BM/18/11/115<br>PAGE 134 | Quarterly Mortality Review Report | Simon Constable<br>Executive Medical Director | Assurance | 12.05 | Enc |

Sustainability

| | | | | | |
|---|---|---|---|---|---|
| BM/18/11/116<br>PAGE 145 | Quarterly Progress on Carter Report, recommendations and Use of Resource Assessment | Andrea McGee<br>Director of Finance +<br>Commercial Development | Assurance | 12.10 | Enc |
| BM/18/11/117<br>PAGE 182 | EPRR Assurance Report | Chirs Evans<br>Chief Operating Officer | Assurance | 12.20 | Enc |

People

| | | | | | |
|---|---|---|---|---|---|
| BM/18/11/118<br>PAGE 202 | Guardian of Safe Working Quarterly report | Alex Crowe<br>Medical Director | Assurance | 12.25 | Enc |

**GOVERNANCE**

| | | | | | |
|---|---|---|---|---|---|
| BM/18/11/120<br>PAGE 217 | Quarterly Strategic Risk Register + BAF | John Culshaw<br>Head of Corporate Affairs | Assurance | 12.40 | Enc |
| BM/18/11/121<br>PAGE 234 | Changes to the Scheme of Reservation & Delegation | Simon Constable<br>Executive Medical Director/<br>Deputy Chief Executive | Approval | 12.45 | Enc |
| BM/18/11/122<br>PAGE 242 | WHH Charity Annual Report + Accounts | Pat McLaren<br>Director of Community<br>Engagement + Fundraising | Assurance | 12.50 | Enc |

| | | | | | |
|---|---|---|---|---|---|
| BM/18/11/123 | Any Other Business | Steve McGuirk,<br>Chairman | N/A | 12.55 | Verbal |
| | Date of next meeting: 30 January 2019, Trust Conference Room | | | | |

**Warrington and Halton Hospitals NHS Foundation Trust**
**Minutes of the Board of Directors meeting held in Public (Part 1) on Wednesday 26 September 2018**
**Trust Conference Room, Warrington Hospital**

| **Present** | |
|---|---|
| Steve McGuirk (SMcG) | Chairman |
| 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 |
| Kimberley Salmon-Jamieson (KSJ) | Chief Nurse |
| Anita Wainwright (AW) | Non-Executive Director |
| **In Attendance** | |
| Michelle Cloney (MC) | Director of HR + OD |
| Alex Crowe (AC) | Medical Director and Chief Clinical Information Officer |
| John Culshaw (JC) | Head of Corporate Affairs |
| Pat McLaren (PMcL) | Director of Community Engagement + Fundraising |
| Julie Burke (JB) | Secretary to Trust Board (Minutes) |
| Cara Hart (CH) | Specialist Nurse Organ Donation (*Item 09/78 only)* |
| Andy Higgs (AH) | Consultant (*Item 09/78 only)* |
| **Observing** | |
| Norman Holding | Public Governor |
| **Apologies** | |
| Mel Pickup | Chief Executive |
| Jean-Noel Ezingeard | Non-Executive Director |
| Lucy Gardner | Director of Strategy |

| *Agenda Ref BM/18/09/* | |
|---|---|
| *BM/18/09/78* | **Organ Donation Presentation**<br>The Chairman welcomed Cara Hart and Andy Higgs to the meeting who provided an overview on Organ Donation activity both regionally, nationally and within the Trust. Through the NHS Blood and Transplant Service they provide specialist teaching and raising awareness of potential organ and tissue donation opportunities, offering support to both staff and families. In the Trust, 7 life-saving and life-changing transplants took place last year due to organ donation from 3 patients and 12 people had benefitted from life-saving transplants this year following organ donations from 3 donors. The Trust Organ Donation team/support service is highly regarded by visiting Transplant Team and within the Trust. To build on current success, staff training on ICU & ED will continue, tissue donation referrals will be standardised to ensure all patients have their end of life wishes explored. The Board thanked Cara and Andy for sharing their work and successes to date, supporting a local iteration of the national 'Opt Out' programme and continued focus on staff training and EoL discussions. |
| *BM/18/09/79* | **Welcome, Apologies & Declarations of Interest**<br>The Chair opened the meeting, introductions were made and newly elected Governor Dalton Boot was welcomed to the meeting.<br>Apologies: as above. Declarations of Interest: None were noted |
| *BM/18/09/80* | **Minutes of the meeting held 25 July 2018** |

| | |
|---|---|
| | The minutes of 25 July 2018 were agreed as an accurate record of proceedings. |
| *BM/18/09/81* | **Actions and Matters Arising**<br>Rolling actions were noted. Action BM18/05/39c and BM/18/06/56 were closed. |
| *BM/18/09/82* | **Chief Executive's report**<br>Deputy CEO provided an update on matters for the Board to note since the last meeting.<br>NHSI Elective Care – The Trust had received correspondence from NHSI outlining Elective Care expectations for 2018-19 and the national focus on RTT and 52 week waits. The Trust had responded in September with assurance of compliance against these performance targets by March 2019. The Trust waiting list remains static allowing a degree of flexibility to manage winter demand.<br>Brexit Contingency Planning – National updates had been received outlining plans to protect patient safety and health care provision in the event of a 'no deal' Brexit scenario, with particular emphasis on supply of medicines, and devices, particularly high volume medicines, as well as the impact of staff and impact on European and Non-European workers. These elements have been incorporated in the Trust EPRR plans. MC advised that in reference to staffing, the Trust had signed up to the EU Settlement Scheme pilot in conjunction with the Home Office and 28 of 58 staff had participated, their status will be honoured post-Brexit.<br>NHS Provider Board Papers – Summary of Board papers and items discuss at various NHS Providers Boards noted, with the Independent Review at Liverpool Community Health highlighted and members of the Board signposted to it once again.<br>The Deputy CEO also stated that the inaugural Quality Academy Board meeting had taken place on 21 September demonstrating the progress made in this area, which will support triangulation and emphasis on quality improvement, linking with the Trust's overall Quality Strategy. The LiA second phase is to be launched 5 October. The two initiatives sit well together.<br>The Deputy CEO also reminded the Board regarding the fact that he and other executive team members and other members of staff and family were running the Chester Marathon on 7th October 2018 for WHH Charity and the Serious Illness Care Programme. |
| *BM/18/09/83* | **Chairman's Report**<br>The Chairman briefed the Board on pertinent matters discussed at the Warrington Chairs meeting of Warrington Together which included, recent media coverage regarding the Independent RCS Spinal Review and commended the transparency of the investigation and review findings; CCG-related matters, including primary care, recognising the importance of continued collaborative working given the current financial climate and any direct impact on the Trust. The CEO and Chairman had expressed an interest to participate and inform any discussions as part of the anticipated Independent Review of BWCHFT. |
| *BM/18/09/84 (a)* | **IPR Dashboard**<br>Quality measures. The Chief Nurse provided an overview of Quality KPIs in month:<br>Incidents - 151 open incidents over 40 days, assurance provided that progress of all open incidents and open SI action plans are monitored through weekly harm meetings and performance management meetings with continuation in the reduction of incidents.<br>Sepsis Antibiotic AED – 88% achieved in July. Matter discussed in detail at Patient Safety Clinical Effectiveness Committee (PSCE) on 25.9.2018 who approved establishment of a Task and Finish Group to take forward and monitor action plan for prescribing and administration to ensure screening carried out within 1 hour. To support this Blood Culture training |

| | |
|---|---|
| | continues for Senior Nurses with half of this cohort of staff fully trained.<br>Falls - overall small improvement noted. KSJ reassured the Board that a number of workstreams are in place which are monitored through PSCE, Quality Assurance Committee(QAC) and Falls Group. Predominant area for slips, trips and falls are bathroom and toilet areas and Estates Review of these areas is underway. The Trust is also part of the National Falls Collaborative (NFC) to further support a reduction in Falls. KSJ explained the Trust is currently recording all falls, including where a patient has had to be helped/lowered to the ground to avoid a fall, this data will be reviewed in Datix and further guidance is awaited through the NHSI on Falls criteria for recording.<br>KSJ also explained that a high proportion of this cohort of patients are vulnerable patients who have 1:1 enhanced care but some patients do not require this level of enhanced care and slips/falls occur due to patient getting up in an unfamiliar environment at night time. Further improvement work is in place.<br>MSA – work continues to reduce the number of breaches with a 'hub' being explored in ITU to support any delays in step down care as utilised in similar organisations.<br><br>VTE - AC explained there had been a delay in the implementation of upgrade from Lorenzo 2.15 (now anticipated on 16.10.18) being able to validate VTE assessments electronically across episodes; this issue had been raised with NHS Digital. VTE assessments and learning from RCAs for VTE had been discussed extensively at PSCE and Medical Cabinet. Workshops and learning from completed RCAs will continue to be circulated widely through a number of CBU forums to share learning and best practice. Best practice and learning from the Ward Accreditation Scheme had been adopted by AMU who are carrying out 2-weekly meetings to develop a similar accreditation scheme through ward rounds and AMU 'huddles' which includes VTE assessment. Manual validation of 45 VTE assessments remain outstanding for the last month. From an assurance perspective, MB advised the Board that the QAC are fully sighted, discuss this at length and is assured of the work taken to date and improvement plans in place.<br><br>Two new indicators had been included in the IPR this month and rated Red.<br>- HCAI CDiff, 5 cases reported, an increase of 1 in month. The Trust continues to work to support national target of 50% reduction by 2020. 26 reported to date, compared to 36 for the same period last year. KSJ reassured the Board of mitigations in place to reduce including a Task and Finish Group for Catheter Care Management and refresh of training for HCSW and Nurses, supported by Urology Nurses.<br><br>Monthly Safe-staffing report. There were no matters to escalate to the Board. In relation to shift fill rates above 100% KSJ explained this relates to high acuity patients and that staffing is reviewed hourly to maximise utilisation of staff. |
| *BM/18/09/84 (b)* | Quality Assurance Committee (QAC) Chair Key Issues Report 4 September<br>The Key Issues Report was taken as read. There were no issues to escalate to the Board. However Margaret Bamforth, Chair of Committee highlighted the patient story within the report, the large amount of work undertaken relating to Learning From Deaths and the increased qualitative and quantitative data that QAC are now receiving providing further |

| | |
|---|---|
| | assurance of progress against CQC and other action plans.<br>- **The Board noted the Quality update and Safe Staffing report.**<br><br>Access and Performance measures. The Chief Operating Officer provided an overview of KPIs:<br>- A&E 4 hour wait – 87.5% achieved against internal trajectory of 88.8%, decrease from July, predominantly due to capacity challenges throughout August. Attendances / admissions remained static, tangible change was the reduction in escalation capacity with the relocation of A3 to C22 which resulted in a net reduction of 12 bed and an increase in average medical outliers to 31 from 16 in July. Breaches linked to performance and attributable to bed delays. Mitigating actions in place include Discharge Lounge, FAU operating 4 days to increase to 5 days in October, close working with and development of the Integrated Discharge Team to improve patient flow. Particular focus over the next 3 months will be to reduce the number of patients with a Los over 21 days, other short term mitigations include review of SOPs for B3 to maximise capacity, and agreeing next steps following the completion of the Venn Capacity and Demand review across Halton and Warrington.<br>- Cancer – standards achieved with the exception of breast symptomatic which is mainly due to patient choice, 50% of referrals are within 7 days. Guidance still awaited regarding the new repatriation cancer standards.<br>- DTOCs within 24 hrs – AR providing support to CBUs to ensure timely completion.<br>Cancelled Ops - decrease in August (16), predominantly due to unavailability of anaesthetist/surgeon and late patient notification. Bi-weekly review group re-established to review all occurrences and escalation process reinforced.<br>Ambulance Handovers – challenges remain and impacted with demand on capacity.<br>- Diagnostics – trajectory achieved.<br>RTT continues to be achieved with no 52 week waits.<br>- AMG added that at TOB on 24.9.2018, she had requested an indication of potential trajectory for Q3 and Q4 as this could affect achievement of A&E STF with direct impact on the cash position.<br>**The Board supported the addition of indicators for 7 and 21 length of stay to the IPR to reflect patient flow challenges and patient outcomes to demonstrate triangulation of information.**<br><br>Workforce measures. The Director of HR & OD provided an overview of KPIs in month:<br>- Pay spend continues to be monitored and interrogated at FSC, with continued reporting of bank utilisation to NHSI. The Trust is part of the C&M Collaborative Board Task and Finish Group to maximise negotiation of competitive rates. To support this, a centralised bank has been established to challenge premium costs.<br>- Sickness absence – 4.39%, improvement in month from 5.08% demonstrating the positive impact from the recently established enhanced nurse reporting.<br>- Agency AHP spend and average length of service had both moved to Green in month.<br><br>Strategic People Committee Key Issues Report 19 September.<br>Key Issues report was taken as read. A Wainwright, Chair of SPC reported the first meeting of |
| *BM/18/09/84 (d)* | |

| | |
|---|---|
| *BM/18/09/84 (c)* | the re-established SPC had taken place in September which had reviewed the ToR and interrogated a number of measures, with particular emphasis on Resuscitation Training and completion of PDRs. They had also reviewed the People Strategy, with proposed amendments for the Board to consider (refer to Minute BM/18/09/98. SPC supported incorporation of mandatory training into the PDR process with PDRs only signed off if training had been completed, or dates scheduled to attend. SC advised that this now forms part of the revalidation process.<br>• **The Board approved the SPC ToR**<br><br><u>Finance and Sustainability measures</u>. The Director of Finance + Commercial Development provided an overview of KPIs:<br>- Significant risk to CIP, YTD savings £0.6m, £0.8m behind plan of £1.4m. From 1 September, responsibility for CIP had transferred to the DoF portfolio, supported by FSC and Board, and all schemes had been reviewed. A proposal had been considered by FSC and TOB in September, and meetings are scheduled with CBUs and Corporate Departments to identify CIP opportunities and requirements to achieve identified gap of £4m, based on budgets and SLR reporting data.<br>- FSC had considered and supported changes to the Capital Programme within the paper. AMcG explained that all schemes are under constant review ensuring that schemes undertaken are required for the delivery of service needs and mitigation of safety and risk issues.<br>• **The Board noted the report and approved changes to the 2018-19 Capital Programme.**<br><br><u>Finance and Sustainability Chairs Key Issues Report - 22.08.2018 + 19.09.2018</u><br>Chair of FSC, TA had escalated 2 matters for discussion to Part 2 of the Trust Board. One commercially sensitive item and one related to a report the August FSC had received following a service line review of Elderly Medicine.<br>FSC had supported the change in portfolio responsibility for CIP to the DoF and oversight arrangements for CBUs.<br>FSC had also requested that the amount of interest paid to date on working capital loans to be included in future finance reports.<br>Due to the re-establishment of the Strategic People Committee, TA and Chair of SPC to agree pay spend reporting to the Board to avoid duplication within the Chair's reports.<br>• **The Board noted the August and September Key Issues Report.**<br>• **The Board confident current IPR reporting is embedded. Forward looking actions / proposal to be taken to Executives to incorporate a summary of mitigation actions being taken as part of the IPR from Exec Leads** |
| *BM/18/09/85* | **RCS Spinal Services Update**<br>The Executive Medical Director reported the RCS Report had been shared at the recent Annual Members meeting. Discussion and review continues at the C&M Spinal Surgery Development Group, to provide a high quality, single spinal surgery service for the region, with the intention of keeping access for patients as local as possible with 2 workstreams, one for specialist spinal trauma and one for complex deformity and cancer work<br>**The Board noted the report.** |
| *BM/18/09/86* | **Annual Health and Safety Report** |

| | |
|---|---|
| | The Chief Nurse highlighted key areas for the Board to note which had been presented and approved at the Quality Assurance Committee in August.<br>- Full compliance declared with all legislative requirements. Management of Sharps Audit had been undertaken and a number of measures put in place relating to safer sharps agenda. Oversight continues through the Health & Safety Sub Committee with escalation through the Quality Assurance Committee.<br>- Incidents reported under RIDDOR were comparable with the previous year<br>- Manual Handling Improvement plan taken forward with oversight at the H&S Sub Committee.<br>• **The Board noted the report.** |
| *BM/18/09/87* | **DIPC, Annual Report and Quarterly Report**<br>The Chief Nurse reported that both reports had been reported to and reviewed at the Quality Assurance Committee in July and September respectively. The Infection Control Strategy is to be refreshed next year and the work to be undertaken following the Estates Review will support maintaining infection control to a minimum.<br>• **The Board noted the update report.** |
| *BM/18/09/88* | **CQC Update Report**<br>The Chief Nurse highlighted key points for the Board to note on progress against the CQC action plan.<br>- Significant number of actions completed, with 203 of 277 compliant with two thirds of 'Must Do' and 'Should Do' actions completed and compliant.<br>- KSJ reassured the Board that no actions are signed off without full evidence.<br>- The Board were asked to note the breakdown of performance of each action type and compliance at core service level.<br>- There was 9 Fundamental Breaches with a number of actions in each, 2 (Red) related to Medical Devices training and APLS training (Regulation 12 and 18). Checks in Radiology (Reg 12) has moved to Green with monthly checks remaining supported by a Trust-wide improvement programme for recording of Medical Devices training support by establishment of a Medical Devices Task and Finish Group.<br>- Significant improvement noted related to Amber Breaches and the 3 now moved to Green.<br>- KSJ assured the Board controls are in place to monitor Must and Should Do's with an Executive lead assigned to each and monitoring through the G2G Steering Group with risks reflected on the Risk Register for additional scrutiny and oversight.<br>- SC explained that the Well Led Steering Group have oversight of progress and evidence to be submitted to CQC against the 8 KLOES.<br>• **The Board noted and approved the report and the assurance of progress made to date. This will be further supported by the next phase of LiA.** |
| *BM/18/09/89* | **Safeguarding Children's Annual Report**<br>The Chief Nurse reported the Annual Report had been reviewed and supported at the Quality Assurance Committee on 4 September 2018, declaring compliance with section 11 of the Children's Act.<br>• **The Board noted and supported the Report and objectives set for 2018-19.** |
| *BM/18/09/90* | **Quarterly Mortality Review Report** |

| | |
|---|---|
| | The Executive Medical Director reported the Report had been reviewed and recommendations approved at the Quality Committee on 3 July.<br>• **The Board noted reviewed, discussed and noted the Report.** |
| *BM/18/09/91* | **Flu Campaign 2017-18**<br>The Director of HRD asked the Board to note and support the 2018 Flu Programme including the Director of HRD as the Board Champion for the current Flu Campaign. The Trust is compliant with the Best Practice Checklist, with the exception of the 2 areas highlighted within the report, vaccines for over 65 years and peer vaccinators. Opt-out figures will be reported in March 2019 with a full evaluation in April 2019.<br>• **The Board noted and supported the recommendations within the Report, including the HRD as the Board Champion.** |
| *BM/18/09/92* | **Emergency Preparedness Annual Report**<br>The Chief Operating Officer explained the report included an overview of work that had taken place in 2017-18 and plans for 2018-19. Key milestones for 2017-18 had been the successful Golden Exercise in June to test emergency and response across the health economy.<br>• **The Board noted the Report and work programme for 2018-19.** |
| *BM/18/09/93* | **Bi-Annual Nurse Staffing Report**<br>- The Chief Nurse highlighted key points for the Board to note within the report which had been approved at the Quality Assurance Committee on 4 September. The Board were asked to note an amendment to the report post QAC, the report identified an initial deficit in Registered nurses of 81.06wte, however there had been a data error identified with the funded establishment on ward C21 in in the Safecare census data which had been rectified. The overall deficit had been recalculated at 58.06wte which is a more favourable position.<br>- Focus remains on recruitment, with 45 HCSW recruited and 20 RNs to commence shortly with an additional 9 RNs following a recruitment event last week.<br>- 9 Trainee Nurse Associates to transfer to WHH employment in February with future recruitment to TNA posts planned.<br>- 'Red flag' recording system introduced.<br>- Patient Care Per Day increased from 6.1-6.6 to 7.1 hours. KSJ explained the Trust use 23% uplift as recommended by the National Quality Board, 23 Wards in the Trust were part of the recent Trust review. Acuity is reviewed hourly, opportunities remain for improvement as Acuity currently reviewed by B5 and B6 staff and ratio is benchmarked against similar organisations for registered staff and HCSWs.<br>• **The Board noted and approved the amended Report.** |
| *BM/18/09/94* | **GMC Re-validation Annual Report**<br>The Executive Medical Director highlighted key points for the Board to note within the report which had been reviewed and discussed at the Strategic People Committee on 19 September, providing assurance that the Trust Medical Appraisal System and Process for monitoring and completion of Annual Appraisals to support GMC revalidation are robust. Appraisals are also reviewed monthly as part of triangulation meetings which also allows any concerns to be raised and considered alongside other concerns. As referred to earlier in the meeting, completion of training will be linked with the appraisal process before appraisals |

| | |
|---|---|
| | are signed off. It was noted, that in parallel, that reserves held for 218-19 Clinical Excellence Awards, further national guidance is awaited.<br>• **The Board noted the Report.** |
| *BM/18/09/95* | **Freedom to Speak Up (FTSU) – Guardian Bi-Annual Report and Toolkit**<br>The Deputy Director of Finance highlighted key points for the Board to note within the report:<br>- 1 disclosure in Q1, and 6 in Q2, with 13 since May 2017, WHH is comparable with similar Trusts in number of disclosures, with 1 over the last 6 months, 0 in Q4 and 1 in Q1.<br>- There has been a focussed campaign to raise awareness of FTSU through the safety huddle, team brief, team meetings and through FTSU Champions. There had been an increase in FTSU Champions across a number of staff groups, genders and BME.<br>- The self review tool had identified areas to develop, which had been submitted to NHSI and will support evidence to be submitted to CQC.<br>- A draft Vision and Strategy and action plan is under development.<br>• **The Board noted the Report and progress of FTSU and thanks JH for her support.** |
| *BM/18/09/96* | **Warrington & Halton Hospitals FT and Warrington and Vale Royal College Memorandum of Understanding**<br>The Director of HR & OD highlighted key points for the Board to note within the report which will support the Trust to develop formal strategic partnership with local colleges to provide learning and education opportunities for potential new recruits. This will support the Trust's aspiration to encourage more young people to become involved at the Trust.<br>This will not exclude working with other partners with the health economy.<br>• **The Board noted and approved the Memorandum of Understanding.** |
| *BM/18/09/97* | **Guardian of Safe Working Q1 Report**<br>The Medical Director highlighted key points for the Board to note within the report-<br>- There had been a significant reduction in the number of exceptions raised in Q1 from 33 in Q4 to 27. The 33 submitted were from 13 trainees covering 11 Educational Supervisors. Two safety exceptions reports were escalated, resolved quickly and satisfactorily.<br>- 17 exception reports remain open from Q1 and AC highlighted that trainee and Educational Supervisor had met to discuss another 8 exception reports with proposed outcome yet to be accepted by trainee.<br>- AC reassured the Board and all exceptions are being proactively managed by the Guardian with reiteration of the process through induction, 1:1 meetings with educational supervisors and e-communication.<br>- There is an increase in reports in Trainees taking time off in lieu as opposed to financial compensation.<br>- The recent launch of the Trello App and Jnr Doctors Forum is supporting more interaction amongst staff with a representative from each staff group to be identified as a further contact to support more fluidity in the flow of communication.<br>- **The Board noted the Report and assurance provided and will continue to report any concerns to the Guardian.** |
| *BM/18/09/98* | **People Strategy**<br>The Director of HR & OD highlighted key points for the Board to note within the People Strategy which had been debated in detail at the Strategic People Committee (SPC) and |

| | |
|---|---|
| | subsequently refreshed for Trust Board approval.<br>- The Strategy had been aligned with national and regional publications, incorporating internal strategies and outcomes from the Staff Opinion Survey. The SPC will interrogate People Measure indicators, qualitative and quantitative data and receive the first report in November. Comments were invited from colleagues.<br>- Additions requested. FTSU to be incorporated in Inclusion section; Staff and patients to be included in LiA (Engagement); successful measures of the Ward Accreditation scheme and patient experience; additional information relating to Quality Academy; reference to Partnership System Working<br>- MC explained that work underway across C&M as part of the STP had been taken into account.<br>• **The Board noted the Report and approved the Refreshed People Strategy subject to these amendments.** |
| *BM/18/09/99* | **Strategic Risk Update**<br>The Head of Corporate Affairs highlighted key points for the Board to note within the report<br>- 1 new risk had been added relating to Resuscitation Training as discussed previously. Updates noted relating to fundamental breaches medical devices, finance and sustainability - debtor, CIP and commissioner correspondence and the significant work undertaken relating to Falls.<br>• **The Board noted the Report and updates. In relation to Resuscitation Risk, it was agreed to add outcomes of patients not adversely affected.** |
| *BM/18/09/100* | **Risk Management Strategy Annual Report**<br>The Chief Nurse reported that the Annual Report had been discussed and supported at the Quality Committee on 4 September 2018. The Committee had been assured of the progress made as part of the Trust Risk Management Processes. Controls and measures in place to report and escalate risk within the organisation with risk registers embedded within CBU<br>• **The Board noted the Report, endorsed the Risk Management processes in place and noted the significant progress made in the last 2 years.** |
| | **Next meeting to be held: Wednesday 28 November 2018** |

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

# BOARD OF DIRECTORS ACTION LOG

| AGENDA REFERENCE: | BM/18/11/104 | SUBJECT: | TRUST BOARD ACTION LOG | DATE OF MEETING | 28 November 2018 |
|---|---|---|---|---|---|

## 1. ACTIONS ON AGENDA

| Minute ref | Meeting date | Item | Action | Owner | Due Date | Completed date | Progress | RAG Status |
|---|---|---|---|---|---|---|---|---|
| BM/18/01/01 | 31.01.2018 | Partnership with King Edward Memorial Hospital Mumbai | Update Report to November Trust Board | **Medical Director** | 28.11.2018 | | 27.6.2018. AC advised that Certificate of Sponship submitted monthly to date had been rejected. It is hoped that these will be accepted in July following recent government legilsation. 3 visa applications submitted and outcome awaited following recent government legislation. | |

## 2. ROLLING TRACKER OF OUTSTANDING ACTIONS

| Minute ref | Meeting date | Item | Action | Owner | Due Date | Completed date | Progress | RAG Status |
|---|---|---|---|---|---|---|---|---|
| BM/18/09/84c | 26.09.2018 | IPR | Forward looking actions / proposal to be taken to Executives on 8.11.2018 to incorporate a summary of mitigation actions being taken as part of the IPR from Exec Leads | **All** | 28.11.2018 | | | |
| BM/18/07/57 | | Junior Doctor Update/Trainee Engagement (Trello) | 6 mth progress/update presentation. | **Medical Director** | 30.01.2019 | | | |
| BM/18/05/34 ii | 24.05.2018 | HEE visit 29 June | Report following the visit on 29 June | **Medical Director** | 30.01.2019 | | Report not yet received from HEE 26.9.2018. Report still awaited. Defer to November. 12.11.2018. Defer to January | |

## 3. ACTIONS COMPLETED AND CLOSED SINCE LAST MEETING

| Minute ref | Meeting date | Item | Action | Owner | Due Date | Completed date | Progress | RAG Status |
|---|---|---|---|---|---|---|---|---|
| BM/18/09/84 | 26.09.2018 | IPR | The Board supported the addition of indicators for 7 and 21 length of stay to the IPR to reflect patient flow challenges. | **Chief Operating Officer** | 28.11.2018 | | Indicators now incorporated into the IPR | |

**RAG Key**

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

**Quarterly Review Meeting Letter**

19 October 2018

Mel Pickup
Chief Executive Officer
Warrington and Halton Hospital NHS FT
Lovely Lane
Warrington
WA5 1QG

Dear Mel,

**Quarterly Review Meeting (QRM) held on 15 October 2018**

Following our meeting on 15th October 2018, I am writing to confirm the outcome of our discussion, which was attended by myself, Rebecca Maguire and Nicola Benzaquen on behalf of NHSI and yourself, Andrea McGee, Simon Constable, Chris Evans, and Kimberley Salmon-Jamieson on behalf of the trust.

**SOF segmentation**

At the time of our meeting, Warrington and Halton NHS Foundation Trust was currently categorised as being in segment 2 of the Single Oversight Framework (SOF). This means that using the metrics that sit below the SOF, NHSI has determined that the trust has a relatively low level of current support needs. The trust's progress against the metrics which inform the SOF are discussed under the headings below.

**Quality of Care**

Simon provided a brief update on 7-day services performance. We understand that the trust is performing well against each standard apart from CS2, which reflects the National picture and is expected to improve following the recent approved business case proposing 7-day shifts in medical surgery. We look forward to discussing the trust's progress against standard CS2 at the next 7-day services follow-up meeting on 26 November.

At the time of our meeting, flu vaccination uptake across the trust's staff group was at 56%. This is a very promising start to the season. Flu continues to be a National priority area and we will be discussing uptake figures with all trusts in QRMs during Winter.

We understand that the trust's lack of substantive geriatricians has negatively affected the feedback received from junior doctors in the GMC 2017 survey, and that workforce reviews are being undertaken, both internally and with Health Education England, to understand how staff structures could be improved and made more sustainable. Becky Maguire will speak to Vince Connolly once Simon has discussed the issues related to recruiting geriatricians with Vince this week, in the hope that NHSI can provide some additional support.

Simon confirmed that the trust's sickness absence levels have reduced from c.5% in July to 4.39% in August, which is very close to the target of 4.2%. If sickness levels begin to increase again, NHSI is currently running a piece of work to reduce levels of sickness absence, which the trust is welcome to be involved in. If you would like more information about this work, please contact Becky Maguire.

**Finance and use of resources**

The trust highlighted its month 6 financial position due to be reported to NHSI excluding PSF, was on plan at £14.2m. The position including PSF was slightly behind plan of £12.5m at £13.0m. The trust has assumed achievement of the financial element of PSF for the first half of the year, which equates to 70% of the total PSF. The remaining 30% relating to A&E has not been accrued. The trust questioned whether there were any plans for the non-achieved PSF to be used as funding and NHSI agreed to confirm this.

The trust continues to manage cash and requires DH loans for revenue funding. We discussed that the trust loans are about to expire, and we confirmed that they would be rolled forward. We agreed to confirm whether interest rates would change after the loans expire.

The trust is now in receipt of regular cash payments from its insurer for the fire last year. These payments are being made monthly and orders of £1.7m have been submitted in total to date. The trust is now estimating a total claim of c.£4.0m, which will be capitalised until a further review of the accounting treatment takes place.

Agency spend is above ceiling at month 6 by c.£1.0m. Some of this overspend relates to a pilot frailty unit opening. We discussed AHP spend also being above ceiling, which was a statistic that had been flagged by the NHSI central agency team. The trust noted that at month 6, AHP spend was above ceiling by c.£0.1m and that it was expecting this spend to come down and that the trust is confident in AHP recruitment. We discussed the staffing change in the NHSI central agency team and noted new support offers which we agreed to follow up on after this meeting.

**Operational Performance**

The trust reported that the Frailty Assessment Unit was now in place and was supporting the timelier assessment and treatment of patients. The trust reported that a permanent discharge lounge would come on stream from the end of October that would provide additional support to the timelier discharge of patients and would help to improve in-hospital capacity & flow and front door A&E performance.

The trust confirmed that they had responded to the NHSI/NHSE request to identify the key actions that were being taken to support the sustained delivery of services over the winter period.

With regard to delivery of the trust's target for reducing the number of stranded patients, the trust provided an overview of the work that has been undertaken to date and the plans to reduce numbers still further going forward. The trust position got worse over the Summer months as demand rose and the system were not prepared for this rise resulting in a peak of circa 150 super-stranded patients. The trust has worked hard with system partners in the last 2 months and this figure is now circa 120

with further planned falls to circa 85 by the end of December supported by the opening of additional transitional care capacity in November and December.

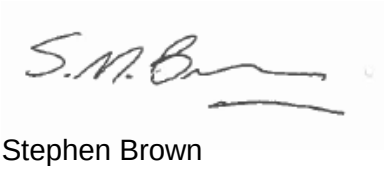
Regarding the continued suspension of the spinal service, Simon reported that the trust's 2 consultants had both been offered honorary contracts at the Royal Liverpool and Walton Hospitals, which would allow them to resume their practice under supervision. At this stage there was no clarity regarding the provision of services going forward and Steve Brown agreed to raise the issue with Vince Connolly.

**Date of next meeting**

Our next Quarterly Review Meeting will be held at 1:00pm on 21st January 2019.

If you have any questions in the meantime, please do not hesitate to get in touch.

Yours sincerely



Stephen Brown
**Senior Delivery & Improvement Lead** (Cheshire & Merseyside)
Direct Line 0300 123 2529 | Mobile: 07825 438435
Email Stephen.brown15@nhs.net | Website improvement.nhs.uk
3 Piccadilly Place | Manchester M1 3BN

cc. Jill Copeland, Delivery & Improvement Director (Cheshire & Merseyside)
Nicola Benzaquen, Finance Lead (Cheshire & Merseyside)
Rebecca Maguire, Assistant Clinical Team Manager (Cheshire & Merseyside)
Angela Kelly, Senior Clinical Lead (Cheshire & Merseyside)

**Summary of Issues/Actions/Support**

| Issue/Item of Concern | Proposed Actions | Action Owners | Predicted end of date of Actions |
|---|---|---|---|
| **Finance and use of resources** | | | |
| Cash | NHSI to confirm whether interest rates on expired loans that would be rolled forward would increase. | Nikki Benzaquen | 31 October 2018 |
| Agency support | NHSI to set up agency support with Irfan Suleman in NHSI central agency team. | Nikki Benzaquen | 31 October 2018 |
| **Operational Performance** | | | |
| Spinal service | Provision of service going forward to be raised with Vince Connolly. | Stephen Brown | 17 October 2018 |

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

**BOARD OF DIRECTORS**

| | | |
|---|---|---|
| **AGENDA REFERENCE:** | **BM/18/11/105 b** | |
| **SUBJECT:** | **Update on the Trust planning and preparedness in the event of a March 2019 'no deal' Brexit** | |
| **DATE OF MEETING:** | 28th November 2018 | |
| **ACTION REQUIRED** | For information and reassurance | |
| **AUTHOR(S):** | Emma Blackwell | |
| **EXECUTIVE DIRECTOR SPONSOR:** | Chris Evans Chief Operating Officer | |
| | | |
| **LINK TO STRATEGIC OBJECTIVES:** | SO3: To deliver well managed, value for money, sustainable services | |
| **LINK TO BOARD ASSURANCE FRAMEWORK (BAF):** | BAF1.4: Business Continuity | |
| | Choose an item. | |
| | Choose an item. | |
| | | |
| **STRATEGIC CONTEXT** | | |
| **EXECUTIVE SUMMARY** (KEY ISSUES): | To reassure the Board that the Trust is being proactive in managing potential business continuity challenges in the event of a March 2019 no deal Brexit. | |
| **RECOMMENDATION:** | The Board is asked to note the contents of this paper and be assured of the preparedness arrangements taking place within the Trust. | |
| **PREVIOUSLY CONSIDERED BY:** | **Committee** | Brexit Sub Group<br>Event Planning Group |
| | **Agenda Ref.** | |
| | **Date of meeting** | |
| | **Summary of Outcome** | |
| **FREEDOM OF INFORMATION STATUS (FOIA):** | Release Document in Full | |
| **FOIA EXEMPTIONS APPLIED:** ***(if relevant)*** | None | |

**BOARD OF DIRECTORS**

| SUBJECT | Update on the Trust planning and preparedness in the event of a March 2019 no deal 'Brexit' | AGENDA REF: | BM/18/11/105 |
|---|---|---|---|

## 1. BACKGROUND/CONTEXT

At the September Trust Board meeting members were informed of the Trusts current preparedness arrangements in the event of a March 2019 'no deal' exit from the EU. Assurance was given that the Trust is being proactive in identifying potential business continuity challenges via the monthly Event Planning Group meetings and is responsively dealing with information as it becomes available.

This paper provides an update on the planning and preparedness taking place to ensure patient care is not affected in the event of a 'no deal' Brexit.

## 2. KEY ELEMENTS

On the 2nd October on behalf of the Trust, Alison Parker Associate Director of Procurement and Maria Keeley Chief Pharmacy Technician attended a DHSC conference which focused on the supply of medicines, medical devices and consumables in the event of a no Brexit deal. The conference informed delegates of the contingency planning by the DHSC to mitigate risks to the procurement of goods and services.

Following this, on the 12th October 2018 Matt Hancock, Secretary of State for Health and Social Care, wrote to all trust chief executives to advise of the requirement to ensure continuity of supply of goods and services in the event of a no deal Brexit. The letter asks for the appointment of a board-linked Senior Responsible Officer to oversee this work and a self-assessment to be completed which would identify all contracts deemed highly impacted, and the Trusts mitigating activities by the 30th November. Chris Evans is the Senior Responsible Officer for the Trust overseeing this piece of work.

The DHSC has requested that Trusts do not look to stockpile medicines and supplies.

**Supplies**

It is estimated that 70% of medical devices and consumables are from the EU and of this 70%, 25% are either manufactured or finished in the EU and the balance of 75% are produced outside the EU but have a touchpoint in the EU i.e. their distribution centre may be in the EU.

DHSC are working on contingency measures which include requesting Suppliers hold 6 weeks of stock, looking at additional storage capacity and dedicated shipment channels. A self-assessment methodology has been developed for Trusts to complete for all products

not purchased via NHS Supply Chain to understand those Suppliers that may be impacted by a 'no deal' outcome and any to ensure a mitigation plan is in place.

A briefing paper has been produced by Alison Parker and shared at the Trust Executive meeting on the 8th November which details the supplier self-assessment methodology and the actions to date to complete this piece of work.

It has been recognised by the Brexit sub-group that the Trust currently uses three distributors (NHS Supplies, Squadron and Bunzl). If the Trust had to revert back to using only NHS Supplies there would potentially be a £200,000 p/a cost increase.

**Medicine Management**

Licensed medicines and vaccines will be managed by the DHSC. Manufacturers and distributors have been asked to hold 6 weeks of stock on behalf of NHS Trusts. Trust Pharmacy departments will need to consider additional products held that are not classified as medicines and not covered by the DHSC.

Concern has been raised nationally from the British Nuclear Medicine Society on the availability of radionuclides for the preparation of radiopharmaceuticals and the likelihood of significant price increases.

Blood products and components have also been flagged as a concern with the rationalisation of immunoglobulins using NHSE guidance.

The Trust Pharmacy department are in the process of completing the supplier self-assessment tool for lines that pharmacy hold that are not in scope such as enteral feeds. In addition to this the Pharmacy business continuity plan is being updated and risk assessments refreshed.

## 3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

To ascertain suppliers to be included within the Supplies self-assessment a number of activities have been undertaken to filter down to those considered 'in scope'. In summary this has resulted in the following:

| **Total Number of Suppliers:** | | | |
|---|---|---|---|
| Used in 01.04.17 to 30.09.18 | 1239 | | |
| Out of Scope | 333 | 27% | |
| Used for Consultancy and Services such as Training, Venue Hire etc. | 253 | 20% | |
| Government Bodies (NHS Trusts, NHS Bodies, Universities, Councils etc.) | 47 | 4% | |
| Balance | 604 | 49% | |
| Suppliers with a Spend > £10,000 | 161 | 27% | £13,860,652 |
| Suppliers with a Spend < £10,000 | 93 | 15% | £712,706 |
| Suppliers with a Spend < £5,000 | 350 | 58% | £567,546 |

Suppliers with a spend of greater than £10,000 will need to be contacted to determine whether they have a 'touch point' in the EU. For those who respond 'Yes' a set of triage questions will need to be asked to identify the level of risk in the event of a 'no deal' Brexit. This piece of work will require the support of the CBU teams. Dependent on the level of risk a mitigation plan will then need to be put into place. The completed Self-Assessment triage and mitigation plan needs to be submitted to the DHSC by the 30th November 2018.

Further actions currently being undertaken by the Trust are:-

- Business Continuity Plans are being updated at Corporate and Service level, progress is being monitored via the Event Planning Group.
- The risk of a 'no deal' Brexit has been added onto the Strategic Trust Risk Register.
- The Human Resource department await further guidance around the recognition of European professionals.
- Brexit remains a standard agenda item on the monthly Event Planning Group.

## 4. IMPACT ON QPS?

As UK Brexit negotiations at Government level are ongoing, the impacts are unknown at this time. However, it is recognised that there may well be an impact on Quality, People and Sustainability.

The risk around failure to provide continuity of services and increase in cost has been added to the Trust risk register and rated at a high level 16.

## 5. MEASUREMENTS/EVALUATIONS

The Brexit Sub Group will evaluate outcomes from the Supplies self-assessment and report to the Event Planning Group.

## 6. TRAJECTORIES/OBJECTIVES AGREED

The Procurement and Pharmacy teams will aim to complete the supplier self-assessment by the 30th November. However, this is very much dependent upon the information suppliers and contract owners are able to provide.

Any further guidance/directions around Brexit will be reviewed by Event Planning Group.

## 7. MONITORING/REPORTING ROUTES

At the October Event Planning Group it was decided that a separate Brexit sub-group would be established with key staff from Supplies/Finance/Pharmacy and HR to support the completion of the self-assessment tool. Chris Evans, as the Senior Responsible Officer is leading these meetings.

## 8. TIMELINES

- Brexit Sub Group – 21st November 2018
- Update to Event Planning Group – monthly
- Briefing Paper to Executive Meeting – 8th November 2018
- Update to Trust Board – 28th November 2018

## 9. ASSURANCE COMMITTEE

Event Planning Group and Trust Operational Board

## 10. RECOMMENDATIONS

The Trust Board is asked to note the contents of the paper and be reassured that the potential Brexit impact on Trust business continuity is being proactively managed as information becomes available.

# Summary of board papers – statutory bodies

## Care Quality Commission board meeting – 19 September 2018

**For more detail on any of the items outlined in this summary, the board papers are available here.**

## Executive team update

### Chief Executive's report

- The forthcoming State of Care 2017/18 report will reflect on the Care Quality Commission's (CQC's) ratings of health and adult social care providers, and will share CQC's findings in relation to improvements and deterioration in the quality of care. This report will also consider what CQC has seen in local health and care systems.

### Chief Inspector of Hospital's report

- CQC published a report on Sexual safety in mental health wards (11 September 2018). We summarise the report here.
  - CQC found that the problem of sexual safety was not confined to providers that admitted men and women to the same ward and that staff as well as patients could be the target of sexual violence.
  - The report recommends the development of guidance on this issue and emphasised the importance of leadership and training to help staff promote sexual safety. It also calls for cultural factors and the physical environment of wards that put people at risk to be addressed, and for reporting to be strengthened.
- CQC also recently published a report-Quality Improvement in Hospitals (11 September 2018) which looks at how several trusts have employed systematic quality improvement processes to drive improvements in the quality of patient care and overall performance. We summarise the report here.

### Chief Inspector of Primary Medical Services' report

- CQC's programme of inspections of independent online primary care services has raised concerns about the limits of the current regime of regulatory oversight. CQC will consider whether it should extend its interpretation of the regulations and the potential impact on its scope.

## Change portfolio report

- CQC has launched 'Insight for mental health NHS trusts' to providers for the first time. This will deliver access to Insight, ratings information about services and local area profiles.

## Healthwatch England update

- The CQC is launching a campaign in October to push for young people to share their experiences with Child and Adolescent Mental Health services to help them improve.

# NHS England board meeting – 26 September 2018

**For more detail on any of the items outlined in this summary, the board papers are available here.**

## Cancer Programme update

- The National Cancer Programme is now in the third year of implementing the Cancer Taskforce Strategy and has made significant progress towards increasing cancer survival and improving patient experience and quality of life.
- Cancer survival rates are at the highest they have ever been. The latest figures show one year survival at 72.3% in 2015; this is a 0.7% increase from 2014.
- NHS England (NHSE) is investing £200m though Cancer Alliances in 17/18 to transform diagnostic services and care during and after treatment.
- Nineteen Cancer alliances were established in 2016, these brought together senior and clinical managerial leaders from across a geographical area to help drive forward the Cancer Taskforce's ambitions.
- The NHS will begin delivering Chimeric Antigen Reception T Cell (CAR-T) therapy from October 2018 to children and young people up to 25 years old:
  - The process of producing this treatment is complex and the first wave of potential providers are being inspected and accredited against the necessary regulatory, safety and quality standards.
  - Provision is expected to begin in London, Manchester and Newcastle, and subject to passing accreditation requirements the first treatments could begin in a couple of weeks.
- The taskforce has engaged with over 50 organisations to date in the development of the cancer section of the Long Term Plan for the NHS. The third annual report of progress in delivering the cancer strategy will be published this autumn.

## Commissioning Committee Board Report

- Based on the report on the outcomes of the CCG 2017/18 improvement and assessment outcomes, the committee approved:
  - CCGs rated as 'inadequate' will go into special measures and that some CCGs that are rated as 'requires improvement' may also enter or remain in special measures.
- Report on the Integrated Care Systems (ICS) programme has noted:
  - ICSs will continue to expand to include voluntary, community, social enterprise and other partners as they mature.
- The Committee will continue to follow its annual work plan, focussing on the main system transformation programmes, design and delivery, in-year performance and finance and oversight of the commissioning system and its development.

## Specialised Services Commissioning Committee Report

- NHSE is updating its strategic priorities for specialised commissioning to provide a clearer focus for implementation and provide the basis for planning for 2019/20 as well as supporting delivery for 2018/19.



Contact: Georgia Butterworth, Senior Policy Officer, georgia.butterworth@nhsproviders.org
Adam Wright, Senior Policy Officer, adam.wright@nhsproviders.org

# NHS Improvement board meeting – 27 September 2018

**For more detail on any of the items outlined in this summary, the board papers are available here.**

## Chief Executive's report

- NHS Improvement (NHSI) published its winter review for 2017/18, which outlines its priorities and key deliverables for this coming winter, including improving staff uptake of the flu vaccine.
- At the end of Q1, trusts were projecting to end 2018/19 £519m in deficit. NHSI has been working with NHS England (NHSE) to identify actions which will result in a balanced financial plan for the NHS. This is the first year that the £4.3bn 'underlying deficit' of the provider sector is being included in the report.
- Acute trusts continue to face high levels of bed occupancy, and there has been a significant increase in patients waiting more than 52 weeks for elective care. Trusts have reduced the number of long waiters.
- Ian highlighted priorities in relation to the long-term plan, including improving outcomes and delivering on finances.
- There are currently 21 providers in special measures; four providers are in special measures for both quality and finances, ten for reasons of quality only, and seven for reasons of finance only.
- NHSI and NHSE have been developing a single operating model and are starting to appoint to the new senior national and regional director roles.

## Update on actions taken in response to Independent review into Liverpool Community Health NHS Trust

- NHSI is working with NHSE and HEE to develop a new talent management strategy for board level appointments, including new guidance on "Appointments to the board" to replace the NHS FT Code of Governance. NHSI is also designing a National Talent Board to oversee and support the work of the Regional Talent Boards. This work will fall within the remit of the jointly-appointed Chief People Officer.

## Improvement report

- NHSI is working in partnership with NHSE, the NHS Leadership Academy and regional stakeholders to implement a new approach to talent management in the Midlands and East Region.
- NHSI has set up the 'Costing Transformation Programme' which supports all trusts to adopt patient level costing. An ICS pilot is underway to link together cost and activity data for a population.
- A new national data collection will be launched this month (in partnership with the NHS Benchmarking Network) asking trusts to measure themselves against new Learning Disability Improvement Standards for NHS Trusts and associated metrics.
- A collaborative to improve transition for children and young people is being developed and will include both physical and mental health services.

## Quality dashboard

- From 10 September 2017 to 10 September 2018, four more trusts have moved to outstanding overall, 11 more to good, and there are five fewer inadequate trusts. However, since April 2018, three trusts have moved from good to requires improvement, which is more than in the whole of 2017/18.
- The South East region is leading a collaborative to reduce mixed sex accommodation breaches.

# Joint NHSE and NHSI board meeting – 27 September 2018

**For more detail on any of the items outlined in this summary, the board papers are available here.**

## Winter 2018/19 planning update

- NHSI and NHSE will support trusts to deliver important progress for winter 2018/19 such as more effective flu vaccines for older people, and a new £145m capital upgrade for A&E departments. There is a national ambition to release a further 4,000 beds from length of stay reductions of long stay patients in hospital over 21 days. Trusts have been segmented based on current and projected performance, and will receive tailored support.

## Financial and operational performance report

- This is the first time that NHSE and NHSI have produced a joint finance report. NHSE and NHSI have agreed a joint programme of actions designed to eliminate the £519m trust deficit.
- Demand for emergency and non-elective NHS services continues to rise but there is evidence that the strategy to ensure patients are treated in the most appropriate setting for their urgent care needs is having an impact on A&E attendance growth.
- The latest data from the mental health dashboard highlights that more CCGs than ever before have met the Mental Health Investment Standards (although 1 in 10 CCGs have cut their mental health spending).

## Development of the Long Term Plan for the NHS

- The Long Term Plan work streams have been asked to be clear about the workforce required to deliver their ambitions, how their proposals are deliverable within the agreed financial settlement, details on how their proposals will be implemented and the impact they will have on inequalities reduction.
- All work streams are working to identify opportunities to reduce variation in practice, improve outcomes and increase efficiency, by building on existing Carter and GIRFT programmes.
- The digital and technology work stream will articulate a new map for digital, data and technology.
- From November 2018 to March 2019, NHSI and NHSE will work with local and regional NHS bodies, including STPs, to map out implications of the national priorities for local services and people.

## Integrated Care Systems programme update

- All but one of the ten first wave ICSs performed above the national average for cancer waiting times in 2017/18. Eight performed above the national average for referral-to-treatment times and seven performed at or above national average for the A&E standard.
- Six of the Wave 1 ICSs delivered a better financial position than they planned in 2017/18.
- All systems have made progress implementing primary care networks at the neighbourhood level. All report full or nearly full coverage, although networks are at different levels of maturity.
- Eight of the ten Wave 1 ICSs are now working under a new financial framework, in which the ICSs link some or all of their provider sustainability funding to the collective financial performance of the system.
- Memoranda of Understanding have been agreed for 2018/19 with each ICS, which include national expectations based on implementing priorities for the coming year.

- ICSs will be a foundational part of the future NHS system architecture, and NHSI/E are considering how to put them on a firm consistent footing across England, as well as how to clarify their essential functions and what support the most challenged systems need.

## Next steps on delivering a single operating model and shared culture

- In designing the single operational model, NHSI and NHSE are committed to deliver 20% efficiency.
- The way NHSI and NHSE's joint enterprise will work is described as follows:
  - NHS system-level decisions will be made jointly between their constituent organisations, corporate and regional teams and through engagement with stakeholders via the input of the NHS Assembly.
  - The locus of decision-making and resources will be centred more on the Regional Directors and their teams.
  - Corporate Directors and their teams will provide strategy, support and services, such as improvement capability, run activities where those activities only need to be done once and benefit from scale, and deliver national regulation, guidance and support to the NHS as a whole.
- NHSI and NHSE state that this model will be adaptive, meaning that as local systems improve, the balance of activities that take place in regions and in the local health system may shift so that services, support, regulation and improvement are all located where they best deliver improved care.
- NHSI and NHSE are developing a shared narrative covering their purpose, identity and priorities which will soon be tested against the long term plan and with the new Joint Executive Group. They will also work to develop a shared culture and set of values and behaviours.
- NHSI and NHSI will undertake a single internal planning process and are aiming for a fully integrated approach for 2020/21.

## Governance model for joint working between NHSE & NHSI

- In terms of executive leadership, proposals include:
  - The creation of a single NHS Executive Group, co-chaired by two CEOS and with membership from national directors from the two organisations and the new regional directors
  - A set of single national director roles, reporting to the two CEOs, which include a single NHS Medical Director, a single NHS Nursing Director/Chief Nursing Officer for England, a single Chief Financial Officer and a single National Director for Transformation and Corporate Development
  - Single regional teams bringing together NHSI & NHSE functions, led by regional directors with a single reporting line to the two CEOs, and with responsibility for the performance of all NHS organisations in their region in relation to quality, finance and operational performance
  - Significant devolution of responsibility to regional directors and a different model of local leadership in the NHS. National teams will provide expertise, challenge, support and intervention
  - Several committees in common, including strategy and delivery and performance.

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

**BOARD OF DIRECTORS**

| | |
|---|---|
| **AGENDA REFERENCE:** | **BM/18/11/107** |
| **SUBJECT:** | **Integrated Performance Dashboard** |
| **DATE OF MEETING:** | 28th November 2018 |
| **ACTION REQUIRED** | **For Discussion** |
| **AUTHOR(S):** | Marie Garnett – Head of Contracts and Performance |
| **EXECUTIVE DIRECTOR SPONSOR:** | Kimberley Salmon-Jamieson, Chief Nurse<br>Michelle Cloney – Director of Human Resources & Organisational Development<br>Andrea McGee - Director of Finance & Commercial Development<br>Chris Evans - Chief Operating Officer |
| | |
| **LINK TO STRATEGIC OBJECTIVES:** | All |
| **LINK TO BOARD ASSURANCE FRAMEWORK (BAF):** | All |
| | |
| | |
| | |
| **STRATEGIC CONTEXT** | To provide the Trust Board with assurance in relation to performance in the following areas:<br>• Quality<br>• Access and Performance<br>• Workforce<br>• Finance Sustainability |
| **EXECUTIVE SUMMARY** (KEY ISSUES): | The Trust has 71 IPR indicators which have been RAG rated as follows:<br><br>**Red: 27 (increased from 25 in September)**<br>**Amber: 9 (increased from 11 in September)**<br>**Green: 32 (increased from 31 in September)**<br>**Non RAG Rated: 3 (the same as September)**<br><br>Excluding Provider Sustainability Funding the Trust has a £16.0m deficit which is £0.2m adverse position against plan. |

| | | |
|---|---|---|
| **RECOMMENDATION:** | The Trust Board is asked to:<br><br>**1.** Note the contents of this report.<br>**2.** Approve amendments to the Capital programme. | |
| **PREVIOUSLY CONSIDERED BY:** | **Committee** | Choose an item. |
| | **Agenda Ref.** | |
| | **Date of meeting** | |
| | **Summary of Outcome** | |
| **FREEDOM OF INFORMATION STATUS (FOIA):** | Choose an item. | |
| **FOIA EXEMPTIONS APPLIED:** ***(if relevant)*** | Choose an item. | |

| SUBJECT | Integrated Performance Dashboard | AGENDA REF: | BM/18/11/107 |
|---|---|---|---|

## 1. BACKGROUND/CONTEXT

The RAG rating for all 71 indicators from September 2017 to October 2018 is set out in Appendix 1. The Integrated Performance Dashboard (Appendix 2) has been produced to provide the Board with assurance in relation to the delivery of all KPIs across the following areas:

- Quality
- Access and Performance
- Workforce
- Finance Sustainability

## 2. KEY ELEMENTS

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

- Red - 27 in October, increased from 25 in September.
- Amber – 9 in October, decreased from 11 in September.
- Green – 32 in October, increased from 31 in September.
- Not RAG rated – 3 in October, the same number as September.

It was agreed at the Trust Board on 26th September 2018 to include Super Stranded Patients as a new KPI within the Access & Performance section. Therefore the total number of KPIs is now 71.

Due to validation and review timescales for Cancer, VTE, Pressure Ulcers and Sepsis, the RAG rating on the dashboard for these indicators is based on September's validated position.

**Quality**

**Quality KPIs**

There are 9 Red indicators in October, an increase of 1 in month.

The 7 indicators which were Red in September and remain Red in October are as follows:

- Incidents – the Trust had 71 open incidents which were over 40 days old in October, a reduction from 86 in September.

- Healthcare Acquired Infections (MRSA) – the Trust reported 1 case of MRSA in April 2018 against a national threshold of zero tolerance; therefore this indicator will be Red for the remainder of the year.
- Healthcare Acquired Infections (CDif) – there were 4 incidents of CDif in October, the same number as September against a threshold of less than 2.
- Healthcare Acquired Infections (Gram Negative Blood Stream Infections) – there were 4 incidents of E. coli in October, a reduction from 6 in September against a threshold of less than 2. The GNBSI threshold was set at 30 cases of E. coli bloodstream infection for the financial year. At the end of Q2 the Trust had reported 29 hospital onset cases (14 above the mid-year trajectory).
- Total Falls & Harm Levels – there were 76 falls in October, a reduction from 85 in September.
- Friends & Family Test (A&E and UCC) – the Trust achieved 81% in October, the same score as September against a target of 87%.
- Mixed Sex Accommodation Breaches (MSA) – there were 12 Mixed Sex Accommodation Breaches in October, the same number as September, against a target of 0.

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

- CQUIN Sepsis Inpatient Screening – the Trust achieved 76% for September's validated position. A data anomaly has been identified in September's data. A deep dive review is underway to understand the issue.
- Friends and Family Inpatient & Day Case – the Trust achieved 94% in October, a decrease from 96% in September against a target of 95%.

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

- Medication Safety – there were no incidents of harm in October (1 in September).

There is 1 Sepsis indicator which cannot be RAG rated this month as the results will not be received from Public Health England until Q3.

**Access and Performance**

**Access and Performance KPIs**

There are 7 Access and Performance indicators rated Red in October, the same number as September.

The 6 indicators which were Red in September and remain Red in October are as follows:

- A&E Waiting Times 4 hour national target – the Trust achieved 84.71% including walk ins and 81.97% excluding walk ins in October, which is an increase from September's

walk in performance of 84.85% and a decrease from September's performance excluding walk ins of 82.10% against a target of 95%.

- A&E Waiting Times improvement trajectory – the Trust's improvement trajectory for October is 90%, therefore the Trust has not achieved this in month.
- Ambulance Handovers 30>60 minutes – there were 242 patients who experienced a delayed handover in October, an increase from 203 in September.
- Ambulance Handover at 60 minutes or more – there were 78 patients who experienced a delayed handover in October, an increase from 77 in September.
- Discharge Summaries % sent within 24 hours – the Trust achieved 89.54% in October, an improvement from September's performance of 87.18% against a target of 95%.
- Cancelled operations on the day (for non-clinical reasons) – there were 23 cancelled operations in October, an increase from 10 in September against a target of 0. The Trust is reviewing internal processes and the performance metrics for cancelled operations.

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

- Cancelled Operations not rebooked within 28 days – there was 1 patient in October an increase of 0 from September against a target of 0.

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

- Breast Symptoms 14 days – the Trust achieved 98.36% for September's validated position, an improvement from August's validated position of 90% against a target of 93%.

**PEOPLE**

**Workforce KPIs**

There are 5 indicators rated Red in October, an increase from 4 in September.

The 3 indicators which were Red in September and remain Red in October are as follows:

- Non-Contracted Pay – remains above budget at 14.17% of total pay in October 2018.
- Agency Nurse Spend – this has increased to £0.27m in October, which exceeds expenditure for the same period last year of £0.18m.
- Agency Medical Spend – this has increased to £0.55m in October, which exceeds expenditure for the same period last year of £0.24m.

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

- Agency AHP Spend – this has increased to £0.21m in October, which exceeds expenditure for the same period last year of £0.1m.

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

- Sickness Absence – the Trust achieved 4.93% in October, a deterioration from September's performance of 4.38% against a target of less than 4.2%.

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

- Average Cost of Top 10 Agency Workers – the average cost was £0.03m in October, less than September's average of £0.05m

## SUSTAINABILITY

### Finance and Sustainability KPIs

There are 6 Red rated Finance and Sustainability indicators in October, the same number as September.

The 6 indicators which are Red in October are as follows:

- Operating Surplus/Deficit – the actual deficit is £14.3m which is £0.7m above the planned deficit of £13.6m. £0.5m PSF has not been achieved in relation to the A&E performance target. The Trust has signed up to a control total of £16.9m deficit which includes Provider Sustainability Funding (PSF) of £4.9m. Performance against the year to date control total (excluding PSF) is £16.0m deficit which is £0.2m over plan.
- Capital Spend – the actual spend is £3.6m which is £1.5m below the planned spend of £5.1m. The phasing of costs associated with the Kendrick Wing fire has resulted in the current underspend.
- Better Payment Practice Code (BPPC) – the challenging cash position results in a year to date performance of 56% which is 39% below the national standard of 95%.
- Agency Spending – the actual year to spend is £6.4m which is £1.3m above the year to date ceiling of £5.1m.
- Cost Improvement Programme Recurrent – best case recurrent CIP has been assessed at £3.5m which is £3.5m below the £7m target.
- Cost Improvement Programme In Year – savings of £1.3m have been delivered year to date which is £1.2m below the plan of £2.5m.

The Income, Activity Summary and Use of Resources Rating Statement as presented to the Finance and Sustainability Committee is attached in **Appendix 3**.

The Trust is working with Commissioners on a shared 3 year plan to improve sustainability using CEP Lite (Capped Expenditure Process) as a framework.

The current forecast delivery of in-year CIP poses a significant risk to the Trust's ability to deliver against the planned £16.9m deficit. Any variance from plan will have an adverse impact on cash and will lead to the need for further loans.

Workshops have been held with CBUs and Corporate Divisions to focus on CIP opportunities and forecast outturn. An additional £1m CIP has been identified from the workshops moving CIP to £4m in year (£3m behind plan). The best, worse and likely case scenarios and forecast outturn with mitigations is being prepared for the next Finance & Sustainability Committee in December 2018.

**Capital Programme**

The 2018/19 capital programme approved by the Board in February 2018 was £7.5m. This has increased to £10.2m to reflect a high level estimate of £2.4m for the Kendrick Wing restructure and £0.3m for externally funded schemes.

The operating position has restricted the amount of cash available for investment so the capital programme is under constant review to ensure that schemes undertaken are required for the delivery of service needs and mitigation of safety and risk issues. There are proposed changes to the capital programme, which have been supported by the Finance and Sustainability Committee on 21st November 2018. These have been summarised in Table 1.

Table 1: proposed changes to the 2018/19 capital programme.

| Scheme | Value £000 |
|---|---|
| **Additional Funding Required** | |
| Warrington Catering Works (1) | 35 |
| Ultrasound Machine (2)* | 56 |
| Laryngoscope (3)* | 9 |
| **Sub total** | **100** |
| **Funding by** | |
| Contingency | (100) |
| **Sub total** | **(100)** |
| **Total** | **0** |

*These schemes were approved by the Director of Finance & Commercial Development due to the urgent nature of the requirement.

(1) Environmental Health recommendation to replacement windows, solar film, fly screens, flooring repair works, stainless steel corner protectors and wall protectors following Environmental Health initial inspection prior to main inspection following on in December.

(2) Ultrasound for Anaesthesia & Intra Vascular Line Insertion necessary to continuation delivery of patient activity.

(3) Purchase of equipment to comply with CQC & NICE Standards and give best possible outcome for unexpected and planned difficult airways for patients and reduce the need for emergency airway procedures such as tracheostomies.

The CQC action plan included a number of recommendations covering the Trust's capital estates and infrastructure. In addition, the Estates Team has completed an assessment of capital works necessary to comply with ward accreditation and PLACE inspection standards. These recommendations and assessments have identified a total funding requirement of circa £1.7m. This includes £0.6m relating to developments for a Midwifery Led Unit. The breakdown of this cost over financial years is summarised in Table 2.

Table 2: analysis of capital costs over 2018/19 and 2019/20

| **Narrative** | **2018/19 £000** | **2019/20 £000** | **Total £000** |
|---|---|---|---|
| Midwifery Led Unit | 600 | 0 | 600 |
| Other schemes | 566 | 554 | 1120 |
| **Total** | **1,166** | **554** | **1,720** |

A further review of the 2018/19 capital programme has been undertaken, including an assessment of service delivery needs and mitigation of potential safety and risk issues. This has identified some slippage, which together with the remaining balance of the CQC allocation means that these costs can be accommodated in this financial year. The funding available from the remaining CQC allocation and the scheme slippages are summarised in Table 3.

Table 3: Remaining CQC allocation and scheme slippage

| **Scheme** | **Value £000** |
|---|---|
| Remaining CQC allocation | 490 |
| Substation C Air Circuit Breakers | 202 |
| AER Machines (assumes 50% completion in 2018/19) | 350 |
| Warrington MRI Scanner* | 1,200 |
| **Sub total** | **2,242** |

This leaves a balance of £1.1m that can be transferred to contingency.

These proposals have been finalised since the Finance and Sustainability Committee on 21st November 2018, however the approach was supported in this committee.

*A review of diagnostic requirements is currently being undertaken. Therefore the £1.2m within the 2019/20 Capital programme pending the outcome of this review.

An updated capital programme is attached in **Appendix 4**.

## 3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

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

## 4. ASSURANCE COMMITTEE

The following committees provide assurance to the Trust Board:

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

## 5. RECOMMENDATIONS

The Trust Board is asked to:

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

## Appendix 1 – KPI RAG Rating November 2017 – October 2018

| | KPI | Nov 17 | Dec 17 | Jan 18 | Feb 18 | Mar 18 | Apr 18 | May 18 | Jun 18 | Jul 18 | Aug 18 | Sep 18 | Oct 18 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **QUALITY** | | | | | | | | | | | | |
| 1 | Incidents | | | | | | | | | | | | |
| 2 | CAS Alerts | | | | | | | | | | | | |
| 3 | Duty of Candour | | | | | | | | | | | | |
| 4 | Adult Safety Thermometer | | | | | | | | | | | | |
| 5 | Children Safety Thermometer | | | | | | | | | | | | |
| 6 | Maternity Safety Thermometer | | | | | | | | | | | | |
| 7 | Healthcare Acquired Infections - MSRA | | | | | | | | | | | | |
| 8 | Healthcare Acquired Infections – CDIFF | | | | | | | | | | | | |
| 9 | Healthcare Acquired Infections – Gram Negative | | | | | | | | | | | | |
| 10 | VTE Assessment* | | | | | | | | | | | | |
| 11 | Safer Surgery | | | | | | | | | | | | |
| 12 | CQUIN Sepsis AED Screening* | | | | | | | | | | | | |
| 13 | CQUIN Sepsis Inpatient Screening* | | | | | | | | | | | | |
| 14 | CQUIN Sepsis AED Antibiotics* | | | | | | | | | | | | |
| 15 | CQUIN Sepsis Inpatient Antibiotics* | | | | | | | | | | | | |
| 16 | CQUIN Sepsis Antibiotic Review* | | | | | | | | | | | | |
| 17 | Total Falls & Harm Levels | | | | | | | | | | | | |
| 18 | Pressure Ulcers* | | | | | | | | | | | | |
| 19 | Medication Safety | | | | | | | | | | | | |
| 20 | Staffing – Average Fill Rate | | | | | | | | | | | | |
| 21 | Staffing – Care Hours Per Patient Day | | | | | | | | | | | | |
| 22 | Mortality ratio - HSMR | | | | | | | | | | | | |
| 23 | Mortality ratio - SHMI | | | | | | | | | | | | |
| 24 | Total Deaths | | | | | | | | | | | | |
| 25 | NICE Compliance | | | | | | | | | | | | |
| 26 | Complaints | | | | | | | | | | | | |
| 27 | Friends & Family – Inpatients & Day cases | | | | | | | | | | | | |
| 28 | Friends & Family – A&E and UCC | | | | | | | | | | | | |
| 29 | Mixed Sex Accommodation Breaches | | | | | | | | | | | | |
| 30 | CQC Insight Indicator Composite Score | | | | | | | | | | | | |

## Appendix 1 – KPI RAG Rating November 2017 – October 2018

| | ACCESS & PERFORMANCE | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 31 | Diagnostic Waiting Times 6 Weeks | | | | | | | | | | | | | |
| 32 | RTT - Open Pathways | | | | | | | | | | | | | |
| 33 | RTT – Number Of Patients Waiting 52+ Weeks | | | | | | | | | | | | | |
| 34 | A&E Waiting Times – National Target | | | | | | | | | | | | | |
| 35 | A&E Waiting Times – STP Trajectory | | | | | | | | | | | | | |
| 36 | Cancer 14 Days | | | | | | | | | | | | | |
| 37 | Breast Symptoms 14 Days | | | | | | | | | | | | | |
| 38 | Cancer 31 Days First Treatment* | | | | | | | | | | | | | |
| 39 | Cancer 31 Days Subsequent Surgery* | | | | | | | | | | | | | |
| 40 | Cancer 31 Days Subsequent Drug* | | | | | | | | | | | | | |
| 41 | Cancer 62 Days Urgent* | | | | | | | | | | | | | |
| 42 | Cancer 62 Days Screening* | | | | | | | | | | | | | |
| 43 | Ambulance Handovers 30 to <60 minutes | | | | | | | | | | | | | |
| 44 | Ambulance Handovers at 60 minutes or more | | | | | | | | | | | | | |
| 45 | Discharge Summaries - % sent within 24hrs | | | | | | | | | | | | | |
| 46 | Discharge Summaries – Number NOT sent within 7 days | | | | | | | | | | | | | |
| 47 | Cancelled Operations on the day for a non-clinical reason | | | | | | | | | | | | | |
| 48 | Cancelled Operations on the day for a non-clinical reason – Not offered a date for readmission within 28 days of the cancellation | | | | | | | | | | | | | |
| 49 | Super Stranded Patients | | | | | | | | | | | | | |

## Appendix 1 – KPI RAG Rating November 2017 – October 2018

| | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **WORKFORCE** | | | | | | | | | | | | |
| **50** | **Sickness Absence** | | | | | | | | | | | | |
| **51** | **Return to Work** | | | | | | | | | | | | |
| **52** | **Recruitment** | | | | | | | | | | | | |
| **53** | **Turnover** | | | | | | | | | | | | |
| **54** | **Non Contracted Pay** | | | | | | | | | | | | |
| **55** | **Agency Nurse Spend** | | | | | | | | | | | | |
| **56** | **Agency Medical Spend** | | | | | | | | | | | | |
| **57** | **Agency AHP Spend** | | | | | | | | | | | | |
| **58** | **Core/Mandatory Training** | | | | | | | | | | | | |
| **59** | **PDR** | | | | | | | | | | | | |
| **60** | **Average cost of the top 10 highest cost Agency Workers** | | | | | | | | | | | | |
| **61** | **Average length of service of the top 10 longest serving agency workers** | | | | | | | | | | | | |
| | **FINANCE** | | | | | | | | | | | | |
| **62** | **Financial Position** | | | | | | | | | | | | |
| **63** | **Cash Balance** | | | | | | | | | | | | |
| **64** | **Capital Programme** | | | | | | | | | | | | |
| **65** | **Better Payment Practice Code** | | | | | | | | | | | | |
| **66** | **Use of Resources Rating** | | | | | | | | | | | | |
| **67** | **Fines and Penalties** | | | | | | | | | | | | |
| **68** | **Agency Spending** | | | | | | | | | | | | |
| **69** | **Cost Improvement Programme – Performance to date** | | | | | | | | | | | | |
| **70** | **Cost Improvement Programme – Plans in Progress (In Year)** | | | | | | | | | | | | |
| **71** | **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 - October 2018

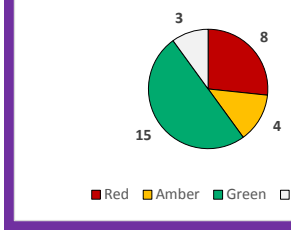
Appendix 2

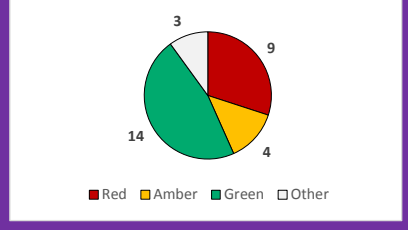
**Key**

Use of Resources Assessment Indicator UoR

**Key Points/Actions**

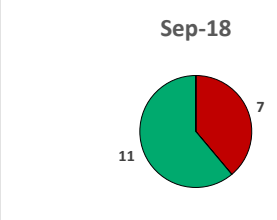
## Quality Improvement

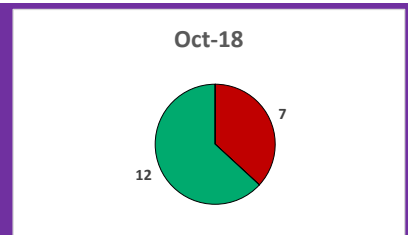



As of 31st October 2018, there are 487 open incidents that require review and sign off. There was 1 Serious Incident reported during October. Whilst this continues to reduce in line with the improvement trajectory, work is ongoing to ensure that this remains a focus for staff. Compliance in month in relation to Duty of Candour remains 100%. The Trust is exceeding all targets in relation to the Adults, Childrens and Maternity Safety Thermometers. There have been 4 hospital onset cases of C-Diff reported in October 2018; Root cause analysis investigations are in progress. The overall number of reported falls has decreased from 85 to 76 which is a 10.6% decrease on the previous month. So far this financial year there has been 561 falls, this time last year for the same period there had been 522 falls which is a 7.5% increase. Work continues with the falls collaborative in the Trust. SHMI has risen to 107.87 from 104.70. This is in part due to a number of deaths in the Diagnostic Groups: Congestive Heart Failure (11) and Pleurisy; Pneumothorax (12).

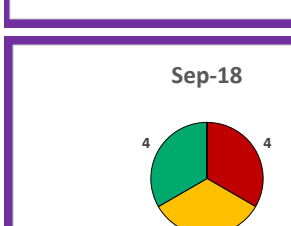
## Access & Performance

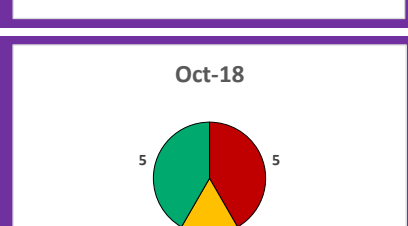



In October 2018, 12 out of the 18 indicators are RAG rated as Green. The Diagnostic target remains compliant after the implementation of the recovery plan. The Trust has continued to achieve the RTT standard in month. A number of actions to improve the A&E positon are being implemented, the Trust achieved 84.71% which is below of the NHSI improvement trajectory of 90%. Ambulance handovers continue to be a challenge, specifically at times of peak attendance. All cancer targets were achieved in month. Discharge Summaries sent within 7 days continues to improve, the Trust is working towards the 95% target. The number of super standard patients is meeting the improvement trajectory to have less than 86 by 31st December 2018.

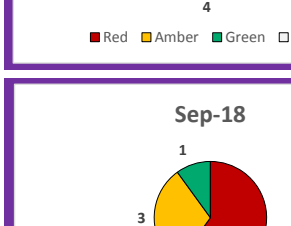
## Workforce

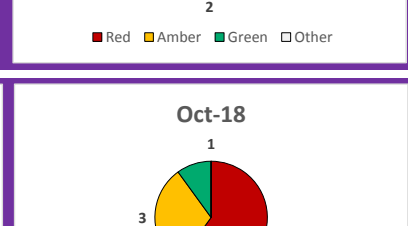



The Trust has seen an increase in sickness absence in month to 4.93%. Return to work compliance continues to be above target at 85.32% which is positive. Recruitment timeframes remain positive at an average of 64.6 days. Turnover has decreased in month to 13.15%, which is 0.15% above target. Pay spend was £300k above budget and temporary staffing expenditure is above the same period last year. Core Skills Training compliance continues to be positive at 88.25%. PDR compliance is below the target in month at 81.45%. The cost and average length of stay of the Top 10 agency workers has reduced from last month.

## Finance




In month the Trust recorded a deficit of £1.2m. This increases the cumulative deficit to £14.3m which is £0.7m above plan. The year to date control total (excluding Provider Sustainability Funding) is a £16.0m deficit which is £0.2m above plan. The main variance in income and expenditure is £1.74m relating to the pay award. Year to date income is £1.9m over recovered, expenditure is £2.5m overspent and non operating expenses are in line with plan. Capital spend is £3.6m which is £1.5m below the planned capital spend of £5.1m. Due to the historic and current operating position the cash balance remains low and at month end the cash balance is £1.2m which is in line with the planned cash balance and the minimum cash requirement under the terms and conditions of the working capital loan. The year to date performance against the Better Payment Practice Code is 56% which is 39% lower than the 95% target. The Trust has recorded a Use of Resources Rating of 3 which is on plan.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

# Integrated Dashboard - October 2018

## Quality Improvement - Trust Position

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

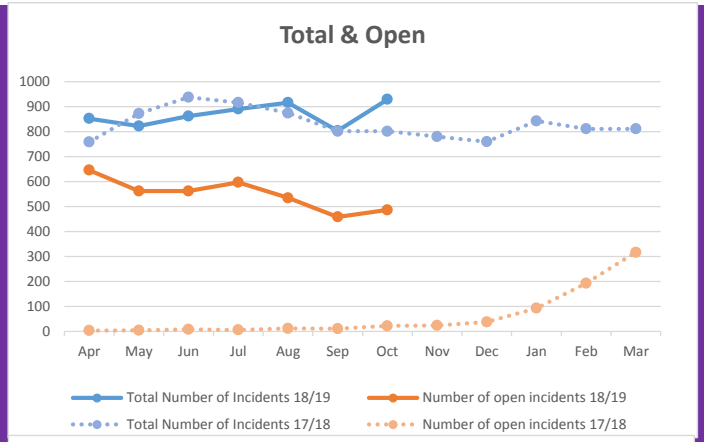
### Patient Safety

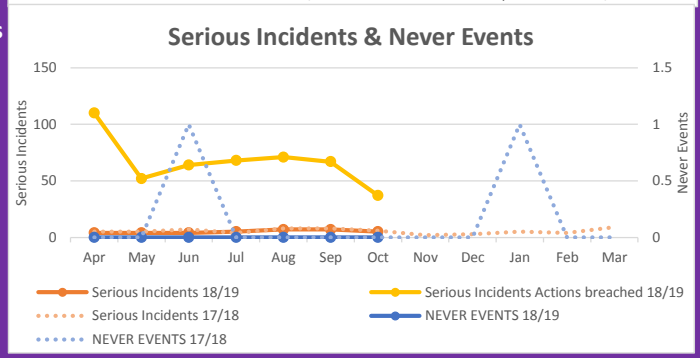
**Incidents**

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

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

The target for Never Events is a zero tolerance.
Green: open incidents within timeframe (within 20 working days) Amber: open incidents outside of timeframe (within 40 working days) Red: open incidents outside of timeframe (over 40 working days old).



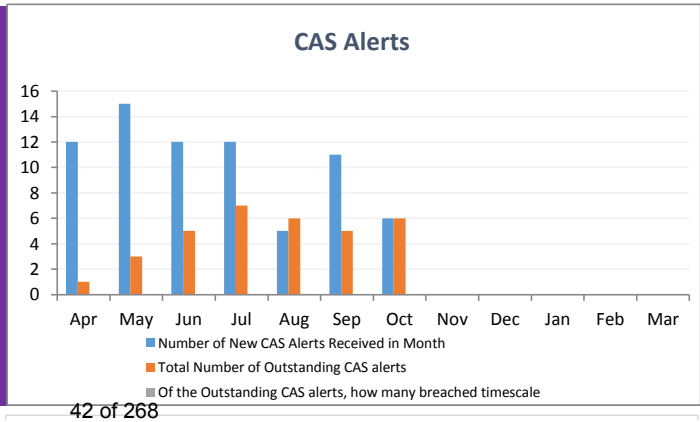




As of 31st October 2018, there are 487 open incidents which require review and sign off. 439 relate to CBUs with the remaining incidents for Corporate or External Organisations. Work will continue to ensure progress is in line with the CQC action to close all backlog incidents. There was a considerable increase in number of incidents reported in the month. The Trust launched the 'Reporting to Improve' campaign at the Safety Summit held in October and work continues to support this campaign. In terms of the numbers of serious incident actions that have breached, over the last month the Trust has reduced this significantly from 67 to 37, a reduction of 45%. This is being monitored via the Weekly Meeting of Harm.

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

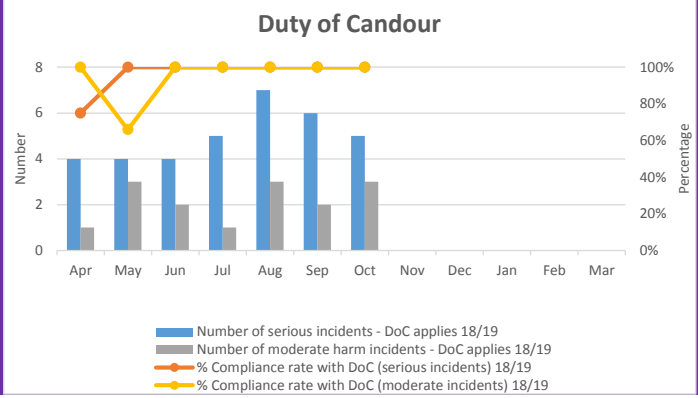
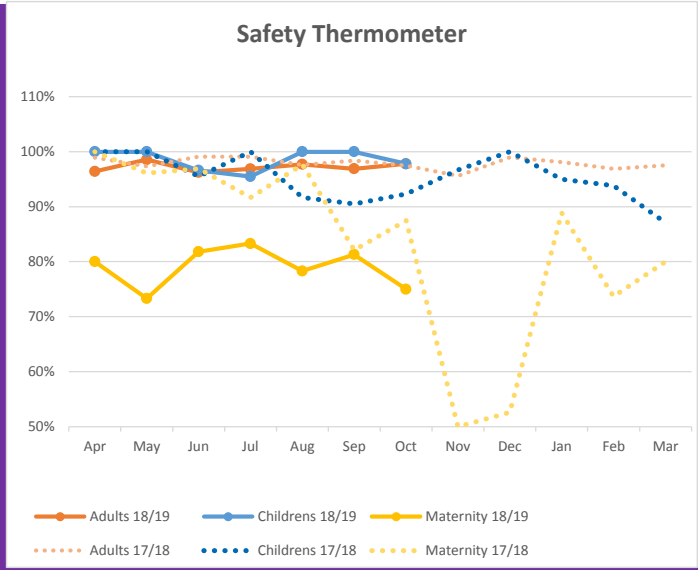
The Central Alerting System (CAS) is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and others, including independent providers of health and social care. Timescales are individual dependant upon the specific CAS alerts.

All CAS alerts should be reviewed and actioned within their individual timeframes.

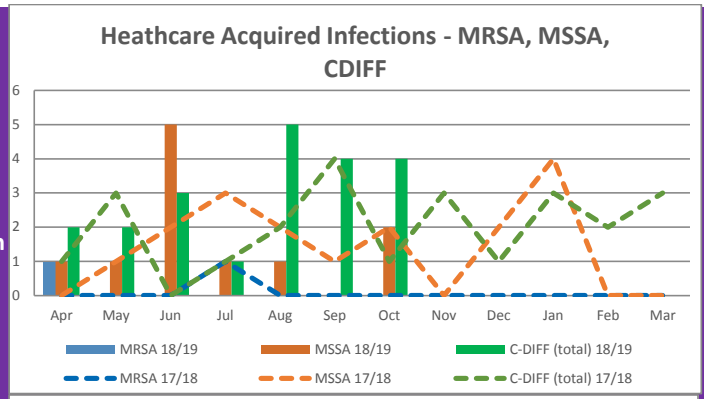
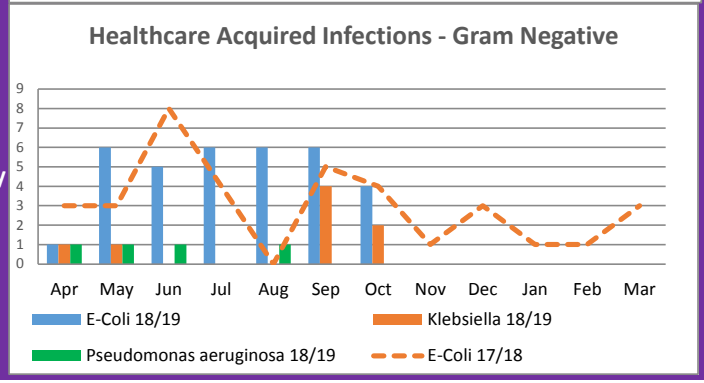



The Trust has received 6 alerts in October, of which 4 have been closed.
There are 6 open alerts within the CAS system for the Trust.
We have no alerts past the close by date.

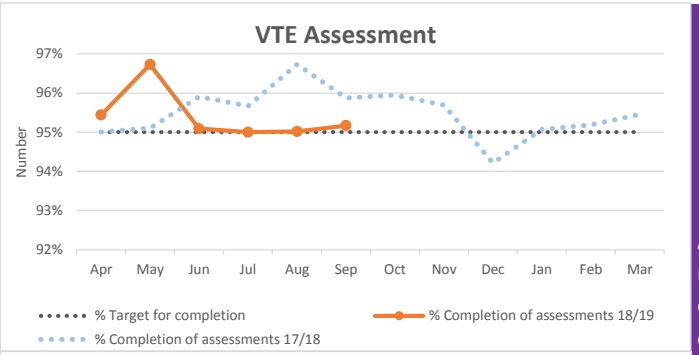
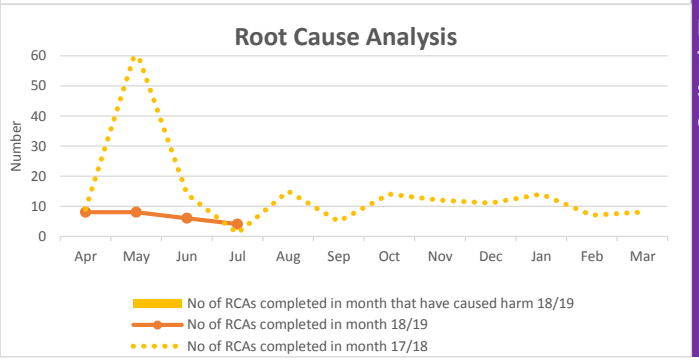
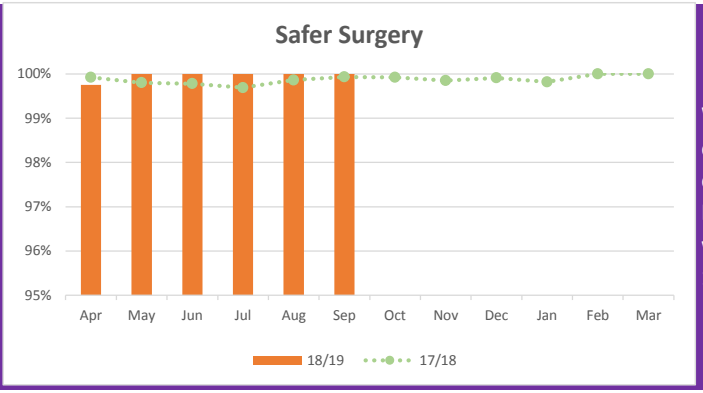
## Quality Improvement - Trust Position

| | Description | Aggregate Position | Trend | Variation |
|---|---|---|---|---|
| **Duty of Candour**<br>Red: <100%<br>Green: 100% | Every healthcare professional must be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress. Duty of Candour is where we contact the patient or their family to advise of the incident; this has to be done within 10 working days. | Duty of Candour has to be completed within 10 working days. |  | There have been 2 breaches in relation to Duty of Candour year to date, where there was a delay in completing Duty of Candour within 10 working days; this was subsequently completed. These breaches occurred in May 2018. As of October 2018, there have been no further breaches and the Datix system in now fully updated for all moderate harm. The above incidents are currently under investigation. |
| **Adult Safety Thermometer**<br>Red: Less than 90%<br>Amber: 90% to 94%<br>Green: 95% or more<br><br>**Childrens Safety Thermometer**<br>Red: Less than 80%<br>Amber: 81% to 84%<br>Green: 85% or more<br><br>**Maternity Safety Thermometer**<br>Red: Less than 70%<br>Amber: 70% to 73%<br>Green: 74% or more | Measures % of adult patients who received "harm free care" defined by the absence of pressure ulcers, falls, catheter-acquired UTI's and VTE ( Safety Thermometer). Children's and Maternity data has been requested. Measures % of child patients who have received an appropriate PEWS (paediatric early warning score), IV observation, pain management, pressure ulcer moisture lesion. Measures % of maternity patients who received "harm free care" in relation to defined by proportion of women that had a maternal infection, 3rd/4th perineal trauma, that had a PPH of more than 1000mls, who were left alone at a time that worried them, term babies born with an Apgar of less than 7 at 5 minutes, mother and baby separation and women that had concerns about safety during labour and birth not taken seriously. | The target for all areas is to achieve over 95%. |  | In October, the Adult Safety Thermometer shows 4 new Pressure Ulcers, 2 Falls with Harm & 5 VTEs, with no individual ward being of concern. Overall the Trust is showing harm free percentage of 97.8%. The Maternity Safety Thermometer showed 75.0% harm free care against a national threshold of 75%, this has deteriorated from a position of 87.5% in September 2018. The decrease relates to the number of caesarean sections and operative deliveries in the survey. Women's perception of safety = 100%, this is an improvement from 93.8% in September 2018. The Children's Safety Thermometer was 97.8% Harm Free Care, 1 patient did not have their EWS trigger escalated appropriately. |

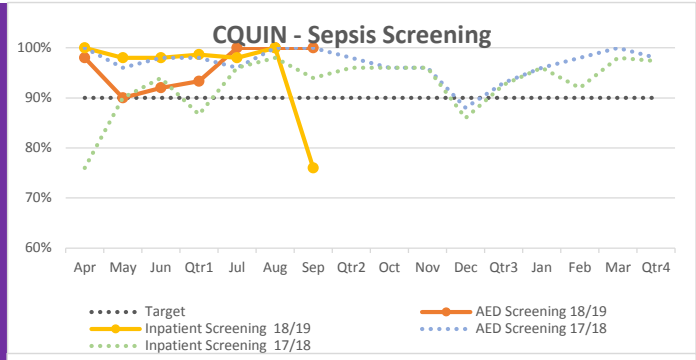
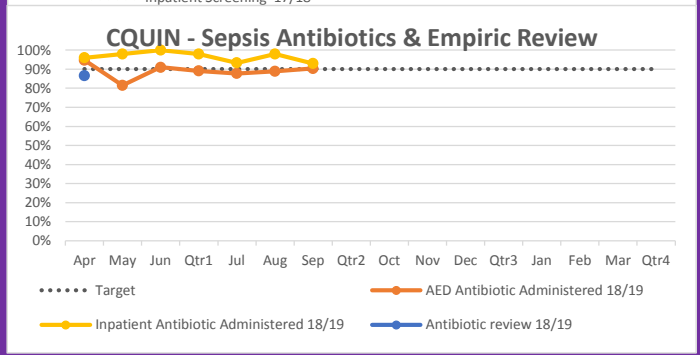
## Quality Improvement - Trust Position

| | Description | Aggregate Position | Trend | Variation |
|---|---|---|---|---|
| **Healthcare Acquired Infections**<br><br>**MRSA**<br>**Red: 1 or more**<br><br>**Healthcare Acquired Infections**<br><br>**C-Difficile**<br>**Red: More than 2**<br>**Amber: 1 to 2**<br>**Green: 0** | Methicillin-resistant Staphylococcus aureus (MRSA) is a bacterium responsible for several difficult-to-treat infections in humans. Those that are sensitive to methicillin are termed methicillin susceptible Staphylococcus aureus (MSSA). Clostridium difficile, also known as C. difficile or C. diff, is a bacterium that can infect the bowel. Escherichia coli (E-Coli) bacteraemia which is one of the largest gram negative bloodstream infections. | MRSA - National objective is zero tolerance of avoidable MRSA bacteraemia. If breached a £10,000 penalty in respect of each incidence in the relevant month. MSSA - Has no National objective set by public health. Clostridium Difficule (c-diff) due to lapses in care; agreed threshold is <=27 cases per year. E-Coli, Klebsiella, Pseudomonas aeruginosa - A national objective has been set to reduce gram negative bloodstream infections (GNBSI) by 50% by March 2021. |  | MRSA bacteraemia - 1 hospital onset case reported by ward A7 in April 2018; this was considered avoidable. Work is in progress with AED to promote timely blood culture sampling.<br><br>Clostridium difficile - 4 hospital onset cases reported in October 2018. Root cause analysis investigations are in progress. Ward A9 has an increased incidence in cases. Ribotyping results are awaited.<br><br>MSSA - 2 hospital onset cases were reported in October. Investigations are in progress. |
| **Healthcare Acquired Infections - Gram Negative**<br><br>**E-Coli**<br>**Red: More than 2**<br>**Amber: 1 to 2**<br>**Green: 0 OR**<br><br>**Klebsiella/Pseudomonas**<br>**Red: More than 1**<br>**Amber: 1** | | |  | Gram negative bloodstream infections (GNBSI) in October: E. coli 4 hospital onset cases; Klebsiella - 1 hospital onset case and 0 cases of Pseudomonas aeruginosa. The GNBSI threshold was set at 30 cases of E. coli bloodstream infection for the financial year. At the end of Q2 the Trust had reported 29 hospital onset cases (14 above the mid-year trajectory). The GNBSI action group is meeting monthly to review key themes from surveillance data and identify preventative action. Use of investigation toolkits has been implemented from the start of Q2. |

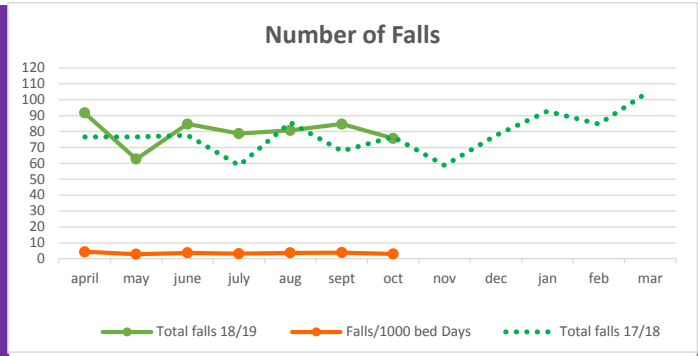
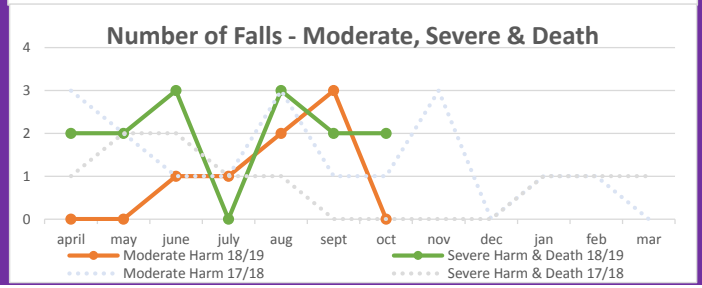
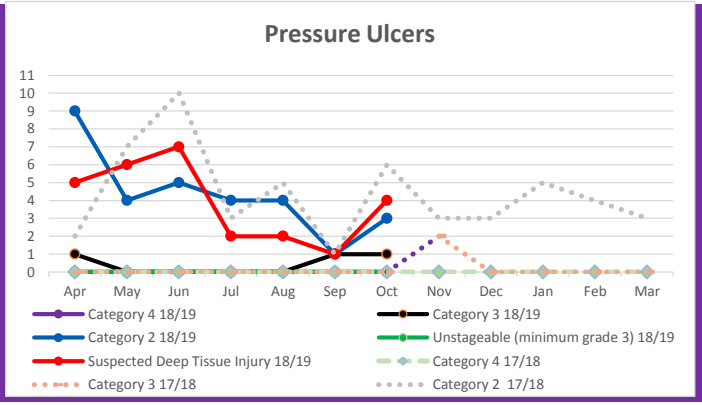
## Quality Improvement - Trust Position

| | Description | Aggregate Position | Trend | Variation |
|---|---|---|---|---|
| **VTE Assessment**<br><br>Red: <95%<br>Green: 95% or above based on previous months' figures due to timescales for validation of data | Venous thromboembolism (VTE) is the formation of blood clots in the vein. This data looks at the % of assessments completed in month and the incidents of preventable harm. We also look at the number of RCA's completed in relation to VTE's. | The target for completion and documentation of VTE risk assessment on admission is 95%. Regarding the VTE backlog, weekly meetings are being held, chaired by the Medical Director where it has been agreed that additional capacity to clear the backlog from 15/16, 16/17, 17/18 (risk assessed by harm and occurrence of PE). |  <br>  | A manual review of health care records is underway to confirm October 2018 compliance position. The RCA review process continues with over 40 backlog cases to be processed. The timeframe for completion is by the end of December 2018. A system upgrade should facilitate improvement in monthly compliance going forward. |
| **Safer Surgery**<br><br>Red: <100%<br>Green: 100% | The Safe Surgery check list is monitored through OMIS BI and checked and validated via 20 case per month by Head of theatre services. | The target is to achieve 100%. |  | We have reviewed ALL surgical procedures conducted since April 2017 as to whether a checklist was completed.<br>In the month of October 100% of check lists were reviewed and the overall score was 100% compliant. |

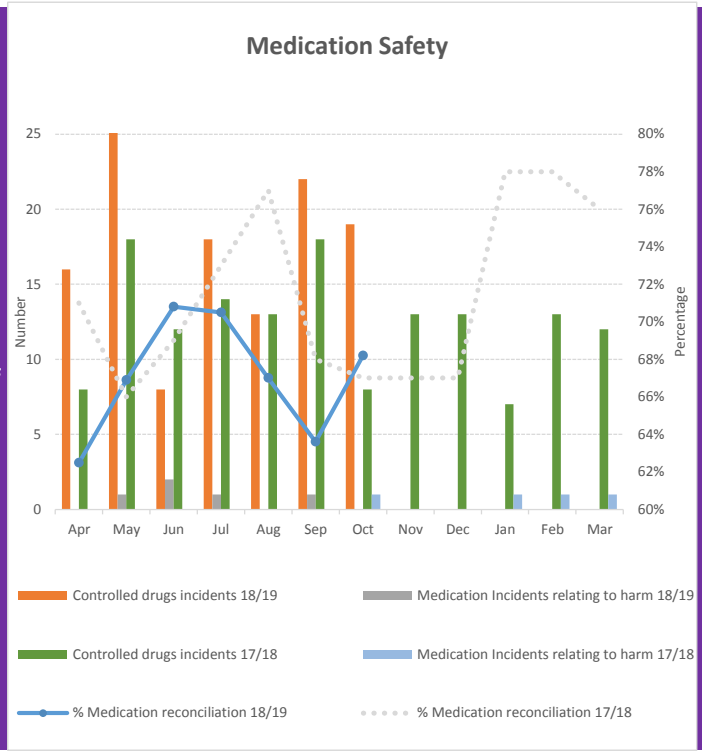
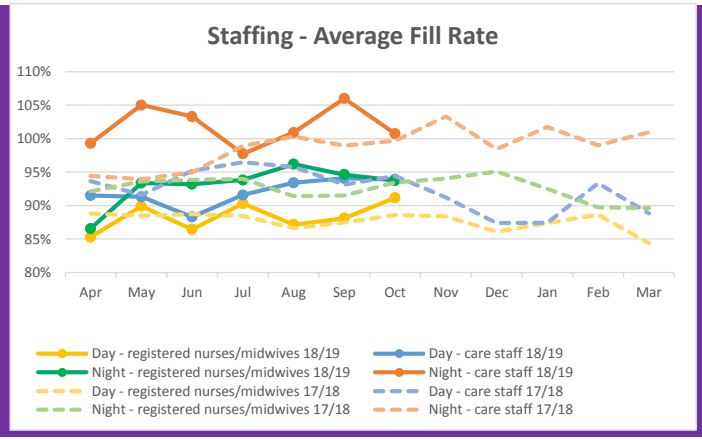
## Quality Improvement - Trust Position

| | Description | Aggregate Position | Trend | Variation |
|---|---|---|---|---|
| CQUIN - Sepsis AED Screening Red: Less than 90% Green: 90% or more<br>CQUIN - Sepsis Inpatient Screening Red: Less than 90% Green: 90% or more<br>CQUIN - Sepsis AED Antibiotics Administration Red: Less than 90%<br>CQUIN - Sepsis Inpatient Antibiotics Administration Red: Less than 90%<br>CQUIN - Sepsis Antibiotic Review | Screening of all eligible patients - acute inpatients. Screening of all eligible patients admitted to emergency areas AED. Inpatient received treatments and empiric review within three days of prescribing antibiotics. Emergency patients received treatment and empiric review within three days of prescribing the antibiotics. | The target is to achieve 90% |  <br>  | Compliance in September for screening in ED was 100% with the administration of antibiotics within the specified timeframe of at 90.4%. Within inpatient areas screening fell to 76% with antibiotics received for 93% of those patients within an hour, however a data anomaly has been identified and a deep dive review is underway to understand the issue. |

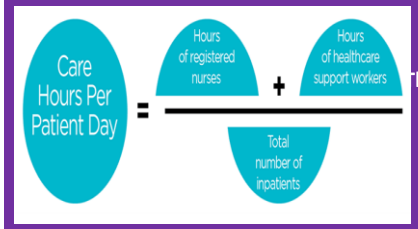
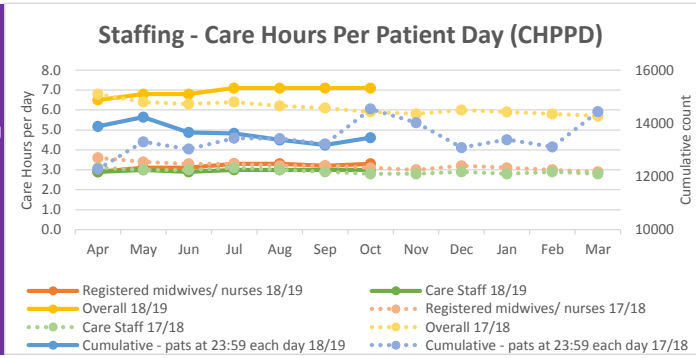
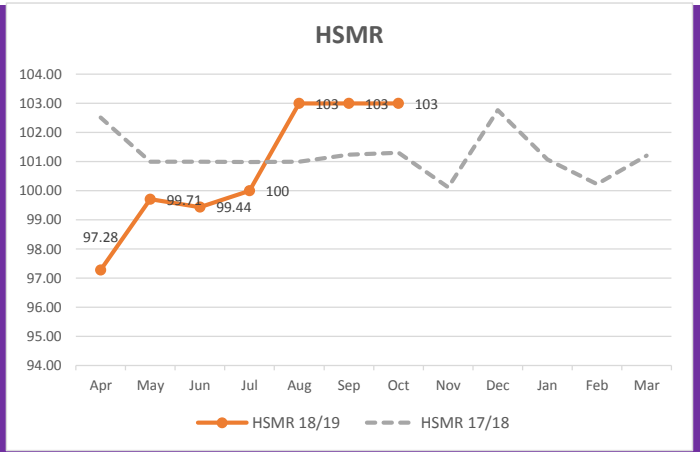
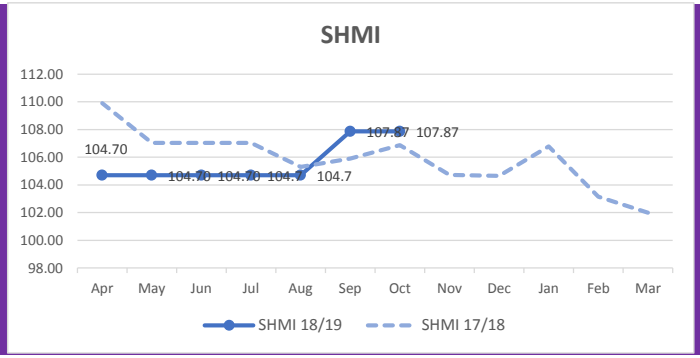
## Quality Improvement - Trust Position

| | Description | Aggregate Position | Trend | Variation |
|---|---|---|---|---|
| Total number of Falls & harm levels<br>Red: <20% decrease from 17/18<br>Green >20% decrease from 17/18 | Total number of falls per month and their relevant harm levels. | 20% reduction in falls in 2018/19 using 2017/18 data as a baseline. |  <br>  | There was 1 Serious Incident reported during October. The overall number of reported falls has decreased from 85 to 76 which is a 10.6% decrease on the previous month. So far this financial year there has been 561 falls. This time last year for the same period there had been 522 falls which is a 7.5% increase. Work continues with the falls collaborative in the Trust. Actions as part of this improvement plan are being implemented and overseen by Patient Safety & Effectiveness Sub Committee, reporting to Quality & Assurance Committee. |
| Pressure Ulcers<br>Category 4<br>Red: 1 or more<br>Category 3<br>Red: More than 3<br>Green: 3 or less<br>Category 2<br>Red: More than 7<br>Green: 7 | Pressure ulcers, also known as pressure sores, bedsores and decubitus ulcers, are localised damage to the skin and/or underlying tissue that usually occur over a bony prominence as a result of pressure, or pressure in combination with shear and/or friction. | Category 4 hospital acquired<br>Category 3 hospital acquired<br>Category 2 hospital acquired |  | The Trust reported 4 category 2 and 1 category 3 pressure ulcers for October 2018. The RCA reports have been reviewed for the category 2 pressure ulcers with themes identified. The category 3 pressure ulcer is currently being investigated through the serious incident process. The Trust has completed the NHSI Quality Improvement Programme with positive results in the identified areas. |

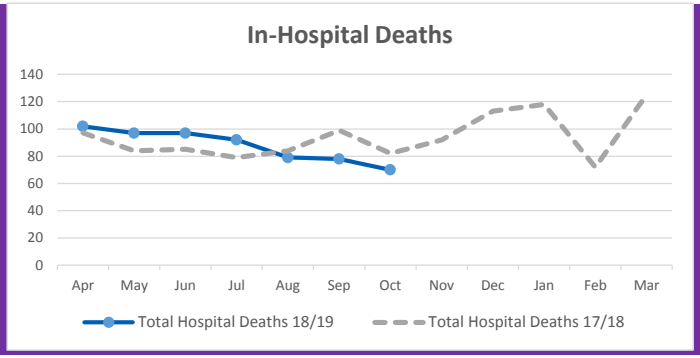
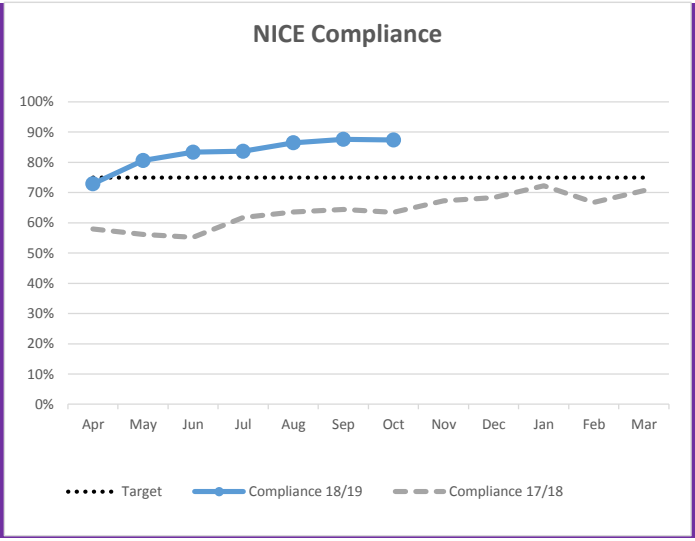
## Quality Improvement - Trust Position

| | Description | Aggregate Position | Trend | Variation |
|---|---|---|---|---|
| Medication Safety<br>Red - any incidents of harm.<br>Green - no incidents of harm. | Overview of the current position in relation to medication, to include; medication reconciliation, controlled drugs incidents and medication incidents relating to harm. | The target for Medication Safety is a zero tolerance for incidents of harm. |  | % of Medicine Reconciliation completed within 24 hours is 4% higher than the previous month but the % overall has increased by 5% (28%↑ & 68%↑). The numbers achieved are affected by admission day, length of stay, Pharmacy staffing capacity particularly at admission points and the absence of a weekend on ward Pharmacy service for admissions. A business case has been submitted and phase 1 approved. The business case for phase 2 & 3 was supported by QAC (October meeting) and is to be reviewed by FSC.<br>28%↑ of Medicine Reconciliations were completed within 24 hours of admission and 50%↑ within 48 hours of admission.<br>The number of Controlled Drug incidents reported in Oct (19) is slightly lower than the previous month (22): There were 3 in Urgent & Emergency Care↓, 6 in Digestive Diseases ↑, 3 in Integrated Care & Medicine↓, 1 in Medical Care↓, 2 in MSK↓, & 1 in Women's &Children's Health↔. Learning is being identified for dissemination to individuals and collectively.<br>There have been 3 moderate medication harm incidents YTD, these were reported in Integrated Care & Medicine. 3 have been reviewed and learning identified for dissemination. The % of medication harm incidents graded 2 or above is on a downward trend. The business cases for a full-time MSO pharmacist and ITU pharmacist have been approved. |
| Staffing - Average Fill Rate<br>Red: 0-79%<br>Amber: 80-89%<br>Green: 90-100% | Percentage of planned verses actual for registered and non registered staff by day and night | Target of >90%. The data produced excludes CCU, ITU and Paediatrics. |  | Staffing levels are monitored daily with responsive plans being put in place to ensure the safe delivery of patient care. Staffing levels are reviewed daily, and we have seen an improvement in shift fill rates across the trust. |

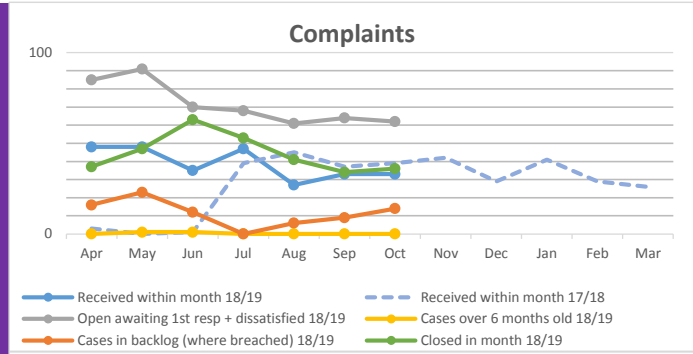
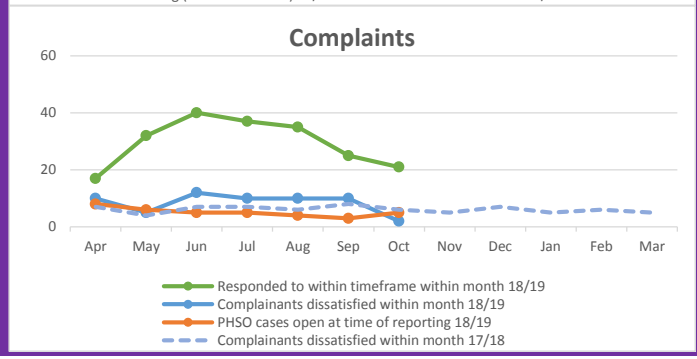
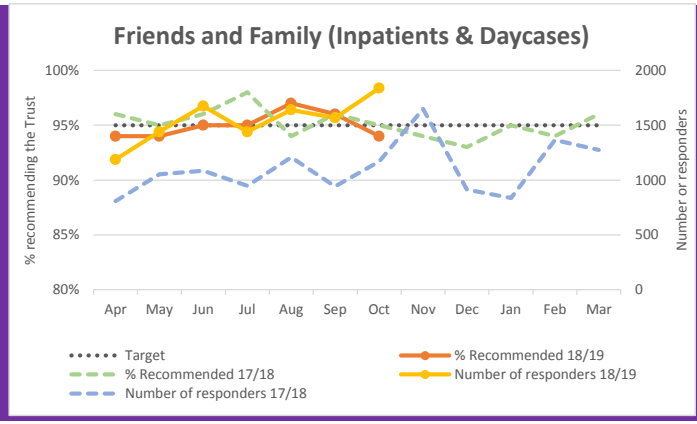
## Quality Improvement - Trust Position

| | Description | Aggregate Position | Trend | Variation |
|---|---|---|---|---|
| **Staffing - Care Hours Per Patient Day (CHPPD)** |  | The data produced excludes CCU, ITU and Paediatrics and does not have an associated target. |  | The Trust is seeing a sustained improvement in CHPPD hours since July 2018, which will continued to be reviewed and monitored on a monthly basis in the Safe Staffing report. |
| **Mortality ratio - HSMR**<br><br>**Red: Greater than expected**<br>**Green: As or under expected** | Hospital Standardised Mortality Ratio (HSMR 12 month rolling). The HSMR is a ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in-hospital deaths (multiplied by 100) for 56 specific Clinical Classification System (CCS) groups. | Target for Green would be to be within expected ranges. |  | The Trust is as expected for HSMR. Our HSMR is currently at 103. Work continues regarding the implementation of our Learning from Deaths Policy. |
| **Mortality ratio - SHMI**<br><br>**Red: Greater than expected**<br>**Green: As or under expected** | Summary Hospital-level Mortality Indicator (SHMI 12 month rolling). SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. | Target for Green would be to be within expected ranges. |  | SHMI has risen to 107.87 from 104.70. This is in part to a number of deaths in the Diagnostic Groups: Congestive Heart Failure (11) and Pleurisy; Pneumothorax . The Mortality Review Group will review all excess deaths to understand if there are any care issues on which we need to take action. In addition, Quality Committee has also asked for a coding report to be presented to the next meeting to understand the impact of coding on the increased mortality indices. |

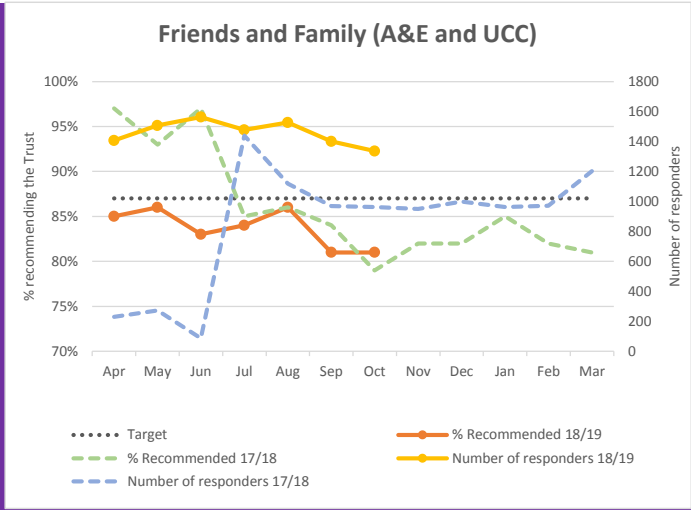
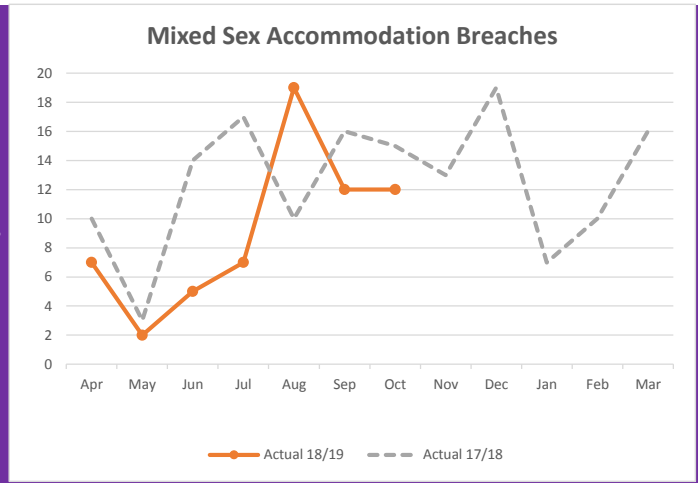
## Quality Improvement - Trust Position

| | Description | Aggregate Position | Trend | Variation |
|---|---|---|---|---|
| Total Deaths | Total Deaths (including A&E) - We screen all deaths within the Trust to ascertain if any harm has been caused. If harm has been caused it is subject to a further review by the Mortality Review Group. | There is no target against this indicator. |  | All Standard Judgment Reviews (SJRs) are being tracked through Mortality Review Group, reporting to Patient Safety & Effectiveness Sub Committee. The Trust will report avoidable mortality in the Quality Account, which is currently being prepared. Any review conducted where these may be potentially avoidable mortality, is reported as a Serious Incident and subject to a full Root Cause Analysis before avoidability is confirmed. |
| NICE Compliance<br><br>Red: <75%<br>Amber: 75% to <100%<br>Green: 100% | The National Institute for Health and Clinical Excellence (NICE) is part of the NHS and is the independent organisation responsible for providing national guidance on treatments and care for people using the NHS in England and Wales and is recognised as being a world leader in setting standards for high quality healthcare and are the most prolific producer of clinical guidelines in the world. | The target is to achieve 100% compliance against all NICE guidance. |  | There are a total of 4 pieces of NICE Guidance which are outside the 90 day assessment period:<br>Trust Wide 1. QS15 - Patient Experience, A Task and Finish Group has been set up for this.<br>2. NG89 - VTEs in over 16's - work has commenced on this regarding completion of baseline assessment.<br>Urgent & Emergency Care 1. NG94 - Emergency and Acute Services in over 16's, which is currently being assessed.<br>Digestive Diseases 1. NG101 - Early and Locally Advanced Breast Cancer. We are awaiting further responses from Clatterbridge.<br>There are a further 3 unknown Technology Appraisals that are within the 90 day assessment period, the reviewer has been contacted for an update. |

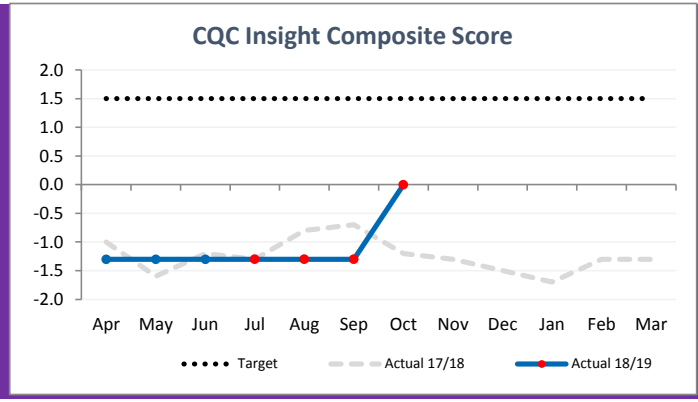
## Quality Improvement - Trust Position

| | Description | Aggregate Position | Trend | Variation |
|---|---|---|---|---|
| **Patient Experience** | | | | |
| Complaints | Overall review of the current complaints position, including; Number of complaints received, number of dissatisfied complaints, total number of open complaints, total number of cases over 6 months old, total number of cases in backlog where they have breached timeframes, number of cases referred to the Parliamentary and Health Service Ombudsman and the number of complaints responded to within timeframe. | Red - Trust not meeting improvement trajectories or complaints open over 6 months old.<br>Amber - No complaints over 6 months old, Trust meeting backlog improvement targets<br>Green - No backlog, complaints responded to within agreed timescales.<br>Please note that the above RAG rating will be reviewed following the completion of the complaints improvement plan. |  <br>  | The Trust now holds no complaints over 6 months and has 14 complaints that have breached their deadline, which is an increase on previous months. Timeliness in responding as per Trust policy has improved in October (59.5% September, 64.2% October). The Trust has received an average amount of complaints in month, based on the amount received over the past year. The Trust has also seen an 80% decrease in the amount of dissatisfied complaints from the previous month. The Trust has finalised a Trust wide Customer care training package as part of the Patient Experience Strategy, and this is now live for staff to book. |
| Friends and Family (Inpatients & Day cases)<br><br>Red: Less than 95%<br>Green: 95% or | Percentage of Inpatients and day case patients recommending the Trust. Patients are asked - How likely are you to recommend our ward to friends and family if they needed similar care or treatment? | The target set is to achieve over 95%. |  | The Trust has dipped slightly below the 95% target for inpatients and day cases Friends and Family feedback with 94% patients recommending our services. However, the overall response rate has continued to increase from 34% to 37.9%. Wards and departments are actively encouraging patients to leave their feedback and positive comments indicating a more than satisfactory patient journey have been displayed on Patient Experience boards. |

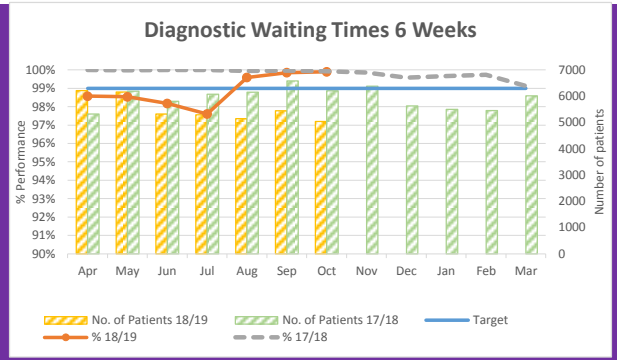
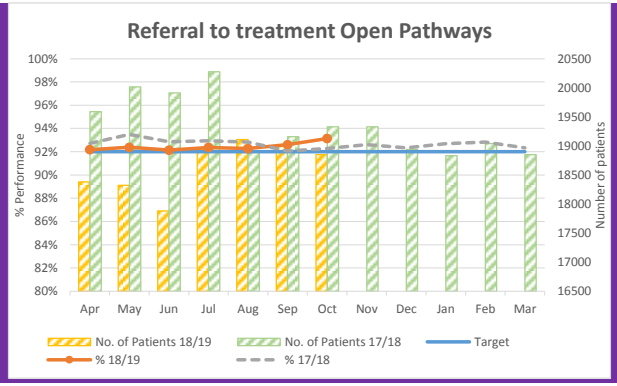
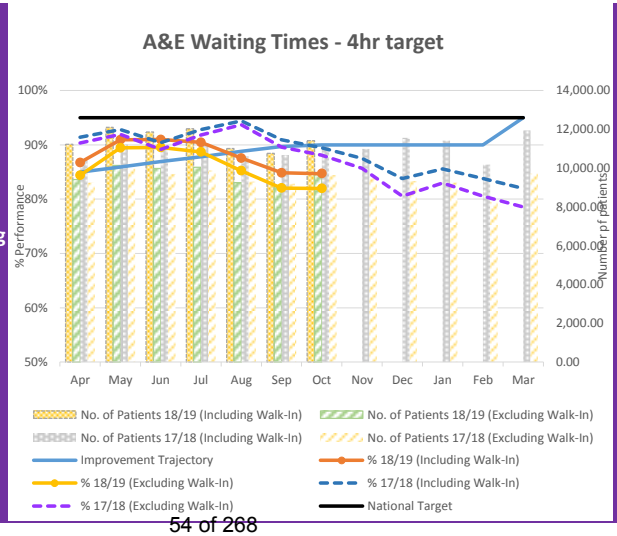
## Quality Improvement - Trust Position

| | Description | Aggregate Position | Trend | Variation |
|---|---|---|---|---|
| Friends and Family (A&E and UCC)<br><br>Red: Less than 87%<br>Green: 87% or more | Percentage of AED (Accident and Emergency Department) patients recommending the Trust : Patients are asked - How likely are you to recommend our AED to friends and family if they needed similar care or treatment? | The target set is to achieve over 87%. |  | The Trust target for patients attending A&E and/or UCC and providing a positive feedback is 81% from a target of 87%, recommending our A&E and Urgent Care services. This has remained static for two months. The response rate has dipped slightly in the previous month. Actions continue to be implemented by the Urgent & Emergency Care CBU, which aims to increase FFT responses, and provide the best service for our patients, families and carers. |
| Mixed Sex Accommodation Breaches<br><br>Red: 1 or more<br>Green: Zero | We submit data to NHS England in relation to the number of occurrences of unjustified mixing in relation to sleeping accommodation. | There is a target of zero tolerance. |  | There have been 12 reported mixed sex accommodation breaches in October 2018: 8 in ICU and 4 in CCU. ICU breaches were a result of the increased need for beds in the Trust, which impacted on patients being able to be moved onto wards. The delayed discharge issue is on critical care risk register with an action plan to address challenges. Breaches on CCU resulted as a need for other patients to be isolated and the need to observe a patient who was confused. |

## Quality Improvement - Trust Position

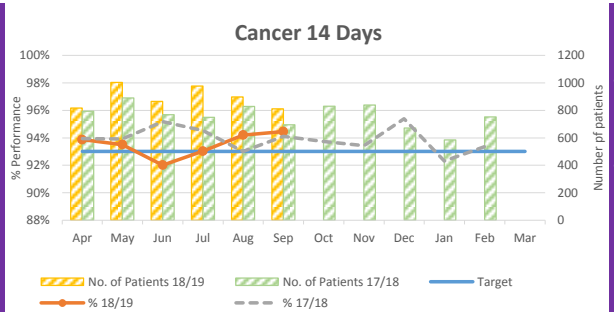
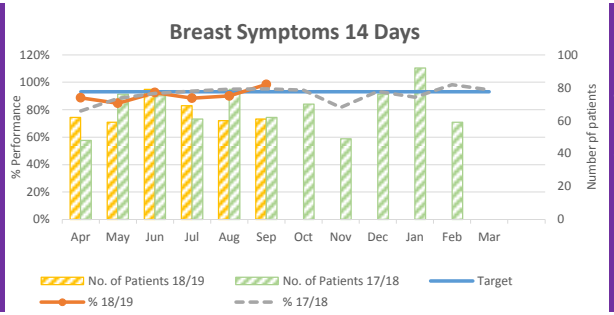
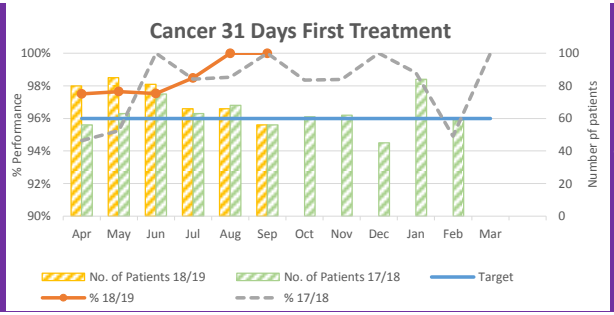
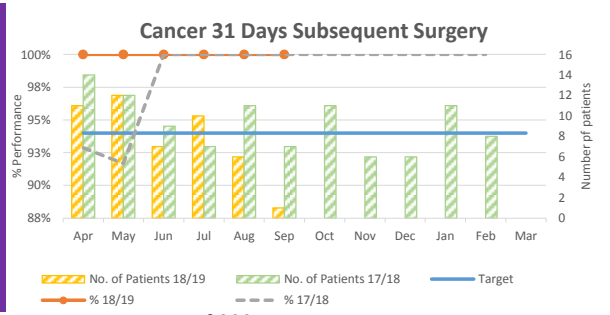
| | Description | Aggregate Position | Trend | Variation |
|---|---|---|---|---|
| CQC Insight Composite Score<br><br>Red (inadequate): <-3<br>Amber (req improvement): >-2.9 - 1.5<br>Green (good/outstanding): >1.5 | **CQC**<br>The CQC Insight report measures a range of performance metrics and gives an overall score based on the Trust's performance against these indicators. This is the CQC Insight Composite Score. | The RAG rating is based on the thresholds within the CQC Insight Report. Scores Below -3 are rated as "Inadequate", between -2.9 and 1.5 scores are rated as "Requires Improvement", scores between 1.5 - 4.9 are rated "Good" , scores of above 5 are rated "Outstanding" |  | The Trust have received an insight report in October 2018 that shows that the composite score has increased to 0. This means that the whilst the score is still showing that the Trust is in a Requires Improvement position, it has moved significantly on this continuum towards Good. (The composite score required to indicate a Good Trust is 1.5). |

## Mandatory Standards - Access & Performance - Trust Position

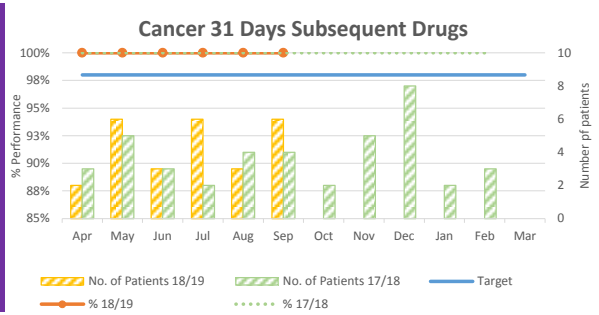
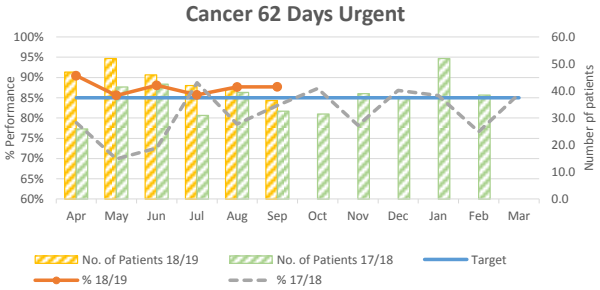
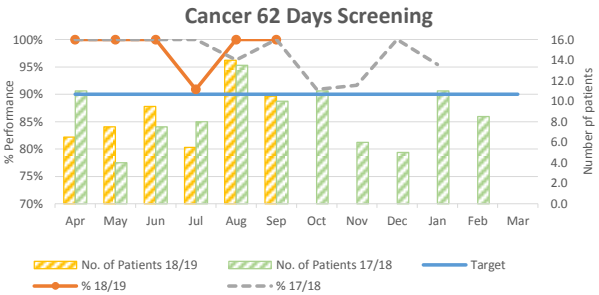
| | Description | Aggregate Position | Trend | Variation |
|---|---|---|---|---|
| Diagnostic Waiting Times 6 Weeks<br><br>Red: Less than 99%<br>Green: 99% or above | All diagnostic tests need to be carried out within 6 weeks of the request for the test being made. The national target is 99% or over within 6 weeks.<br><br>This metric also forms part of the Trust's Sustainability and Transformation Plan (STP) Improvement trajectory.<br><br>The proposed tolerance levels applied to the improvement trajectories are also illustrated. | The Trust achieved 99.9% in October 2018. |  | The Diagnostic target met the planned trajectory to be compliant in October. This resulted in a performance of 99.9% against a target of 99%. The business case for additional support and equipment has been agreed. Compliance against this standard is being monitored and is expected to continue to be compliant going forward. |
| Referral to treatment Open Pathways<br><br>Red: Less than 92%<br>Green: 92% or<br><br>RTT - Number of patients waiting 52+ weeks Green = 0, otherwise Red | Percentage of incomplete pathways waiting within 18 weeks. The national target is 92%<br><br>This metric also forms part of the Trust's STP Improvement trajectory.<br><br>The proposed tolerance levels applied to the improvement trajectories are also illustrated. | The Trust achieved 93.14% in October 2018. |  | The Trust achieved the 18 week referral to treatment target, achieving 93.14% against a target of 92%; this is a difficult target which remains challenging. |
| Four Hour Standard - National Target<br><br>Red: Less than 95%<br>Green: 95% or above<br><br>Four Hour Standard Waiting Times - STP Trajectory<br><br>Red: Less than trajectory<br>Green: Trajectory or | All patients who attend A&E should wait no more than 4 hours from arrival to admission, transfer or discharge. The national target is 95%<br><br>This metric also forms part of the Trust's STP improvement trajectory.<br><br>The proposed tolerance levels applied to the improvement trajectories are also illustrated. | The Trust achieved 84.71% (including walk in) and 81.97% (excluding walk in) in October 2018. |  | The Trust achieved 84.71% (including Widnes UCC) which fell below the agreed NHSI performance improvement trajectory of 90.0%.<br>There are a number of actions in place to support improvement against this standard which include, ward reconfiguration of A3, C21 and CCU, development of a dedicated Discharge Lounge, focus on stranded and super stranded patients and a review of ward rounds.<br>In addition, the Urgent & Emergency Care CBU are reviewing their footprint to maximise assessment capacity throughout the winter. |

# Integrated Dashboard - October 2018

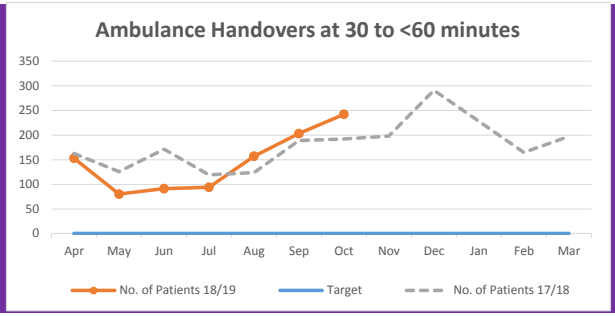
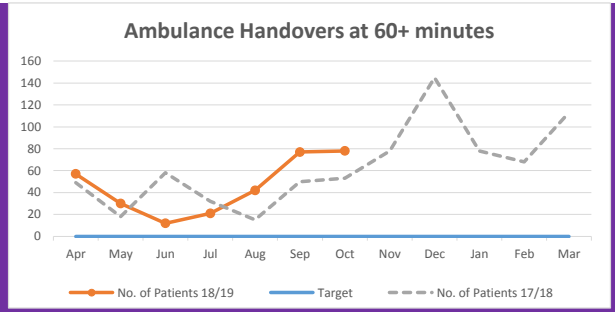
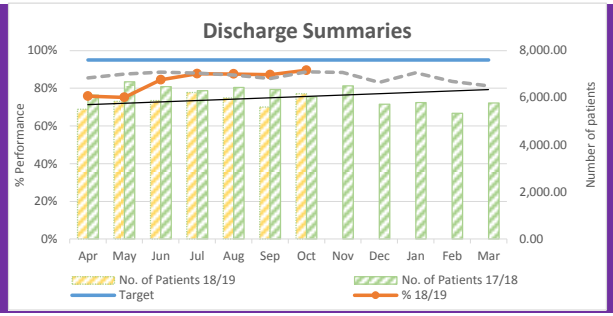
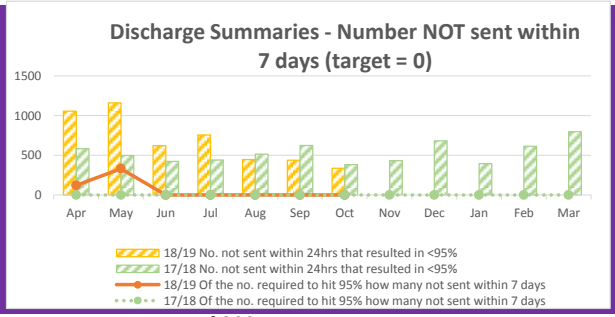
## Mandatory Standards - Access & Performance - Trust Position

| | Description | Aggregate Position | Trend | Variation |
|---|---|---|---|---|
| Cancer 14 Days<br><br>Red: Less than 93%<br>Green: 93% or above | All patients need to receive first appointment for cancer within 14 days of urgent referral. The national target is 93%. This target is measured and reported on a quarterly basis. | The Trust achieved 94.45% in September 2018 - please note cancer validation is not completed until 8 weeks after the end of the reporting period. |  | The Trust achieved the Cancer 14 day target in September.<br><br>The October data is in draft format and will only be released once fully validated and uploaded in October. |
| Breast Symptoms 14 Days<br><br>Red: Less than 93%<br>Green: 93% or above | All patients need to receive first appointment for any breast symptom (except suspected cancer) within 14 days of urgent referral. The national target is 93%. This target is measured and reported on a quarterly basis. | The Trust achieved 98.36% in September 2018 - please note cancer validation is not completed until 8 weeks after the end of the reporting period. |  | The 2 week wait for Breast Symptomatic has achieved 98.36% in September 2018. This was the result of a focused piece of capacity and demand work. This has also improved the number of people who are able to access appointments within 7 days. |
| Cancer 31 Days First Treatment<br><br>Red: Less than 96%<br>Green: 96% or above | All patients to receive first treatment for cancer within 31 days of decision to treat. This national target is 96%. This target is measured and reported on a quarterly basis. | The Trust achieved 100% in September 2018 - please note cancer validation is not completed until 8 weeks after the end of the reporting period. |  | The Trust achieved this target in September 2018. |
| Cancer 31 Days Subsequent Surgery<br><br>Red: Less than 94%<br>Green: 94% or above | All patients to receive a second or subsequent treatment for cancer within 31 days of decision to treat/surgery. The national target is 94%. This target is measured and reported on a quarterly basis. | The Trust achieved 100% in September 2018 - please note cancer validation is not completed until 8 weeks after the end of the reporting period. |  | The Trust achieved this target in September 2018. |

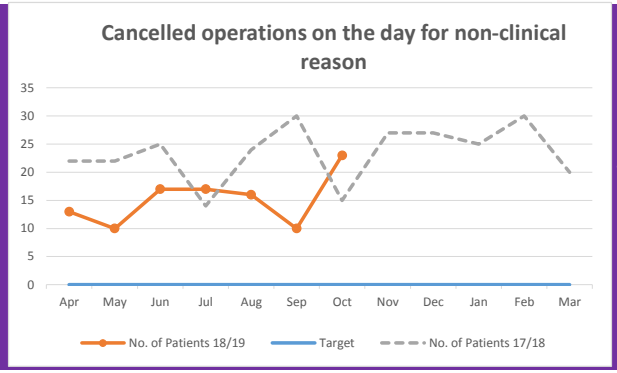
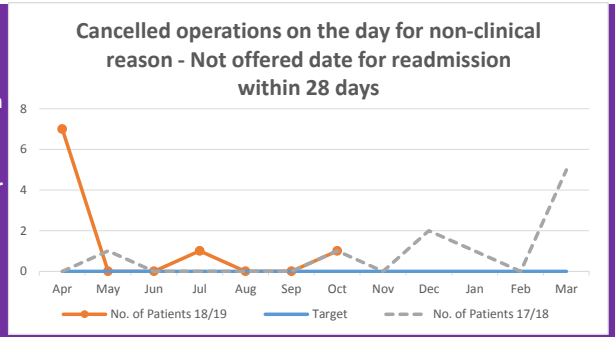
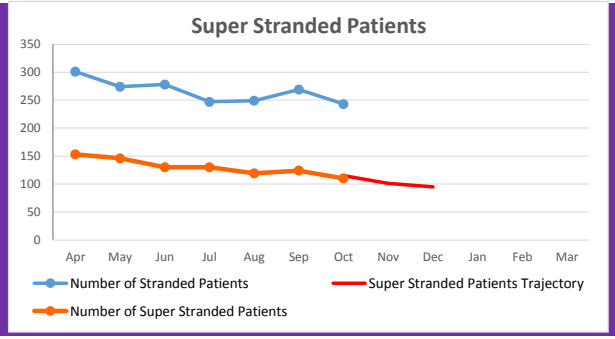
## Mandatory Standards - Access & Performance - Trust Position

| | Description | Aggregate Position | Trend | Variation |
|---|---|---|---|---|
| Cancer 31 Days Subsequent Drug<br><br>Red: Less than 98%<br>Green: 98% or above | All patients to receive a second or subsequent treatment for cancer within 31 days of decision to treat – anti cancer drug treatments. The national target is 98%. This target is measured and reported on a quarterly basis. | The Trust achieved 100% in September 2018 - please note cancer validation is not completed until 8 weeks after the end of the reporting period. |  | The Trust achieved this target in September 2018. |
| Cancer 62 Days Urgent<br><br>Red: Less than 85%<br>Green: 85% or above | All patients to receive first treatment for cancer within 62 days of urgent referral. The national target is 85%.<br><br>This metric also forms part of the Trust's STP Improvement trajectory.<br><br>The proposed tolerance levels applied to the improvement trajectories are also illustrated. | The Trust achieved 87.67% in September 2018 - please note cancer validation is not completed until 8 weeks after the end of the reporting period. |  | The Trust achieved this target in September 2018. |
| Cancer 62 Days Screening<br><br>Red: Less than 90%<br>Green: 90% or above | All patients must wait no more than 62 days from referral from an NHS screening service to first definitive treatment for all cancers. The national target is 90%. This target is measured and reported on a quarterly basis. | The Trust achieved 100% in September 2018 - please note cancer validation is not completed until 8 weeks after the end of the reporting period. |  | The Trust achieved this target in September 2018. |

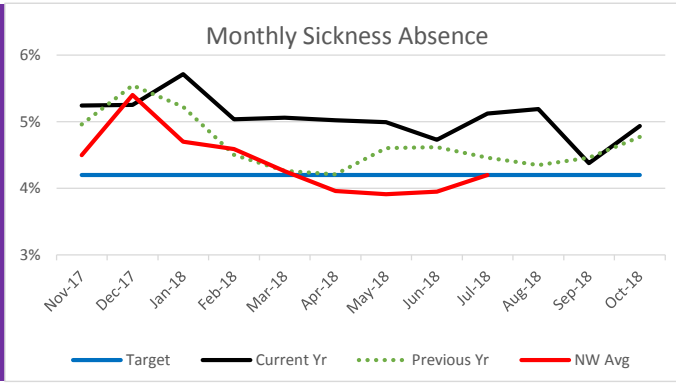
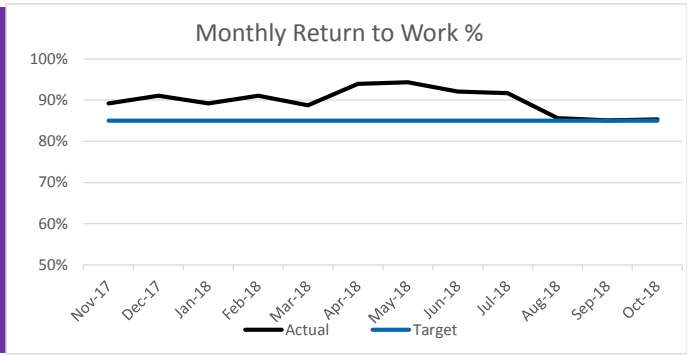
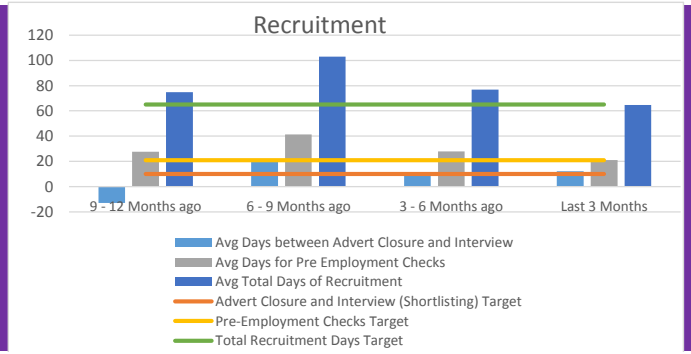
## Mandatory Standards - Access & Performance - Trust Position

| | Description | Aggregate Position | Trend | Variation |
|---|---|---|---|---|
| Ambulance Handovers 30 to <60 minutes<br><br>Red: More than 0<br>Green: 0 | Number of ambulance handovers that took 30 to <60 minutes (based on the data record on the HAS system). | There were 242 patients where the ambulance handover was between 30 and 60 minutes in October 2018. |  | Ambulance handovers remain a challenge particularly when we have peaks in attendances within an hour, in line with the under achievement in performance against the NHSI trajectory this position has deteriorated in October. |
| Ambulance Handovers at 60 minutes or more<br><br>Red: More than 0<br>Green: 0 | Number of ambulance handovers that took 60 minutes or more (based on the data record on the HAS system). | There were 78 patients where the ambulance handover was more 60 minutes in October 2018. |  | Ambulance handovers remain a challenge particularly when we have peaks in attendances within an hour, the number of handovers greater than 60 minutes has increased in line with performance. Work continues to focus on reducing number waiting over 60 minutes. |
| Discharge Summaries - % sent within 24hrs<br><br>Red: Less than 95%<br>Green: 95% or above | The Trust is required to issue and send electronically a fully contractually complaint Discharge Summary within 24 hrs of the patients discharge. | The Trust achieved 89.54% in October 2018. |  | The Trust continues to drive compliance improvement across all CBUs. This is monitored via the weekly & monthly KPI meetings. There is an SoP in place to support compliance against this standard. |
| Discharge Summaries - Number NOT sent within 7 days<br><br>Red: Above 0 | If the Trust does not send 95% of discharge summaries within 24hrs, the Trust is then required to send the difference between the actual performance and the 95% required standard within 7 days of the patients discharge. | All discharge summaries in order to meet the 95% threshold were sent in October 2018. |  | The Trust achieved this target in October 2018. |

## Mandatory Standards - Access & Performance - Trust Position

| | Description | Aggregate Position | Trend | Variation |
|---|---|---|---|---|
| Cancelled Operations on the day for a non-clinical reason<br><br>Red: Above zero | Number of operations cancelled on the day or after admission for a non-clinical reason. | There were 23 operations cancelled on the day due to non-clinical reasons in October 2018. |  | This has remained a challenge in October with bed pressures and unforeseen absences. |
| Cancelled Operations on the day for a non-clinical reason - Not offered a date for readmission within 28 days of the cancellation | All service users who have their operation cancelled on the day or after admission for a non-clinical reason, should be offered a binding date for readmission within 28 days. | There was 1 patient whose operation was cancelled on the day for non-clinical reasons whom was not readmitted within 28 days in October 2018. |  | Unfortunately, this was due to consultant availability, the patient has subsequently been listed and treated on 01/11/2018. |
| Super Stranded Patients<br>Green: Meeting Trajectory<br><br>Red: Missing Trajectory | 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. | There were 243 stranded patients and 110 super stranded patients at the end of October 2018. |  | This standard is being routinely monitored and supported by weekly delayed discharge and LoS forums. Improvement has been made, however, this needs to continue to achieve the ambition of 86 super stranded by the end of December 2018. |

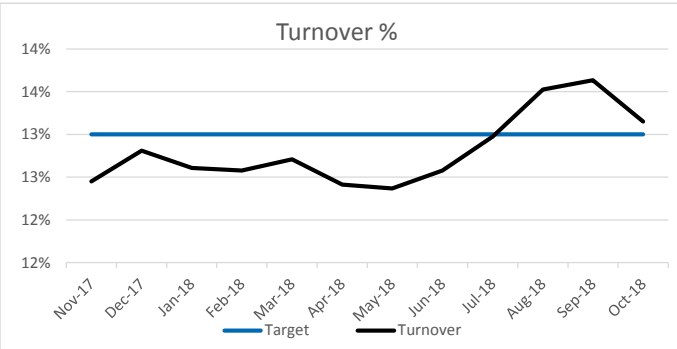
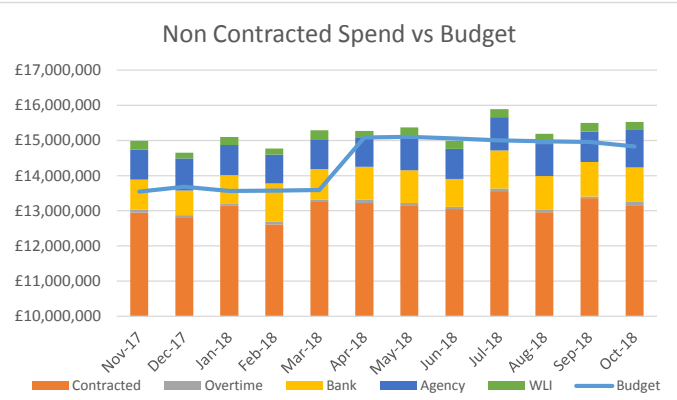
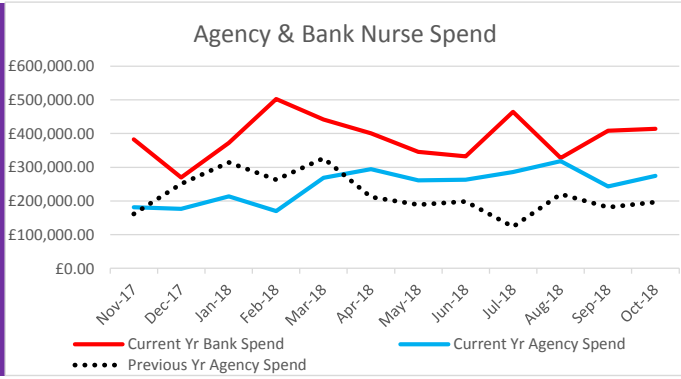
## Workforce

| | Description | Aggregate Position | Trend | Variation |
|---|---|---|---|---|
| Sickness Absence<br><br>Red: Above 4.5%<br>Amber: 4.2% to 4.5%<br>Green: Below 4.2% | UoR<br><br>Comparing the monthly sickness absence % with the Trust Target (4.2%) previous year, and North West average | Sickness absence was 4.93% in October 2018, against a target of 4.2%. |  | The two highest reasons for absence are Mental Health and Musculoskeletal illnesses. These will be a key focus in the Trust refreshed People Strategy. In addition, the HR Team will be liaising with peer group Trusts to explore additional opportunities to support a reduction in sickness absence. |
| Return to Work<br><br>Red: Below 75%<br>Amber: 75% to 85%<br>Green: Above 85% | A review of the completed monthly return to work interviews. | The RTW Interview compliance for October 2018 was 85%. |  | Monthly return to work interview compliance has consistently been above target for the last 12 months. Over the past 3 months, management delays in recording the interviews on ESR / E-Rostering have meant that the figure has been reported as below target. This appears to have been resolved in October 2018, The HR Team will continue to stress the importance of timely recording of return to work interviews. |
| Recruitment<br><br>Red: 76 days or above<br>Amber: 66 to 76 days<br>Green: 65 days or | A measurement of the average number of days it is taking to recruit into posts.<br><br>It also shows the average number of days between the advert closing and the interview (target 10) to measure if we are taking too long to complete shortlisting and also highlights the number of days for which it takes successful candidates to complete their pre-employment checks | Average time to recruit was 64.6 days over the last 3 months, against a target of 65 days. |  | Average time to recruit over the last 3 months has been within target. The Recruitment Team continue to work with the Regional Streamlining Group to identify opportunities to further reduce timescales. |

Warrington and Halton Hospitals NHS
NHS Foundation Trust

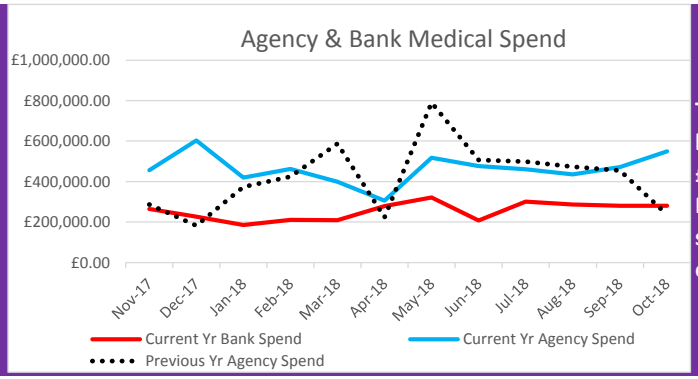
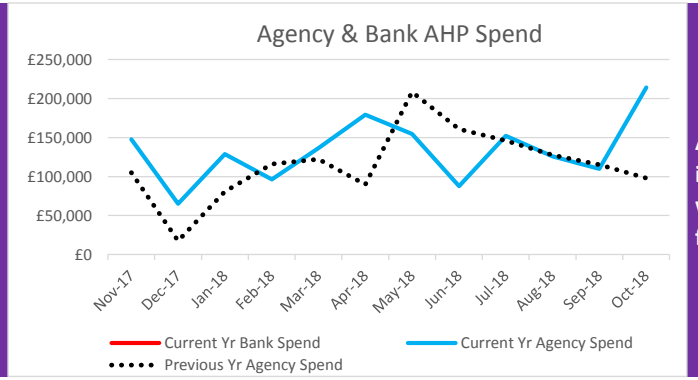
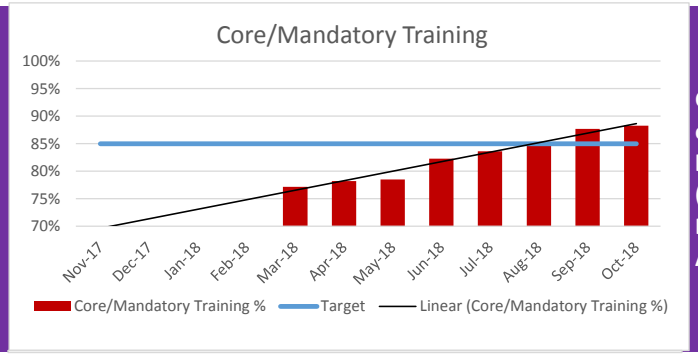
# Integrated Dashboard - October 2018

## Workforce

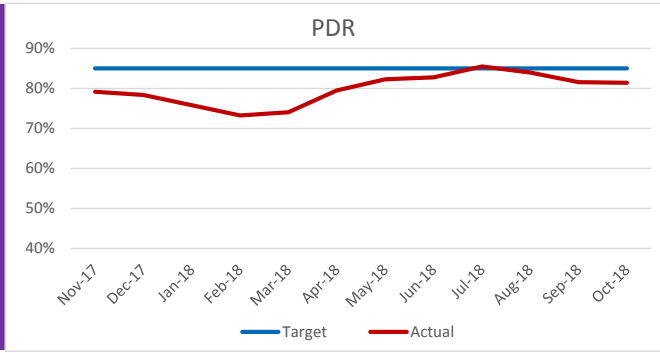
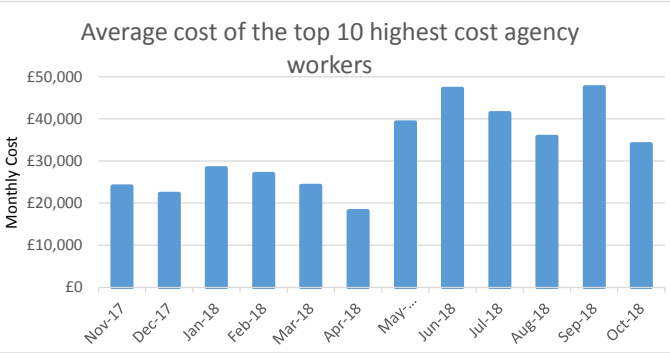
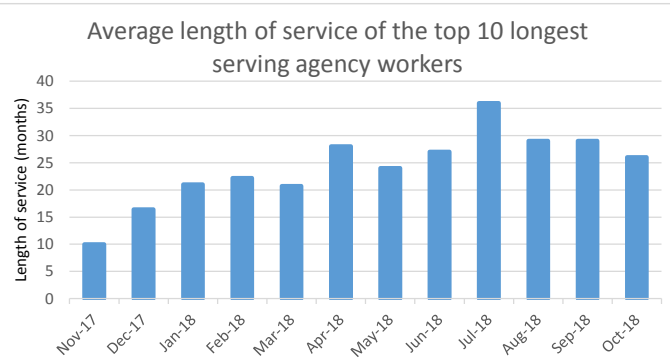
| | Description | Aggregate Position | Trend | Variation |
|---|---|---|---|---|
| Turnover<br><br>Red: Above 15%<br>Amber: 13% to 15%<br>Green: Below 13% | UoR<br><br>A review of the turnover percentage over the last 12 months | Turnover has reduced in month to 13.15%, against a target of 13%. |  | Turnover has reduced in month and is now 0.15% above target. The refreshed People Strategy includes a focus on how we retain talent within the organisation, including reviewing data collection at exit, retention initiatives and building career pathways. |
| Non Contracted Pay<br><br>Red: Greater than Budget<br><br>Green: Less than Budget | UoR<br><br>A review of the Non-Contacted pay as a percentage of the overall pay bill year to date | Total pay spend in October 2018 was £15.5m against a budget of £15.2m. Contracted pay spend was £13.2 and the remaining £2.3m was spent on temporary staffing including agency, bank, overtime and WLIs. |  | Temporary staffing usage in October 2018 was 15.2%. A number of work streams to address temporary staffing spend are on going and are managed via the Premium Pay Spend Review Group. These include a review of plans in areas with high temporary staffing usage, a centralised temporary staffing model and collaborative work across Cheshire and Mersey Region. |
| Agency Nurse Spend<br><br>Red: Greater than Previous Yr<br>Green: Less then | UoR<br><br>A review of the monthly spend on Agency Nurses | Agency Nurse Spend was £275k and Bank Nurse Spend £414k in October 2018. |  | Throughout October 2018 there were 8,377 hours of agency work undertaken at a cost of £275k. Temporary staffing usage in Nursing and Midwifery equated to approximately 123 FTE. There were 11,229 hours of bank work undertaken at a cost of £414k. Temporary staffing usage in Nursing and Midwifery equated to approximately 123 FTE. |

# Integrated Dashboard - October 2018

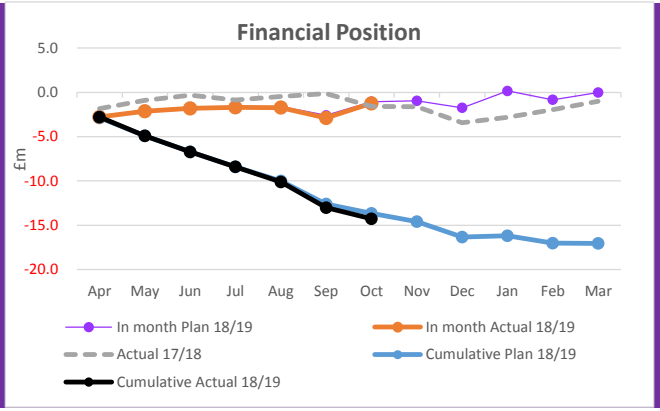
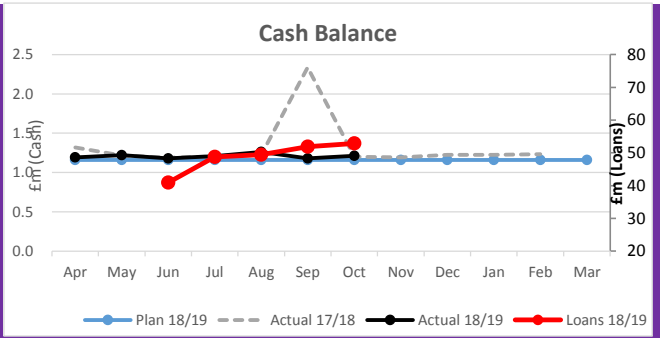
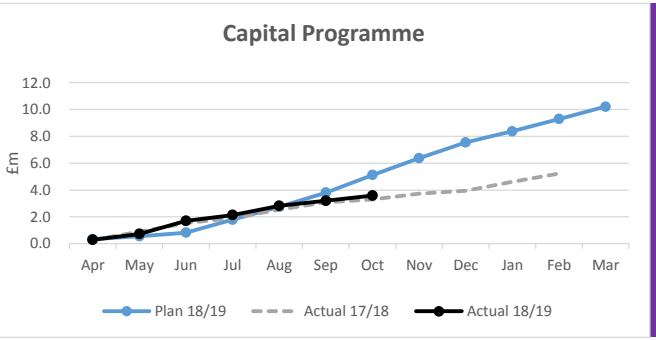
## Workforce

| | Description | Aggregate Position | Trend | Variation |
|---|---|---|---|---|
| Agency Medical Spend<br><br>Red: Greater than Previous Yr<br>Green: Less then | UoR<br><br>A review of the monthly spend on Agency Locums | Medical Agency Spend was £549k and Bank Medical Spend was £281k in October 2018. |  | Throughout October 2018 there were 5,297 hours of agency work undertaken at a cost of £549k. Breach cap form compliance was 100%. Medical bank spend was £281k. Temporary staffing usage across the Medical workforce equated to approximately 52.2 FTE. |
| Agency AHP Spend<br><br>Red: Greater than Previous Yr<br>Green: Less then Previous Yr | UoR<br><br>A review of the monthly spend on AHP Locums | AHP Agency Spend was £214k in month. |  | AHP Agency Spend and hours worked have increased significantly in month. Additional work is underway to understand the reason for the increase. |
| Core/Mandatory Training<br><br>Red: Below 70%<br>Amber: 70% to 85%<br>Green: Above 85% | A summary of the Core/Mandatory Training Compliance, this includes:<br><br>Conflict Resolution, Equality & Diversity, Fire Safety, Health & Safety, Infection Prevention & Control, Information Governance, Moving & Handling, PREVENT, Resuscitation and Safeguarding. | Core Skills Mandatory Training Compliance was 88.25% in October 2018. |  | Core Skills Training remains above target overall. Focus in now on specific topics with low compliance, including Conflict Resolution (83%), Moving and Handling (84%), Resuscitation Training (78%), Safeguarding Adults (81%). |

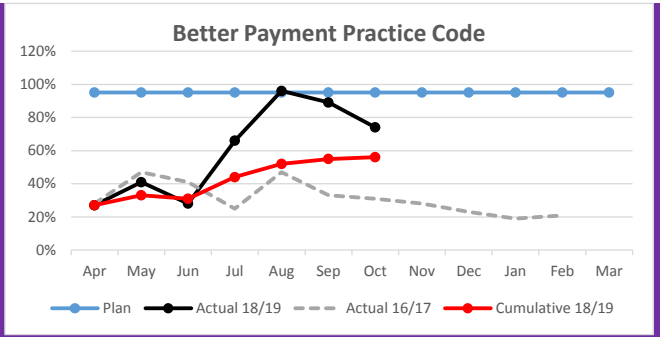
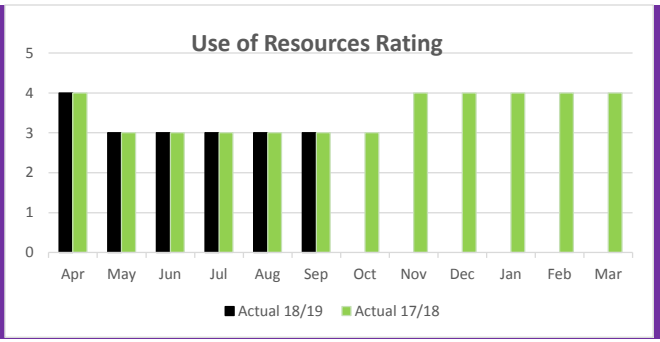
## Workforce

| | Description | Aggregate Position | Trend | Variation |
|---|---|---|---|---|
| PDR<br><br>Red: Below 70%<br>Amber: 70% to 85%<br>Green: Above 85% | A summary of the PDR Compliance rate | PDR Compliance was 81.5% in October 2018. |  | Compliance has dipped significantly below target and must be a focus for CBUs and Corporate Departments over the next month. Compliance in Clinical Services in October 2018 was 81% and in Corporate Services compliance was 83%. |
| Average cost of the top 10 highest cost Agency Workers<br><br>Red: Greater than previous month<br><br>Green: Less than | Monthly costs for the top 10 highest cost Agency Workers | The monthly cost for the top earning agency workers ranged from £57k to £25k, with the average cost being £34k. |  | The high cost agency workers data is scrutinised monthly and work is on-going to produce mitigation plans, with a focus on departments which have a consistently high usage of all elements of premium pay. This work is reported through to the Premium Pay Spend Review Group. |
| Average length of service of the top 10 longest serving agency workers<br><br>Red: Greater than previous month | The length of service (months) of the Top 10 agency workers who have been working at the trust for a minimum of 3 shifts per week for a consecutive period of 6 weeks. | The length of service for the longest serving agency workers ranged from 54 months to 16 months with the average length of service being 26 months. |  | The length of service for agency workers is reported on a weekly basis to NHSI. |

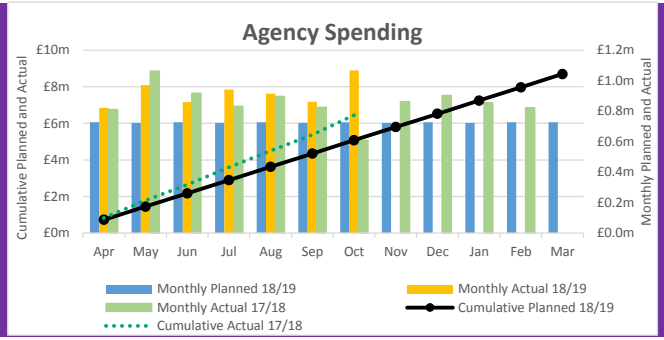
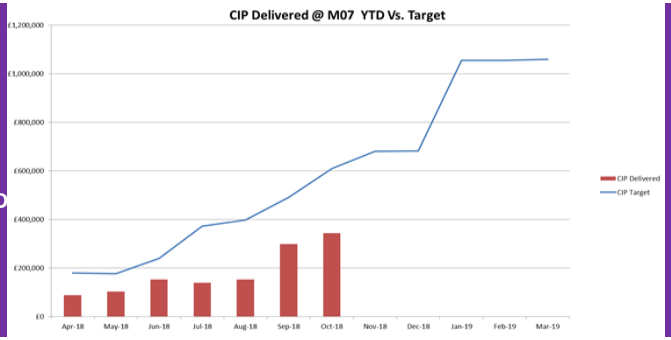
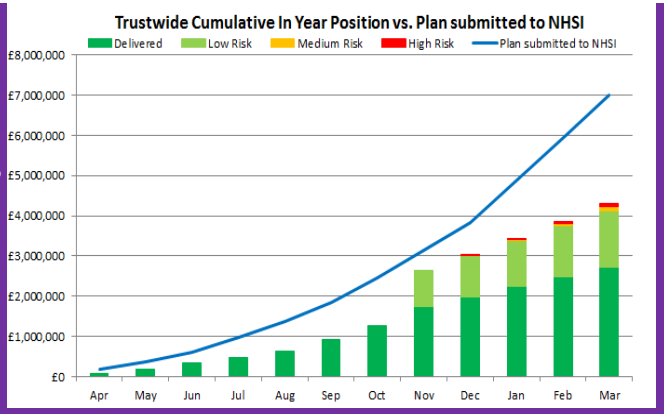
## Sustainability & Mandatory Standards - Finance

| | Description | Aggregate Position | Trend | Variation |
|---|---|---|---|---|
| Financial Position<br><br>Red: Deficit Position<br>Amber: Actual on or better than planned but still in deficit<br>Green: Surplus | UoR<br>Operating surplus or deficit compared to plan. | The actual deficit in the month is £1.2m which increases the cumulative deficit to £14.3m. |  | The cumulative deficit of £14.3m is £0.7m below plan. The year to date control total (excluding Provider Sustainability Funding) is a £16.0m deficit which is £0.2m worse than plan. |
| Cash Balance<br><br>Red: Less than 90% or below minimum cash balance per NHSI<br>Amber: Between 90% and 100% of planned cash balance<br>Green: On or better than plan | UoR<br>Cash balance at month end compared to plan (excluding cash relating to the hosting of the Sustainability and Transformation Partnership). | The current cash balance of £1.2m equates to circa 2 days operational cash. |  | The current cash balance of £1.2m is in line with plan. |
| Capital Programme<br><br>Red: Off plan <80% - >110%<br>Amber: Off plan 80-90% or 101 - 110%<br>Green: On plan 90%-100% | UoR<br>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). | The actual capital spend in the month is £0.4m which increases the cumulative spend to £3.6m. |  | The cumulative capital spend of £3.6m is £1.5m below above the planned capital spend of £5.1m. The phasing of the capital expenditure relating to the Kendrick Wing fire is the main reason for the current position. |

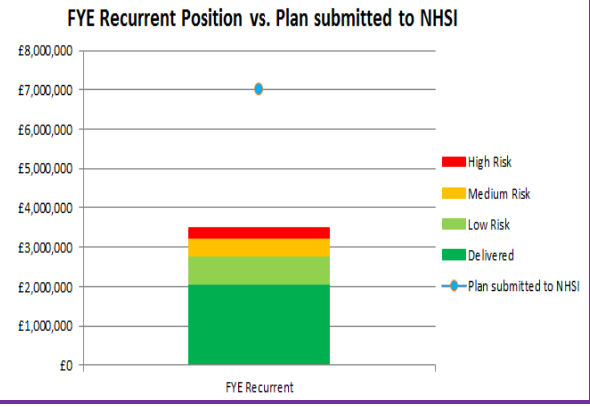
## Sustainability & Mandatory Standards - Finance

| | Description | Aggregate Position | Trend | Variation |
|---|---|---|---|---|
| Better Payment Practice Code<br><br>Red: Cumulative performance below 85%<br>Amber: Cumulative performance between 85% and 95%<br>Green: Cumulative performance 95% or | UoR<br>Payment of non NHS trade invoices within 30 days of invoice date compared to target. | In month the Trust has paid 74% of suppliers within 30 days which results in a year to date performance of 56%. |  | The cumulative performance of 56% is 39% below the national standard of 95%, this is due to the low cash balance and the need to manage cash very closely. |
| Use of Resources Rating<br>Red: Use of Resource Rating 4<br>Amber: Use of Resource Rating 3<br>Green: Use of Resource Rating 1 and 2 | UoR<br>Use of Resources Rating compared to plan. | The current Use of Resources Rating is 3. Capital Servicing Capacity, Liquidity, I&E margin are scored at 4, Agency Ceiling is scored at 3 and performance against control total is scored at 2. |  | The current Use of Resources Rating of 3 is in line with the planned rating. |
| Fines and Penalties<br><br>Red: Greater than zero<br>Green: Zero | Monthly fines and penalties | Fines and Penalties are levied by commissioners as outlined in the contracts. |  | The Trust has not been notified by commissioners of any fines or penalties as of month 7. A previous penalty levied by NHS England for the non-achievement of CQUIN has been withdrawn as the Trust was able to demonstrate compliance. The Trust has agreed with commissioners in Warrington & Halton to reinvest any fines and penalties as part of the sustainability contract. |

## Sustainability & Mandatory Standards - Finance

| | Description | Aggregate Position | Trend | Variation |
|---|---|---|---|---|
| Agency Spending<br><br>Red: More than 105% of ceiling<br>Amber: Over 100% but below 105% of ceiling<br>Green: Equal to or less than agency ceiling. | UoR<br>Agency spend compared to agency ceiling | The actual agency spend in the month is £1.1m which increases the cumulative spend to £6.4m |  | The cumulative agency spend of £6.4m is £1.3m (27%) above the cumulative agency ceiling of £5.1m. |
| Cost Improvement Programme - In year performance to date<br>Red: 0-70% Plan delivered YTD<br>Amber: 70-90% Plan delivered YTD<br>Green: >90% Plan delivered YTD | Cost savings delivered compared to plan. | CIP savings delivered M7 £0.34m vs target £0.62m (55%).<br><br>M7 YTD CIP £1.27m delivered vs YTD target £2.47m (52% of target). |  | CIP savings delivered in M7 is £0.28m behind plan.<br><br>YTD M7 the Trust is £1.2m behind Plan |
| Cost Improvement Programme - Plans in Progress - In Year<br>Red: Forecast is less than 50% of annual target<br>Amber: Forecast is between 50% and 90% of the annual target<br>Green: Forecast is more than 90% of the annual target | Planned improvements in productivity and efficiency - In Year forecast vs £7m target. | The best case in year forecast for CIP is £4.29m (61% of target). |  | The best case in year forecast for CIP is £4.29m - £2.71m below £7m target. |

## Sustainability & Mandatory Standards - Finance

| Description | Aggregate Position | Trend | Variation |
|---|---|---|---|
| Cost Improvement Programme - Plans in Progress - Recurrent<br>Red: Forecast is less than 50% of annual target<br>Amber: Forecast is between 50% and 90% of the annual target<br>Green: Forecast is more than 90% of the annual target | **Planned improvements in productivity and efficiency - Full Year Forecast vs. £7m target.** | **The best case recurrent forecast for CIP is £3.49m (49.9% of target).** |  | **The best case recurrent forecast for CIP is £3.49m - £3.51m below £7m target.** |

**Appendix 3**

**Income Statement, Activity Summary and Use of Resources Ratings as at 31st October 2018**

| Income Statement | Month | | | Year to date | | |
|---|---|---|---|---|---|---|
| | Budget £000 | Actual £000 | Variance £000 | Budget £000 | Actual £000 | Variance £000 |
| **Operating Income** | | | | | | |
| **NHS Clinical Income** | | | | | | |
| Elective Spells | 3,081 | 2,663 | -418 | 19,961 | 18,044 | -1,917 |
| Elective Excess Bed Days | 9 | 48 | 39 | 59 | 132 | 73 |
| Non Elective Spells | 4,754 | 4,574 | -180 | 33,855 | 34,505 | 651 |
| Non Elective Excess Bed Days | 162 | 115 | -47 | 1,155 | 1,596 | 441 |
| Outpatient Attendances | 3,047 | 3,075 | 27 | 19,742 | 19,847 | 104 |
| Accident & Emergency Attendances | 1,118 | 1,247 | 129 | 7,711 | 8,498 | 787 |
| Other Activity | 5,779 | 6,439 | 660 | 39,503 | 40,065 | 562 |
| **Sub total** | **17,950** | **18,161** | **211** | **121,986** | **122,688** | **702** |
| **Non NHS Clinical Income** | | | | | | |
| Private Patients | 20 | 0 | -20 | 51 | 82 | 31 |
| Non NHS Overseas Patients | 4 | 0 | -4 | 26 | 29 | 4 |
| Other non protected | 95 | 86 | -9 | 665 | 503 | -162 |
| **Sub total** | **119** | **86** | **-32** | **742** | **615** | **-127** |
| **Other Operating Income** | | | | | | |
| Training & Education | 641 | 642 | 0 | 4,488 | 4,643 | 155 |
| Donations and Grants | 0 | 0 | 0 | 0 | 98 | 98 |
| Provider Sustainability Fund (PSF) | 494 | 494 | 0 | 2,224 | 1,703 | -521 |
| Miscellaneous Income | 1,575 | 2,028 | 453 | 11,022 | 12,593 | 1,571 |
| **Sub total** | **2,710** | **3,163** | **453** | **17,734** | **19,037** | **1,303** |
| **Total Operating Income** | **20,779** | **21,411** | **632** | **140,461** | **142,339** | **1,878** |
| **Operating Expenses** | | | | | | |
| Employee Benefit Expenses | -14,827 | -15,467 | -640 | -105,021 | -107,689 | -2,668 |
| Drugs | -1,419 | -1,579 | -159 | -9,956 | -9,574 | 381 |
| Clinical Supplies and Services | -1,717 | -1,764 | -47 | -12,122 | -12,470 | -348 |
| Non Clinical Supplies | -3,125 | -3,109 | 16 | -21,730 | -21,675 | 55 |
| Depreciation and Amortisation | -501 | -500 | 1 | -3,504 | -3,439 | 65 |
| Restructuring Costs | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total Operating Expenses** | **-21,589** | **-22,419** | **-830** | **-152,332** | **-154,847** | **-2,515** |
| **Operating Surplus / (Deficit)** | **-810** | **-1,009** | **-199** | **-11,871** | **-12,508** | **-637** |
| **Non Operating Income and Expenses** | | | | | | |
| Profit / (Loss) on disposal of assets | 0 | 0 | 0 | 0 | 1 | 1 |
| Interest Income | 3 | 8 | 5 | 21 | 46 | 25 |
| Interest Expenses | -63 | -63 | 0 | -528 | -530 | -2 |
| PDC Dividends | -181 | -181 | 0 | -1,269 | -1,269 | 0 |
| Net Impairments | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total Non Operating Income and Expenses** | **-241** | **-236** | **5** | **-1,777** | **-1,753** | **24** |
| **Surplus / (Deficit)** | **-1,051** | **-1,245** | **-193** | **-13,647** | **-14,261** | **-614** |
| Donations & Grants Income | 0 | 0 | 0 | 0 | -98 | -98 |
| Depreciation on Donated & Granted Assets | 13 | 14 | 1 | 91 | 95 | 4 |
| **Performance against Control Total inc PSF** | **-1,038** | **-1,231** | **-193** | **-13,556** | **-14,264** | **-708** |
| Less PSF | -494 | -494 | 0 | -2,224 | -1,703 | 521 |
| **Performance against Control Total exc PSF** | **-1,533** | **-1,725** | **-192** | **-15,780** | **-15,967** | **-187** |
| **Activity Summary** | **Planned** | **Actual** | **Variance** | **Planned** | **Actual** | **Variance** |
| Elective Spells | 3,285 | 3,223 | -62 | 21,281 | 19,954 | -1,327 |
| Elective Excess Bed Days | 38 | 137 | 100 | 245 | 487 | 242 |
| Non Elective Spells | 2,989 | 2,837 | -152 | 21,279 | 19,913 | -1,366 |
| Non Elective Excess Bed Days | 667 | 114 | -553 | 4,752 | 6,653 | 1,901 |
| Outpatient Attendances | 28,408 | 28,813 | 405 | 184,036 | 183,379 | -656 |
| Accident & Emergency Attendances | 9,546 | 9,654 | 108 | 65,847 | 67,452 | 1,605 |
| **Use of Resources Ratings** | **Planned Metric** | **Actual Metric** | **Variance Metric** | **Planned Metric** | **Actual Metric** | **Variance Metric** |
| **Metrics** | | | | | | |
| Capital Servicing Capacity (Times) | | | | -4.51 | -4.32 | 0.19 |
| Liquidity Ratio (Days) | | | | -8.2 | -30.9 | -22.7 |
| I&E Margin (%) | | | | -9.65% | -10.03% | -0.38% |
| Performance against control total (%) | | | | 0.00% | -0.38% | -0.38% |
| Agency Ceiling (%) | | | | 0.00% | 26.89% | 26.89% |
| **Ratings** | | | | | | |
| Capital Servicing Capacity (Times) | | | | 4 | 4 | 0 |
| Liquidity Ratio (Days) | | | | 3 | 4 | 1 |
| I&E Margin (%) | | | | 4 | 4 | 0 |
| Performance against control total (%) | | | | 1 | 2 | 1 |
| Agency Ceiling (%) | | | | 1 | 3 | 2 |
| **Use of Resources Rating** | | | | **3** | **3** | **0** |

**Appendix 4**

**2018/19 Capital Programme**

**Proposed Amendments**

| Description | Approved Programme 2018/19 | Approved Amendments M1 - M6 2018/19 | Proposed Amendments M7 2018/19 | Additional Proposed Amendments M7 2018/19 | Total Revised Programme 2018/19 |
|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 |
| **Estates** | | | | | |
| Backlog - Replace emergency back-up generators | 400 | 7 | 0 | 0 | 407 |
| Staffing | 177 | 0 | 0 | 0 | 177 |
| Fire - Appleton Wing, Fire Damper Second Phase, Installation | 0 | 16 | 0 | 0 | 16 |
| Backlog - All areas, fixed installation wiring test | 50 | 0 | 0 | 0 | 50 |
| Backlog - footpath, road and car park surface repairs | 0 | 2 | 0 | 0 | 2 |
| Six Facet Survey (annual rolling programme) to include dementia & disability | 60 | 0 | 0 | 0 | 60 |
| Backlog - Asbestos re-inspection & removals | 30 | 0 | 0 | 0 | 30 |
| Halton Endoscopy Essential power supply to rooms 1 & 2 | 20 | 0 | 0 | 0 | 20 |
| Backlog - Air Con/ Cooling Sys upgrade. Ph1-Survey | 12 | 0 | 0 | 0 | 12 |
| Automatic sliding / entrance doors across all sites | 20 | 0 | 0 | 0 | 20 |
| External Fire Escapes Replace (Kendrick & Appleton) | 40 | 3 | 0 | 0 | 43 |
| Estates Minor Works | 50 | 3 | 0 | 0 | 53 |
| High Voltage Maintenance | 40 | 0 | 0 | 0 | 40 |
| Substation C air circuit breakers | 404 | 0 | 0 | (202) | 202 |
| Electrical Infrastructure Upgrade | 200 | 0 | 0 | 0 | 200 |
| North Lodge fire compartmentation | 150 | 0 | 0 | 0 | 150 |
| Appleton Wing fire doors | 100 | 0 | 0 | 0 | 100 |
| Thelwall House emergency escape lighting | 100 | 0 | 0 | 0 | 100 |
| North Lodge & Kendrick lightening protection works | 100 | 0 | 0 | 0 | 100 |
| Cheshire House fire doors | 25 | 0 | 0 | 0 | 25 |
| CCU relocation to Ward A3 | 728 | 0 | 0 | 0 | 728 |
| Removal of redundant chillers - Croft Wing | 30 | 0 | 0 | 0 | 30 |
| Replacement Combi Oven (Halton Kitchems) | 0 | 9 | 0 | 0 | 9 |
| Ophthalmic Flat Roof Replacement | 0 | 23 | 0 | 0 | 23 |
| Delamere Centre (Can Treat) Enhancements (ext. funded) | 0 | 84 | 0 | 0 | 84 |
| Discharge Lounge/Bereavement Office | 0 | 208 | 0 | 0 | 208 |
| Essential Power Supply - Halton Pharmacy | 0 | 6 | 0 | 0 | 6 |
| Bathroom A9 | 0 | 28 | 0 | 0 | 28 |
| N20 Exposure | 0 | 100 | 0 | 0 | 100 |
| Urology - Minor Refurb | 0 | 7 | 0 | 0 | 7 |
| B3 Door | 0 | 5 | 0 | 0 | 5 |
| Catering EHO Works | 0 | 0 | 35 | 0 | 35 |
| Kendrick Wing Fire - Estates | 0 | 706 | 238 | 0 | 944 |
| Kendrick Wing Fire - F & F | 0 | 44 | 6 | 0 | 50 |
| Kendrick Wing Fire - Miscellaneous | 0 | 116 | 22 | 0 | 138 |
| Pharmacy Clinical Trials Room | 0 | 16 | 0 | 0 | 16 |
| | **2,736** | **1,383** | **301** | **(202)** | **4,218** |
| **Medical Equipment** | | | | | |
| AER Machines (4 W 2 H) | 700 | 0 | 0 | (350) | 350 |
| Warrington MRI Scanner (replacement) | 1,200 | 0 | 0 | (1,200) | 0 |
| ICU Ventilators | 250 | (11) | 0 | 0 | 239 |
| NICU Incubators | 108 | (108) | 0 | 0 | 0 |
| Spectrophotometer | 0 | 10 | 0 | 0 | 10 |
| Oral Surgery Dental Chair x1 | 158 | (91) | 0 | 0 | 67 |
| Ultrasound Machine | 0 | 58 | 0 | 0 | 58 |
| Training Simulation Equipment (HEE) (ext. funded) | 0 | 77 | 0 | 0 | 77 |
| Obstretrics Simulation Monitors (HEE) (ext. funded) | 0 | 7 | 0 | 0 | 7 |
| Anaerobic Cabinet | 0 | 20 | 0 | 0 | 20 |
| Transducer - Baby Hips | 0 | 7 | 0 | 0 | 7 |
| Ultrasound Machines LOGIQER7 x 2 | 0 | 0 | 56 | 0 | 56 |
| Kendrick Wing Fire -Medical Equipment | 0 | 419 | (1) | 0 | 418 |
| Neonatal Monitors | 0 | 35 | 0 | 0 | 35 |
| CMAC Video Laryngoscope | 0 | 0 | 9 | 0 | 9 |
| | **2,416** | **423** | **64** | **(1,550)** | **1,353** |
| **IM&T** | | | | | |
| Technology & Devices refresh and developments | 500 | (26) | 0 | 0 | 474 |
| Procurement of Lorenzo work list activity | 0 | 38 | 0 | 0 | 38 |
| SAM | 30 | 0 | 0 | 0 | 30 |
| Security (Stonesoft firewall replacement/renewal) | 200 | 0 | 0 | 0 | 200 |
| Server refresh | 100 | 0 | 0 | 0 | 100 |
| VDI Roll Out | 150 | 0 | 0 | 0 | 150 |
| SIP Setup Costs | 15 | 0 | 0 | 0 | 15 |
| BI Tool | 27 | 0 | 0 | 0 | 27 |
| IPPMA/ePrescribing/ePMA | 250 | (59) | 0 | 0 | 191 |
| ePMA Lorenzo Digital Exemplar (LDE) | 0 | 59 | 0 | 0 | 59 |
| Video MDT (PDC) (ext. funded) | 0 | 100 | 0 | 0 | 100 |
| Meditech Restoration | 0 | 22 | 0 | 0 | 22 |
| Deontics Care Pathway | 0 | 8 | 0 | 0 | 8 |
| Kendrick Wing Fire - IT | 0 | 223 | 8 | 0 | 231 |
| | **1,272** | **365** | **8** | **0** | **1,645** |
| CQC Reserve | 500 | (10) | 0 | 676 | 1,166 |
| Kendrick Wing Fire Balance | 0 | 892 | (273) | 0 | 619 |
| Contingency | 624 | (365) | (100) | 1,076 | 1,235 |
| **Totals** | **7,548** | **2,688** | **0** | **0** | **10,236** |

# BOARD OF DIRECTORS

| | | |
|---|---|---|
| **AGENDA REFERENCE:** | **BM/18/11/107 a** | |
| **SUBJECT:** | **Safe Staffing Assurance Report - September** | |
| **DATE OF MEETING:** | 28 November 2018 | |
| **ACTION REQUIRED** | **The Board of Directors are asked to note the contents of the report** | |
| **AUTHOR(S):** | **Rachael Browning – Associate Chief Nurse** | |
| **EXECUTIVE DIRECTOR SPONSOR:** | **Kimberley Salmon –Jamieson –Chief Nurse** | |
| | | |
| **LINK TO STRATEGIC OBJECTIVES:** | SO1: To ensure that all care is rated amongst the top quartile in the North West of England for patient safety, clinical outcomes and patient experience | |
| **LINK TO BOARD ASSURANCE FRAMEWORK (BAF):** | BAF2.2: Nurse Staffing | |
| | BAF1.3: National & Local Mandatory, Operational Targets | |
| | BAF1.1: CQC Compliance for Quality | |
| | | |
| **STRATEGIC CONTEXT** | SO1: To ensure that all care is rated amongst the top quartile in the North West of England for patient safety, clinical outcomes and patient experience. | |
| **EXECUTIVE SUMMARY** (KEY ISSUES): | Ward staffing data continues to be systematically reviewed to ensure we safely staff our wards and provide mitigation and action when actual falls below 90% of planned staffing levels.<br><br>It is a recommendation of the National Quality Board (NQB) that the Board of Directors receives a monthly Safe Staffing paper, which includes Care Hours Per Patient Day (CHPPD) and planned vs actual staffing levels, highlighting areas where average fill rates fall below 90%, along with mitigation to ensure safe, high quality care is consistently delivered. | |
| **RECOMMENDATION:** | It is recommended that the Board of Directors note and approve the monthly Safe Staffing Assurance Report. | |
| **PREVIOUSLY CONSIDERED BY:** | **Committee** | Strategic People Committee |
| | **Agenda Ref.** | SPC/18/11/28 |
| | **Date of meeting** | 21 November 2018 |
| | **Summary of Outcome** | Noted |
| **FREEDOM OF INFORMATION STATUS** | | |
| **FOIA EXEMPTIONS APPLIED:** ***(if relevant)*** | | |

## Safe Staffing Assurance Report

The purpose of this paper is to provide transparency with regard to the nursing and midwifery ward staffing levels during September 2018. The Trust has a duty to ensure nursing and midwifery staffing levels are sufficient to maintain safety and provide quality care. This paper provides assurance that any shortfalls on each shift were reviewed and addressed as required with mitigating actions, including staffing levels and skill mix. It is well documented that nurse staffing levels make a difference to patient outcomes (mortality and adverse events, including levels of harm), patient experience, quality of care and the efficiency of care delivery.

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

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

**Care Hours Per patient Day**

Warrington and Halton Hospitals NHS Trust currently collect and report CHPPD data on a monthly basis.
The September Trust wide staffing data was analysed and cross-referenced for validation by the Deputy Chief Nurse, Lead Nurses, and the Associate Chief Nurse (Clinical Effectiveness).

Chart 1 illustrates this data to September 2018, which is showing a gradual improvement; this will continue to be monitored via the Trust monthly safer staffing report.

**Chart 1**

| Finyear | Month | Cumulative count over the month of patients at 23:59 each day | CHPPD - Registered | CHPPD - Care Staff | CHPPD All |
|---|---|---|---|---|---|
| 2018/19 | Apr | 15539.5 | 3.5 | 3.0 | 6.5 |
| | May | 15689 | 3.9 | 2.8 | 6.8 |
| | Jun | 14983 | 4.0 | 2.8 | 6.8 |
| | Jul | 15037 | 4.2 | 2.9 | 7.1 |
| | Aug | 14879 | 4.2 | 2.9 | 7.1 |
| | Sep | 14608 | 4.1 | 2.9 | 7.1 |
| 2018/19 Total | | 90735.5 | 4.0 | 2.9 | 6.9 |

**Key Messages**

Although some areas are above the 90% target year to date, it is acknowledged that the percentage of Registered Nurses/Midwives on some wards in the day is below the target. However, mitigation and responsive plans are in place to ensure that the safe delivery of patient care is discussed at every bed meeting and escalated as appropriate. Shift fill rates continue to improve month on month.

Recruitment remains a priority for the senior nursing team, we have 13 new Registered Nurses and 15 Health Care Assistants who joined the Trust in September 2018, with further recruitment and 'Keep in Touch' events planned for the year ahead.

The reduction in the number of additional beds open across the Trust has been sustained in September, the following areas are the only additional beds open at this time, AMU (8) and A5 (1), both areas are reviewed daily to determine the additional staffing required to ensure patient safety.

**Patient Harm by Ward**

In September 2018 we reported a total of 4 pressure ulcers, 2 (grade 2) on wards C21 and CDU, and 2 (grade 3) on ward B3. Each of these cases are currently being reviewed by the Tissue Viability nurse and the Associate Chief Nurse, Patient Safety to identify themes and shared learning. There have been 2 x patient falls with moderate or major harm falls reported this month, one on Ward C21 and one on Ward B3. All of the above falls are currently being investigated as part of the Serious Incident reporting process.

**Infection Incidents**

We had 4 cases of CDT in the month of September on Wards, A4, A6, A7 and A5; all of these cases are currently being investigated with review meeting planned in November 2018.

No cases of MRSA have been reported in September.

**Appendix 1** **MONTHLY SAFE STAFFING REPORT – September 2018**

## Monthly Safe Staffing Report – September 2018

| | | Day | Day | Day | Day | Day | Day | Night | Night | Night | Night | Night | Night | CHPPD | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Division | 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% | | | | | | | |
| SWC | SAU | 900 | 925.5 | 675 | 585 | 102.8% | 86.7% | - | - | - | - | - | - | | | | |
| SWC | Ward A5 | 1725 | 1350 | 1260 | 1343.5 | 78.3% | 106.6% | 1035 | 1035 | 1035 | 977.5 | 100% | 94.4% | 990 | 2.4 | 2.3 | 4.8 |
| SWC | Ward A6 | 1725 | 1241.5 | 1260 | 1322 | 72% | 104.9% | 1035 | 1023 | 1035 | 920 | 98.9% | 88.9% | 960 | 2.4 | 2.3 | 4.7 |
| SWC | Ward CMTC | 1272.5 | 1248.5 | 839.5 | 829 | 98.1% | 98.7% | 690 | 690 | 667 | 667 | 100% | 100% | 312 | 6.2 | 4.8 | 11.0 |
| SWC | Ward B4 | 670 | 666.5 | 392 | 399.5 | 99.5% | 101.9% | 230 | 230 | 230 | 230 | 100% | 100% | 68 | 13.2 | 9.3 | 22.4 |
| SWC | Ward A9 | 1725 | 1267.5 | 1380 | 1445 | 73.5% | 104.7% | 1035 | 1035 | 1035 | 1035 | 100% | 100% | 931 | 2.5 | 2.7 | 5.1 |
| SWC | Ward B11 | 2100 | 2021 | 750 | 760 | 96.2% | 101.3% | 1596 | 1589.7 | 166.4 | 166.4 | 99.6% | 100% | 420 | 8.6 | 2.2 | 10.8 |
| SWC | NCU | 1725 | 1496 | 345 | 264.5 | 86.7% | 76.7% | 1725 | 1414.5 | 345 | 345 | 82% | 100% | 318 | 9.2 | 1.9 | 11.1 |
| SWC | Ward C20 | 910 | 867 | 690 | 644 | 95.3% | 93.3% | 690 | 690 | 0 | 1 | 100% | - | 365 | 4.3 | 1.8 | 6.0 |
| SWC | Ward C23 | 1380 | 978 | 690 | 655.5 | 70.9% | 95% | 736 | 713 | 690 | 586.5 | 96.9% | 85% | 335 | 5.0 | 3.7 | 8.8 |
| SWC | Delivery Suite | 2415 | 2157 | 345 | 266.5 | 89.3% | 77.2% | 2415 | 2418.5 | 345 | 310.5 | 100.1% | 90% | 212 | 21.6 | 2.7 | 24.3 |
| ACS | Ward A1 | 2325 | 1850 | 1937.5 | 1630.5 | 79.6% | 84.2% | 1627.5 | 1580.5 | 651 | 750 | 97.1% | 115.2% | 974 | 3.5 | 2.4 | 6.0 |
| ACS | Ward A2 | 1380 | 1237 | 1380 | 1113 | 89.6% | 80.7% | 1035 | 1024.5 | 770.5 | 874 | 99% | 113.4% | 868 | 2.6 | 2.3 | 4.9 |
| ACS | Ward C22 | 1162.5 | 955.5 | 1035 | 1155 | 82.2% | 111.6% | 690 | 690 | 724.5 | 977.5 | 100% | 134.9% | 630 | 2.6 | 3.4 | 6.0 |
| ACS | Ward A4 | 1610 | 1425.5 | 1380 | 1219 | 88.5% | 88.3% | 1035 | 989 | 1035 | 1138.5 | 95.6% | 110% | 1020 | 2.4 | 2.3 | 4.7 |
| ACS | Ward A8 | 1380 | 1041 | 1725 | 1417.5 | 75.4% | 82.2% | 1380 | 1081 | 1035 | 1360 | 78.3% | 131.4% | 1020 | 2.1 | 2.7 | 4.8 |
| ACS | Ward B12 | 1035 | 1031 | 2415 | 2224.5 | 99.6% | 92.1% | 690 | 690 | 1725 | 1690 | 100% | 98% | 630 | 2.7 | 6.2 | 8.9 |
| ACS | Ward B14 | 1380 | 1265.5 | 1380 | 1249.5 | 91.7% | 90.5% | 690 | 690 | 690 | 943 | 100% | 136.7% | 720 | 2.7 | 3.0 | 5.8 |
| ACS | Ward B18 | 1426 | 1175 | 1426 | 1397 | 82.4% | 98% | 1069 | 736 | 1069 | 1173 | 68.8% | 109.7% | 720 | 2.7 | 3.6 | 6.2 |
| ACS | Ward B19 | 1035 | 1007.5 | 1380 | 1332.5 | 97.3% | 96.6% | 690 | 690 | 1035 | 1023.5 | 100% | 98.9% | 720 | 2.4 | 3.3 | 5.6 |
| ACS | Ward A7 | 1725 | 1521 | 1380 | 1266 | 88.2% | 91.7% | 1380 | 1276.5 | 1035 | 1138.5 | 92.5% | 110% | 990 | 2.8 | 2.4 | 5.3 |
| ACS | Ward C21 | 1035 | 1133 | 1035 | 1264.9 | 109.5% | 122.2% | 713 | 713 | 1035 | 1253.5 | 100% | 121.1% | 714 | 2.6 | 3.5 | 6.1 |
| ACS | CCU | 1380 | 1315.5 | 345 | 157 | 95.3% | 45.5% | 1035 | 1035 | 0 | 0 | 100% | - | 209 | 11.2 | 0.8 | 12.0 |
| ACS | ICU | 4830 | 4525.25 | 1035 | 966 | 93.7% | 93.3% | 4830 | 4508 | 690 | 506 | 93.3% | 73.3% | 482 | 18.7 | 3.1 | 21.8 |

# Appendix 2

## September 2018 - Mitigating Actions

| | DAY | | NIGHT | | MITIGATING ACTIONS |
|---|---|---|---|---|---|
| | Average fill rate - registered nurses/midwives (%) | Average fill rate – Health Care support staff (%) | Average fill rate - registered nurses/midwives (%) | Average fill rate - Health Care support staff (%) | |
| **SAU** | 102.8% | 86.7% | - | - | **Vacancy rate:** - 0.8 Band 6 vacancy **Action taken:** - ECF completed to recruit to post. Attendance management policy followed, monthly meeting with HR and welfare meetings arranged |
| **Ward A5** | 78.3% | 106.6% | 100% | 94.4% | **Vacancy rate:** - RN 2.0wte Band 5 vacancies. HCA - 3.35wte recruited 2 awaiting start dates, 1.35wte vacancy remains. **Action taken:** - x2 newly qualified starting Oct 18. 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 |
| **Ward A6** | 72% | 104.9% | 98.9% | 88.9% | **Vacancy rate:** - RN 3.31wte vacancies HCA-3.15wte vacancies Sickness rate – 6.17% **Action taken:** - 2.0wte HCA recruited, commenced in post Sept 18. 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 |
| **CMTC** | 98.1% | 98.7% | 100% | 100% | **Vacancy rate**: 5.6wte HCA vacancies **Sickness rate** – 10.48% **Action taken:** Daily staffing review against acuity and activity. Sickness absence being managed in line with Trust policy. |
| **B4** | 99.5% | 101.9% | 100% | 100% | **Vacancy rate:** - RN 1.0 wte HCA 2.74wte. 2 Associate Nurses commencing in Jan 19 when qualified. Sickness rate – 3.70% attendance management policy followed, monthly meeting with HR and welfare meetings arranged **Action taken:** Staffing and activity reviewed daily. |
| **Ward A9** | 73.5% | 104.7% | 100% | 100% | **Vacancy rate:** Band 6 - 0.54wte Band 5 - 2.0 and HCA 4.0. **Action taken**: All vacancies filled and awaiting start dates |
| **Ward B11** | 96.2% | 101.3% | 99.6% | 100% | **Vacancy Rate:** Band 5 – 1wte, HCA 1.0wte. **Sickness rate** – 4.56wte long term sick **Action taken:** Recruitment process underway. Staffing reviewed daily and support provided if necessary. Sickness absence being managed in line with the Trust policy. |
| **NCU** | 86.7% | 76.7% | 82% | 100% | **Vacancy rate:** 1.78wte Band 6. **Action taken:** - recruitment process in place with interviews date arranged. Staffing reviewed daily and support provided if necessary. |
| **Ward C20** | 95.3% | 93.3% | 100% | - | **Vacancy rate:** -1.0wte Band 6 1 HCA |

| | | | | | |
|---|---|---|---|---|---|
| | | | | | recruited<br>**Action taken:** - Start dates arranged for October 2018<br>Staffing reviewed daily and support provided if necessary. |
| **Ward C23** | 70.9% | 95% | 96.9% | 85% | **Vacancy Rate: :** Band 5 2.88wte vacancies<br>Sickness rate – 5%<br>**Action taken:** recruitment process in place. Staffing reviewed daily by the matron and staff moved to support if required and additional shifts request via NHSP. Sickness is being managed in line with Trust policy. |
| **Delivery Suite** | 89.3% | 77.2% | 100.1% | 90% | **Vacancy Rate:** 3.0wte band 5 midwives<br>**Action taken:** Daily review of staffing and staffed moved from other areas depending on acuity and occupancy. Recruitment process underway. Sickness is being managed in line with Trust policy. |
| **Ward A1 - AMU** | 79.6% | 84.2% | 97.1% | 115.2% | **Vacancy rate:** - Recruitment ongoing vacancies at 1.0wte Band 6 and 3.0wte Band 5.<br>**Action taken:** – Daily review of staffing and acuity, staff moved from other areas to support and additional staff access via NHSP. Sickness being managed in line with Trust policies. |
| **Ward A2** | 89.6% | 80.7% | 99% | 113.4% | **Vacancy rate:** - 3.0wte Band 5,<br>Sickness rate – 9%<br>**Action taken:** 3.0wte band 5 commencing in October 2018. Ongoing NHSP and agency requested to support safe staffing, acuity reviewed daily.<br>Sickness being managed in line with Trust policies. |
| **Ward C22** | 82.2% | 111.6% | 100% | 134.9% | **Sickness rate-** 2%<br>**Action taken**: - Sickness being managed in line with Trust policies. |
| **Ward A4** | 88.5% | 88.3% | 95.6% | 110% | **Vacancy rate:-** RN 2.32wte HCA 5.0<br>**Action taken:** - Staffing reviewed daily against acuity and activity. Vacancies currently being recruited to. |
| **Ward A8** | 75.4% | 82.2% | 78.3% | 131.4% | **Vacancy rate:** - 10 full time posts vacant, with a recruitment and support plan in place.<br>Sickness rate - 3.0wte LTS minimal ST sickness throughout the month of August 2018<br>**Action taken:** - recruitment of 1 ward manager full time, 3 full time band 6 sister posts, 2 band 5 full time nurses to be in post by early October 2018. 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 (Forget-me-not)** | 99.6% | 92.1% | 100% | 98% | **Vacancy rate:** - 14wte HCA vacancies following the nurse staffing business case<br>**Action taken**: - 3 HCA due to start in Oct 18 and 1 apprentice leaving a vacancy of 9wte, recruitment plan in place. Daily review by the matron to review staffing levels and acuity, staff moved from other areas to support. |
| **Ward B14** | 91.7% | 90.5% | 100% | 136.7% | **Vacancy rate:-** 2.5wte Band 5 and 3.5wte HCA<br>**Action taken:** - Staffing reviewed daily against acuity and activity. |
| **Ward B18** | 82.4% | 98% | 68.8% | 109.7% | **Vacancy rate:** -4.1wte RN vacancies<br>**Action taken:** - Recruitment ongoing, staffing reviewed on daily basis by matron |

| | | | | | |
|---|---|---|---|---|---|
| | | | | | and ward manager |
| **Ward B19** | 97.3% | 96.6% | 100% | 98.9% | **Vacancy rate:** -2.89wte RN and 5.1wte HCA<br>**Action taken:** - HCA vacancies recruited to and start dates in place for Oct 18, 1 band 5 requested a transfer to the ward. Ward reviewed daily for acuity and staffing. |
| **Ward A7** | 88.2% | 91.7% | 92.5% | 110% | **Vacancy rate: -** Band 5 -4.23wte, HCA 2.64wte.<br>**Action taken:** - Staffing reviewed daily against acuity and activity. Recruitment process underway. |
| **Ward C21** | 109.5% | 122.2% | 100% | 121.1% | **Vacancy rate: -** 5.80 wte HCA<br>**Sickness Rate:** 8.13%<br>**Action taken:** Staffing reviewed daily against acuity and activity. Sickness being managed appropriately in line with trust policies. |
| **Coronary Care Unit** | 95.3% | 45.5% | 100% | - | **Vacancy rate: -** Band 5 -0.72wte, HCA 1.57.<br>**Action taken:** Staffing reviewed daily against acuity and activity, staff support accessed from other areas when required. |
| **Intensive Care Unit** | 93.7% | 93.3% | 93.3% | 73.3% | **Vacancy rate:** – minimal vacancies<br>Sickness rate – July – 6.82%<br>**Action taken:** - Sickness absence managed robustly in line with Trust Attendance Management Policy. Rota shortfall managed with temporary staffing, mainly own staff via NHSP. |

Rachael Browning
Associate Chief Nurse
September 2018

# BOARD OF DIRECTORS

| | | |
|---|---|---|
| **AGENDA REFERENCE:** | **BM/18/11/107 a** | |
| **SUBJECT:** | **Safe Staffing Assurance Report - October** | |
| **DATE OF MEETING:** | 28 November 2018 | |
| **ACTION REQUIRED** | **The Board of Directors are asked to note the contents of the report** | |
| **AUTHOR(S):** | **Rachael Browning, Associate Chief Nurse** | |
| **EXECUTIVE DIRECTOR SPONSOR:** | **Kimberley Salmon-Jamieson, Chief Nurse** | |
| | | |
| **LINK TO STRATEGIC OBJECTIVES:** | SO1: To ensure that all care is rated amongst the top quartile in the North West of England for patient safety, clinical outcomes and patient experience | |
| **LINK TO BOARD ASSURANCE FRAMEWORK (BAF):** | BAF2.2: Nurse Staffing | |
| | BAF1.3: National & Local Mandatory, Operational Targets | |
| | BAF1.1: CQC Compliance for Quality | |
| | | |
| **STRATEGIC CONTEXT** | SO1: To ensure that all care is rated amongst the top quartile in the North West of England for patient safety, clinical outcomes and patient experience. | |
| **EXECUTIVE SUMMARY** (KEY ISSUES): | Ward staffing data continues to be systematically reviewed to ensure we safely staff our wards and provide mitigation and action when actual falls below 90% of planned staffing levels.<br><br>It is a recommendation of the National Quality Board (NQB) that the Board of Directors receives a monthly Safe Staffing paper, which includes Care Hours Per Patient Day (CHPPD) and planned vs actual staffing levels, highlighting areas where average fill rates fall below 90%, along with mitigation to ensure safe, high quality care is consistently delivered. | |
| **RECOMMENDATION:** | It is recommended that the Board of Directors note and approve the monthly Safe Staffing Assurance Report. | |
| **PREVIOUSLY CONSIDERED BY:** | **Committee** | Strategic People Committee |
| | **Agenda Ref.** | SPC/18/11/28 |
| | **Date of meeting** | 21 November 2018 |
| | **Summary of Outcome** | Noted |
| **FREEDOM OF INFORMATION STATUS** | | |
| **FOIA EXEMPTIONS APPLIED:** ***(if relevant)*** | | |

# Safe Staffing Assurance Report

The purpose of this paper is to provide transparency with regard to the nursing and midwifery ward staffing levels during October 2018. The Trust has a duty to ensure nursing and midwifery staffing levels are sufficient to maintain safety and provide quality care. This paper provides assurance that any shortfalls on each shift were reviewed and addressed as required with mitigating actions, including staffing levels and skill mix. It is well documented that nurse staffing levels make a difference to patient outcomes (mortality and adverse events, including levels of harm), patient experience, quality of care and the efficiency of care delivery.

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

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

**Care Hours Per patient Day**

Warrington and Halton Hospitals NHS Trust currently collect and report CHPPD data on a monthly basis.
The September Trust wide staffing data was analysed and cross-referenced for validation by the Deputy Chief Nurse, Lead Nurses, and the Associate Chief Nurse (Clinical Effectiveness).

Chart 1 illustrates this data to October 2018, which is showing a sustained improvement; this will continue to be monitored via the Trust monthly safer staffing report.

**Chart 1**

| Financial year | Month | Cumulative count over the month of patients at 23:59 each day | CHPPD - Registered | CHPPD - Care Staff | CHPPD All |
|---|---|---|---|---|---|
| 2018/19 | Apr | 15539.5 | 3.5 | 3.0 | 6.5 |
| | May | 15689 | 3.9 | 2.8 | 6.8 |
| | Jun | 14983 | 4.0 | 2.8 | 6.8 |
| | Jul | 15037 | 4.2 | 2.9 | 7.1 |
| | Aug | 14879 | 4.2 | 2.9 | 7.1 |
| | Sep | 14608 | 4.1 | 2.9 | 7.1 |
| | Oct | 15093.97 | 4.2 | 2.9 | 7.1 |
| 2018/19 Total | | 105829.47 | 4.0 | 2.9 | 6.9 |

**Key Messages**

Although some areas are above the 90% target year to date, it is acknowledged that the percentage of Registered Nurses/Midwives on some wards in the day is below the target. However, mitigation and responsive plans are in place to ensure that the safe delivery of patient care is discussed at every bed meeting and escalated as appropriate. Shift fill rates continue to improve month on month.

Recruitment remains a priority for the senior nursing team; we have 26 new Registered Nurses and 12 Health Care Assistants who joined the Trust in October 2018, with further recruitment and 'Keep in Touch' events planned for the year ahead.

The reduction in the number of additional beds open across the Trust has been sustained in October, the following areas are the only additional beds open at this time, AMU (8) and A5 (1), both areas are reviewed daily to determine the additional staffing required to ensure patient safety.

**Patient Harm by Ward**

In October 2018 we reported a total of 4 pressure ulcers. These comprised of 4 grade 2 pressure ulcers on wards CDU, A5, B12 and C21 and 1 grade 3 pressure ulcer on ward A9. Each of these cases are currently being reviewed by the Tissue Viability nurse and the Associate Chief Nurse, Patient Safety to identify themes and shared learning. There has been 1 patient falls with moderate or major harm falls reported this month on ward B19, which is currently being investigated as part of the Serious Incident reporting process.

**Infection Incidents**

We had 4 cases of CDT in the month of October on Wards, A4, A6 and 2 cases on A9; all of these cases are currently being investigated in line with trust process

No cases of MRSA have been reported in October.

**Appendix 1** **MONTHLY SAFE STAFFING REPORT –October 2018**

## Monthly Safe Staffing Report –October 2018

| | | Day | Day | Day | Day | Day | Day | Night | Night | Night | Night | Night | Night | CHPPD | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Division | 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% | | | | | | | |
| SWC | SAU | 930 | 922.5 | 697.5 | 660 | 99.2% | 94.6% | 0 | 0 | 0 | 0 | - | - | - | - | - | - |
| SWC | Ward A5 | 1782.5 | 1362.75 | 1302 | 1403 | 76.5% | 107.8% | 1069.5 | 1058 | 1069.5 | 1069.5 | 98.9% | 100% | 1023 | 2.4 | 2.4 | 4.8 |
| SWC | Ward A6 | 1782.5 | 1380 | 1302 | 1345.5 | 77.4% | 103.3% | 1069.5 | 1046.5 | 1069.5 | 977.5 | 97.8% | 91.4% | 992 | 2.4 | 2.3 | 4.8 |
| SWC | Ward CMTC | 1253.5 | 1222 | 805 | 774.5 | 97.5% | 96.2% | 690 | 684 | 437 | 402.5 | 99.1% | 92.1% | 238 | 8.0 | 4.9 | 13.0 |
| SWC | Ward B4 | 802.5 | 733.5 | 427.5 | 427.5 | 91.4% | 100% | 252.5 | 253 | 241.5 | 241.5 | 100.2% | 100% | 57.97 | 17.0 | 11.5 | 28.6 |
| SWC | Ward A9 | 1782.5 | 1550 | 1426 | 1377.5 | 87% | 96.6% | 1069.5 | 1058 | 1426 | 1345 | 98.9% | 94% | 983 | 2.7 | 1.5 | 4.2 |
| SWC | Ward B11 | 2215 | 2184.2 | 812.5 | 820 | 98.6% | 100.9% | 1649.2 | 1649.2 | 124.8 | 124.8 | 100% | 100% | 547 | 7.0 | 1.7 | 8.7 |
| SWC | NCU | 1782.5 | 1775 | 356.5 | 276 | 99.6% | 77.4% | 1782.5 | 1491 | 356.5 | 264.5 | 83.6% | 74.2% | 323 | 10.1 | 1.7 | 11.8 |
| SWC | Ward C20 | 966 | 952.5 | 713 | 697.5 | 98.6% | 97.8% | 713 | 667 | 0 | 0 | 93.5% | - | 421 | 3.8 | 1.7 | 5.5 |
| SWC | Ward C23 | 1426 | 1034 | 713 | 633 | 72.5% | 88.8% | 782 | 747.5 | 713 | 678.5 | 95.6% | 95.2% | 346 | 5.1 | 3.8 | 8.9 |
| SWC | Delivery Suite | 2495.5 | 2201 | 356.5 | 266.5 | 88.2% | 74.8% | 2495.5 | 2418.5 | 356.5 | 345 | 96.9% | 96.8% | 212 | 21.8 | 2.9 | 24.7 |
| ACS | Ward A1 | 1937.5 | 1969 | 1937.5 | 1812.5 | 101.6% | 93.5% | 1627.5 | 1527.5 | 651 | 819 | 93.9% | 125.8% | 942 | 3.7 | 2.8 | 6.5 |
| ACS | Ward A2 | 1426 | 1280.9 | 1426 | 1168 | 89.8% | 81.9% | 1069.5 | 997.5 | 1069.5 | 874 | 93.3% | 81.7% | 868 | 2.6 | 2.4 | 5.0 |
| ACS | Ward C22 | 1185 | 1055 | 1069 | 1189 | 89% | 111.2% | 713 | 713 | 713 | 1035 | 100% | 145.2% | 651 | 2.7 | 3.4 | 6.1 |
| ACS | Ward A4 | 1690.5 | 1436.5 | 1426 | 1244 | 85% | 87.2% | 1069.5 | 931.5 | 1069.5 | 1115.5 | 87.1% | 104.3% | 1023 | 2.3 | 2.3 | 4.6 |
| ACS | Ward A8 | 1426 | 1196 | 1426 | 1598 | 83.9% | 112.1% | 1426 | 1138.5 | 1069.5 | 1299.5 | 79.8% | 121.5% | 1054 | 2.2 | 2.7 | 5.0 |
| ACS | Ward B12 | 1069.5 | 989 | 2495 | 2139 | 92.5% | 85.7% | 713 | 713 | 1817 | 1846 | 100% | 101.6% | 651 | 2.6 | 6.1 | 8.7 |
| ACS | Ward B14 | 1426 | 1286 | 1426 | 1341 | 90.2% | 94% | 713 | 713 | 1069 | 1046 | 100% | 97.8% | 741 | 2.7 | 3.2 | 5.9 |
| ACS | Ward B18 | 1426 | 1414.5 | 1426 | 1314.5 | 99.2% | 92.2% | 1069.5 | 816.5 | 1069.5 | 1219 | 76.3% | 114% | 744 | 3.0 | 3.4 | 6.4 |
| ACS | Ward B19 | 1069 | 1071 | 1426 | 1426 | 100.2% | 100% | 713 | 713 | 1069.5 | 1148.5 | 100% | 107.4% | 744 | 2.4 | 3.5 | 5.9 |
| ACS | Ward A7 | 1782.5 | 1591 | 1426 | 1198.5 | 89.3% | 84% | 1414 | 1230.5 | 1069.5 | 1159.5 | 87% | 108.4% | 1022 | 2.8 | 2.3 | 5.1 |
| ACS | Ward C21 | 1069.5 | 1075 | 1171 | 1115.5 | 100.5% | 95.3% | 713 | 713 | 1069.5 | 1058 | 100% | 98.9% | 744 | 2.4 | 2.9 | 5.3 |
| ACS | CCU | 1426 | 1283.5 | 356.5 | 170.5 | 90% | 47.8% | 1069.5 | 1058 | 0 | 0 | 98.9% | - | 241 | 9.7 | 0.7 | 10.4 |
| ACS | ICU | 4991 | 4715 | 1069.5 | 948.75 | 94.5% | 88.7% | 4991 | 4732.25 | 1069.5 | 667 | 94.8% | 62.4% | 526 | 18.0 | 3.1 | 21.0 |

# Appendix 2

## October 2018 - Mitigating Actions

| | DAY | | NIGHT | | MITIGATING ACTIONS |
|---|---|---|---|---|---|
| | Average fill rate - registered nurses/midwives (%) | Average fill rate – Health Care support staff (%) | Average fill rate - registered nurses/midwives (%) | Average fill rate - Health Care support staff (%) | |
| **SAU** | 99.2% | 94.6% | - | - | **Vacancy rate:** - RN 1.15wte band 5, 1 wte band 4<br>Sickness rate – 0.65%<br>**Action taken:** - ECF completed to recruit to post. Attendance management policy followed |
| **Ward A5** | 76.5% | 107.8% | 98.9% | 100% | **Vacancy rate:** HCA - 3.35wte recruited 2 awaiting start dates, 1.35wte vacancy remains.<br>Sickness rate – 3.66%<br>**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 |
| **Ward A6** | 77.4% | 103.3% | 97.8% | 91.4% | **Vacancy rate:** - RN 4.23wte vacancies HCA-2.76wte vacancies<br>Sickness rate – 12.28%<br>**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 |
| **CMTC** | 97.5% | 96.2% | 99.1% | 92.1% | **Vacancy rate**: 5.6wte HCA vacancies<br>**Sickness rate** – 6.83%<br>**Action taken:** Daily staffing review against acuity and activity. Sickness absence reduced in month and being managed in line with Trust policy. |
| **B4** | 91.4% | 100% | 100.2% | 100% | **Vacancy rate:** - HCA 2.74wte.<br>2 Associate Nurses commencing in Jan 19 when qualified.<br>Sickness rate – 9.17%<br>**Action taken:** Staffing and activity reviewed daily. attendance management policy followed, monthly meeting with HR and welfare meetings arranged |
| **Ward A9** | 87% | 96.6% | 98.9% | 94% | **Vacancy rate:** Band 6 - 0.54wte Band 5 - 2.0 and HCA 4.0.<br>**Action taken**: All vacancies filled and awaiting start dates |
| **Ward B11** | 98.6% | 100.9% | 100% | 100% | **Vacancy Rate:** HCA 1.0wte.<br>**Sickness rate** – 4.56wte long term sick<br>**Action taken:** Staffing reviewed daily and support provided if necessary. Sickness absence being managed in line with the Trust policy. |
| **NCU** | 99.6% | 77.4% | 83.6% | 74.2% | **Vacancy rate:** 1.78wte Band 6.<br>**Action taken:** - recruitment process in place. Staffing reviewed daily and support provided if necessary. |
| **Ward C20** | 98.6% | 97.8% | 93.5% | - | **Vacancy rate:** -ward fully established<br>**Action taken:** Staffing reviewed daily and support provided if necessary. |

| | | | | | |
|---|---|---|---|---|---|
| **Ward C23** | 72.5% | 88.8% | 95.6% | 95.2% | **Vacancy Rate: :** Band 5 2.88wte vacancies<br>Sickness rate – 4.4%<br>**Action taken:** recruitment process in place. Staffing reviewed daily by the matron and staff moved to support if required and additional shifts request via NHSP. Sickness is being managed in line with Trust policy. |
| **Delivery Suite** | 88.2% | 74.8% | 96.9% | 96.8% | **Vacancy Rate:** 1.0wte band 7<br>**Action taken:** recruitment process in place. Daily review of staffing and staffed moved from other areas depending on acuity and occupancy. Recruitment process underway. Sickness is being managed in line with Trust policy. |
| **Ward A1 - AMU** | 101.6% | 93.5% | 93.9% | 125.8% | **Vacancy rate:** - Recruitment ongoing vacancies at 1.0wte Band 6 and 3.0wte Band 5.<br>Sickness rate – 6.3%<br>**Action taken:** – Daily review of staffing and acuity, staff moved from other areas to support and additional staff access via NHSP. Sickness being managed in line with Trust policies. |
| **Ward A2** | 89.8% | 81.9% | 93.3% | 81.7% | **Vacancy rate:** - 0.72wte Band 5,<br>**Action taken:** Daily review of staffing and acuity, staff moved from other areas to support and additional staff access via NHSP. |
| **Ward C22** | 89% | 111.2% | 100% | 145.2% | **Sickness rate-** 2%<br>**Action taken**: - Sickness being managed in line with Trust policies. |
| **Ward A4** | 85% | 87.2% | 87.1% | 104.3% | **Vacancy rate:-** RN 2.64wte band 5 HCA 3.10wte<br>**Action taken:** - Staffing reviewed daily against acuity and activity. Vacancies currently being recruited to. |
| **Ward A8** | 83.9% | 112.1% | 79.8% | 121.5% | **Vacancy rate:** - RN 4wte band 5<br>Sickness rate - 3.0wte LTS minimal ST sickness throughout the month of October 2018<br>**Action taken:** Recruitment process in place. Ward support by the continued use of NHSP and agency to ensure safe staffing levels. Pharmacy Technician support morning and lunchtime supports nursing staff. |
| **Ward B12 (Forget-me-not)** | 92.5% | 85.7% | 100% | 101.6% | **Vacancy rate:** - 9wte HCA vacancies following the nurse staffing business case<br>**Action taken**: - Recruitment plan in place, with a number of staff recently recruited to the vacacancies. Daily review by the matron to review staffing levels and acuity, staff moved from other areas to support. |
| **Ward B14** | 90.2% | 94% | 100% | 97.8% | **Vacancy rate:-** 2.5wte Band 5 and 2.05wte HCA<br>**Action taken:** - recruitment plan in place. Staffing reviewed daily against acuity and activity. |
| **Ward B18** | 99.2% | 92.2% | 76.3% | 114% | **Vacancy rate:** -3.63wte RN vacancies<br>**Action taken:** - Recruitment ongoing, staffing reviewed on daily basis by matron and ward manager |
| **Ward B19** | 100.2% | 100% | 100% | 107.4% | **Vacancy rate:** -2.89wte RN and 4.2 wte HCA<br>**Action taken:** - HCA vacancies recruited to and start dates in place for Oct 18, 1 band 5 requested a transfer to the ward. Ward reviewed daily for acuity and staffing. |

| | | | | | |
|---|---|---|---|---|---|
| **Ward A7** | 89.3% | 84% | 87% | 108.4% | **Vacancy rate: -** RN 1 wte band 6. **Action taken:** - Staffing reviewed daily against acuity and activity. Recruitment process underway. |
| **Ward C21** | 100.5% | 95.3% | 100% | 98.9% | **Vacancy rate: -** RN 3wte band 5<br>**Sickness Rate:** 8.13%<br>**Action taken:** Recruitment process in place. Staffing reviewed daily against acuity and activity. Sickness being managed appropriately in line with trust policies. |
| **Coronary Care Unit** | 90% | 47.8% | 98.9% | - | **Vacancy rate: -** RN Band 5 2.8wte, HCA 1.57.<br>**Action taken:** Staffing reviewed daily against acuity and activity, staff support accessed from other areas when required. |
| **Intensive Care Unit** | 94.5% | 88.7% | 94.8% | 62.4% | **Vacancy rate:** – RN 12.0 wte band 5, 3.98 wte HCA interview dates in place.<br>Sickness rate –8.57%<br>**Action taken:** - recruitment process underway. Sickness absence managed robustly in line with Trust Attendance Management Policy. Rota shortfall managed with temporary staffing, mainly own staff via NHSP. |

Rachael Browning
Associate Chief Nurse
October 2018

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

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

| AGENDA REFERENCE: | BM 18 11 107(b) | COMMITTEE OR GROUP: | Trust Board | DATE OF MEETING | 28 November 2018 |
|---|---|---|---|---|---|

| | |
|---|---|
| Date of Meeting | 6 November 2018 |
| Name of Meeting + Chair | Quality Assurance Committee, Chaired by Margaret Bamforth |
| Was the meeting quorate? | Yes |

| REF | AGENDA ITEM | ISSUE AND LEAD OFFICER | Recommendation / Assurance/ mandate to receiving body | Follow up/ Review date |
|---|---|---|---|---|
| **QAC/18/11/125** | Matters arising | EOL Steering Group to report to QAC wef January 2019 for additional scrutiny and assurance<br><br>NHSI Digital Submission + IG fundamental breaches. Chair had met with colleagues and provided with assurance on work to date and current status. QAC to receive high level assurance reports. If the Chair is made aware of any future assurance issues outside of QAC, these will be reported to QAC as appropriate. | | **QAC Jan 2019**<br><br>**QAC Jan 2019** |

| | | | | |
|---|---|---|---|---|
| **QAC/18/11/126** | Patient Story | A patient story was presented to QAC of an individual who had accessed services within the hospital. During their treatment journey a number of learning opportunities had been identified across a number of departments which had been shared with staff, learning implemented and strengthened processes had been in put place to prevent similar future occurrences. The Trust and staff had been commended for the transparency and openness of the internal review by the family and external agencies. | The Committee received and discussed the patient story | |
| **QAC/18/09/94** | **Getting to Good (G2G) Steering Group** | • Core service compliance 78%, with 60 actions on track, 34 'Must Do's completed, 27 due by end of October. 15 outstanding actions aligned to training compliance.<br>• A comprehensive list was provided of those actions where there had not been a report provided. An update on the fundamental breaches was included.<br>• Positive CQC Insight report had been received, showing a significant improvement with a move from minus 1.2 to Zero and will support the Trust in moving from RI to Good (1.5 required). | The Committee noted an discussed the update | **QAC Jan 2019** |
| **QAC/18/11/128** | **Deep Dive / Service Review – Learning From SIs** | **Deep Dive / Service Review – Learning From SIs**<br>QAC received an overview of Serious Incidents from April 2017 to October 2018 on trends, themes and assurance on programmes of improvement implemented. Significant improvement reported in incident reporting.<br>• Since 1 April 2017, 22 complaint reviews flagged as SI and learning had been shared to maximise | The Committee noted the assurance provided and the action plans to complete lessons learned audits for the next three quarters. | **QAC Jan 2019** |

| | | | | |
|---|---|---|---|---|
| | | learning.<br>• Main themes included falls. This agenda will be supported by the Falls Lead Nurse, Surgical/invasive procedures, LoCSSIPs roll-out and training across all clinical settings to commence.<br>• MIAA had undertaken a Trust-wide review of MDT processes.<br>• Number of work programmes in place to support the MH agenda. Areas had been identified in the Trust internal review of Peri-natal Mortality and learning maximised through internal governance processes. Assurance provided to QAC and Board in Duty of Candour procedures now in place.<br>• Action plans in place to complete lessons learned audits for the next three quarters. | | |
| **QAC/18/09/129** | **Maternity Safety Champion** | • Quarterly reporting to QAC wef January 2019.<br>• Improvement in National Maternity Survey scoring.<br>• 8 areas of improvement and 4 requiring further improvement with action plans in place.<br>• Improvement in compliance with GIRFT actions.<br>• Elective (CS) Primigravida women, audit to be undertaken to identify reasons why this cohort of patients had an elective CS to be undertaken. | The Committee received and discussed the report and agreed that a quarterly Maternity Safety Champion report would be presented to the Committee, highlighting trends and trends etc. | **QAC Jan 2019** |

| | | | | |
|---|---|---|---|---|
| **QAC/18/11/135** | **Clinical Audit Quarterly Report** | • New reporting mechanisms in place<br>• Plan for Phase 3 of relocations are being reviewed, principle for moves agreed to facilitate other moves/relocations to begin to facilitate re-location of the team.<br>• Priority audits, aligned to the CQC action plan with clinical leads and action plans in place for the audit programme.<br>• National Audit action plans escalated to the QAC. A 24% increase in clinical audits reported with action plans increasing from 242 to 300 | The Committee noted the report and item of escalation. NELA Action Plan to next QAC | **QAC Jan 2019** |
| **QAC/18/11/136** | **LD Improvement Standards** | • Mortality benchmark gap analysis for patients with LD when SJR is undertaken re: LeDeR national recommendations undertaken, reporting partial compliance in 24 areas and 4 non-compliant. Actions plans in place to achieve full compliance. | The Committee noted the report and received assurance that compliance monitoring will be via the Safeguarding Committee. | |
| **QAC/18/11/137** | **Ward Accreditation** | • 100% of planned assessments have taken place, with 16 undertaken at May 2018.<br>• 2 wards are awaiting validation; 7 achieved bronze and 7 silver, action plans are monitoring by the Nursing and Midwifery Board.<br>• Improvement areas identified and reviewed, priority 1 list includes environmental issues to be completed as part of environmental capital programme.<br>• Rolling programme of Ward Accreditation will continue, in addition it will be rolled out in other departments, outpatients and theatres. | The Committee noted the report and supported the continued implementation of the programme Trust-wide | **QAC Jan 2019** |

| | | | | |
|---|---|---|---|---|
| **QAC/18/11/139** | **Strategic Risk Register + BAF** | • Three new risks were proposed for escalation to the BAF:<br>o HCAI Surveillance<br>o Continuity of Palliative Care<br>o Consultant Microbiologist Staff<br>• One risk proposed for removal from the BAF<br>o Complaints | The Committee reviewed, discussed and approved the inclusion of the three risks on the BAF and removal of the Complaints risk. | **QAC Jan 2019** |
| **QAC/18/11/144g** | **GPDR Readiness Action Plan progress + IG Update** | An updated on the GDPR action plan was presented to the Committee:<br>• 5 IG risks are on the BAF, rated as Amber. IG/GDPR, no IG breaches reportable to the ICO are outstanding,<br>• New Information Asset register to be deployed by IAOs by end of 2018<br>• IG training compliance 86.29%<br>• Cyber Security Firewall enhanced significantly to further protect email, systems continually updated.<br>• Risk highlighted relating to server patching, applied to 57%, there are 200 servers.<br>• NHSI IG baseline completed, non compliance reported with 15 standards. | • The Committee noted the report and items of assurance and escalation<br>• Action plan to be presented to next Audit Committee.<br>• MIAA to undertake an audit with outcome in February/March. | **Audit Committee Nov 2018** |

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

# CHAIR'S KEY ISSUES REPORT

| AGENDA REFERENCE: | BM/18/11/107c | COMMITTEE OR GROUP: | Trust Board Directors | DATE OF MEETING | 28 November 2018 |
|---|---|---|---|---|---|

| | |
|---|---|
| Date of Meeting | 24 October 2018 |
| Name of Meeting + Chair | Finance & Sustainability Committee - Terry Atherton |
| Was the meeting quorate? | Yes |

| REF | AGENDA ITEM | ISSUE | Recommendation / Assurance/ mandate to receiving body | Follow up/ Review date |
|---|---|---|---|---|
| **FAC/18/10/125** | Pay Assurance Dashboard Monthly Report | Future reports to show in month and cumulative figures highlighting the pay award, cross referenced to the finance report to support understanding of the pay variance.<br><br>Agency and bank spend in September high, triangulating with budget and cost pressures. Difficulty in supply of doctors in particular specialities. Cross referenced with outstanding cost pressures.<br><br>Risk to future adverse pay variance in relation to the unfunded medical cost pressures in quarters 3 and 4 and back loaded CIP.<br><br>COO to bring WLI report to November FSC to ensure consistently applied across the Trust. | The Committee reviewed, discussed and noted the report. Additional information regarding pay variance to be included from next month. WLI paper on agenda next month. | FSC Nov 2018 |

| | | | | |
|---|---|---|---|---|
| **FSC/18/10/126** | Risk Register | No new risks. Updates provided relating to finance risk regarding commissioner pressures and potential impact on Trust Control Total. HCA to amend narrative relating to CCG support to the Trust and any potential impact on the Trust Control Total. | The Committee reviewed, discussed and noted the report. | FSC Nov 2018. |
| **FSC/18/10/127** | Corporate Performance Report | A&E – slight deterioration, achieving 84.85% in month, Q2 position 87.73% trajectory not achieved. October position 84.25%, improvement in last 7 days.<br>No PSF received in relation to A&E for Q1 and Q2. | The Committee reviewed, discussed and noted the report. | FSC Nov 2018. |
| **FSC/18/10/128** | Winter Plan | Venn report shows shortfall of system beds this winter. Plan presented showing number of approaches including frailty and discharge lounge. Winter funds provided to councils – potential of investment in additional capacity. | The Committee reviewed, discussed and noted the presentation. | |
| **FSC/18/10/129** | Monthly Finance report | On plan excluding PSF with £14.2m deficit. Position £13m deficit including PSF with a variance of £0.4m relating to unclaimed A&E PSF.<br>Use of resources score of 3 and therefore remains on plan.<br>Pay variance month 1 to 6 £0.6m - future reports to show in month and cumulative figures highlighting the impact of the pay award.<br>Amendments to the capital programme were supported.<br>CIP workshops underway and report to be presented to next FSC in November. Discussing potential of incentives to encourage over performance. Current forecast £4m shortfall.<br>Cumulative interest charge on loans from inception in 2015/16 is £1.2m.<br>Concern with aged debtor discussed – letter has been received from debtor. Legal advice has been sought and a letter is being | The Committee supported the amendments to the capital programme, reviewed, discussed and noted the report and the financial challenges faced.<br>Additional information to be provided on the pay variance. | FSC Nov 2018. |

| | | | | |
|---|---|---|---|---|
| | | prepared. Also obtaining quote for a joint legal action. Meeting with CCG regarding Trust exposure on 14 November 2018, and requested sight of MIAA report.<br>Capital minutes - CE – to confirm responsibility for maintenance / ownership of ECG Machines placed in primary care.<br>FRG minutes and items for escalation. DoF to seek wider clinical representation at FRG<br>Escalated items to FSC and Board noted. JC to support process of escalation between FRG and FSC. | | |
| **FSC/18/10/130** | Cost Pressure Report | The number of cost pressures has reduced from 9 to 6, value now £1.1m. Majority relate to medical pressures. Work continues to improve medical staffing vacancies. | The Committee reviewed and noted the report. | FSC Dec 2018. |
| **FSC/18/10/131** | Combined Financial Position | Commissioners are forecasting break even however there is risk regarding other acute providers over performing. | The Committee reviewed, discussed and noted the report. | FSC Jan 2019 |
| **FSC/18/10/132** | Strategy Delivery | Supporting local councils with bids to One Public Estate for funds to support business case preparation for Warrington and Halton new hospital/campus projects. | The Committee reviewed, discussed and noted the report. | FSC monthly |
| **FSC/18/10/133** | Proposed Tariff Changes | Planning timetable and latest information on emerging tariffs noted. First draft plan deadline 17 January 2019, final plan 4 April 2019. 5 year plans requiring organisational sign off required Summer 2019. | The Committee reviewed, discussed and noted the report. | |
| **FSC/18/10/134** | Integrated Care Providers Consultation | Agreed that there is an opportunity to pilot a care pathway such as frailty using the ICP framework, however there is some way to go regarding the detail. Agreed to feedback to the consultation a number of points regarding the opt in/out of GPs, how the private sector is incorporated and how financial viability is assessed. | The Committee reviewed, discussed and noted the report and supported the consultation feedback. | |

# Strategic People Committee Chair's Report

| Agenda Ref | | COMMITTEE OR GROUP: | Strategic People Committee | DATE OF MEETING | 22 November 2018 | CHAIR : | Anita Wainwright, Non-Executive Director |
|---|---|---|---|---|---|---|---|

**Attendance**

| | |
|---|---|
| Anita Wainwright | Non-Executive Director (Chair) |
| Ian Jones | Non-Executive Director |
| Michelle Cloney | Director of HR and OD |
| Deborah Smith | Deputy Director of HR and OD |
| Mick Curwen | Head of Strategic HR Projects |
| Dan Moor | Deputy Chief Operating Officer |
| Andrea McGee | Director of Finance |
| Pat McLaren | Director of Community Engagement |
| Alex Crowe | Medical Director |
| Steve Bennet | Head of Transformation |

**Apologies**

| | |
|---|---|
| Kimberley Salmon-Jamison | Chief Nurse |
| Simon Constable | Executive Medical Director |
| Chris Evans | Chief Operating Officer |
| Lucy Gardner | Director of Strategy |

**In attendance**

| | |
|---|---|
| Julie Burke | Secretary to the Trust Board |

| AGENDA ITEM | LEAD OFFICER | Issue / Exception Report | Recommendation / Assurance/ Action/Decision |
|---|---|---|---|
| | Sharon Wright | Staff Story | **Assurance**:<br>Sharon Wright, Clinical Educator, attended SPC to share her staff story, with a particular focus on the fantastic work she has undertaken with the WHH Preceptorship Programme. The Programme has been nationally recognised via a case study in the NHS Employers National Engagement Brief. |

| | | | |
|---|---|---|---|
| | | | **Action:**<br>SPC requested that there is additional publicity around this success – patients as well as potential employees.<br>Considering broadening the programme to include next steps after preceptorship and integrating with medical staff. |
| SPC/18/11/19 | Director of HR and OD | Director of HR and OD Report | **Assurance:**<br>The Director of HR and OD presented a paper providing an overview of a range of strategic national work streams which impact on the workforce at WHH, including:<br>• Developing the long-term plan for the NHS<br>• We are the NHS – national recruitment campaign<br>• NHS Improvement and NHS Employers: Retention programme one year on<br>• Nurse Associate Training<br>• Supporting EU staff - Settled Status (Brexit)<br>• Pension Saving Statements – annual allowance<br>• Terms and Conditions Refresh 2018<br>• Closing band 1 to new entrants<br>• Junior Doctor Contract Review<br>• Streamlining Staff Movement Resource Hub<br>• Flu Fighter campaign<br>**Action**:<br>SPC have requested a more detailed paper on Pensions Saving Statements and Annual Allowance.<br>SPC have requested an update on Regional Streamlining at the next meeting.<br>Apprenticeship Levy – more detailed paper to OPC in December 2018 |
| SPC/18/11/20 | Head of Strategic HR Projects | BAF and Risk Register – Workforce | **Assurance**:<br>The SPC received a paper outlining the workforce risks which form part of the BAF; Strategic Risk Register and the HR & OD Risk Register, including any updates.<br>Recommendation:<br>Risk 133 Employee Engagement – SPC recommend that the risk score is |

| | | | |
|---|---|---|---|
| | | | reviewed:<br>likelihood 2 x impact 6 = 8<br>Head of Strategic HR Projects to take recommendation forward<br>**Action**:<br>Going forward this paper will include analysis on themes of all workforce related risk |
| SPC/18/11/21 | Director of HR and OD | CQC – Getting to Good, Moving to Outstanding - Workforce | **Assurance**:<br>The SPC received a report which provided an update on work progressing within the Trust related to the Key Lines of Enquiry<br>detailed below:<br>- (KLOE)1: Leadership, capacity, capability to deliver high quality sustainable care<br>- (KLOE)3: Culture of high quality sustainable care<br>- (KLOE)7: Are people who use services, public, staff and external partners engaged and involved to support high quality sustainable services.<br>- (KLOE)8: Robust systems and processes for learning, continuous improvement and innovation (including reports submitted to the G2G, M2O Steering Group on Mandatory Training, Role Specific Training, Resuscitation Training, Customer Care & Appraisal / PDR)<br><br>**Action**:<br>Discussion to take place with Chair and Director of HR and OD outside of meeting to discuss whether KLOE 4 should be included in this report going forward. |
| SPC/18/11/22 | Medical Director | HENW/GMC Annual Reports | **Escalate**:<br>HEENW had held their Formal Annual Assessment Visit on the 29th June 2018. WHH have not yet received our Formal Report back from HEENW. This is expected by December 2018.<br><br>The results of the GMC Survey of Doctors in Training at WHH were published in July 2017. The results highlighted a number of concerns, particularly with regards to CMT doctors. A summary and overview of the results was provided |

| | | | |
|---|---|---|---|
| | | | to SPC.<br><br>Following the survey results, HENW conducted a follow up visit on 9 November 2018.<br><br>WHH remains under 'Enhanced Monitoring' with HEE NW for failing to provide training placements to the required standards, in some areas.<br><br>It is expected that the outcome reports for both HENW visits will be received in December 2018 and will demonstrate good progress. Following the visit in November 2018 HENWE have informed the Trust that no additional site visits will be required until 2019. In addition, a recent internal trainee survey highlights improvements.<br><br>**Action**:<br>The Medial Director will review the risk assessment and therefore review risk score on the risk register<br>This will be a standing item on SPC agenda going forward. |
| SPC/18/11/23 | Head of Strategic HR Projects | Policies and Procedures Report | The following policies were ratified by SPC:<br>• Annual Leave Policy for Consultant Medical and Dental Staff<br>• Career Break Policy<br>• Medical Illustration Policy<br>• Performance Improvement Policy<br>• Shared Parental Leave Policy<br>• Special Leave Policy Extract: Update on Parental Leave |
| SPC/18/11/24 | Deputy Director of HR and OD | Employee Relations Report | **Assurance**:<br>The SPC received a report highlighting all employee relations cases where there has been suspension, exclusion or action short of, and also all high risk cases. The report also highlighted any themes emerging from partnership working across the Trust:<br>• Facilities Time for Union Representatives |

| | | | |
|---|---|---|---|
| | | | • Staff Facilities<br>• Specialty and Associate Specialist Doctors<br>• Junior Doctor Experience |
| SPC/18/11/25 | Head of Strategic HR Projects | Pay, Terms and Conditions | **Assurance**:<br>Focus in recent weeks has been on the closure of band 1. There has been very good engagement from managers and work is progressing appropriately. |
| SPC/18/11/26 | Medical Director | Guardian of Safe Working | This item is featured on the Trust Board Agenda |
| SPC/18/11/28 | Chief Nurse | Monthly Staffing Report | This item is featured on the Trust Board Agenda |
| SPC/18/11/29 | Director of Strategy | Trust Strategic Projects (People Exception Report) | This item is featured on the Trust Board Agenda |

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

**REPORT TO BOARD OF DIRECTORS**

| | | |
|---|---|---|
| **AGENDA REFERENCE:** | **BM/18/11/109** | |
| **SUBJECT:** | **Learning from Experience Report - Q2 2018/19** | |
| **DATE OF MEETING:** | 28 November 2018 | |
| **ACTION REQUIRED** | **Note the report** | |
| **AUTHOR(S):** | Ursula Martin, Director Integrated Governance + Quality | |
| **EXECUTIVE DIRECTOR SPONSOR:** | Kimberley Salmon-Jamieson, Chief Nurse | |
| | | |
| **LINK TO STRATEGIC OBJECTIVES:** | All | |
| **LINK TO BOARD ASSURANCE FRAMEWORK (BAF):** | All | |
| | 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 fourth new integrated "Learning from Experience" (LFE) report. It focuses on the learning from incidents, complaints, claims and inquests over Quarter 2, 2018/19 (July - September). | |
| **RECOMMENDATION:** | The Board is asked to;<br>• Note and approve the contents of the report<br>• Receive assurance that the Learning from Experience process continues within the organisation.<br>• The presentation of the data is included within the slide deck provided. | |
| **PREVIOUSLY CONSIDERED BY:** | **Committee** | Quality + Assurance Committee |
| | **Agenda Ref.** | |
| | **Date of meeting** | November 2018 |
| | **Summary of Outcome** | Assurance provided |
| **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

**BOARD OF DIRECTORS**

| SUBJECT | Learning from Experience Report Q2 | AGENDA REF: | BM/18/11/109 |
|---|---|---|---|

## 1. BACKGROUND/CONTEXT

This report relates to the period 1st July 2018 to 30th September 2018. It contains a quantitative and qualitative analysis (using information obtained from the Datix risk system) and includes incidents, complaints, claims and inquests. The report includes a summary of key issues identified in Q2 and makes specific recommendations in respect to the findings, which will be followed up in the next report.

The purpose of the report is to:

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

### 2. Review of recommendations

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

## 2. KEY ELEMENTS

### 2.1 Issues for Assurance:

- There was an increase in incident reporting within the Trust in Q2 (2539 in Q1 vs 2612 in Q2). This is positive as the rise in incidents seen are overall in the no to low harm category, and we are currently promoting incident reporting through the Trust's Report to Improve campaign.

- There was a decrease in complaints opened Trust wide in Q1 (130 in Q1 vs 107 in Q2).
- The majority of areas managed to increase or maintain their performance for responding to complaints on time, Digestive Disease beings the only CBU that did not, and there was an increase overall from Q1 (56.6% in Q1 vs 71.4% in Q2).
- The Trust currently has 10 breached complaints but no complaints over 6 months.
- The Parliamentary and Health Service Ombudsman (PHSO) has commenced 2 investigations into the Trust in Q2. 1 investigation was opened in Q1.
- The Trust currently has 3 open PHSO cases. The PHSO finalised 3 investigations during this period. The PHSO did not uphold 2 complaints and partially upheld 1 complaint.
- The PALS office is in the process of being reviewed and redesigned to make it more accommodating for our patients and service users.
- The Head of Complaints and PALS now attends the End of Life Steering Group to discuss relevant complaints.
- There were 420 non clinical incidents report in Q2 and the top 2 categories related to: violence and aggression, damage or theft to property, equipment, hit by object, sharps and slip/trip/fall.
- Current H&S initiatives taken as a result of incident reporting include the following - *metal barriers installed where possible along the edge of pavements to protect the paving flags and pedestrians using these routes, during August 2018, a sharps audit was completed followed by a Sharps Promotional day on both the Warrington and Halton sites. Refresher training and updated advice to staff that use Chlor Clean as part of their work.*
- ABC, Specialist Medicine and Urgent & Emergency Care have the highest number of deaths reported in Q2.
- The Mortality Structured Judgement Review (SJR) process has identified that the majority of SJRs conducted have found that our overall standard of care is rated as “Good” or “Excellent.”
- Membership of the Mortality Review Group has been strengthened with new members appointed.
- Trust hospital standardised mortality ratio **(**HSMR) has risen slightly but we are still rated as “Green” and ‘As Expected’ .

**2.2 Items escalated to Quality Assurance Committee**

- The Trust reported 531 incidents open in the Q1 LFE report. To date that has further reduced to 419 as CBUs are being supported to take a more proactive approach to investigating and closing incidents.

**Providing feedback and closing incidents in a timely manner remains an important focus of the *‘Reporting to Improve’* initiative and work will continue to ensure that performance improves. Training continues for managers to use the Datix system and to assist in the closure of incidents. Open incidents have reduced 25% since April 2018.**

- Incidents relating to staffing and pressure ulcers decreased in Q2; however, issues relating increased.

**Through NHS Improvement, the Trust continues to participate in the 90 days falls collaborative. The improvement plan will involve a review of patient and relative information regarding falls prevention and will also involve a relaunch of the enhanced care documentation. Safety Huddles have included this is a daily focus in the past months and the H&S Team and Estates are focusing on a programme of inspection and improvement of the environment to support this. The Trust has also introduced specific falls prevention training in 2018.**

- Mediation incidents increased in this period - Omitted / delayed medication, increased by 13, Prescription Error - Wrong / unclear dose, increased by 14 and Administration - Wrong / unclear dose, increased by 11

**Pharmacy Team have been asked to review the reasons for this and report in Q3.**

- Reporting of SI investigations has increased in Q2 with 19 investigation commenced - highest categories are for patient falls, unexpected death and delay in treatment.
- There was also an increase in incidents causing Moderate to Catastrophic harm in Q4 (34 in Q1 vs 43 in Q2).

**The Trust 72hr Review process is helping to identify learning, grade incidents accurately and decide on the level of investigation. A full review of learning from Serious Incidents from April 2017 up to Year to Date was provided to the Quality Assurance Committee in November 2018, along with the actions taken to date and further assurances required. Falls remains an area of concern, and the Quality Assurance Committee have requested further assurance regarding this.**

- There was a decrease in complaints closed in the Trust in Q1 (134 in Q1 vs 121 in Q2).
- Clinical Care, Communication and Attitude and Behaviour are the highest reported reason for complaints and PALS enquires to be received.

**The Trust Customer Care training has been designed to help staff members provide support to patients and families and to respond in a caring and responsive manner.**

- In Q2 there were 3 complaints that were deemed to be SIs and RCA investigations are currently being undertaken into these complaints.
- There has been an increase in the number of claims received this quarter - 45 Claims have been received under treatment / procedure and under diagnosis - delayed/ failed are the highest number received. 2 non-clinical claims were received in this period.
- 39 of the claims were received as a request for notes under the pre-action protocol for clinical disputes.

**The Claims Governance Group was launched in November 2018 to support the review and management of claims.**

- Lack of a DNACPR order continues to be the largest trigger for mortality SJR. This explains the themes identified around a lack of earlier recognition of end of life.

- The output from the SJRs will continue to support improvement and learning as part of the End of Life Care Pathways and the programme of training.
- Other themes relate to verification of death not being undertaken in a systematic way

**A group is now reviewing the Trust Policy and a Trust wide process for all verifications of death so these will be done in the same way, irrespective of who performs the verification.**

## 3. Recommendation

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

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

# REPORT TO BOARD OF DIRECTORS

| | | |
|---|---|---|
| **AGENDA REFERENCE:** | **BM/18/11/110** | |
| **SUBJECT:** | Infection Prevention and Control | |
| **DATE OF MEETING:** | 27/11/18 | |
| **ACTION REQUIRED** | **For Assurance** | |
| **AUTHOR(S):** | Lesley McKay Associate Chief Nurse for Infection Prevention and Control | |
| **EXECUTIVE DIRECTOR SPONSOR:** | Kimberley Salmon-Jamieson, Chief Nurse/ DIPC<br>Choose an item. | |
| | | |
| **LINK TO STRATEGIC OBJECTIVES:** | SO1: To ensure that all care is rated amongst the top quartile in the North West of England for patient safety, clinical outcomes and patient experience | |
| **LINK TO BOARD ASSURANCE FRAMEWORK (BAF):** | BAF1.1: CQC Compliance for Quality<br>BAF1.3: National & Local Mandatory, Operational Targets<br>Choose an item. | |
| | | |
| **STRATEGIC CONTEXT** | Healthcare associated infection is a metric used to measure Trust performance. | |
| **EXECUTIVE SUMMARY** (KEY ISSUES): | This report provides a summary of infection prevention and control activity for Quarter 2 (Q2) of the 2018/19 financial year (FY) and highlights the Trust's progress against infection prevention and control key performance indicators. During Q2:-<br>• 17 E. coli bacteraemia cases – the Trust is above trajectory (by 14 cases) for the 50% reduction target set by NHSI for 2021. The trajectory for this year is 30 cases and the Trust has reported 29 cases for Q1 and Q2<br>• A nil return was submitted for MRSA bacteraemia. The Trust remains at 1 case for the FY<br>• MSSA bacteraemia cases have reduced in Q2<br>• 10 C. difficile cases. The Trust is above trajectory by 4 cases<br>• Attendance at mandatory infection control training has improved (overall compliance 89%). The risk has been removed from the IPC risk register | |
| **RECOMMENDATION:** | The Board is asked to note the contents of the report. | |
| **PREVIOUSLY CONSIDERED BY:** | **Committee** | Quality + Assurance Committee |
| | **Agenda Ref.** | QAC/18/11/132 |
| | **Date of meeting** | 06/11/2018 |

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

| SUBJECT | Infection Prevention and Control Q2 report 2018/19 |
|---|---|

## 1. BACKGROUND/CONTEXT

This report describes the overview of infection prevention and control activity for Quarter 2 (Q2) of the 2018/19 financial year (FY). The report highlights the Trust's progress against Healthcare Associated Infection (HCAI) reduction targets and an update on activity for audit, education, surveillance and policy reviews. The report was discussed at Quality Assurance Committee on 6th November 2018.

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 each quarter 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 reduce gram-negative bloodstream infections (GNBSIs) by 50% by March 2021. The initial focus is on E. coli bloodstream infections as these organisms represent a large portion (55%) of all GNBSIs.

## 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 | Apr | May | Jun | Jul | Aug | Sep |
|---|---|---|---|---|---|---|---|---|
| C. difficile | ≤26 | Over trajectory | 2 | 2 | 3 | 1 | 5 | 4 |
| MRSA BSI | Zero tolerance | Over trajectory | 1 | 0 | 0 | 0 | 0 | 0 |
| MSSA BSI | No target | No target | 1 | 1 | 5 | 1 | 1 | 0 |
| E. coli BSI | 10% reduction | Over trajectory | 1 | 6 | 5 | 5 | 6 | 6 |
| Klebsiella BSI | 10% reduction | Over trajectory | 1 | 1 | 0 | 0 | 0 | 4 |
| P. aeruginosa BSI | 10% reduction | Over trajectory | 1 | 1 | 1 | 0 | 1 | 0 |

A breakdown of all hospital onset cases by ward when tested is included at appendix 1.

### Overview of each HCAI indicator

### Clostridium difficile

- 10 hospital onset cases reported. The Trust is 4 cases above trajectory
- Periods of increased incidence noted on A2 and A7
    - Ribotyping results for A2 are awaited

- Ribotyping results for A7 are different therefore this was not an outbreak

All cases are under review and will be assessed for lapses in care by the CCG review panel in November 2018.

Additional actions have been implemented including: enhanced environmental hygiene using chlorine based disinfectants, further education on antibiotic prescribing is being carried out as part of World Antibiotic Awareness Week and Matrons and Lead Nurses are supporting peer challenge in relation to hand hygiene practices.

## Bacteraemia

### Gram positive bacteraemia

#### Meticillin resistant Staphylococcus aureus (MRSA) bacteraemia

- Nil hospital onset cases reported

#### Meticillin sensitive Staphylococcus aureus MSSA bacteraemia

- 2 hospital onset cases

Areas for care improvement have been noted from root cause analysis investigations in relation to cannula management. The Deputy Chief Nurse is undertaking a review to support improvements, to ensure patients receive the most appropriate IV access device for the treatment they require.

### Gram negative bacteraemia (GNBSI)

#### E coli bacteraemia

- 17 hospital onset cases

#### Klebsiella Spp.

- 4 hospital onset cases

#### Pseudomonas aeruginosa

- 1 hospital onset case

The majority of GNBSI cases are associated with urinary tract infection. The GNBSI Reduction Group have reviewed a number of change ideas to support reduction of cases and developed a local action plan based on the NHSI resource pack. The actions focus on prevention of urinary tract infection by improved personal hygiene and urinary catheter reduction strategy. Additional actions focus on prevention of hospital acquired pneumonia, another cause of GNBSI.

Quality improvement methodology is being used and a driver diagram has been developed and agreed. The change ideas listed are being reviewed and where appropriate implemented to support reductions in cases.

Comparative data on GNBSI cases across the Northwest is included in appendix 2. The Trust has the lowest rate per 100,000 bed days across the LDS alliance.

**Outbreaks**

- Nil outbreaks

| Indicator | Apr | May | Jun | Jul | Aug | Sep |
|---|---|---|---|---|---|---|
| Outbreaks | 0 | 0 | 0 | 0 | 0 | 0 |

**Clinical incidents**

**Decontamination**

- Foreign body (part of a cleaning brush) identified in a surgical instrument-set at Cheshire and Merseyside Treatment Centre (CMTC)
- No direct contact with the patient
- The decontamination facility has been reviewed and questions raised to the company to discuss the process in place for internal lumen brush replacement timescales with their quality controller
- Duty of Candour has been completed with the patient

This was not a serious incident and no harm was caused to the patient. However, it was considered necessary to review the facility as there were 3 incidents relating to surgical instrument sets within a short time period.

**Surveillance systems**

- An adequately resourced surveillance system is required to support the early detection of potential outbreaks
- This risk is scored at 16 on the infection control risk register
- A meeting has been held with the DIPC to review options

There are a number of control measures currently in place 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 is currently 89% (sustained for the last 3 months)
- Low attendance at training has been removed from the infection prevention and control risk register
- There are departments within each CBUs with lower than the required minimum attendance at training and the individual areas are asked to add this to their local risk register

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

## Infection prevention & control audits

- A total of 10 audits were completed in Q2. Findings are shown in Table 1
- Environment issues are being prioritised and urgent problems addressed following walkabouts led by the Chief Nurse. This includes replacing the tiled flooring on ward A7 and removal of carpets from Halton Outpatients Department
- Ward kitchens have been added to the capital programme. Two kitchens per annum will be upgraded over the forthcoming years starting with A7/A8 and C21/C22
- An awareness raising event for correct use of personal protective equipment (PPE) took place in October via the Trust Wide Safety Huddle. The themes included glove awareness to highlight infection risks from over use of gloves and the requirement for handwashing after removal of PPE

**Table 2: Infection prevention and control audit results**

| Ward | A2 | A5 | A9 | B14 | B18 | B19 | C20 | C21 | B1 | B4 |
|---|---|---|---|---|---|---|---|---|---|---|
| Environment | 68% | 90% | 87% | 86% | 92% | 84% | 94% | 81% | 84% | 93% |
| Ward Kitchens | 78% | 83% | 90% | 81% | 83% | 83% | 73% | 87% | 93% | 96% |
| Handling/Disposal of Linen | 89% | 94% | 100% | 89% | 89% | 94% | 89% | 89% | 100% | 100% |
| Departmental Waste | 95% | 94% | 100% | 95% | 95% | 100% | 94% | 100% | 94% | 100% |
| Safe Handling Disposal of Sharps | 96% | 91% | 96% | 100% | 96% | 96% | 96% | 96% | 100% | 91% |
| Patient Equipment (General) | 98% | 89% | 89% | 100% | 95% | 95% | 95% | 96% | 98% | 93% |
| Patient Equipment (Specialist) | N/A | 67% | 100% | 88% | 100% | N/A | 75% | 100% | 100% | n/a |
| Personal Protective Equipment | 93% | 80% | 80% | 67% | 82% | 100% | 87% | 83% | 100% | 100% |
| Short Term Catheter Management | 94% | 88% | 94% | 100% | 100% | 94% | 87% | 100% | 100% | N/A |
| Enteral Feeding | N/A | 57% | N/A | 100% | 87% | 87% | N/A | N/A | N/A | N/A |
| Care of Peripheral Intravenous Lines | 90% | 82% | 82% | 91% | 100% | 100% | 82% | 100% | 100% | 100% |
| 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 |
| Isolation Precautions | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 93% | 100% | 100% |
| Hand Hygiene | 97% | 90% | 95% | 95% | 92% | 100% | 92% | 82% | 97% | 95% |
| Overall Compliance | **91%** | **85%** | **93%** | **92%** | **93%** | **94%** | **90%** | **92%** | **97%** | **97%** |

## Environmental hygiene

- A request has been made to review established hours for cleaning in areas reporting concerns about cleanliness standards. The X-ray department have highlighted a shortfall and are reviewing current establishment
- The Infection Prevention and Control Nurses co-ordinate walkabouts with Matrons and Domestic Supervisors which include a review of environmental hygiene. Any issues highlighted are addressed by the Matron
- A review of cleaning methods for high dusting and cleaning toilets is in progress. The outcome is expected in December 2018

## Infection control policies

Updated policies ratified by the Infection Control Sub-Committee include:-

- ANTT Policy

- Hand Hygiene Policy
- Infection Control Policy
- Mandatory Reporting Of HCAIs
- Personal Protective Equipment Guidelines
- Peripheral Cannula Insertion Guidelines
- Peripheral Cannula (Midline) Insertion Guidelines
- Pest Control Policy
- SOP For Single Patient Testing Viral Gastroenteritis
- Standard Precautions Guidelines
- Terminal Cleaning Guidelines
- Waste Management Policy

**Antimicrobial stewardship**

- Quarterly point prevalence audit (August) showed 90% compliance with the Trust's Antibiotic Formulary. This is aligned to the 90% target set by the CCG
- Five wards had less than 90% compliance (A1; GPAU; A6; C20; B3). Results are reported directly to Consultants' 'in charge of patients' for action

There was a reduction in Consultant Medical Microbiologist staffing which had a potential to impact on the stewardship agenda. This was added to the risk register. Recruitment has been completed and 1.7 whole time equivalent staff have been appointed.

## 3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

Work continues to meet the recommendations of the external review of Infection Prevention and Control.

The SOP for ICU side room ventilation is outstanding. A Ventilation Assurance Group is being established to ensure there is effective management of all ventilation systems across the Trust.

## 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

## 6. TRAJECTORIES/OBJECTIVES AGREED

- The Clostridium difficile threshold for 2018/19 is ≤ 26 cases
- The zero tolerance to avoidable MRSA bacteraemia cases remains in place
- There is a Department of Health ambition to reduce GNBSIs by 50% by 2021

## 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 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 are submitted to the Quality Assurance Committee when increased incidences of infection are identified.

## 8. TIMELINES

- 2018/19 Financial Year

## 9. ASSURANCE COMMITTEE

- Infection Control Sub-Committee

## 10. RECOMMENDATIONS

The Board is asked to note the content of the report and note the progress made.

We are WHH

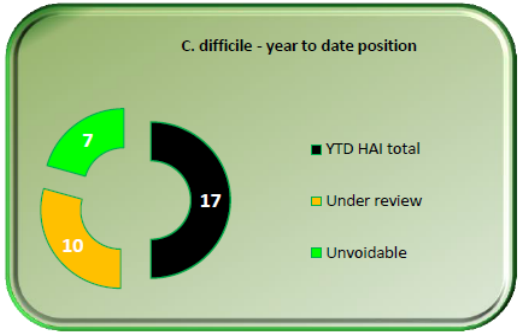
Warrington and Halton Hospitals NHS Foundation Trust

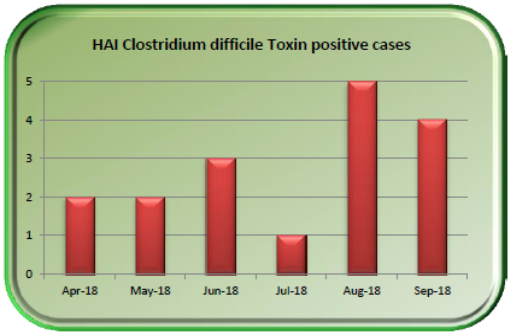
# APPENDIX 1 HEALTHCARE ASSOCIATED INFECTION DATA 2018/19

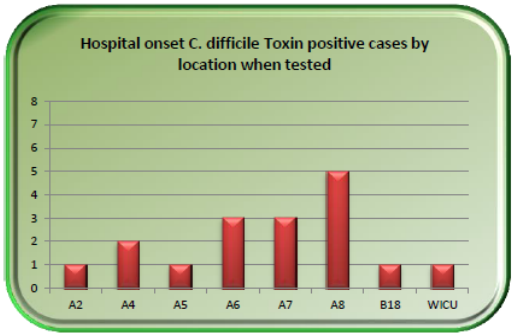
## Clostridium difficile data 2018/19

CDT | Bacteraemias | IPCT activity | Antibiotics | MDROs

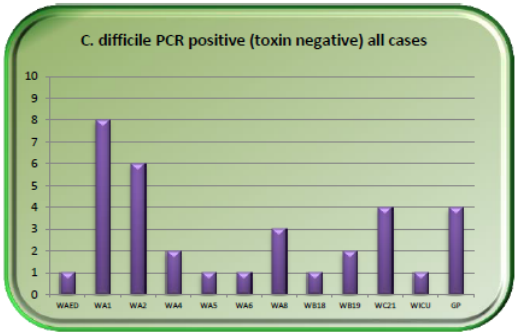
### Hospital onset Clostridium difficile (toxin positive) cases - Annual threshold = 26 cases

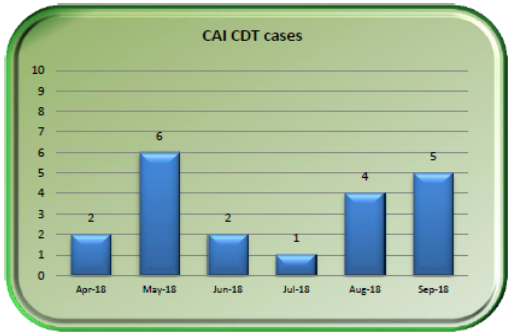


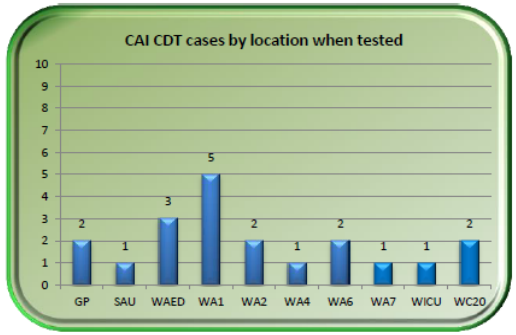




### PCR positive/toxin negative (all) cases and community onset Clostridium difficile (toxin positive) cases



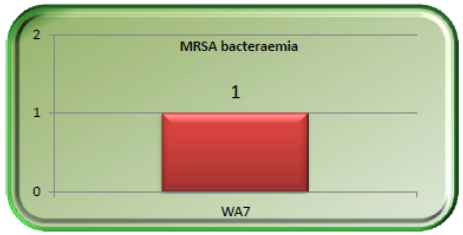
We are WHH

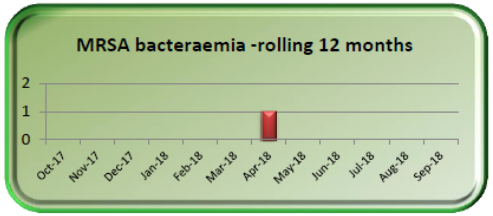
Warrington and Halton Hospitals NHS Foundation Trust

# MRSA/MSSA data 2018/19

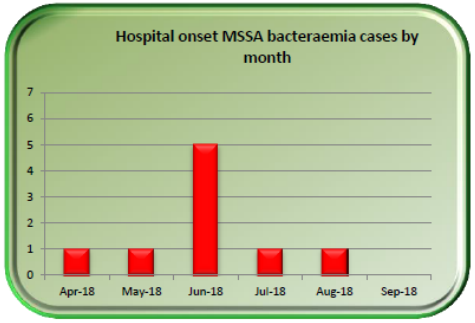
CDT | Bacteraemias | IPCT Activity | Antibiotics | MDROs

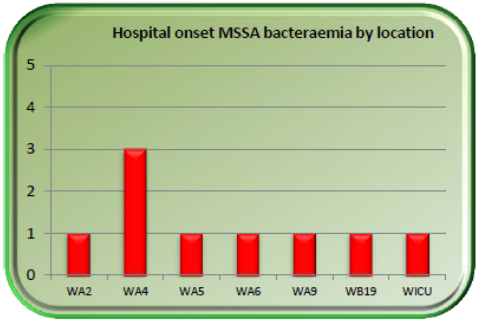
## Hospital onset MRSA bacteraemia data Zero tolerance

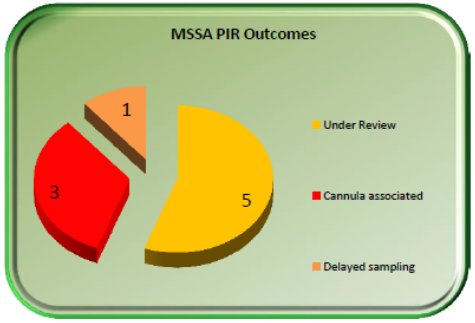



## MSSA bacteraemia data (no thresholds set)



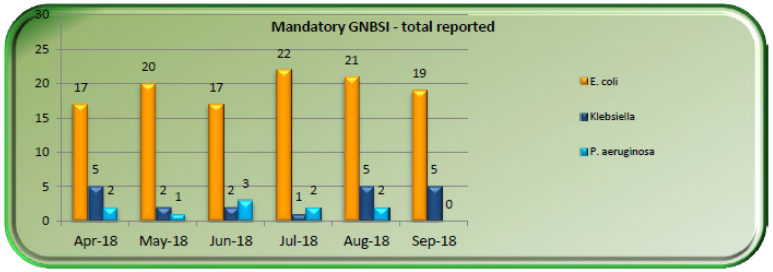
We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

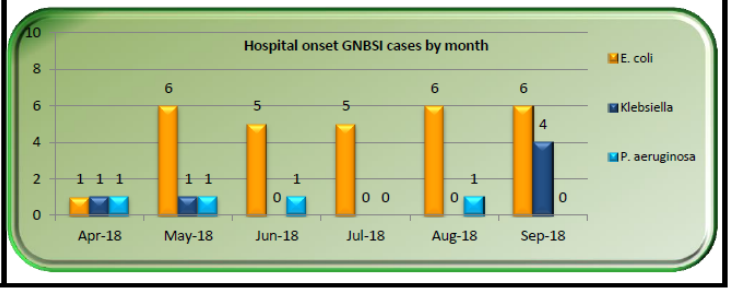
# E. coli data 2018/19

CDT | Bacteraemias | IPCT Activity | Antibiotics | MDROs

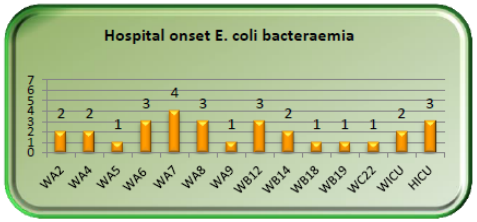
## Mandatory GNBSI bacteraemia (total reported)



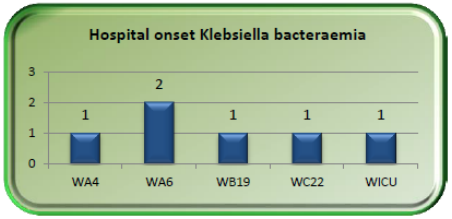

## Hospital onset GNBSI cases (all)



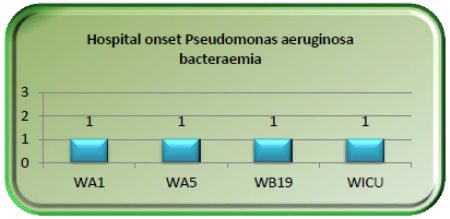

## Hospital onset E. coli bacteraemia




## Hospital onset Klebsiella bacteraemia




## Hospital onset Pseudomonas aeruginosa bacteraemia



## APPENDIX 2 E. coli northwest comparative data

Public Health England

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

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

| | October 2017 to September 2018 | |
|---|---|---|
| Organisation Name | Counts | Rates per 100,000 |
| AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST | 86 | 34.1 |
| ALDER HEY CHILDREN'S NHS FOUNDATION TRUST | 6 | 8.6 |
| BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST | 73 | 28.2 |
| BOLTON NHS FOUNDATION TRUST | 42 | 20.5 |
| COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST | 29 | 15.3 |
| EAST CHESHIRE NHS TRUST | 17 | 15.7 |
| EAST LANCASHIRE HOSPITALS NHS TRUST | 51 | 16.3 |
| LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST | 67 | 22.7 |
| LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST | 6 | 12.8 |
| LIVERPOOL WOMEN'S NHS FOUNDATION TRUST | 4 | 14.7 |
| MANCHESTER UNIVERSITY NHS FOUNDATION TRUST | 132 | 20.2 |
| MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST | 22 | 12.8 |
| NORTH CUMBRIA UNIVERSITY HOSPITALS NHS TRUST | 27 | 14.9 |
| PENNINE ACUTE HOSPITALS NHS TRUST | 57 | 14.6 |
| ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TR | 67 | 25.2 |
| SALFORD ROYAL NHS FOUNDATION TRUST | 63 | 24.5 |
| SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST | 36 | 27.4 |
| ST HELENS AND KNOWSLEY HOSPITAL SERVICES NHS TRUST | 61 | 24.9 |
| STOCKPORT NHS FOUNDATION TRUST | 33 | 14.6 |
| TAMESIDE HOSPITAL NHS FOUNDATION TRUST | 19 | 12.4 |
| THE CHRISTIE NHS FOUNDATION TRUST | 35 | 61.2 |
| THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST | 9 | 44.2 |
| THE WALTON CENTRE NHS FOUNDATION TRUST | 8 | 15.3 |
| UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST | 49 | 23.1 |
| WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST | 42 | 23.0 |
| WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST | 54 | 22.0 |
| WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST | 23 | 14.8 |
| North West | 1118 | 20.8 |

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

**BOARD OF DIRECTORS**

| | | |
|---|---|---|
| **AGENDA REFERENCE:** | **BM/18/11/111** | |
| **SUBJECT:** | **CQC Update report** | |
| **DATE OF MEETING:** | 28 November 2018 | |
| **ACTION REQUIRED** | **Review, Discuss and approve** | |
| **AUTHOR(S):** | Ursula Martin, Director of Governance & Quality | |
| **EXECUTIVE DIRECTOR SPONSOR:** | Kimberley Salmon-Jamieson, Chief Nurse<br>Choose an item. | |
| | | |
| **LINK TO STRATEGIC OBJECTIVES:** | All | |
| | | |
| **EXECUTIVE SUMMARY** (KEY ISSUES): | The following are key issues to highlight within the report:<br>• An update is given regarding progress against the CQC action plan. A significant number of actions have been actioned<br>• Work continues on the fundamental breaches within the CQC report, with all actions showing progress. A position statement is included within the report.<br>• The Trust is in the process of completing an internal audit reviewing compliance/evidence with those actions which have been signed off as compliant on the action plan. This is to ensure that there is internal assurance in place and sustainable actions.<br>• An update has been given on the Well Led assessment work to date. | |
| **RECOMMENDATION:** | Discuss and note the Report | |
| **PREVIOUSLY CONSIDERED BY:** | **Committee** | Quality Committee |
| | **Date of meeting** | November 2018 |
| | **Summary of Outcome** | |
| **FREEDOM OF INFORMATION STATUS (FOIA):** | Release Document in Full | |
| **FOIA EXEMPTIONS APPLIED:** ***(if relevant)*** | None | |

**BOARD OF DIRECTORS**

| SUBJECT | CQC Update Report | AGENDA REF: | BM/18/11/111 |
|---|---|---|---|

## 1. BACKGROUND/CONTEXT

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

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

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

## 2. KEY ELEMENTS

### 2.1 CQC action plan performance

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

- 79% of the action plan has been delivered and is compliant
- 72% of all Must Do and Should Do actions are compliant
- All training actions (16) have been merged into 1 action – which is all areas to be compliant with mandatory and core skill training
- MIAA have begun their second round of auditing the actions that we have deemed to be compliant. This involves observing the actions in practice. This report will be finalised and presented to Executive Directors, the Getting to Good Steering Group and the Audit Committee.
- The aim is to have the action plan completed by end December 2018.

| | Report completed - Compliant | Report completed - further evidence requested | on track | Amended date agreed | Action closed-merged with another | Grand Total |
|---|---|---|---|---|---|---|
| However | 135 | 3 | 5 | 9 | 9 | 161 |
| Must | 38 | 3 | 4 | 5 | 3 | 53 |
| Should | 46 | 4 | 3 | 5 | 5 | 63 |
| **Grand Total** | **219** | **10** | **12** | **19** | **17** | **277** |

The following shows compliance at core service level

| | Amended date agreed | on track | Report completed - Compliant | Report completed - further evidence requested | Action closed-merged with another | Grand Total | % Compliant |
|---|---|---|---|---|---|---|---|
| Children and Young People | 1 | | 11 | | 1 | 13 | 84.6 |
| Critical Care | 2 | 2 | 35 | | 1 | 40 | 87.5 |
| End of Life | | 1 | 1 | 3 | | 5 | 20 |
| Maternity and Gynae | 2 | 6 | 55 | 1 | 1 | 65 | 84.6 |
| Medical Care (inc Older People's care) | 5 | | 34 | 1 | 6 | 46 | 73.9 |
| Outpatients and Diagnostic imaging | 3 | 3 | 36 | | | 42 | 85.7 |
| Surgery | 2 | | 24 | 2 | 3 | 31 | 77.4 |
| Trustwide | 2 | | 10 | 3 | 3 | 18 | 55.6 |
| Urgent and Emergency Care | 2 | | 13 | | 2 | 17 | 76.5 |
| **Grand Total** | **19** | **12** | **219** | **10** | **17** | **277** | **79.1** |

## 2.2 Fundamental breach Analysis

Within the Trust's CQC report, there were a number of fundamental breaches listed. Appendix 1 of this report outlines the breaches and position, with actions taken to date. All breaches have actions in place and are being monitored by Executive leads and Getting to Good Steering Group.

The position is as follows

Number of breaches in total – 9 fundamental breaches (with a number of actions within each).

| RAG status of breaches | Number | Details | To note |
|---|---|---|---|
| **GREEN** | **2** | - Regulation 12 – equipment and checks in radiology<br>- Regulation 12 – checks of equipment trollies and anaesthetics machines | Since the last Board report in June, the Trust has moved to Green with regard to the 6 breaches highlighted by the CQC. Further checks of all regulations are underway. |
| **AMBER** | **5** | - Regulation 11- Consent and Mental Capacity<br>- Regulation 12- checks in theatre Halton to prevent Never Events | Significant progress been made in all these areas and audits underway and being finalised to assess effectiveness of actions |

| RAG status of breaches | Number | Details | To note |
|---|---|---|---|
| | | - Regulation 13- Safeguarding training<br>- Regulation 15 – premises (radiology, gynae, maternity)<br>- Regulation 17 – Governance a) Risk Management b) record keeping c) IG and records being maintained securely | and improvements made |
| **RED** | **2** | - Regulation 12 – medical devices training<br>- Regulation 18 – a) staffing b) APLS training for staff | Assessment of competencies for medical devices commences w/c 26th November 2018 in high risk areas.<br>A full assessment of risk for Regulation 18 is being undertaken, given the work we have implemented with regard to investment, recruitment, staffing escalation processes and resuscitation training. |

### 2.3 Well Led

The Well Led Steering Group have met a number of times, chaired and led by Deputy Chief Executive/Executive Medical Director. A gap analysis has been undertaken against all of the Key Lines of Enquiry and an action plan has been developed. The Trust have commissioned the support of a Senior Governance Consultant regarding CQC preparation and to support the Well Led agenda. A Board work shop will be held in December 2018 regarding CQC and giving in-depth overview of the Well Led gap analysis and action plan and next steps.

## 3 RECOMMENDATIONS

Trust Board are asked to discuss and note the

- CQC action plan progress and update
- The update on fundamental breaches
- The update on Well Led assessment.

## Appendix 1 – Fundamental Breach Action Updates

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

<table>
<tr><th>Fundamental breach</th><th>Action/Progress</th><th>Executive Lead</th><th>RAG</th></tr>
<tr><td>Regulation 11- Consent and Mental Capacity</td><td>the Trustwide MCA audit is being finalised to show improvements that have been made following the audit that was conducted in December 2017.<br><br>MIAA have also conducted an audit on Safeguarding and MCA/DoLS<br><br>Last validated training data (September 2018 shows the following compliance<br><br><table><tr><td>Mental Capacity Act</td><td>90.45%</td></tr><tr><td>Deprivation of Liberty Safeguards</td><td>TNA currently under review</td></tr><tr><td>Patient Consent</td><td>No TNA in place</td></tr></table><br>The Trust has appointed a medical lead for Consent, who is reviewing training requirements.<br><br>At the December Getting to Good Steering Group, there will be a review of whether there is assurance to move this fundamental breach to Green rating, when taking into account all of the above.</td><td>Chief Nurse</td><td></td></tr>
<tr><td>Regulation 12 – medical devices training</td><td>A full inventory of medical devices in the Trust has been undertaken and work is finalising to ensure that the list at ward level correlates with the Trust’s system E-Quip.<br><br>All medical devices have competency assessments in place.<br><br>A training needs analysis has been completed for medical devices within the Trust – this is being reviewed and approved by the Medical Devices Safety Group 21 November 2018.</td><td>Chief Nurse</td><td></td></tr>
</table>

| Fundamental breach | Action/Progress | Executive Lead | RAG |
|---|---|---|---|
| | High risk areas have been identified to prioritise the roll out of the requirement to have records of assessment of competency for medical devices within the Trust. This work commences w/c 26th November 2018. This is a Trustwide exercise as currently there is no systematic way to record competency. The Trust is working with the company that have developed E-Quip to ensure going forward these competencies can be recorded on the E-Quip system; this development work is well underway. In the interim and so not to hold up the assessment of competency required, paper copies will be held at ward/Dept level as evidence of competency.<br><br>Planned roll out to be completed by end December 2018. | | |
| Regulation 12- checks in theatre Halton to prevent Never Events | All actions following the Never Events have been implemented. MIAA are currently auditing this in practice, and following this audit, we will be able to determine whether we are compliant with the regulatory breach identified. | Medical Director | |
| Regulation 12 – checks of equipment trollies and anaesthetics machines | This is being audited by MIAA to ensure compliance still in place. | Chief Nurse | |
| Regulation 12 – equipment and checks in radiology | Fully compliant with the breaches identified as part of CQC inspection.<br><br>Further work underway to assess compliance will all Radiation Protection Regulations and will be reported to Getting to Good Steering Group. | Chief Operating Officer<br><br>Medical Director (radiation safety lead) | |

<table>
<tr><th>Fundamental breach</th><th>Action/Progress</th><th>Executive Lead</th><th>RAG</th></tr>
<tr><td>Regulation 13- Safeguarding training</td><td>November 2018 Update<br><br>Last validated training data (September 2018 shows the following compliance – which is a significant improvement.<br><br><table><tr><td>Safeguarding Adults - Level 1</td><td>93.90%</td></tr><tr><td>Safeguarding Adults - Level 2</td><td>77.57%</td></tr><tr><td>Safeguarding Children - Level 1</td><td>94.17%</td></tr><tr><td>Safeguarding Children - Level 2</td><td>88.14%</td></tr><tr><td>Safeguarding Children - Level 3</td><td>88.82%</td></tr></table><br>Anticipate compliance when October figures validated.</td><td>Chief Nurse</td><td></td></tr>
<tr><td>Regulation 15 – premises (radiology, gynae, maternity)</td><td>Business Case and decision regarding MLA/Induction of Labour with Executive Directors for approval.<br><br>Halton clinic and outpatients work being completed as part of the CQC action plan.<br><br>Review of CT Waiting area underway.</td><td>Chief Operating Officer</td><td></td></tr>
<tr><td>Regulation 17 – Governance<br>a) Risk Management<br><br>b) record keeping</td><td><u>Risk Management</u><br><br>All CBU risk registers in place and mechanisms through Risk Review Group to feed into the Strategic Risk Register and Board Assurance Framework. Senior Governance Consultant appointed supporting work on Board Assurance Framework review. Work underway at ward/dept level to have ward/dept level risk registers in place, which shows true ward to Board assessment and escalation of risk.</td><td>Chief Nurse/Medical Director /Director of Informatics</td><td></td></tr>
</table>

| Fundamental breach | Action/Progress | Executive Lead | RAG |
|---|---|---|---|
| c) IG and records being maintained securely | Information Governance<br>Storage for records across the Trust on wards and departments has been reviewed and lockable trollies purchased.<br>An audit of information governance has also been undertaken, which shows variable practice across the Trust. Actions being implemented and a repeat audit will be undertaken.<br><br>Record Keeping audit<br>This has been undertaking across the Trust and shared. A repeat audit will be undertaken to further assess compliance. | | |
| Regulation 18 – a) staffing b) APLS training for staff | Staffing<br><br>Nurse staffing business case – plans in place to implement at every ward level<br><br>A further audit of our staffing escalation processes has been undertaken, and will be presented to the December Getting to Good Steering Group.<br><br>From a nurse staff perspective, actions still being progressed regarding<br><br>- Maternity staffing and Birth Rate Plus Ratios<br>- Paediatric/Neo natal staffing review<br><br>Medical staffing – a full risk assessment regarding medical staffing is being undertaken across the Trust and presented to getting to Good Steering Group in December 2018.<br><br>Resuscitation Training<br><br>The latest compliance figures (as at September 2018) shows the following – which is a significant | Chief Nurse/Medical Director | |

| Fundamental breach | Action/Progress | Executive Lead | RAG |
|---|---|---|---|
| | improvement<br><br>• **Level 1 – this training forms part of Mandatory Training requirements**<br>All Trust staff are required to complete this training.<br>Compliance in September 2018 was **97%**<br>• **Level 2 – this training forms part of Mandatory Training requirements**<br>All clinical staff across the Trust are required to complete this training.<br>Compliance in September 2018 was **70%**<br>• **Level 3 – this training is required by nominated individuals across the Trust**<br>Nominated individuals from specific areas in the Trust are required to complete this training.<br>In September 2018 107 staff had completed this training.<br>• **Level 4– this training is required by nominated individuals across the Trust**<br>Nominated individuals from specific areas in the Trust are required to complete this training.<br>In September 2018 138 staff had completed this training.<br>Note training needs analysis appended for information<br><br>Further work required on assessing whether rotas now have a staff member each shift with the relevant advanced Life Support (Level 4 training) in place | | |

| LEVEL 1 | LEVEL 2 | LEVEL 3 | | LEVEL 4 | |
|---|---|---|---|---|---|
| SEMA – summoning emergency medical assistance<br>Once only, e-learning | Adult In Hospital Life Support (e-learning followed by practical session) Yearly<br>And / or<br>Paediatric basic life support - Yearly | RC(UK) Immediate Life Support, (ILS), yearly | RC(UK) paediatric immediate life support, (PILS), yearly | RC(UK) Advanced Life Support (ALS) 4 yearly<br><br>Annual refreshers required for these in-house<br>WHH Adult Advanced Life Support | RC(UK) EPALS / ALSG APLS (Advanced paediatric life support) 4 yearly<br><br>Annual refreshers required for these in-house<br><br>WHH Paediatric Advanced Life Support |
| All Trust Staff | Porters<br>Electricians<br>Medical Engineers<br>All patient facing staff with the exception of those requiring level 3 or 4 | Dentists<br>Dental Nurses<br>Cardiac Physiologists<br>Physician Associates<br>Theatre Recovery Staff<br>ODP's that do not require level 4<br>5th Year Medical students | Paediatric Nurses<br>A&E nurses<br>Theatre Recovery Staff<br>ODPs<br>UCC nurses<br>Physician Associates in Paeds or A&E | Acute care team members<br>Anaesthetists<br>A&E Doctors<br>Nominated Critical Care Nurses<br>Nominated Theatre Practitioners<br>Rotating FY1 & FY2 (WHH ALS)<br>Cardiac Arrest Team Members<br>Nominated UCC nurses<br>Nominated senior nurses at Halton and CMTC | Paediatricians<br>Anaesthetists<br>A&E Doctors<br>Nominated paediatric nurses<br>Rotating FY1 & FY2 (WHH PALS)<br>Nominated UCC Nurses<br>Nominated A&E Nurses |

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

**REPORT TO BOARD OF DIRECTORS**

| | | |
|---|---|---|
| **AGENDA REFERENCE:** | **BM/18/11/112** | |
| **SUBJECT:** | **Safeguarding Adults Annual Report** | |
| **DATE OF MEETING:** | 28 November 2018 | |
| **ACTION REQUIRED** | **Approve** | |
| **AUTHOR(S):** | John Goodenough, Deputy Chief Nurse | |
| **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 | |
| **LINK TO BOARD ASSURANCE FRAMEWORK (BAF):** | BAF1.1: CQC Compliance for Quality | |
| | | |
| | | |
| | | |
| **STRATEGIC CONTEXT** | The attached Safeguarding Annual report provides assurance to WHHFT Trust Board, with regards to meeting statutory and legal obligations to keep adults at risk safe from harm and abuse whilst in our care. | |
| **EXECUTIVE SUMMARY** (KEY ISSUES): | Safeguarding Adults at Risk is a Care Quality Commission standard (CQC) and a duty at the centre of our daily business. All staff at Warrington and Halton Hospitals NHS Foundation Trust (WHHFT) have a responsibility to ensure they are able to discharge their statutory safeguarding duties and to understand their joint responsibility in ensuring adults at risk are supported. Clinical Business Units report assurance regarding their responsibilities via the Safeguarding Committee and then to the Quality Committee.<br>The attached Safeguarding Annual report provides assurance to WHHFT Trust Board, with regards to meeting statutory and legal obligations to keep Adults at Risk safe from harm and abuse whilst in our care. | |
| **RECOMMENDATION:** | For the Trust Board to receive the report | |
| **PREVIOUSLY CONSIDERED BY:** | **Committee** | Quality Assurance Committee |
| | **Agenda Ref.** | QAC/18/11/130 |
| | **Date of meeting** | 6 November 2018 |
| | **Summary of Outcome** | Supported |

| | |
|---|---|
| **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

| | |
|---|---|
| **AGENDA REFERENCE:** | **BM/18/11/113** |
| **SUBJECT:** | **Ward Accreditation Programme – Accreditation for Excellence and Care (ACE)** |
| **DATE OF MEETING:** | **28 November 2018** |
| **ACTION REQUIRED** | **The Board of Directors are asked to note the paper.** |
| **AUTHOR(S):** | Rachel Browning Associate Chief Nurse, Clinical Effectiveness |
| **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 |
| **LINK TO BOARD ASSURANCE FRAMEWORK (BAF):** | BAF2.1: Engage Staff, Adopt New Working, New Systems |
| | BAF2.4: Engaging & Involving Workforce |
| | BAF2.5: Right People, Right Skills in Workforce |
| | |
| **STRATEGIC CONTEXT** | |
| **EXECUTIVE SUMMARY** (KEY ISSUES): | Warrington and Halton Hospitals NHS Foundation Trust launched the Ward Accreditation programme across the Trust in May 2018, with a commitment to accredit all wards in 2018.<br><br>The purpose of the programme is to ensure high quality, safe and compassionate care services across the organisation. Ward Accreditation sets clear expectations in relation to the achievement of specific safety and quality standards, setting ambitious and realistic goals, taking wards on a quality improvement journey using 'tests of change' methodology and learning.<br><br>Following implementation, 100% of the planned assessments are on track, with all wards receiving their own individual feedback report and associated action plan for improvement.<br><br>In order to provide an update from 'Ward to Board' this report will provide an overview of current progress and achievements of the programme to October 2018. |
| **RECOMMENDATION:** | To discuss and note the roll out the Ward Accreditation programme at WHH. |

| | | |
|---|---|---|
| | | |
| **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 | |

| SUBJECT | Ward Accreditation - ACE - Accreditation for Care and Excellence. | AGENDA REF: | BM/18/11/113 |
|---|---|---|---|

## 1. BACKGROUND/CONTEXT

In May 2018 Warrington and Halton Hospitals (WHH) launched the Ward Accreditation programme across the Trust. The purpose of the programme is to ensure high quality, safe and compassionate care services across the organisation. The programme sets clear expectations in relation to the achievement of specific safety and quality standards, setting ambitious and realistic goals, taking wards on a quality improvement journey. The framework provides a process of assurance from 'Ward to Board' and includes an 'award status' based on level of success achieved.

The Ward Accreditation Programme aims to strengthen leadership at ward level, support improvement in the quality of care our patients receive, reduce avoidable harm and improve patient experience. In addition, training in quality improvement 'tests of change' has been linked in with ward accreditation to further ongoing accreditation achievements, learning and improvements in care at ward level

The following report provides an overview of progress and achievements to date.

## 2. KEY ELEMENTS

**Assessment process**

The assessment follows a structured approach as detailed below in chart 1, to ensure consistency, analysis and a senior team meeting to review and validate the overall assessment.

***Chart 1***

The ward assessments are led by the Chief Nurse, Deputy Chief Nurse and Associate Chief Nurses, supported by the senior nursing teams. All assessments are unannounced (except to the assessment team) and include a review of care records and documentation, real time observations of care given, discussions with patients, carers and staff members. In addition, review of the ward quality metrics, staff training data, complaints, incidents and safety thermometer data is included to ensure the assessment process is not just 'a moment in time'.

**Implementation**

The programme commenced in May 2018, with a formal launch workshop with the ward managers and senior nursing teams to ensure understanding and expectations of the programme. A commitment has been given that all wards will be accredited this year.

**Implementation Progress Update**

- The Ward Accreditation Programme is on schedule with 100% of the planned assessments having taken place.
- 16 wards out of the 30 wards to be assessed have been accredited to date
- 93.75% of the wards have achieved bronze or silver to date.
- 8 wards have achieved a silver rating, 7 achieved bronze and one white ward (which is due further assessment).
- All wards have received their own individual feedback report, which includes 3 areas of positive feedback and 3 areas for improvements
- All wards assessed have a local action plan for improvement, which is monitored in the CBU and presented to the Nursing and Midwifery Forum meeting for sign off when completed.

**Ratings**

The Ward Accreditation Programme is focused on celebrating achievements, and results completed for the 30 assessment standards which are combined to make an overall 'awarded status' based on the level of success achieved.

**Award Status and Definition**

**Our journey so far……**

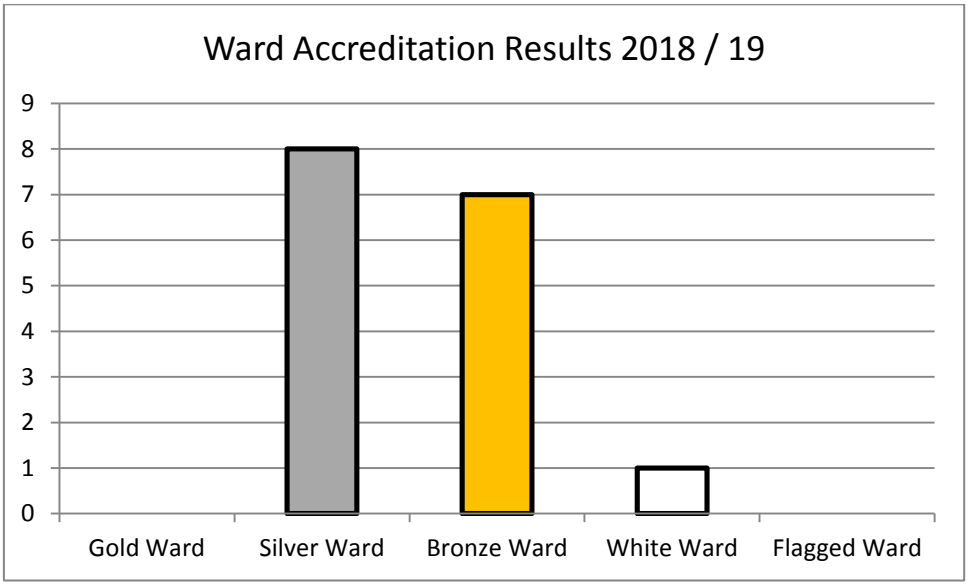
Since the introduction of the programme in May 2018 a total of 16 wards have been accredited. The ratings achieved for each of the wards are detailed as follows in chart 2;

***Chart 2***

| Ward | Speciality | Award Status |
|---|---|---|
| A5 | Surgery | Silver |
| AMU | Acute Medical Admissions | Bronze |
| B19 | Medicine | Silver |
| B12 | Dementia Ward | Silver |
| B1 | Step Down Care - Halton | Silver |
| CMTC | Elective Orthopaedic - Halton | Bronze |
| ED | Emergency | Silver |
| B10/11 | Paediatrics | Bronze |
| C21 | Cardiology | Bronze |
| B4 | Elective Surgery - Halton | Silver |
| B18 | Medical Co-hort | Bronze |
| CCU | Acute Cardiology | Silver |
| C23 | Maternity – Antenatal and Post Natal | Bronze |
| A8 | Acute Medical | Bronze |
| A9 | Trauma and Orthopaedic | White |
| UCC | Medical Assessment | Silver |

The overall rating for the wards currently assessed is as shown in chart 3. Quality improvement methodology is a relatively new concept for some of our team and as such training and development has been provided to support this process. Achievement of a gold rating in the first year would be extremely optimistic given the level of data and sustained improvement that would need to be demonstrated during the assessment. It is however pleasing to note that we have had 8 wards achieving silver, and of those 7 silver ward 5 of the ward manager have undertaken the Ward Manager Development Programme with the senior nursing team. One ward has been awarded a White rating and is receiving additional support to ensure improvement; the ward is due for reassessment before the end of November 2018.

***Chart 3***




Following the assessment the ward team receive a written report. In order to provide assurance of continual monitoring of progress, the Lead Nurse and Matron formulate an action plan from the assessment report which is managed and monitored at CBU level with monthly updates given to the Nursing and Midwifery Forum meetings. Final sign off of the action plan is undertaken by the Chief Nurse or Deputy Chief Nurse.

**Learning and sharing - Themes**

The assessment process has highlighted a number of areas that require greater focus to ensure improvement, as well as good practice and successes, both of which are shared across the wards to support trust wide learning and improvement.

**Celebrating success**

1. ***Compassionate and Patient Centred Care*** – the assessment teams have seen some excellent examples of how our staff have gone above and beyond to improve the experience of our patients and their families. Wards are responsive to patient need providing themed activities, birthday parties, weddings and musical events for patients. Wards have embraced the 'EndPJParalysis' initiative, and some wards are providing clothing for patients for transferring home. A number of wards provide activities for their specific patient groups, for example gardening activities, 'mocktails' to support increasing fluid intake and themed parties or events. Many of the wards have shared outstanding care examples during their accreditation assessment

2. ***Ward leadership*** – The assessment leads undertakes an in depth interview process with the ward manager as part of the accreditation visit. The team have seen

examples of effective leadership at ward level. This has resulted in a proactive and engaged ward team, with a culture of development and patient experience at the heart of the ward values. This is evidenced by consistency and improvements in PDR and mandatory training rates, improved sickness absence, turnover in line with the Trust targets and a positive response and utilisation of their patient experience data. These improvements are shared and discussed on the Ward Manager meetings, in order to support other managers to make similar improvements.

3. ***Use of 'Safety Huddles'*** – Wards are using the Safety Huddle process for communication, and to cascade key information to the team to create safe and responsive teamwork. This process is embedded and is proving to be an effective way of sharing information at ward and trust level. We have seen great examples of the safety huddles in action. The documentation process and how issues highlighted at the daily trust wide safety brief reaches staff at ward level.

**Areas for improvement**

1. ***De-cluttering, ward environment issues*** – The assessment team have seen variation across the wards in stock and storage management and progressing and escalating estates and facilities issues. The assessment team have provided the wards with an electronic handbook to support standardisation and labelling process to improve this, as well as undertaking work with the housekeepers to ensure that we have consistency across the wards. The assessment process has also identified a number of estates issues, which have required assistance in escalating for action, as a result significant issues have been escalated to the Chief Nurse and Chief Operating Officer. A meeting is also in place with the Assistant Chief Nurse, estates and facilities to prioritise and progress issues of this nature on a monthly basis.

2. ***Documentation*** - The assessment team have seen some variation in the standards of record keeping across the wards. Some areas have made progress and improvements following the introduction of a local record keeping audit programme at ward level as part of their quality improvement actions. However, in order to ensure improvements across the Trust and provide a standardised system of monitoring of compliance a Trust wide record keeping audit programme has been introduced, with all areas having a multi-disciplinary record keeping audit undertaken and ward and department level every 6 months.

3. ***Use of data*** – With the recent introduction of the Ward Quality Metrics, improvements are starting to be made in the way the teams use their data to make quality improvements at ward level. For some of the staff this is a relatively new concept, therefore training sessions have been provided for the Ward Managers and senior nursing teams to support the move to utilising data and quality improvement methodology to showcase test of change for improvement projects. Moving forwards support will be provided to ensure that ward and departments use their data over time to test change and demonstrate sustainable improvements. The accreditation team are seeing 100% in the data collection and have quality

improvements boards on all wards to display their data, an example of which is shown in chart 5.

***Chart 5***

*Additional information*:
Standards: notice boards in patient/public areas

**Quality Improvement** - Links to N&M strategy - Improvement and innovation

"We will strive for excellence by utilising innovation, technology and improvement to shape the future of nursing and midwifery"

This board is to display data over time on Quality Metrics Dashboard, heatmap and using QI change data to share current improvement work – highlighting any issues, improvement work and successes

*Data to be displayed as data over time showing last 13 months and can be obtained as follows:*

**Quality Metrics Dashboard:**
*Display monthly dashboard showing graphs from ward quality metrics*

**Quality Metrics Heatmap:**
*Display monthly heatmap showing at a glance results table and improvement actions from ward quality metrics*

**QI project data:**
*Display QI project data sheets – you may have more than one project underway – Display your most recent completed QI work and your current QI project – this data should how your QI work is improving something for patients and/or staff*

Any current or recent QI work not displayed elsewhere - the problem and solutions should be described and any improvements monitored using the QI project data tool

Any relevant information to explain improvements and innovations that are happening on your ward can be displayed on this board

Further work will be undertaken with the teams to ensure that the improvements they are making are displayed and shared with patients, relatives and staff at ward level.

**Staff feedback**

Senior Nurse - *"It has raised the standards with ownership of the environment and improvements in patient safety and patient care."*

Senior Nurse - *"Unity between the ward managers, learning and supporting each other through the process"*

Housekeeper - "*My ward is 100% better now, every day – thankyou"*

Housekeeper - *"It's positive, it's been really good"*

**Challenges and next steps**

The Ward Accreditation Programme has set an ambitious commitment to have all wards assessed by December 2018. The assessments have been led by the Chief Nurse and senior nursing team, which have placed a significant demand on the very senior team due to the number of assessments to be undertaken (on occasions 2 per week). As we move to extend the programme in 2019, to include non-ward based areas, consideration will need to be given to the sustainability and investment in the programme going forward. The Chief Nurse was very keen to move forward with the Ward Accreditation Programme and as such moved the programme forward without formal resource. This will need review in 2019.

Work has already commenced to develop the quality metrics for outpatients, theatres and therapies which will commence in January 2019. Following the 3 month pilot of the quality metrics, an accreditation programme will commence in these areas in April 2019.

## 3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

The Ward Accreditation Programme at WHH has been successfully implemented with 100% of the planned assessments having taken place to date. To date 16 wards have been assessed, 8 rated as silver 7 bronze and one white ward who is receiving targeted support for improvement.

Themes have been identified as part of the ward accreditation programme, which is shared across the teams to ensure a continual improvement demonstrating our commitment to being a safe, caring, well led, responsive and effective organisation.

Staff engagement has been an extremely positive feature of the programme with teams working together to make the improvements at ward level.

As we move to extend the programme to include non-ward based areas in 2019, consideration will need to be given for additional resource to ensure sustainability

## 4. RECOMMENDATIONS

The Trust Board are asked to note the progress and continue to support the implementation of the Ward Accreditation Programme across the organisation.

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

# REPORT TO BOARD OF DIRECTORS

| | | |
|---|---|---|
| **AGENDA REFERENCE:** | **BM/18/11/115** | |
| **SUBJECT:** | **Quarterly Mortality Review Report** | |
| **DATE OF MEETING:** | 28 November 2018 | |
| **ACTION REQUIRED** | **Approve** | |
| **AUTHOR(S):** | Dr Phil Cantrell, Lead Clinician for Mortality | |
| **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 | |
| **LINK TO BOARD ASSURANCE FRAMEWORK (BAF):** | BAF1.1: CQC Compliance for Quality | |
| | Choose an item. | |
| | Choose an item. | |
| | | |
| **STRATEGIC CONTEXT** | The national Learning from Deaths initiative has been launched in 2018 and implemented in this Trust through a policy which incorporates a qualitative assessment of inpatients deaths with standardised mortality ratios. | |
| **EXECUTIVE SUMMARY** (KEY ISSUES): | This briefing paper overviews Trust mortality data and provides local and national context. It also outlines the actions in place to ensure robust oversight and monitoring, through a comprehensive mortality peer review process, as well as improvement plans to reduce Trust mortality rates and the Trust mortality ratio figures. | |
| **RECOMMENDATION:** | The Board is asked to note the contents of the briefing paper and discuss and approve the recommended options. | |
| **PREVIOUSLY CONSIDERED BY:** | **Committee** | Quality Assurance Committee |
| | **Agenda Ref.** | QAC/18/11/134 |
| | **Date of meeting** | 6 November 2018 |
| | **Summary of Outcome** | Approved |
| **FREEDOM OF INFORMATION STATUS (FOIA):** | Release Document in Full | |

| SUBJECT | Trust Mortality |
|---|---|

## 1. BACKGROUND/CONTEXT

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

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

## 2. KEY ELEMENTS

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

### 2.1 Structured Judgement Reviews

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.

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.

## 2.2 Focused Reviews

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

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

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

## 2.3 Mortality Data Analysis

There are three main types of overall data used:

### 2.3.1 Crude Mortality Rates

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

### 2.3.2 HSMR (Hospital Standardised Mortality Ratio)

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

Adjustments are made for:

| | |
|---|---|
| • sex<br>• age<br>• admission method<br>• comorbidities (based on Charlson score) | • month of admission<br>• socio economic deprivation quintile (using Carstairs)<br>• primary diagnosis sub-group |

| | |
|---|---|
| • number of previous emergency admissions<br>• history of previous emergency admissions in the last 12 months | • palliative care<br>• year of discharge |

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

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

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

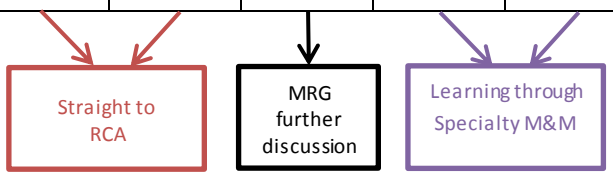
## 3. MEASUREMENTS/EVALUATIONS

### 3.1 Structured Judgement Reviews

There have been **109** mortalities that have triggered a Structured Judgement Review by a member of MRG. **74** Structured Judgement Reviews that been completed between April 2018 and September 2018.

### 3.1.1 Dashboard for Structured Judgement Review Ratings

| Time Period | Overall Assessment Care Rating Following SJR | | | | | Total SJRs |
|---|---|---|---|---|---|---|
| | 1: Very Poor | 2: Poor | 3: Adequate | 4: Good | 5:Excellent | |
| April/May/June/ July/Aug/Sept | 0 | 3 | 20 | 28 | 23 | 74 |



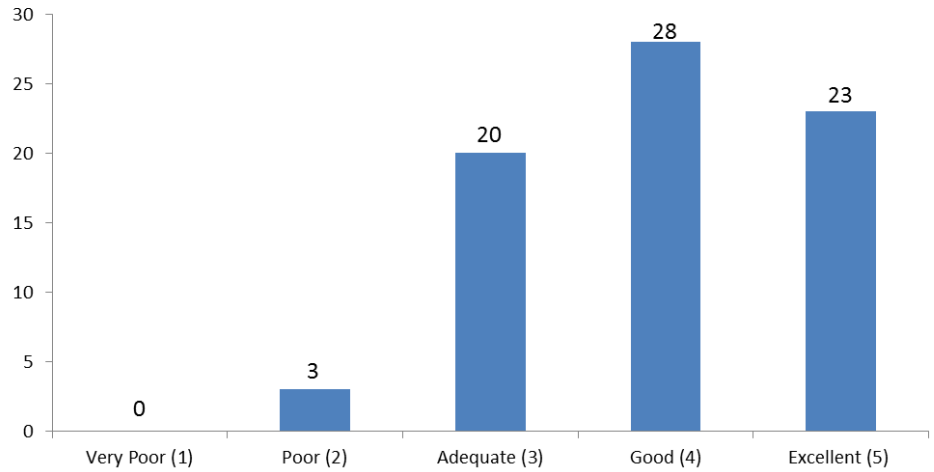



**Figure 1: Overall Care Rating Following SJR April 2018 - September 2018**

## 3.1.2 Previous Quarter's RCA Outcome

The following data outlines those deaths that have been deemed by the Trust to be potentially avoidable, 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.

The following data gives information from Q4 and Q1. Q2 data is not included within this report, as investigations would be in the process of being concluded.

| Quarter | Deaths subject to RCA which have concluded in Quarter | Number of potentially avoidable deaths as per RCA outcome | Comments |
|---|---|---|---|
| 4 (2017/18) | 7 | 1 | 3 cases undetermined as 1 case due to go to inquest and 2 case awaiting external reviews as part of litigation process |

| | | | |
|---|---|---|---|
| 1 (2018/19) | 3 | 0 | |

Detail of cases where there was potential avoidability. 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.

| Summary |
|---|
| 2018/668 – Patient had a primary intracerebral haemorrhage. The patient presented with end-stage renal disease and was receiving regular peritoneal dialysis while awaiting a renal transplant. The patient had a complex condition and was suffering from renal failure and uncontrolled hypertension and also had both retinal and intracranial haemorrhages in the past due to these conditions. In October 2017 the patient had a spontaneous Intracerebral haemorrhage most likely due to uncontrolled hypertension secondary to renal failure. The investigation team identified that inadequately treated hypertension was the main contributory factor in the occurrence of a spontaneous intracerebral haemorrhage. The administration of anticoagulants is considered a confounding factor. |

## 3.1.3 Themes from Structured Judgement Reviews

**Verification of Deaths**

This was not being undertaken in a uniform manner. A group is now reviewing the Trust Policy and a Trust wide process for all death verifications will be done in the same way, irrespective of who performs the verification.

**Inconsistent Acute Oncology Review of Patients**

This is due to too few Oncologists, resulting in patients not being seen.

One case was particularly difficult. The patient's transport to the Clatterbridge Centre for Oncology hospital from this Trust for chemotherapy was cancelled, no chemotherapy over the next two days as these slots were reserved for new patients. Patient was too unwell to travel on the next available day; patient died thinking that this was because he did not get his treatment. He was likely too unfit from the first day and an acute oncology review at that stage could have had a discussion with the patient and his family that he was at the end of life.

**Action:** Discussion with Clatterbridge has taken place to ensure that adequate cover is now in place.

**Antibiotics in Sepsis**

Two cases identified where the patient did not get antibiotics within the agreed timeframe for sepsis.

**Action:** Cases sent to Sepsis Lead for use when reinforcing Sepsis Pathway.

**End-of-Life Care**

- Nursing home agreed to take patient following hospital stay for end-of-life care. Good management plan in place. Palliative Care involved, DNACPR etc but patient was readmitted to hospital.
  **Action:** Interface incident completed to allow feedback to GPs.
- Patient with numerous medical and surgical problems; AKI, severe LVF, blocked ureteric stents. Unfit for any major treatment. Two MET calls but no DNACPR or end-of-life care discussed or put into place by parent team.
  **Action:** There is an End-of-Life Strategy Group in the Trust looking at these issues.
- DNACPR discussion not had with elderly, very frail patient, who was admitted in heart failure. It was felt by the reviewer that she would be unlikely to benefit from CPR. The focus of admission seemed to be on acute disease and she was readmitted two days later with a cardiac arrest and inappropriate CPR. Patient and family unprepared for the outcome.
- Respiratory patient with end stage interstitial pulmonary fibrosis. The known outcome of this is death within 2-3 years but there is no discussion regarding planning for palliation when deterioration occurs.
  **Action:** Discussed with Respiratory lead. He will manage these patients as his cancer patients with appropriate discussion and preparation for the end stage of the disease. He will discuss with his Team.
- Patient with dementia, admitted with faecal peritonitis secondary to bowel perforation. Early management was good but stormy post-operative time over 5-6 weeks with deterioration. Patient should have had earlier end-of-life discussions with ceilings of care in place.

**Equipment Failure**

- Morbidly obese 36 year old female (237 kg) on ITU. Unable to weigh patient. Bariatric equipment broken. Weight was underestimated by33% - potential error in drug dosing. Felt unlikely to alter outcome.
  **Action:** Awareness raising of availability of equipment widely communicated. Process for replacing malfunctioning equipment now in place.

**Learning Disability**

- Bed-bound, 69 year old. Previous CVA. Multiple recent admissions (Whiston & WHHFT). Awaiting 'Best Interests' meeting. DNACPR and ceilings of care discussed with next of kin. Reviewed by Safeguarding Team. Deteriorated. Palliative care only.
- 57 year old male; Halton patient. Learning disability not made known to Safeguarding Team. Halton LD Matron informed Trust of the death.
  **Learning :** MET call but no senior review the following morning to review reason for MET call. Discussed at MRG. Requested confirmation that Bristol had been informed.
- Paediatric Patient (17 years). Profound hypoxic brain damage 2002. Died at home. Unaware that Bristol needs to be informed (as community death – possibly happened in community). Fed back to Paediatric Team.

**Lack of Bed on Orthopaedic Ward**
Patient with fractured neck of femur, no bed available on A9 leading to a delay in surgery. The patient developed pneumonia and experienced a further delay.
**Action:** Highlight need for all #NOF to go to correct ward to avoid delays.

### 3.1.4 Areas of Good Practice

**End of Life Care**
Excellent examples where the mortality of a patient was anticipated well and conversations with the family initiated. A DNACPR and ceiling of care were put in place alongside anticipatory medications. The patient was moved into a side room with the family present until he passed away.

**Communication**
An excellent example of clinicians involving a patient and their family in discussions regarding the patient's malignant disease. Unfortunately due to the development of a massive pulmonary embolism the patient went into respiratory and cardiac arrest before the Palliative Care team were able to assess the patient. The patient received CPR, but this was unsuccessful.

## 3.2 Focused Reviews

The below table sets out the progress with focused reviews on mortality outliers:

| Diagnosis Group | Trigger | Observed deaths/ expected deaths | Date due for completion | Learning Identified |
|---|---|---|---|---|
| Neoplasms Of Unknown Or Uncertain Behaviour | SHMI | 24/13 | May 2018 | Presented 22/05/18 |
| Liver Disease, alcohol-related | HSMR & SHMI | 31/28 | June 2018 | Presented 19/06/18 |
| Fractured Neck of Femur | SHMI | 24/13 | June 2018 | Presented 19/06/18 |
| Pleurisy, Pneumothorax and Pulmonary Collapse | HSMR & SHMI | 12/6.5 | | |
| Intestinal Infections | | | | |

**Fractured Neck of Femur**
Triggered as an outlier (statistically significant of more deaths than expected) in July, August, October and November 2016. Cases were taken from the months where we had a spike in deaths.

Fourteen cases were reviewed.

**Problems Identified:**

- Regular review from senior clinician essential.
- NEWS scoring and MET call triggers poor. This has been addressed with nursing and junior staff.
- No cover for orthogeriatrician when he is on leave.

**Action taken:**

- Items a) and b) will be reaudited in June 2019 following discussion with the Team.
- Item c) has been highlighted to the Medical Director.
- Twelve of the fourteen cases – management was appropriate.
- Two cases have been sent for a Concise Review.

**Alcohol Related Liver Disease – For further review at the next MRG**
SHMI – 31 deaths (27 in hospital) – 18 expected.

- The percentage of patients in this category were coded as 'low risk' is increasing.
- We looked at 14 deaths.
- All had a DNACPR in place; all had a past history of alcohol excess.
- Thirteen of the 14 presented with end stage liver disease and died of their end stage liver disease.
- One patient presented with extensive small bowel ischaemia so advanced surgery not appropriate. Should not have been coded with ARLD as the primary diagnosis.

**Learning:**

- One patient on a gynae ward (outlier). Therefore care not optimised as if on gastro ward.
- One case of incorrect death certificate.
- No clear pathway for decisions regarding end-of-life, ceilings of care in this group.
- Share this with the CCG to help improve care in the community (all had recurrent admissions).

## 3.3 Crude Mortality

Crude mortality should be viewed with caution, as it does not take into account the complexities of the patients, but it is useful to monitor numbers of observed deaths.

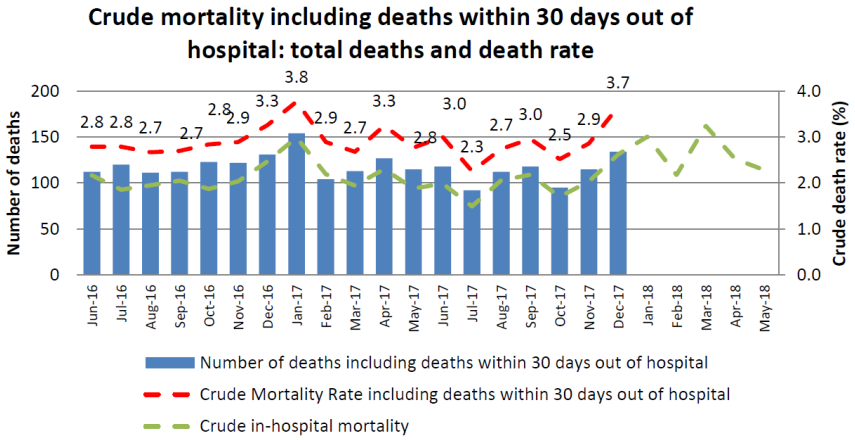



**Figure 2: Crude Mortality June 2016 to May 2018**

## 3.4 HSMR

- **We are not a national outlier, with a HSMR of 101.54 for May 2017 – April 2018.**

**Quarter 2 HSMR:**

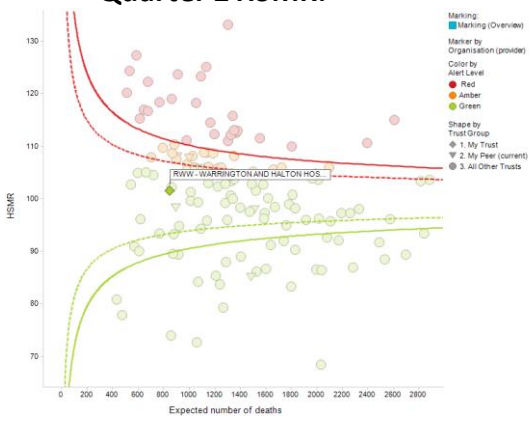
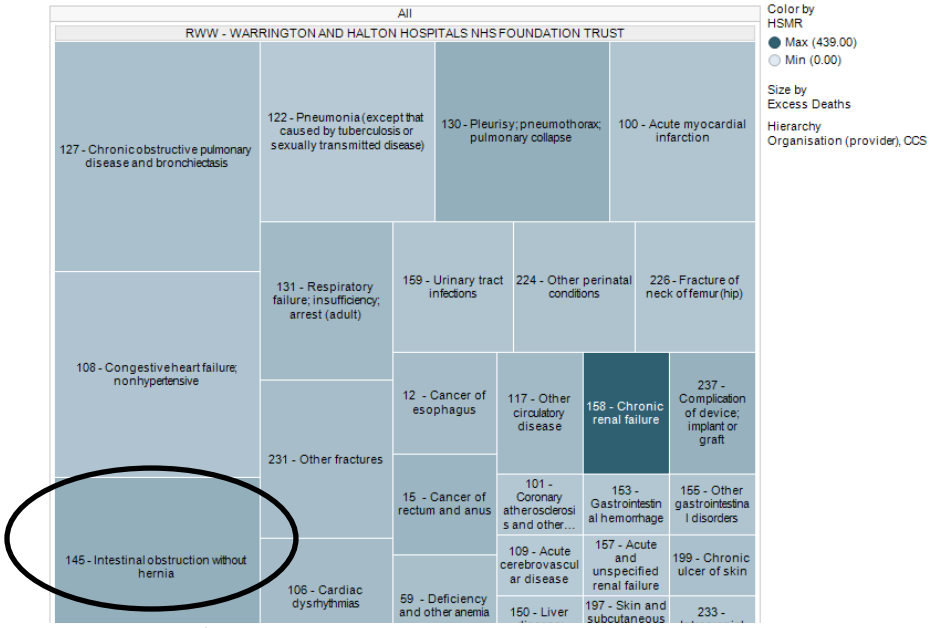



**Figure 3: Funnel Plot for HSMR May 2017 to April 2018**

### 3.4.1 HSMR by diagnostic grouping

HSMR looks at 56 diagnosis groups which cover approximately 80% of in-hospital deaths nationally. Of these groups, we are showing a statistically significantly high HSMR result in the 12 month period of May 2017 – April 2018 for the following groups:




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

The darker the colour, the higher the number of observed deaths against "expected" deaths.

**Figure 4: HSMR by Diagnostic Group**

### 3.4.2 Weekend/Weekday HSMR

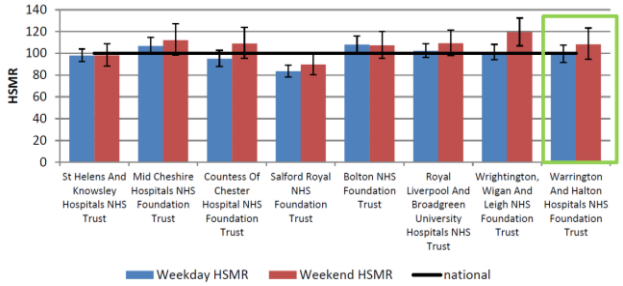



**Figure 5: Weekend/Weekday HSMR**

- This graph shows there is some difference between the weekday and weekend HSMR for the latest 12 months, but neither score is statistically significantly high.
- Error bars denote 95% confidence intervals.

## 3.5 SHMI

We are unable to comment on SHMI for Quarter 1 and Quarter 2 as the source data was not available from NHS Digital.

## 3.6 Summary

- HSMR is not an outlier for the last 12 months.
- Weekend / weekday mortality is widening, however the result is not statistically significant.
- Two members of MRG plan to lead on a focused review into Intestinal Infections.

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

**BOARD OF DIRECTORS**

| | | |
|---|---|---|
| **AGENDA REFERENCE:** | **BM/18/11/116** | |
| **SUBJECT:** | **Progress on Lord Carter Report Recommendations & Use of Resource Assessment (UoRA)** | |
| **DATE OF MEETING:** | 28th November 2018 | |
| **ACTION REQUIRED** | **For Discussion** | |
| **AUTHOR(S):** | Marie Garnett, Head of Contracts & Performance | |
| **EXECUTIVE DIRECTOR SPONSOR:** | Andrea Mcgee, Director of Finance & Commercial Development | |
| | | |
| **LINK TO STRATEGIC OBJECTIVES:** | All | |
| **LINK TO BOARD ASSURANCE FRAMEWORK (BAF):** | BAF1.3: National & Local Mandatory, Operational Targets | |
| | BAF1.4: Business Continuity | |
| | BAF3.3: Clinical & Business Information Systems | |
| | | |
| **STRATEGIC CONTEXT** | The purpose of this report is to update the Board of Directors on the latest position regarding progress made against the recommendations contained in Lord Carter's report "Operational productivity and performance in English NHS Acute hospitals" issued in February 2016. The report has been updated to incorporate progress against the Use of Resources indicators in readiness for the Use of Resources Assessment (UoRA). | |
| **EXECUTIVE SUMMARY** (KEY ISSUES): | The Trust continues to work through the Lord Carter Recommendations and it progressing preparation for the Trust's Use of Resource Assessment by the CQC and NHSI. | |
| **RECOMMENDATION:** | The Board of Directors is requested to note the contents of the report. | |
| **PREVIOUSLY CONSIDERED BY:** | **Committee** | Not Applicable |
| | **Agenda Ref.** | |
| | **Date of meeting** | |
| | **Summary of Outcome** | |
| **FREEDOM OF INFORMATION STATUS (FOIA):** | Release Document in Full | |
| **FOIA EXEMPTIONS APPLIED:** ***(if relevant)*** | None | |

# PROGRESS ON THE CARTER REPORT RECOMMENDATIONS & USE OF RESOURCE ASSESSMENT

## 1. PURPOSE

The purpose of this report is to update the Board of Directors on the latest position regarding the progress made against the recommendations contained in Lord Carter's report "Operational productivity and performance in English NHS Acute hospitals" issued in February 2016 and to update on progress and preparation towards the Use of Resource Assessment (UoRA) which will form part of the Trust CQC inspection rating.

## 2. BACKGROUND,

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

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

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

Table: The breakdown of the £5 billion savings:

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

In May 2018, as part of the Trust's Getting to Good, Moving to Outstanding programme, a UoRA workstream was established. The UoRA will be carried out by CQC and NHSI and is designed to improve understanding of how effectively and efficiently the Trust uses its resources. During the next 12 months, the Trust will take part in an assessment day at which executive and operational leads will evidence the Trust's progress in improving its use of resources. Prior to the assessment day, the Trust will submit evidence and narrative. 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 will form the basis 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.

## 3. PROGRESS

This paper presents the quarterly update report for Quarter 2. 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 is monitoring and actioning improvements for each indicator and is gathering evidence which demonstrate the Trust's effective Use of Resources.

## 4. CONCLUSION

The Trust continues to make progress against the Lord Carter recommendations. It is vital that the Operational and Executive leads for each KLOE fully understand their performance and identify and monitor actions for improvement and have an overview of the Trust's performance for all KLOEs.

## 5. RECCOMENDATION

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

**Andrea McGee**
**Director of Finance and Commercial Development**
**20th November 2018**

## Appendix 1 – Benchmarking Performance against the National Median

| KLOE Indicator | Quarter 1 | Quarter 2 | Quarter 3 | Quarter 4 |
|---|---|---|---|---|
| **KLOE 1 - Clinical** | | | | |
| Pre Procedure Elective Bed Days | Q4 2017/18 | Q1 2018/19 | | |
| Pre Procedure Non Elective Bed Days | Q4 2017/18 | Q1 2018/19 | | |
| Emergency Readmission (30 Days) | Q4 2017/18 | Q1 2018/19 | | |
| Did Not Attend (DNA) Rate | Q4 2017/18 | Q1 2018/19 | | |
| **KLOE 2 - People** | | | | |
| Staff Retention Rate | March 2018 | June 2018 | | |
| Sickness Absence Rate | February 2018 | May 2018 | | |
| Pay Costs per Weighted Activity Unit | 2016/17 | 2016/17 | | |
| Medical Costs per WAU | 2016/17 | 2016/17 | | |
| Nurses Cost Per WAU | 2016/17 | 2016/17 | | |
| AHP Cost per WAU (community adjusted) | 2016/17 | 2016/17 | | |
| **KLOE 3 – Clinical Support Services** | | | | |
| Top 10 Medicines - Percentage Delivery of Savings | March 2018 | March 2018 | | |
| Pathology - Overall Costs Per Test | Q2 – 2017/18 | Q4 2017/18 | | |
| **KLOE 4 – Corporate Services** | | | | |
| Non Pay Costs per WAU | 2016/17 | 2016/17 | | |
| Finance Costs per £100m Turnover | 2016/17 | 2016/17 | | |
| Human Resource Costs per £100m Turnover | 2016/17 | 2016/17 | | |
| Procurement Process Efficiency and Price Performance Score Clinics | Q4 2016/17 | Q4 2016/17 | | |
| Estates Costs Per Square Meter | 2016/17 | 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

**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 2 2018/19

**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's Strategy was signed off at the Trust board in Q2 2018/19. Quarterly reports will be presented to the Strategic Peoples Committee. | • Ongoing monitoring and management of the dashboard.<br>• The Strategic Peoples Committee will provide oversite of the refreshed Peoples Strategy. | Trust Board, TOB, Strategic Peoples 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 Peoples Committee | Complete |
| **HR Polices reviewed to ensure they are clear, simple and transparent** | • The Human Resources (HR) & Organisations Development (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. | • The Trust is undertaking a programme to review and where required simplify HR policies which will be monitored by the Strategic Peoples Committee. | Strategic Peoples Committee | Ongoing Monitoring |

Warrington and Halton Hospitals NHS
NHS Foundation Trust

**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 2 2018/19

| | Progress/Performance | Actions to Improve Position/Actions for Next Quarter | Assurance | Status |
|---|---|---|---|---|
| **"Fit to Care" Heath & Wellbeing Programme** | • As part of national CQUIN, support for a wide range of wellbeing approaches aimed at supporting staff back into work have been established.<br>• A programme of exercise classes has been implemented.<br>• The Trust piloted a weight management clinic.<br>• Health topics have focused on the different effects of stress both physically and mentally.<br>• Drop in sessions have been held for staff on healthy hearts and stress management.<br>• The Trust had a Wellbeing clinic on site for staff to access. Over 1000 people accessed its information on BMI, blood pressure and body fat within the first week.<br>• Heath topics on exercise and movement at work and hydration have been in focus around the Trust. May's health focus was hydration and will be supported by our NHS 70th water bottles which will be given to all our staff.<br>• Q1 2018/19 saw the Trust launch of its Mental Health first aid courses which aim to help mangers spot the signs of mental health and signpost colleagues to support.<br>• A Financial Wellbeing clinic was held on site for staff. | • As part of the refreshed Peoples Strategy, a full review of the fit to care programme will take place during Q3 and Q4.<br>• Wellbeing initiatives will continue to be offered and monitored for effectiveness. | Strategic Peoples Committee | Rolling Programme |
| **Development of Workforce Streaming Programme across the North West** | • The Trust continues to work with colleagues across the North West to agree unified ways or working and to reduce bureaucracy.<br>• Key actions to date include:<br>o Implementation of factual references.<br>o Streamlining of notice periods for new starters.<br>o Agreed honorary contract process and streamlining of mandatory training across the region.<br>o Values based recruitment.<br>• The HR Director/Deputy Director networks have agreed milestones for year 3.<br>• Region wide TUPE guidelines have been agreed. | • The programme continues to work through the agreed milestones for year 3 for the following workstreams (Training, Occupational Health, PREP, Recruitment, Medical Staffing and Systems). Updates are provided to the Operational Peoples Committee by the Internal Implementation Group and externally to regional groups. | Operational Peoples Committee | Ongoing |

Warrington and Halton Hospitals NHS
NHS Foundation Trust

**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 2 2018/19

| | Progress/Performance | Actions to Improve Position/Actions for Next Quarter | Assurance | Status |
|---|---|---|---|---|
| **Staff Opinion Survey** | • The 2017/18 Staff Opinion Survey (SOS) closed in December 2017. The Trust response rate was 46% compared to 38% for the 2016 survey.<br>• Results from the SOS have been received by the Trust and a proposed change in approach was presented to and approved by the Trust board in March 2018.<br>• A staff engagement event "The Perfect Day" took place in early May 2018 and outputs are linked to Listening In To Action (LIA)<br>• Themes from the 2017/18 staff survey were used to develop the refreshed Peoples Strategy. | • The 2018/19 SOS was launched in late September and will continue throughout October. A full communications plan aimed at obtaining a high response rate has been launched. | Trust Board, TOB, Strategic Peoples Committee | Rolling Programme |
| **Reduction in the high rates of bullying and harassment with a sustained campaign led personally by each trust Chief Executive** | • Bullying and harassment is a key element of the SOS and is measured by a number of metrics.<br>• In the 2016 staff survey, the Trust scored either average or better than average for all metrics related to bullying and harassment, compared with other Trusts nationally.<br>• The Freedom to Speak Up Guardian has a network of champions to support staff to raise concerns. Links have been made with Junior Doctors and the People Champions as this agenda continues to embed.<br>• The Trust performed in the upper quartile in the 2017 staff survey in relation to bullying and harassment in comparison with other Acute Trusts. The survey did highlight a need to look into the number of staff experiencing physical violence from other staff.<br>• 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 will be 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.<br>• Work has been undertaken with the Trust's communications team to ensure staff know who to raise concerns with and how they would go about this. | • The current Dignity At Work Policy will be refreshed with a focus on being proactive and prevention, a first draft will be reviewed by the Strategic Peoples Committee during Q3.<br>• An Equality, Diversity and Inclusion Strategy is being produced, the first draft will be presented to the Equality and Diversity sub-committee in Q3. | Strategic Peoples Committee | Ongoing Monitoring |

Warrington and Halton Hospitals NHS
NHS Foundation Trust

**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 2 2018/19

| | 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 85% (July 2018) and 84% (August 2018) against a target of 85%.<br>• HR Business Partners have worked with CBUs to develop a recovery plan, although this people measure continues to create challenges across clinical and non-clinical staff groups with the exception of medical workforce.<br>• The PDR process has been reviewed, with a particular focus on engaging staff and condensing timescales to avoid winter pressures. Focus groups took place with staff and management in April with recommendations took to the Workforce committee in May 2018.<br>• Proposals around strengthening reporting arrangements for nursing staff have been made. | • HR Business Partners will continue to work with the CBU managers to further improve PDR compliance.<br>• As part of the new NHS pay award, from April 2019 the Trust will be required to further strengthen the link between performance and pay progression. The HR team will be working with colleagues from other Trusts to ensure this is implemented regionally in a consistent way. | Trust Board, TOB, Strategic Peoples Committee | Ongoing Monitoring |
| **Improving Sickness Absence** | • Sickness absence was 4.39% in August 2018.<br>• An audit has been completed on compliance with the Trust's Attendance Management Policy and a number of recommendations are being implemented.<br>• Promotion and improvement of flu vaccination uptake took place in Q3/4.<br>• Mental Health "Train the Trainer" training is complete.<br>• A new clinical supervision framework has been rolled out which will help to address some of the stress/anxiety related absences. | • An ongoing programme of Mental Health first aid training is being rolled out across the Trust.<br>• There is a focus on mental health and MSK related absence in the refreshed peoples strategy. | Trust Board, TOB, Strategic Peoples Committee | Ongoing Monitoring |

Warrington and Halton Hospitals NHS
NHS Foundation Trust

**Key**

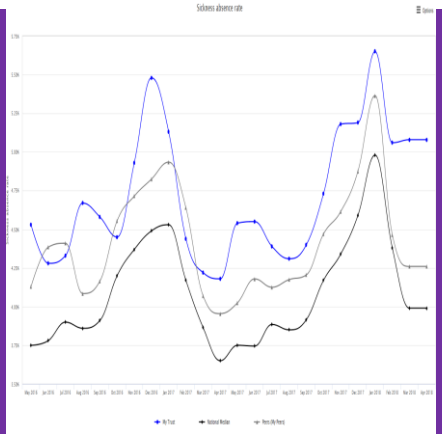
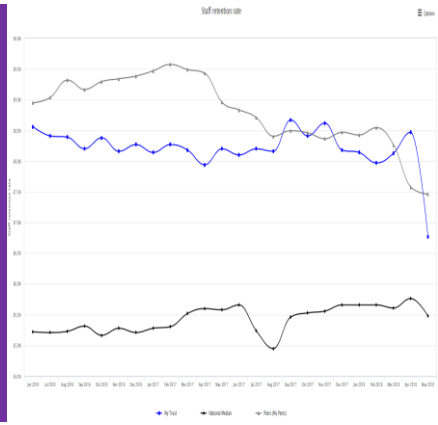
- Complete/Green on Model Hospital (against National median)
- On track for completion
- Progress off track - plans in place to get back on track/Amber on the Model Hospital
- Progress significantly off track/Red on Model Hospital
- Not started/Awaiting further information/New actions parameters to be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

UoR Use of Resource Assessment Indicator

**Appendix 2**

# Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 2 2018/19

## KLOE 2 - People

| | Progress/Performance | | | Actions to Improve Position/Actions for Next Quarter | Assurance | Status |
|---|---|---|---|---|---|---|
| **Sickness Absence Rate** | UoR<br>Percentage of staff FTE sick days. | **National Median = 3.99%**<br>Peer Median = 4.21%<br>1. STHK 3.2%<br>2. Bournemouth 3.72%<br>3. Chester 3.86%<br>4. Sunderland 4.12%<br>5. Mid-Cheshire 4.21%<br>6. N Lincolnshire 4.31%<br>**Source: HSCIC - NHS Digital iView Stability Index** | **April 2018**<br>7. North Tees 4.38%<br>8. Wirral 4.72%<br>9. Gateshead 4.97%<br>10. WHH 5.08%<br>11. Southport 5.64% |  | Absence remains above the Trust target; October 2018 sickness rate is 4.47%. | > Increased focus on workforce KPIs (sickness and RTW) with the CBUs.<br>> HR team delivering bespoke actions, training and coaching within hotspot areas.<br>> Development of guidance on Return to Work (RTW) for managers.<br>> Roll out and promotion of Mental Health First Aider training.<br>> Benchmarking against similar neighbouring Trust is taking place to understand and implement |
| **Staff Retention Rate** | UoR<br>The percentage of staff that remained stable over 12 months period. | **National Median = 85.5%**<br>Peer Median = 87.5%<br>1. Wirral 89%<br>2. Gateshead 88.7%<br>3. STHK 88.4%<br>4. Sunderland 87.7%<br>5. North Tees 87.7%<br>6. Mid-Cheshire 87.3%<br>**Source: HSCIC - NHS Digital iView Stability Index** | **May 2018**<br>7. N Lincolnshire 86.9%<br>8. WHH 86.8%<br>9. Bournemouth 86.6%<br>10. Southport 86.5%<br>11. Chester 84.8% |  | The Trust retention rate remains above national median but below our peers. October 2018 retention is 86.5%.<br><br>Greater focus is being given to retention and with the formulation of the WHH Recruitment and Retention group. An action plan will be developed following a review of current data and best practice across the NHS. | Key actions include:<br>> Reviewing best practice across the NHS as an aid to developing our action plan.<br>> Improving our understanding of reasons for leaving and analysis of current data to inform priorities.<br>> Improve the promotion of development opportunities and benefits of working at WHH.<br>> Establish a method for employees to discuss their options before seeking alternative employment. |

Warrington and Halton Hospitals NHS
NHS Foundation Trust

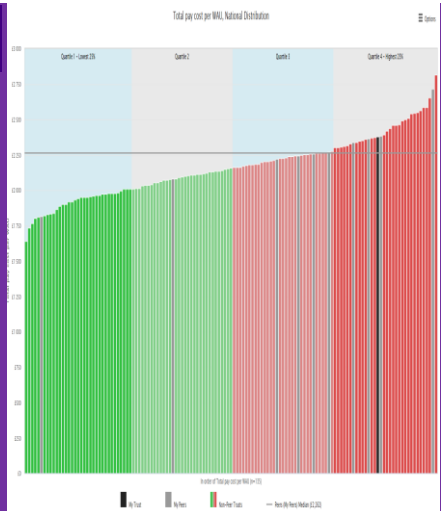
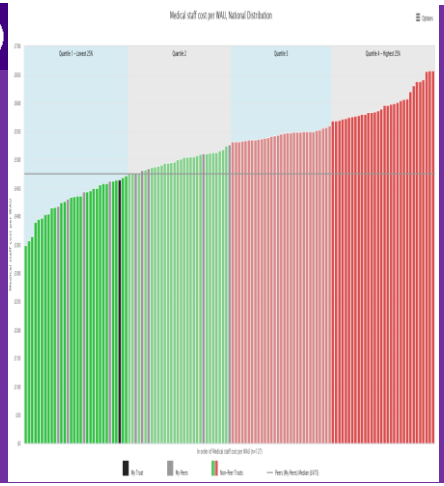
**Key**

- 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 2 2018/19

| | Progress/Performance | Actions to Improve Position/Actions for Next Quarter | Assurance | Status |
|---|---|---|---|---|
| **Pay Costs per Weighted Activity Unit** | UoR<br>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.<br><br>This metric shows the amount the trust spends on pay per WAU across all areas of NHS clinical activity.<br><br>**National Median = £2157** **2016/17**<br>Peer Median = £2262<br><br>1. Bournemouth £1817<br>2. Sunderland £2081<br>3. Chester £2219<br>4. STHK £2244<br>5. Gateshead £2256<br>6. Wirral £2269<br>7. Mid-Cheshire £2338<br>8. North Tees £2363<br>9. WHH £2377<br>10. N Lincolnshire £2383<br>11. Southport £2715<br><br>**Source: Trust consolidated annual accounts/reference cost data.** |  <br>Pay Costs per WAU exceeds the peer and national medians.<br><br>The below shows the WAU staff costs per staff group and the percentage difference compared to<br><br>Staff Group / Trust / Peer %<br>Medical £465 -4.5%<br>Nursing £764 -6.2%<br>AHP £188 19.1%<br>Scientists £192 9.4%<br>Corp Supp £413 -3.1%<br>Agency £169 32.0%<br>Non-Sub £183 8.2%<br><br>This data shows that the Trust is utilising more agency staffing than our peers. | The key actions focus on reducing reliance and improving value for money for temporary staff (Allied Health Professional (AHP) explained below).<br>> The temporary staffing team continue to support the CBUs to improve locum fill and pay rates.<br>> Agree and standardise medical bank rates, per grade.<br>> Process medical bank bookings through the Brookson system, improving fill rate and compliance.<br>> Working with Cheshire and Merseyside challenge agencies to improve their pay rates.<br>> Process all other agency work through the Brookson system. | |
| **Medical Costs per WAU** | UoR<br>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.<br><br>This metric shows the amount the trust spend on pay for medical staff per WAU across all areas of NHS clinical activity.<br><br>**National Median = £526** **2016/17**<br>Peer Median = £475<br><br>1. Mid-Cheshire £419<br>2. Gateshead £431<br>3. Bournemouth £443<br>4. North Tees £462<br>5. WHH £465<br>6. Chester £475<br>7. Sunderland £481<br>8. Wirral £485<br>9. Southport £510<br>10. N Lincolnshire £526<br><br>**Source: ESR, Trust consolidated annual accounts and reference cost.** |  <br>The Trust is below the national and peer median which is excellent news, however the large number of vacancies within this workforce will have contributed to this.<br><br>As we seek to recruit to these posts, we could therefore see costs per WAU increase. To mitigate this, we're currently completing a Medical Establishment Review, using the RCP Medical Safe Staffing Methods as our guide. | The key actions relate to the Medical Establishment Review.<br>> Agree the baseline Medical Establishment by Ward.<br>> Complete a time and motion study to understand activity.<br>> Analyse the established medical model and the proposed effective establishment, within the context of RCP Safe Medical Staffing Guide.<br>> Identify the gaps within the Medical Workforce based on the analysis, developing innovative solutions to fill the gaps. | |

Warrington and Halton Hospitals NHS
NHS Foundation Trust

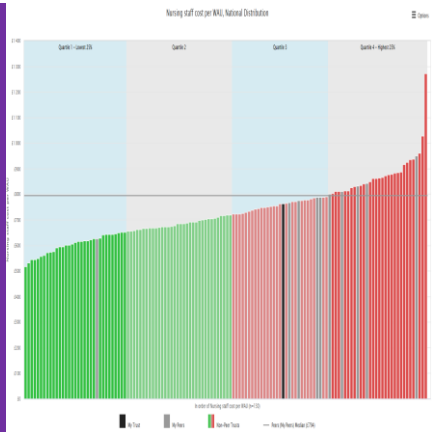
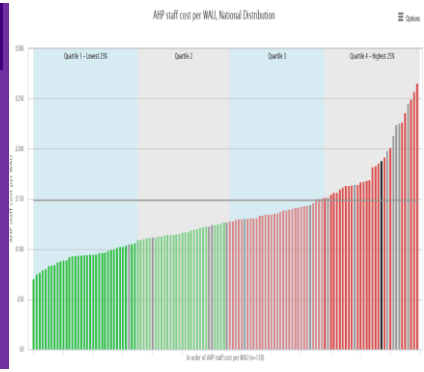
**Key**

- 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 2 2018/19

| | Progress/Performance | | | Actions to Improve Position/Actions for Next Quarter | Assurance | Status |
|---|---|---|---|---|---|---|
| **Nurses Cost Per WAU** | UoR<br>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 = £718**<br>Peer Median = £794<br>1. Bournemouth £627<br>2. WHH £764<br>3. Sunderland £767<br>4. Chester £775<br>5. Gateshead £787<br>6. N Lincolnshire £788 | **2016/17**<br>7. STHK £809<br>8. Wirral £811<br>9. Mid-Cheshire £832<br>10. North Tees £842<br>11. Southport £951<br>**Source: ESR, Trust consolidated annual accounts and reference cost.** |  | The Trust is below the peer median for our Nursing Costs per WAU which is positive, however again the large number of vacancies will have contributed to this.<br>The Trust seeks to reduce reliance on temporary staffing by offering alternative retention and recruitment solutions with the expansion of the Band 6 nursing workforce, advanced practice and specialist interest roles. | The key actions are:<br>> Working alongside the WHH Recruitment and Retention group, develop retention strategies<br>> Continue the successful Staff Nurse recruitment open days<br>> Improve the promotion of the Band 6 nursing roles, as both a retention and attraction tool. | |
| **AHP Cost per WAU (community adjusted)** | UoR<br>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 = £127**<br>Peer Median = £138<br>1. Bournemouth £111<br>2. STHK £112<br>3. Wirral £124<br>4. Chester £127<br>5. Mid-Cheshire £131<br>6. Gateshead £145 | **2016/17**<br>7. Sunderland £146<br>8. N Lincolnshire £163<br>9. WHH £168<br>10. Southport £224<br>11. North Tees £236<br>**Source: ESR, Trust consolidated annual accounts and reference cost.** |  | The AHP data is misleading and NHSI recommend validating the figures with local data.<br>WHH employ a number of AHPs that do not contribute to the clinical care of WHH patients and therefore AHP costs per WAU will be distorted.<br>The Trust is reviewing possible solutions to increase it's AHP workforce to support the Nursing vacancies. | The key actions are:<br>> Validate the data with local intelligence, producing and accurate cost per WAU.<br>> Continue to support Workforce Redesign projects to offer alternative solutions where appropriate.<br>> Mirror the Nursing recruitment campaigns and attend University job fairs to fill vacancies and reduce vacancy gaps. | |

Warrington and Halton Hospitals NHS
NHS Foundation Trust

**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 2 2018/19

| | Progress/Performance | Actions to Improve Position/Actions for Next Quarter | Assurance | Status |
|---|---|---|---|---|
| | **Recommendation 2 -** NHS Improvement should develop and implement measures for analysing staff deployment during 2016, including metrics such as Care Hours Per Patient Day (CHPPD) and consultant job planning analysis, so that the right teams are in the right place at the right time collaborating to deliver high quality, efficient patient care.<br><br>**Lead Director(s):** Medical Director & Chief Nurse | | | |
| **Care hours per patient** | • The Trust continues to systematically collect and submit Care Hours per Patient Day (CHPPD) data since the national changes in April 2016.<br>• The data is included in the monthly safe staffing and assurance report presented by the Chief Nurse at the Trust Board. | • Care Hours are reviewed each month as part of the Integrated Performance Report (IPR).<br>• 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.<br>• The corporate nursing team has taken over management of the e-roster team.<br>• The E-Rostering team is collocated with the operational management team in a centralised location.<br>• Capacity and demand meetings are held after the bed meetings and the staffing template updated in real time.<br>• The interface between e-roster and NHS(P) is now in place and temporary staff must now be booked via e-roster.<br>• Safe Care acuity is now embedded and the information is used for 6 monthly safe staffing review.<br>• 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.<br>• 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

**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 2 2018/19

| | 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.<br>• The deadline for completion of job plans (both Consultants & SAS doctors) as at 1st April 2017 is long overdue but continues to progress and as at 30th September 2018 the completion rate for the annual round is 93.3% (i.e. 167 of 179 individuals in post on 1st April 2017). Any Job plan plans still outstanding will be subject to mediation.<br>• 2019/20 Job planning round is in the process of being launched. Of 204 clinicians (both Consultant & SAS doctors) 160 job plans have been released for review as at 30th September 2018.<br>• The Consultant Job planning policy has been reviewed and a revised policy was agreed for implementation on 19th June 2018.<br>Terminology within Allocate has been streamlined for easier input.<br>Proposal for reducing sign off levels from 3 to 2 has been accepted.<br>• The project involving Programmed Activity (PA) corporate budgets for Medical Leadership, Education & Training, Quality & Governance and Appraisal & Revalidation has been completed. The Trust is in the process of providing an SOP to detail the revised process for the financial management of PAs. | • Job planning progress will continue to be monitored on a weekly basis.<br>• Job planning compliance is scrutinised at a fortnightly HR meeting when data is presented to the Head of Medical Staffing & Education.<br>• Mediation meetings will be convened to ensure all residual 2017/18 job plans reach conclusion.<br>• Consistency panels are to take place over a planned 3 week period rather than on an ad hoc basis. | Operational Peoples Committee | Ongoing development and daily monitoring |

**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 2 2018/19

| | 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.<br>• The HPTP was completed in May 2017. | • Model hospital metrics are monitored at the Trust's Medicines Governance Committee.<br>• A business case has been prepared to enhance ward service on a Sunday which will improve medicines reconciliation data, this will be reviewed by the Executive Team during Q3. | 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 – outline business case was approved by the Trust board in October 2017, NHS Digital approved the business case in principle in November 2017.<br>• The ePMA rollout plan was signed off by the Digital Operational Group and the IM&T Committee in Q1.<br>• Preparatory work and testing has identified several issues for which solutions have been identified by the system supplier.<br>• The ePMA pilot commenced on CDU on 5th March 2018. Positive feedback from staff/system users has been received. 2nd ePMA pilot at Halton UCC – the pilot was a success and operation of the system has continued post pilot.<br>• ePMA was upgraded to version 2.14 in April 2018 and included several fixes and developments.<br>• The 2nd pilot on B1 in Halton commenced in July. An evaluation of the risks has been undertaken post pilot and it has been agreed by the project team to continue rollout once the developments have been implemented in the system.<br>• A "market place" event took place for staff to evaluation the potential equipment that will be used on the wards and in pharmacy as part of the ePMA rollout. Recommendation are to be reported to the IM&T Committee. | • The Trust is working with the supplier on further developments to ensure flow between A&E and non-elective wards is robust. Lorenzo is due to be upgraded to version 2.16 in September and v2.17 in 2019. When v2.17 is available the required system improvements will be in place to enable to Trust to implement ePMA across the emergency admissions pathways.<br>• Further developments by the system supplier are required before further planned roll out to B4 and the CMTC, it is anticipated this stage of the implementation will be complete by the end of Q3. | Trust Board/IM&T Committee | Project expected completion – March 2020 |

Warrington and Halton Hospitals NHS
NHS Foundation Trust

**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 2 2018/19

| | Progress/Performance | Actions to Improve Position/Actions for Next Quarter | Assurance | Status |
|---|---|---|---|---|
| **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.<br>• PHE SACT data has been reviewed, based on this the Trust is achieving current data quality targets.<br>• A Blueteq drop in presentation day to be 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 – commencing 1st April 2018.<br>• The Trust met with CCG commissioners to agree an implementation plan for Blueteq from 1st April 2018. Technical issues were addressed as well as issues with the structure of the forms.<br>• Q1 2018/19 – Blueteq was implemented for endocrinology drugs. | • The Trust continues to monitor the contents of the Schedule 6 schema reports to address any data quality issues.<br>• Robust processes are to be developed and implemented with finance colleagues to ensure data is shared and updated on a monthly basis to keep on top of data quality issues.<br>• Further work with the Information team to minimise the need for report modifications and manual data entry is required.<br>• Implementation of Blueteq has been paused due to technical issues with the system which the CSU are working to resolve. A new implementation plan is being developed in conjunction with the CCG. | Medicines Governance Committee | Ongoing Work Programme |
| **80% of trusts' pharmacist resource utilised for direct medicines optimisation activities, medicines governance and** | • The Trust is achieving the recommendation for pharmacists.<br>• The Trust is aiming to increase time that pharmacy assistants and technicians spend on ward / with inpatients.<br>• All Pharmacy technicians have now been upskilled to carry out medicines reconciliation with new starters being trained as they commence in post.<br>• The ward medicines management technician role has been reviewed with the Associate Directors of Nursing. | • The ongoing training program continues to upskill pharmacy technicians on medicines optimisation and administration.<br>• Three wards now have a pharmacy technician administering medicines to patients. A plan in place to increase this to in accordance with the nursing recruitment plans.<br>• A draft business case for a 7 day emergency admissions Pharmacy service has been developed and will be presented to the Executive Team during Q3. | Quality & Assurance Committee | Ongoing Monitoring |

Warrington and Halton Hospitals NHS
NHS Foundation Trust

**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 2 2018/19

| | Progress/Performance | Actions to Improve Position/Actions for Next Quarter | Assurance | Status |
|---|---|---|---|---|
| **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.<br>• Average number of deliveries to the Trust per day is 14 which is below the national median.<br>• 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 |

## 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.

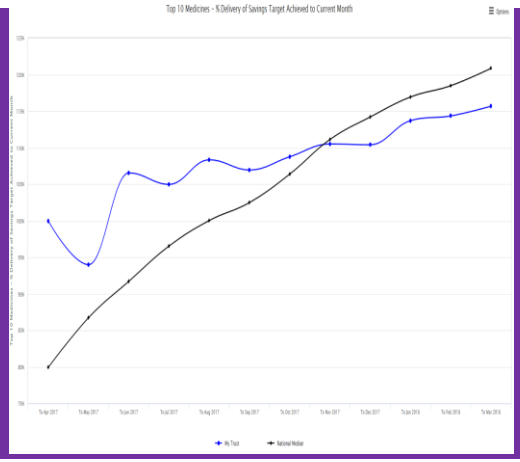
**National Median = 100%** **March 2018**

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%

**Source: Rx-Info Define© (processed by Model Hospital)**




1. Infiximab (biosimilar) – 98% savings (green)
2. Etanercept (biosimilar) – 83% savings (green)
3. Imatinib (biosimilar) - achieved
4. Rituximab (biosimilar) – 55% savings (red)
5. Valganciclovir – (generic)
6. Caspofungin (generic) - 90% savings
7. Linezolid (generic) - 204% savings
8. Prednisolone Soluble cost saving switches - 498% savings
9. Voriconazole – 87% savings
10. Trastuzumab – Not commissioned

1. Infiximab (biosimilar) – no potential to improve - 2 patients remain on branded medication, 1 has allergy to the biosimilar, the other refuses to switch.
2. Etanercept (biosimilar) – switchover in progress.
4. Rituximab (biosimilar) – no potential to improve - all patients in rheumatology on biosimilar, some haematology patients still on MabThera (brand) as no Truxima s/c for maintenance.
5,6,7&9. All patients on generics level of savings achieved reflect usage

Warrington and Halton Hospitals NHS
NHS Foundation Trust

**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 2 2018/19

**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 Transformation

| | Progress/Performance | Actions to Improve Position/Actions for Next Quarter | Assurance | Status |
|---|---|---|---|---|
| **Establishment of a shared pathology across the local economy** | • NHSI has proposed 29 Pathology Networks across the country, with Cheshire & Merseyside being "North 4". An STP wide Pathology Board has been created with a Clinical Director and Pathology Manager from each of the Trusts in the region. The first meeting was held on 21st November 2017.<br>• Three main working groups have been established (Blood Sciences, Microbiology & Cellular Pathology). The Pathology Manager for WHH is leading on the Cellular Pathology workgroup.<br>• STP Cheshire & Mersey Pathology Board met in Q1– the CEO of Aintree Hospital NHS Trust has been named Executive lead for the relaunched group. The need for project management has been identified. It was agreed there will be 3 hubs across the footprint with WHH/STHK working together as one hub. | • A Transition Management Team has been established (Wirral Chester, Aintree, Liverpool and Southport & Ormskirk)<br>• Branch work stream meeting established to look at equipment with a view to joint procurement opportunities and contract alignments.<br>• The Trust has been asked to carry out a SWOT analysis and scoring around different options for the future of pathology services across the STP.<br>• The next Transitional Management Team meeting is in November 2018.<br>• The STP is looking at options to carry out external analysis of Trust data to look at where each Trust can improve efficiency. | Strategic Development and Delivery Committee | Project – expected completion 2020 |
| **Development of pathology service specification** | • The original plan called for a new specification to be developed, however this has now been superseded by the STP wide pathology board. | N/A | N/A | N/A |
| **Introduce the Pathology Quality Assurance Dashboard** | • A Pathology Quality Assurance Dashboard (PQAD) has been developed.<br>• PQAD implemented in "shadow" form from November 2016. | • Monthly data indicators continue to be submitted.<br>• POAQ data is reviewed monthly at the KPI sub-committee.<br>• 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. | KPI Sub-Committee | Rolling Programme |

Warrington and Halton Hospitals NHS
NHS Foundation Trust

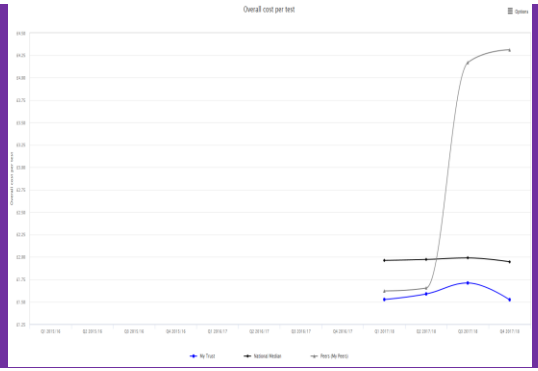
**Key**

- 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 2 2018/19

| | Progress/Performance | | Actions to Improve Position/Actions for Next Quarter | Assurance | Status |
|---|---|---|---|---|---|
| **KLOE 3 - Clinical Support Services** | | | | | |
| **Pathology - Cost Per Test** | UoR<br>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.<br>**National Median = £1.95** **Q4 2017/18**<br>Peer Median = £4.31<br>1. WHH £1.52<br>2. Gateshead £1.67<br>3. Bournemouth £6.96<br>**Source: NHSI Q Pathology Data Collection 17/18** |  | Model hospital data is only available for 3 of our selected peers, however we benchmark well against peer and national median and also against Trusts within our STP footprint. Overall the Trusts 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.<br>> SWOT analysis and scoring is being carried out against potential options.<br>> Workstream meeting looking at equipment costs and joint procurement opportunities are taking place.<br>> Analysis of data across the footprint to identify where efficiencies can be made. | |

Warrington and Halton Hospitals NHS
NHS Foundation Trust

**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 2 2018/19

**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):** Chief Operating Officer & Director of Transformation

| | Progress/Performance | Actions to Improve Position/Actions for Next Quarter | Assurance | Status |
|---|---|---|---|---|
| **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.<br>• 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.<br>• 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.<br>• A report of the Top 25 variances has been produced which compares the Trust nationally and against peers. Actions will be produced to address variance where it is possible to do so. This will be run and reviewed on a monthly basis. | • 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. | 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.<br>• 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. | • The PTP will be refreshed during Q3 using the new NHSI format which contains additional requirements.<br>• A briefing paper will be presented to the Trust board to highlight any changes to the plan.<br>• The Trust will continue to measure progress against the PTP. | Finance & Sustainability Committee | Project Implementation |
| **Adoption plan for Scan4Safety** | • The Trust adoption plan for Scan4Safety (formally the Global Standard: GS1) and pan European Public Procurement Online (PEPPOL) standards has been drafted.<br>• The Trust has recruited the Supply Chain Manager who will lead on the Scan4Safety project.<br>• The Deputy Head of Procurement presented Scan4Safety to the Finance & Sustainability Committee and Trust Operational Boards.<br>• A briefing paper was presented to the Trust Board, Trust Operational Board and Finance and Sustainability Committee during Q2.<br>• The Project Initiation Document has been drafted and project group terms of reference has been created. | • A project group is in the process of being established to review the requirements and will be instrumental in developing a feasibility study to be considered by the Trust Board. The Deputy Head of Procurement is meeting with individuals who will make up the project group to discuss objectives and roles and responsibilities. Part of the remit of the group will be to view various systems, explore options including pricing, and to undertake site visits. This will culminate in a Statement of Need, Feasibility Study and Outline Business Case. If this is approved the next step would be the procurement that would result in a full business case to be signed off. | Trust Board | Project Implementation |

Warrington and Halton Hospitals NHS
NHS Foundation Trust

**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 2 2018/19

| | Progress/Performance | Actions to Improve Position/Actions for Next Quarter | Assurance | Status |
|---|---|---|---|---|
| **NHS Standards of Procurement - to achieve level 1 by October 2016, develop improvement plan to meet target by** | • The Trust has achieved NHS Standards of Procurement Level 1 accreditation.<br>• The procurement team has identified and collated evidence in order to meet the criteria for Level 2 accreditation. | • The Trust to submit evidence to the Finance Skills Development Network (FSD) and will undertake pre-assessment during Q3, with the full assessment taking place thereafter. | Finance & Sustainability Committee | Project Implementation |
| **Benchmarking – Model Hospital Procurement** | • The Trust is currently ranked 50/136 Trusts – placing the Trust in the middle of upper quartile.<br>• Data has been submitted for the Model Hospital.<br>• 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.<br>• 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. | Finance & Sustainability Committee | Ongoing |
| **Key Procurement Metrics** | • Target of 80% addressable spend transaction volume on catalogue - Trust currently at 92% (Q2 2018/19).<br>• Target of 90% addressable spend transaction volume with a purchase order - Trust currently at 95% (Q2 2018/19).<br>• 90% addressable spend by value under contract - Trust currently at 75% (Q2 2018/19). | • Addressable Spend Transaction Volume<br>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.<br>• Addressable Spend under Contact<br>The procurement team has recently reviewed processes around the Contract Register with a view to improve addressable spend under contract. This review has highlighted a number of issues, which has resulted in the % being reduced. | Finance & Sustainability Committee | Ongoing Monitoring |

Warrington and Halton Hospitals NHS
NHS Foundation Trust

**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 2 2018/19

| | Progress/Performance | Actions to Improve Position/Actions for Next Quarter | Assurance | Status |
|---|---|---|---|---|
| **Procurement Process Efficiency and Price Performance Score Clinics** | **KLOE 4 - Corporate Services** | | | |

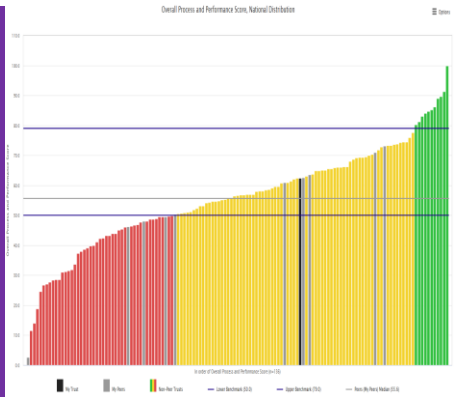
UoR

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 = 79.0** **Q4 2016/17**
**Peer Median = 55.6**

| | |
|---|---|
| 1. Chester 73.2 | 7. Mid-Cheshire 50.3 |
| 2. N Lincolnshire 71.0 | 8. North Tees 49.6 |
| 3. Bournemouth 63.6 | 9. Sunderland 48.0 |
| 4. Wirral 62.6 | 10. STHK 46.3 |
| 5. WHH 62.5 | 11. Gateshead 2.6 |
| 6. Southport 60.9 | |

**Source: Purchase Price Index and Benchmark (PPIB) tool**



The procurement team has undertaken a review of all procurement metrics and has produced a strategy to achieve the upper 25% for each metric. In addition, the monthly PPIB report is reviewed which specifically looks at the prices the Trust is paying for goods with a view to how these can be improved upon. The Trust is meeting with colleagues from Southport & Ormskirk and St Helens & Knowsley to review the model hospital reporting process to ensure each Trust is reporting the same data in the same format.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

**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 2 2018/19

**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

| | Progress/Performance | Actions to Improve Position/Actions for Next Quarter | Assurance | Status |
|---|---|---|---|---|
| **Strategic estates strategy inc cost reduction for 16/17 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.<br>• Phase 1 is being delivered and monitored through Strategic Development and Delivery Committee. The strategy has been refreshed to reflect local clinical strategy and STP estates strategy. | • The Trust continues to explore internal and partnership collaboration opportunities for relocation of back and clinical support functions.<br>• The new estates and facilities strategy which will align with the Trust's clinical strategy has commenced.<br>• A 12 month estates and facilities workforce plan is in development.<br>• The Associate Director of Estates and Facilities has been nominated as co-chair for the One Halton estates and facilities sub-group. | Estates and Facilities sub-Committee, TOB, Strategic Development and Delivery Committee | Ongoing management and monitoring of the plan |
| **Investing in energy saving schemes such as LED lighting, combined heat and power units, and smart energy management systems** | • The Trust has procured an energy infrastructure upgrade (CHP) which will save carbon, energy, money and future investment, upgrading their facilities using private sector capital repaid through guaranteed savings.<br>• Estates have accessed funding from Carbon Energy Fund (CEF) replacing 4000 halogen bulbs with more cost effective LED. Trust has invested in Combined Heat. | • A full survey has been completed across both sites to look at replacing the external lighting with LED lighting and this could be funded through the CEF scheme with shares of savings between the Trust and Veolia.<br>• The Trust has made a bid for funding to upgrade emergency lighting which is anticipated will reduce costs as the fittings are being replaced with LED.<br>• There is a survey being carried out around fans and controls within all our air handling units which should provide some additional energy efficiency and reduce our Carbon Footprint. | Estates and Facilities Sub-Committee | Complete |
| **Estates and facilities costs embedded into trusts' patient costing and service line** | • Estates and Facilities costs are incorporated into PLICS system. Quarterly service lines 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 |

Warrington and Halton Hospitals NHS
NHS Foundation Trust

**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 2 2018/19

| | Progress/Performance | Actions to Improve Position/Actions for Next Quarter | Assurance | Status |
|---|---|---|---|---|
| **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. Model Hospital data for 2016/17 has been published and benchmarks appear to be inaccurate due to discrepancies in data from other NHS trusts which has been confirmed by NHSI.<br>• Model hospital metrics are continually monitored and the Trust has recently established a work stream around Use of Resource Assessment as part of the Getting to Good, Moving to Outstanding programme. | • A PLACE assessment took place in June 2018; results have been developed into an action plan which is monitored by the estates and facilities operational board and the quality assurance committee.<br>• A business case outlining the resources required to meet the CQC recommendations and PLACE improvements has been prepared and will be presented to the executive team in Q3. | Estates and Facilities Sub-Committee/TOB/ Quality Assurance Committee | Ongoing Monitoring |
| **All trusts (where appropriate) have a plan to operate with a maximum of 35% of 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 for 2016/17 reports the Trust utilises 41% of its estate for non-clinical use and has 2.2% of empty space. Whilst efforts to minimise the use of trust accommodation for non-clinical purposes have been made it difficult given the complexities of the numerous corporate functions.<br>• The current estate strategy aims to address the under-utilised space 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 data available for 2017/18 demonstrates an improvement in the use of space for non-clinical activity down to 36%. | • The estates and facilities function is fully involved in the Halton Healthy New Towns and New Hospital for Warrington initiatives to ensure changes to estates centre around patient care. | Strategic Development and Delivery Committee | Ongoing Monitoring |

Warrington and Halton Hospitals NHS
NHS Foundation Trust

**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 2 2018/19

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

## KLOE 4 - Corporate Services

**Estates & Facilities Costs (£ per m2)**

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.

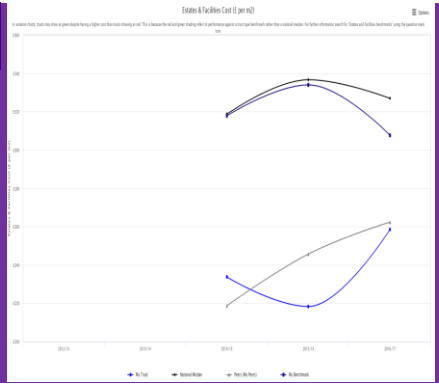
**National Median = £308** — **2016/17**

Peer Median = £262

1. North Tees £194
2. Wirral £199
3. Mid-Cheshire £212
4. Sunderland £238
5. Bournemouth £258
6. WHH £259
7. Chester £266
8. Gateshead £281
9. Southport £294
10. N Lincolnshire £320
11. STHK £397

Source: ERIC 2016-17 Total Estates and Facilities Running Costs

UoR



The Trust benchmarks well against peer and national median. 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 an adverse effect on overall estates and facilities costs. Estates and facilities costs are continually monitored. Where efficiencies can be made, proposals/business cases will be produced for consideration form the Trusts Executive Team.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

**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 2 2018/19

**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):** Chief Operating Officer and Director of Transformation

| | 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 8.2% of income based on planned income as of Q2 2018/19. It is unclear if Nursing & Governance should be included as a corporate service, this is being looked into. If we exclude this function, the Trust's costs would be 6.4% based on planned income.<br>• The Trust will collaborate with other organisations where appropriate to provide services in a more streamlined way maximizing opportunities to procure and work at scale, reduce waste and support the delivery of clinical services, facilitating change where required.<br>• A series of workshops were held during 2017 to discuss and explore ideas for collaboration and financial efficiency with corporate functions from each LDS organisation participating.<br>• Reports for each corporate function have been compiled using the latest NHSI Model Hospital data and distributed to corporate service leads for them to use as a start point for internal service reviews (see Corporate Services A&C Review section for more detail).<br>• Potential schemes of how rationalisation of services can happen have been developed and will be taken to the executive team for discussion.<br>• Schemes will also be developed as part of the work with commissioners at the collaborative and sustainability group.<br>• NHSI operational productivity team visited the Trust on 16th August 2018 to look at the | • This requirement will be taken forward internally by the Deputy Directors forum with each Deputy Director responsible for developing a plan.<br>• As a follow up to the NHSI productivity session, a specific corporate service session is arranged for 17th October 2018 which will focus on IM&T, Finance and HR. | Strategic Development and Delivery Committee | Rolling Programme |
| **Corporate CIP Targets** | • All corporate divisions have been assigned costs savings targets in 2017/18. The targets and the progress to date in identifying schemes to meet the targets are summarised. The cost savings being delivered either reduce costs or increase income, thereby improving their respective percentage cost figures.<br>• CIP targets for 2018/19 are to be set against specific programmes of work linked to the organisation's agreed portfolio of strategic projects. The main project impacting on corporate functions is the Corporate Services review. | • Corporate CIP Performance as at M6 end - £0.2m year to date against a target of £0.29m, the full year target is £1.1m. | Finance & Sustainability Committee | Rolling Programme |

Warrington and Halton Hospitals NHS
NHS Foundation Trust

**Key**

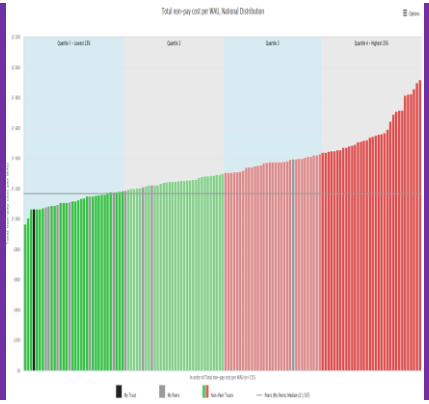
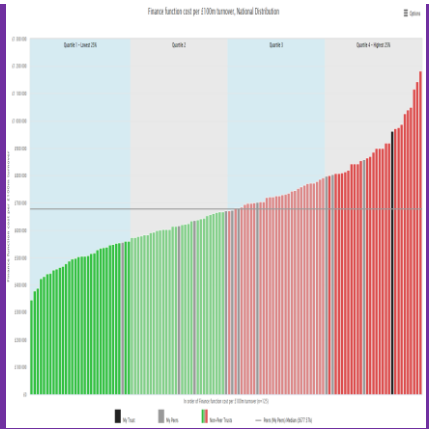
- Complete/Green on Model Hospital (against National median)
- On track for completion
- Progress off track - plans in place to get back on track/Amber on the Model Hospital
- Progress significantly off track/Red on Model Hospital
- Not started/Awaiting further information/New actions parameters to be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

UoR Use of Resource Assessment Indicator

**Appendix 2**

# Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 2 2018/19

## KLOE 4 - Corporate Services

| | Progress/Performance | | | Actions to Improve Position/Actions for Next Quarter | Assurance | Status |
|---|---|---|---|---|---|---|
| **Non Pay Costs per WAU** | 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.<br><br>This metric show the amount the trust spends on non-pay per WAU across all areas of NHS clinical activity. | **National Median = £1301**<br>Peer Median = £1167<br><br>1. WHH £1066<br>2. Chester £1079<br>3. Mid-Cheshire £1088<br>4. Wirral £1096<br>5. North Tees £1115<br>6. Bournemouth £1154<br><br>**Source: HSCIC - NHS Digital iView Stability Index** | **2016/17**<br><br>7. Southport £1181<br>8. STHK £1190<br>9. N Lincolnshire £1213<br>10. Gateshead £1224<br>11. Sunderland £1357 |  | WHH costs are lower than the national and peer group median. However ways of reducing costs whilst maintaining quality are continually reviewed. | |
| **Finance Costs per £100m Turnover** | UoR<br><br>Total finance cost divided by trust turnover multiplied by a £100m | **National Median = £671k**<br>Peer Median = £677k<br><br>1. Sunderland £556k<br>2. Bournemouth £617k<br>3. N Lincolnshire £637k<br>4. Chester £671k<br>5. Mid-Cheshire £673k<br>6. Wirral £682k<br><br>**Source: Trust consolidated annual accounts and NHSI improvement 16/17 data collection template.** | **2016/17**<br><br>7. STHK £702k<br>8. Gateshead £799k<br>9. North Tees £799k<br>10. Southport £858k<br>11. WHH £962k |  | For 2016/17 the Trust actual position £0.96m – the Trust is currently in the process of carrying out a review against the draft benchmarking report and model hospital data to understand opportunities for efficiencies. Benchmarking for 2017/18 shows Finance Costs/£100m turnover as £0.85m. | 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. The Trust has engaged with NHSI Corporate improvement team to identify opportunities and good practice, this will be taken forward by the Trust Deputy Directors group. |

Warrington and Halton Hospitals NHS
NHS Foundation Trust

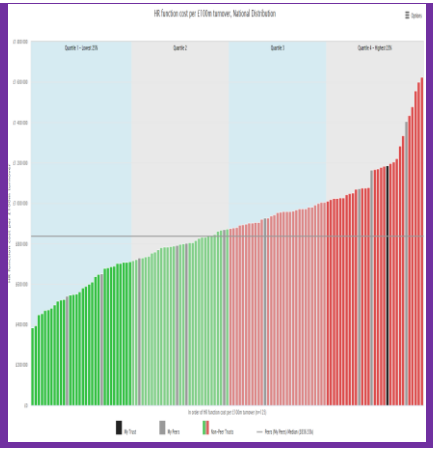
**Key**

- 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 2 2018/19

| | Progress/Performance | | | Actions to Improve Position/Actions for Next Quarter | Assurance | Status |
|---|---|---|---|---|---|---|
| **Human Resource Costs per £100m Turnover** | UoR<br>HR is made up of a number of sub compartments taken into consideration when considering total HR costs per £100m turnover. | **National Median = £874k**<br>**Peer Median = £837k**<br>1. Sunderland £542k<br>2. Wirral £650k<br>3. Gateshead £729k<br>4. STHK £792k<br>5. Bournemouth £802k<br>6. Chester £871k | **2016/17**<br>7. N Lincolnshire £926k<br>8. Mid-Cheshire £1.07m<br>9. North Tees £1.2m<br>10. WHH £1.2m<br>11. Southport £1.4m<br>**Source: Trust consolidated annual accounts and NHSI improvement 16/17 data collection template.** |  | Model hospital data is from 2016/17 data, the Trust is currently in the process of carrying out a review against the draft benchmarking report and model hospital data to understand opportunities for efficiencies. Benchmarking for 2017/18 shows HR Costs/£100m turnover as £1.19m | 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. The Trust has engaged with NHSI Corporate improvement team to identify opportunities and good practice, this will be taken forward by the Trust Deputy Directors group. | |

Warrington and Halton Hospitals NHS
NHS Foundation Trust

**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 2 2018/19

**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 Transformation

| | Progress/Performance | Actions to Improve Position/Actions for Next Quarter | Assurance | Status |
|---|---|---|---|---|
| **Variation in Theatres and Outpatients** | • Unwarranted variation within theatres and outpatients is being addressed through the theatres and outpatient work streams of the transformation programme.<br>• A new theatre scheduling process was launched in November 2017 and is designed to provide improved visibility and forward planning around utilising theatre and anaesthetic capacity.<br>• Shortfalls in anaesthetic capacity have proved to be a bottleneck in terms of ensuring efficient use of theatre capacity. A business case has recently been approved for additional capacity and work ongoing to ensure available capacity is utilised as effectively as possible.<br>• Theatre Listing' meetings immediately follow '6-4-2' scheduling meetings and examine the patients on each individual list for the following week.<br>• Theatre '6-4-2' scheduling meetings introduced in October 2017 and are now fully established entering the financial year 2018/19. Theatre sessions are now 'locked down' at two weeks.<br>• Capacity and Demand work for Outpatients commenced in December 2017 with the aim of understanding the exact clinic requirements for each specialty to deliver their activity plans and then ensuring we have robust monitoring systems in place to track delivery. | • From 1st October 2018, the specialties have been re-aligned against the CBUs. As part of this, Theatres and Anaesthetics now come under the same CBU (Digestive Diseases), this is expected to improve pathways and coordination of activity.<br>• A programme of work around improving Theatre Utilisation and Late Starts will commence.<br>• A new programme linked to the Trust's Listening in Action (LIA) initiative will focus on the communication between Theatres and Wards.<br>• The Associate Director of Operations and Performance will establish a new project around Pre-Ops. | Strategic Development and Delivery Committee | Ongoing |

Warrington and Halton Hospitals NHS
NHS Foundation Trust

**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 2 2018/19

| | Progress/Performance | Actions to Improve Position/Actions for Next Quarter | Assurance | Status |
|---|---|---|---|---|
| **Variation in Theatres and Outpatients** | Analysis of Outpatient Capacity and Demand for the following specialties is now complete:<br>Haematology, Colorectal, Breast, Orthotics, General Surgery, Gastroenterology, Upper GI, Anaesthetics, Cardiology, Respiratory, Pain Management, Vascular, Hepatology.<br>• A new list planning process has been 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.<br>• The 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.<br>• The new rota master system has been implemented with the aim of improving anaesthetic scheduling. This has assisted with future forecasting.<br>• The KPI Sub-Committee continue to monitor Theatre utilisation, Late starts and Cancellations.<br>• A Theatre Transformation Board to be chaired by the CBU Manager for Digestive Diseases has been established.<br>• The Transformation Team have developed a capacity and demand summary which CBU managers will monitor. | | | |

Warrington and Halton Hospitals NHS
NHS Foundation Trust

**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 2 2018/19

| | Progress/Performance | Actions to Improve Position/Actions for Next Quarter | Assurance | Status |
|---|---|---|---|---|
| **Emergency Care Improvement Programme** | • An Improvement Programme around improvements in patient flow has agreed a number of key work streams across mid Mersey following a system review, these work streams feed into the Mid-Mersey A&E delivery board.<br>• The Trust has its own internal flow board which focuses on 9 key work streams to support improvements in flow.<br>• Red 2 Green patient data is now collected on all wards through daily board rounds and a process to share the data around patient delays with partner organisations is now in place with partner organisations expected to respond with actions in place to reduce the delays.<br>• Frailty work stream – strategy document ratified by the Trust Board sub-committees in November 2017 and Frailty Assessment Unit completed. Frailty Assessment Unit opened in May as a pilot 2 days per week, early indications has shown a positive impact on patient experience and flow.<br>• Significant work has been progressed via the Trust's Impact 5 event. Progress against the identified objectives will be monitored through the Trust's internal patient flow board.<br>• Refreshed Patient Flow Steering Group will now move to govern a more strategic programme of work.<br>• The FAU pilot was completed, with further funding to extend opening hours from 2 – 4 days per week. 86% of patients were discharged back to their own home during the pilot. The Trust will work with commissioners to continually monitor outcomes.<br>• The Emergency Care Improvement Programme visited the Trust in May and June. There was an NWAS challenge for all conveyances and a walk through of the urgent/emergency care system. Positive informal feedback was received. | • It is anticipated that the opening hours of the FAU will be extended to 5 days per week during Q3 subject to recruitment.<br>• The Trust is currently developing a new discharge lounge which will be opened during Q3.<br>• Estate has been identified for the Integrated Discharge Team, with a business case submitted to the BCF for enhanced support. This will be progressed during Q3.<br>• The Trust will continue to work with One Halton and Warrington Together to ensure proposals are developed consistently with an integrated approach.<br>• Outcomes from the Venn Consulting system wide capacity and demand review are expected during Q3. The Trust will work with partners to ensure there is capacity in the right place. | A&E Delivery Board<br><br>Flow Board | Ongoing |
| **Specialty level reviews across local delivery system** | • The Trust is participating in a series of specialty level reviews across the Local Delivery System (LDS).<br>• Agree and implement plans to reduce variation within pathways across the LDS.<br>• Initial specialty reviews have now been held in urology, trauma & orthopaedics and ophthalmology.<br>• A programme of workshops across priority specialties has been agreed, led by the LDS Director of Service Redesign.<br>• A new clinical strategy is being developed and will be launched early in 2018/19. This will support delivery of the Trusts objectives by the clinical teams. | • A new clinical model around the Stroke Pathway has been agreed, the Trust with system partners are currently working to agree the financial model.<br>• GIRFT reviews continue to take place within a number of specialities across the Cheshire & Mersey footprint.<br>• The Trust is working with Cheshire and Mersey Cancer Alliance to develop optimal pathways beginning with Colorectal, the Trust is supported by Aqua.<br>• The Trust has signed up with NHSI to carry out a length of stay evaluation programme.<br>• Work to re-invigorate the DTOC process to include daily validation with weekly reviews and a weekly corporate flow meeting. | Strategic Development and Delivery Committee | Ongoing |

Warrington and Halton Hospitals NHS
NHS Foundation Trust

**Key**

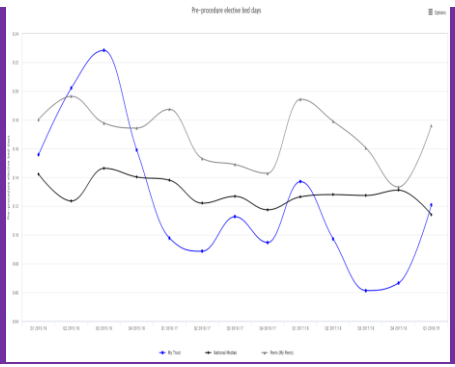
- Complete/Green on Model Hospital (against National median)
- On track for completion
- Progress off track - plans in place to get back on track/Amber on the Model Hospital
- Progress significantly off track/Red on Model Hospital
- Not started/Awaiting further information/New actions parameters to be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

UoR Use of Resource Assessment Indicator

**Appendix 2**

# Lord Carter Progress & Use of Resources KLOE Indicators - Quarter 2 2018/19

## KLOE 1 - Clinical

| | Progress/Performance | | | | Actions to Improve Position/Actions for Next Quarter | Assurance | Status |
|---|---|---|---|---|---|---|---|
| **Pre Procedure Elective Bed Days** | UoR<br>The number of bed days between the elective admission date and the date that the procedure taken place. | **National Median = 0.11**<br>Peer Median = 0.18<br>1. North Tees 0.02<br>2. Bournemouth 0.04<br>3. Mid-Cheshire 0.06<br>4. WHH 0.11<br>5. Sunderland 0.15<br>6. Southport 0.16<br>**Source: Hospital Episode Statistics** | **Q1 2018/19**<br>7. STHK 0.2<br>8. Chester 0.27<br>9. Gateshead 0.3<br>10. Wirral 0.47<br>11. N Lincolnshire 0.53 |  | There has been improvement in pre-procedure non elective bed days. The Trust is below the national and peer medians. However the margins between the different Trusts are fairly minor. | We will continually monitor this metric to ensure we remain below the national median. Where further improvements are identified, action plans will be implemented to address. | |
| **Pre Procedure Non Elective Bed Days** | UoR<br>The number of bed days between an emergency admission date and the date the procedure taken place. | **National Median = 0.69**<br>Peer Median = 0.67<br>1. Bournemouth 0.26<br>2. North Tees 0.52<br>3. WHH 0.56<br>4. Mid Cheshire 0.64<br>5. Sunderland 0.67<br>6. Wirral 0.67<br>**Source: Hospital Episode Statistics** | **Q1 2018/19**<br>7. Chester 0.67<br>8. STHK 0.85<br>9. Gateshead 0.93<br>10. Southport 1.06<br>11. N Lincolnshire 1.15 |  | The Trust benchmarks below the national and peer median for this metric, which is an improvement from Q4 2017/18. | We will continually monitor this metric to ensure we remain below the national median. Where further improvements are identified, action plans will be implemented to address. | |

Warrington and Halton Hospitals NHS
NHS Foundation Trust

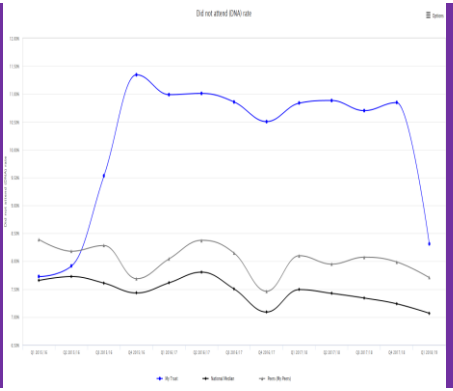
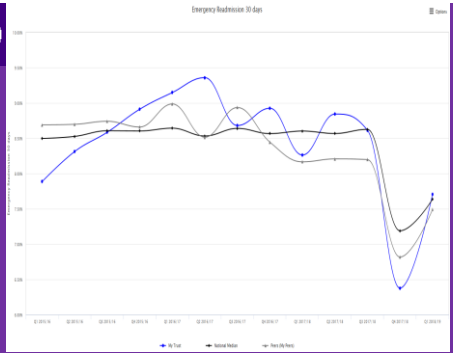
**Key**

- 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 2 2018/19

| | Progress/Performance | | | Actions to Improve Position/Actions for Next Quarter | Assurance | Status |
|---|---|---|---|---|---|---|
| **Did Not Attend (DNA) Rate** | UoR<br>Rate of patients not attending their outpatient appointment. | **National Median = 7.07%**<br>Peer Median = 7.71%<br>1. Chester 5.76%<br>2. Mid-Cheshire 5.84%<br>3. Bournemouth 6.42%<br>4. Southport 7.35%<br>5. N Lincolnshire 7.5%<br>6. North Tees 7.91%<br>**Source: Hospital Episode Statistics** | **Q1 2018/19**<br>7. Gateshead 8.25%<br>8. WHH 8.31%<br>9. Wirral 8.42%<br>10. Sunderland 8.84%<br>11. STHK 12.6% |  | There has been a significant improvement between Q4 2017/18 and Q1 2018/19 and this is mainly due to the introduction of the text message reminder service. Whist there is still action to be taken, this represents a positive step forward. | The Trust will continue to roll out and develop the text messaging reminder services to the remaining appropriate services. Further education for patients via the Trust's Communications team in conjunction with the CCG should also improve the situation. |
| **Emergency Readmission (30 Days)** | 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 = 7.64%**<br>Peer Median = 7.49%<br>1. N Lincolnshire 6.02%<br>2. Chester 6.02%<br>3. Bournemouth 6.81%<br>4. Wirral 7.21%<br>5. Sunderland 7.45%<br>6. Southport 7.53%<br>**Source: Hospital Episode Statistics** | **Q1 2018/19** UoR<br>7. Gateshead 7.65%<br>8. WHH 7.71%<br>9. Mid Cheshire 8.99%<br>10. STHK 9.07%<br>11. North Tees 9.36% |  | The Trust is slightly above the national and peer medians for this metric. | 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

**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 2 2018/19

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

**Lead Director:** Director of Information Management & Technology

| | 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.<br>• The Trust continues to optimise Lorenzo functionality to ensure that it meets with developing business and clinical needs. This project is monitored by the IM&T Project Board.<br>• During Q4 2017/18 the Trust has tested and implemented 2 upgrades of Lorenzo.<br>• The Trust has introduced paperless referrals in Q4 and will optimise and review benefits during Q1 2018/19.<br>• Updates to Outpatient Letters took place during Q4.<br>• The Trust has been selected as a Digital Exemplar for work relating to the use of the Electronic Patient Record and will review next steps during Q1 2018/19.<br>• Business case for "patient knows best" the clinical portal for Warrington, was signed off during Q1, it is anticipated this will be rolled out in 2019. | • Work has commenced of the GP viewer which will give Trust clinicians access to Warrington GP records via Lorenzo. Following tests this is now anticipated this functionality will be available during Q4 2018/19.<br>• The Trust's business case has been submitted to NHS Digital as part of the Digital Exemplar programme. The business case has been approved. Implementation will commence in October. It is anticipated the PID will be complete November 2018.<br>• The Trust has tested the GP viewer for Warrington GP records in Lorenzo. The software is not what the Trust expected in terms of providing all of the '10 tabs' that are available via the Medical Interoperability Gateway (MIG). The Trust is looking at an alternative solution testing of this solution will take place during Q3 2018/19. Sharing agreements will be signed off for during Q4 2018/19. | IM&T Sub-Committee/ Trust Board | Project Implementation – expected completion – Plan up to 2020 on track. |
| **Electronic Document Management** | • A business case for an Electronic Document Management System has been developed. There has been some minor delays to the development of the full business case, however it is anticipated that the full business case will be approved during Q1 2018/19.<br>• Due to the development of the LDE business case and the feedback received from clinicians and medical records staff a review of actual requirements now Lorenzo has been live for 3 years is to be undertaken to ensure the investment required is for the right solution<br>• The CCIO has supported this work and we are renaming the project paperless 2020 strategy. | • The Trust will tender for EDMS system; once this has been completed a full implementation plan will be developed with the successful bidder.<br>• The CIO for Nursing and AHP has been looking at components of EDMS that are actually required to enable paperless by 2020<br>• This will lead to a revised business case to consider all elements outstanding to achieve paperless by 2020. | IM&T Sub-Committee | Project Implementation – Initiation |
| **ePMA** | • Electronic prescribing and medicines administration (EPMA) Business case and PID signed off by Trust Board and NHS Digital – outline business case was approved by the Trust board in October 2017, NHS Digital approved the business case in principle in November 2017.<br>• ePMA pilot commenced on CDU in March with a further pilot in Halton Urgent Care centre commencing at the end of March. Learning from all pilots will be used in the development of new functionality and develop fixes to any issues identified. | • Further testing and build phases will be required throughout 2018/19 with further rollouts commencing in March 2019.<br>• Key issue identified during pilot testing will be fixed in 2.15 release. Due to software issues 2.15 is now expected during Q3 2018/19 | IM&T Sub-Committee | Project Implementation |

Warrington and Halton Hospitals NHS
NHS Foundation Trust

**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 2 2018/19

| | Progress/Performance | Actions to Improve Position/Actions for Next Quarter | Assurance | Status |
|---|---|---|---|---|
| **Collaborative working across the healthcare economy** | **Recommendation 10 -** DH, NHS England and NHS Improvement, working with local government representatives, to provide a strategy for trusts to ensure that patient care is focussed equally upon their recovery and how they can leave acute hospitals beds, or transfer to a suitable step down facility as soon as their clinical needs allow so they are cared for in the appropriate setting for themselves, their families and their carers.<br>**Lead Director:** Not Applicable | | | |
| | Further information from national bodies is awaited. | | | |
| | **Recommendation 11 -** Trust boards to work with NHS Improvement and NHS England to identify where there are quality and efficiency opportunities for better collaboration and coordination of their clinical services across their local health economies, so that they can better meet the clinical needs of the local community.<br>**Lead Director:** Not Applicable | | | |
| | • The Trust is working in collaboration with external providers and commissioners within the STP and LDS to seek to address clinical and financial constraints through service, productivity and rationalisation opportunities.<br>• Pathway Integration and efficiency through the local health economy will be digitally enabled through the use of Care Record, risk stratification and patients accessing personal health records. An example of this is the work being carried out by the STP around pathology. | | | |
| **Development of a Model Hospital** | **Recommendation 12 - N**HS Improvement should develop the Model Hospital and the underlying metrics, to identify what good looks like, so that there is one source of data, benchmarks and good practice.<br>**Lead Director:** Not Applicable | | | |
| | • 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.<br>• The key metrics include Clinical Service Lines (Emergency, General Surgery, Urology and Paediatrics) Operational (Theatres, Procurement, Pathology, Estates) and People (Nursing, AHP, Medical, Workforce Analysis).<br>https://model.nhs.uk | Ongoing Monitoring | |

Warrington and Halton Hospitals NHS
NHS Foundation Trust

**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 2 2018/19

| | 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.<br>• 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 | | | |
| | Further information from national bodies is awaited. | | | |

Warrington and Halton Hospitals NHS
NHS Foundation Trust

**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 2 2018/19

| | Progress/Performance | | Actions to Improve Position/Actions for Next Quarter | Assurance | Status |
|---|---|---|---|---|---|
| **KLOE 5 - Finance** | | | | | |
| **Capital Services Capacity** | UoR<br>The degree to which the provider's generated income covers its financial obligations<br>**Source: Provider returns** | **WHH Model = -4.82 (July 2018)**<br>**WHH Current = -4.62 (Sept 2018)** |  | The operating performance of the Trust results in an operating deficit so the Trust is focussing on improving its operating performance through income generation and cost reduction whilst maintaining the quality of healthcare. | |
| **Liquidity (Days)** | UoR<br>Days of operating costs held in cash or cash-equivalent forms, including wholly committed lines of credit available for drawdown.<br>**Source: Provider returns** | **WHH Model = -29.66 days (July 2018)**<br>**WHH Current = -31 (Sept 2018)** |  | As of 30th September 2018, the Trust has 31 days of cash/cash equivalent to meet operational obligations. This does not include the use of loans, as of 30th September, the Trust has drawn down loans of £51.9m. | |

Warrington and Halton Hospitals NHS
NHS Foundation Trust

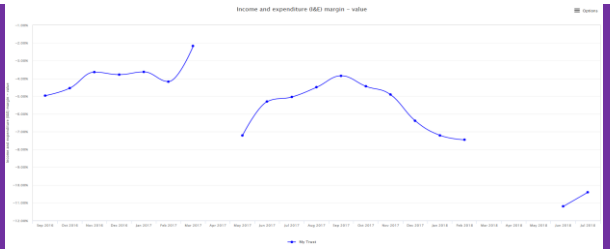
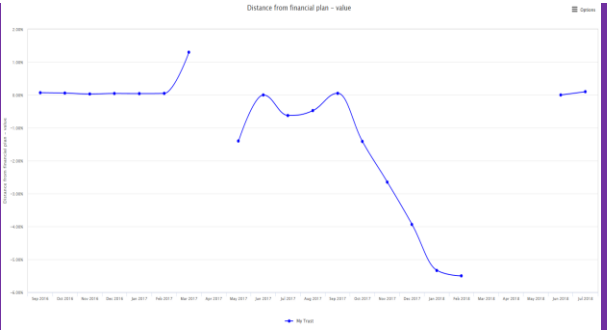
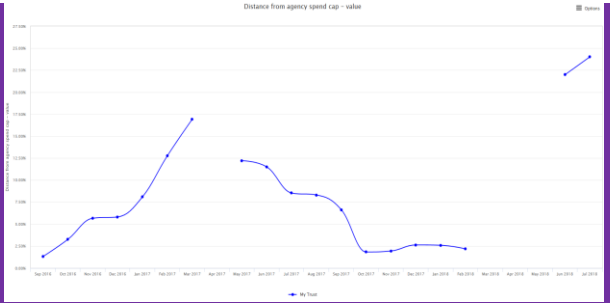
**Key**

- 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 2 2018/19

| | Progress/Performance | | Actions to Improve Position/Actions for Next Quarter | Assurance | Status |
|---|---|---|---|---|---|
| **Income & Expenditure Margin** | UoR<br>The income and expenditure surplus or deficit, divided by total revenue. | **WHH Model = -10.40% (July 2018)**<br>**WHH Current = 10.79% (Sept 2018)**<br>**Source: Provider returns** |  | The Trust has a deficit plan of £17.0m. | |
| **Distance from Financial Plan** | UoR<br>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 = 0.1% (July 2018)**<br>**WHH Current = 0.3% (Sept 2018)**<br>**Source: Provider returns** |  | As of 30th September 2018, performance is at £13m deficit which is on plan. | |
| **Agency Spend - Cap Value** | UoR<br>The extent to which the trust is meeting the target for the amount spend on agency workers for the financial year. | **WHH Model = 24.2% (July 2018)**<br>**WHH Current = 23.5% (Sept 2018)**<br>**Source: Provider returns** |  | The Trust has exceeded the agency ceiling due to the continued reliance of agency staff to cover gaps from vacancies and meet demand but is continuing to increase staffing levels through recruitment and utilising new staffing models. The Trust is working to convert agency staff to bank staff and recruit into substantive posts. | |

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

**BOARD OF DIRECTORS**

| | |
|---|---|
| **AGENDA REFERENCE:** | **BM/18/11/117** |
| **SUBJECT:** | **Emergency Preparedness, Resilience and Response (EPRR) Assurance 2018/19** |
| **DATE OF MEETING:** | 28th November 2018 |
| **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.<br><br>NHS England 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 2018/19 EPRR assurance process, the Trust has undertaken the annual self-assessment against the NHS England EPRR core standards. Of the 64 core standards, the Trust is fully compliant with 54, and partially compliant with 10 standards but with evidence of progress towards full compliance.<br><br>This gives an overall compliance level of 'Partial' compliance. An improvement plan has been produced to address the 10 partially compliant standards.<br><br>The Trust is required to report the outcome of the 2018/19 EPRR Audit to Board. |

| | | |
|---|---|---|
| **RECOMMENDATION:** | The Board is asked to note the 'Partial' compliance rating, and the Improvement Plan. | |
| **PREVIOUSLY CONSIDERED BY:** | **Committee** | Event Planning Group |
| | **Agenda Ref.** | |
| | **Date of meeting** | |
| | **Summary of Outcome** | Approved |
| **FREEDOM OF INFORMATION STATUS (FOIA):** | Release Document in Full | |
| **FOIA EXEMPTIONS APPLIED:** ***(if relevant)*** | None | |

**BOARD OF DIRECTORS**

| SUBJECT | Emergency Preparedness, Resilience and Response (EPRR) Assurance 2018/19 | AGENDA REF: | |
|---|---|---|---|

## 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 range of scenarios is extremely wide and includes mass casualty incidents, infectious disease outbreaks, severe weather, criminal/terrorist events, loss of power/utilities and staff absence.

The NHS England EPRR Core Standards are the minimum standards which NHS organisations and providers of NHS funded care must meet.

## 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 (appendix 1). 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, Core Standards ratings and improvement plan to the Clinical Commissioning Group and the NHS England EPRR Area Team. The NHS England Area Team will further assess the submission and supporting evidence, and submit a Regional assessment through to the NHS England National Board.

**Warrington and Halton Hospital Statement of Compliance**

Following the self-assessment and in line with the definitions of compliance (appendix 2), Warrington and Halton Hospital has declared itself as demonstrating a **Partial** compliance against the EPRR Core Standards.

The Trust was rated against 64 applicable standards, and reported full compliance with 54 standards. 10 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 | 14 | 0 | 0 |
| Command and control | 2 | 2 | 0 | 0 |
| Training and exercising | 3 | 3 | 0 | 0 |
| Response | 7 | 6 | 1 | 0 |
| Warning and informing | 3 | 3 | 0 | 0 |
| Cooperation | 4 | 4 | 0 | 0 |
| Business Continuity | 9 | 7 | 2 | 0 |
| CBRN | 14 | 7 | 7 | 0 |
| Total | 64 | 54 | 10 | 0 |

The Trust compliance level has dropped from last year's level of 'substantial'. However, the number and descriptions of the Standards are different this year so direct comparison is not wholly possible.

The Trust EPRR Manager has recently returned from a period of 12 month extended leave and is committed to ensuring that by the end of this calendar year the Trust, if re-assessed, would achieve a 'substantial' compliance.

## 3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

For the standards that were rated as partially compliant an improvement plan has been compiled (appendix 3) and progress is being 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.

The Core Standards that have now been achieved are:-

- ✓ CBRN 61 – The organisation has the expected number of PRPS available for immediate deployment.
- ✓ CBRN 64 – There are effective disposable arrangements in place for PPE no longer required, as indicated by manufacturer/supplier guidance.

The Trust requires a further three standards to be achieved to gain a substantial compliance. It is expected that three out of the following standards will be achieved by the end of December 18:-

- **Response 33 – The organisation has 24 hour access to a trained Loggist.**
  PA's/Administrators will attend in house training scheduled for the 6th December 2018.

- **Business Continuity 51 – The organisation has established business continuity plans.**
  All CBU's have reported they are underway with developing or refreshing their BCP's and have provided assurance they will be complete by the end of December. The majority of corporate BCP's have already been updated.

- **Business Continuity 55 – The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers.**
  The Supplies team are currently reviewing their BCP's with assurance this will be complete by the end of November.

- **CBRN 68 – Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient.**
  ED Reception action card has been updated and circulated to reception staff.
  Awareness sessions will be scheduled in December for triage teams.

The remaining standards are linked to CBRN training. NWAS have failed to provide the necessary and scheduled CBRN train the trainer courses, the last were cancelled at short notice. It has been recognised regionally by the NHS England Cheshire and Merseyside team as being an area of concern. NHS England and NWAS are working together to ensure full CBRN and PRPS training is delivered early in the new year.

## 4. IMPACT ON QPS?

The risk of failure to provide adequate decontamination capability has been added onto the Trust risk register.

## 5. MEASUREMENTS/EVALUATIONS

The statement of compliance is detailed in appendix 2.

## 6. TRAJECTORIES/OBJECTIVES AGREED

The Trust EPRR Improvement Plan is detailed in appendix 3.

## 7. MONITORING/REPORTING ROUTES

Progress on the Trust EPRR Improvement Plan will be monitored via the monthly Event Planning Group.

## 8. TIMELINES

It is expected that the Trust will achieve a 'Substantial' compliance by the end of December 2018.

## 9. ASSURANCE COMMITTEE

Trust Event Planning Group
Local Health Resilience Partnership

## 10. RECOMMENDATIONS

The Trust has completed a self-assessment against the NHS England EPRR Core Standards and has been rated a 'Partial' compliance level. An action plan has been produced to address the standards that did not achieve full compliance, with an expectation that the Trust will be able to show 'Substantial' compliance by the end of December 2018. Progress will be reported via the monthly Event Planning Group.

The Board is asked to note the contents of this paper and be assured that the Trust is working towards achieving a 'Substantial' compliance to the EPRR core standards.

**Appendix 1 – WHH 2018/19 EPRR Core Standards Assurance Excel Spreadsheet**

Core Standards self assessment tool v1.0 (

**Appendix 2 – WHH 2018/19 EPRR Statement of Compliance**

Signed statement of compliance.pdf

**Appendix 3 – WHH 2018/19 EPRR Improvement Plan**

2018-19 EPRR Improvement Plan.doc

Please select type of organisation: **Acute Providers**

| 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 | 14 | 0 | 0 |
| Command and control | 2 | 2 | 0 | 0 |
| Training and exercising | 3 | 3 | 0 | 0 |
| Response | 7 | 6 | 1 | 0 |
| Warning and informing | 3 | 3 | 0 | 0 |
| Cooperation | 4 | 4 | 0 | 0 |
| Business Continuity | 9 | 7 | 2 | 0 |
| CBRN | 14 | 7 | 7 | 0 |
| Total | 64 | 54 | 10 | 0 |

| Deep Dive | Total standards applicable | Fully compliant | Partially compliant | Non compliant |
|---|---|---|---|---|
| Incident Coordination Centres | 4 | 4 | 0 | 0 |
| Command structures | 4 | 4 | 0 | 0 |
| Total | 8 | 8 | 0 | 0 |

| **Overall assessment:** | Partially compliant |
|---|---|

Instructions:
Step 1: Select the type of organisation from the drop-down at the top of this page
Step 2: Complete the Self-Assessment RAG in the 'EPRR Core Standards' tab
Step 3: Complete the Self-Assessment RAG in the 'Deep dive' tab
Step 4: Ambulance providers only: Complete the Self-Assessment in the 'Interoperable capabilities' tab
Step 5: Click the 'Produce Action Plan' button below

| Ref | Domain | Standard | Detail | Acute Providers | Evidence - examples listed below | Self assessment RAG<br><br>Red = Not compliant with core standard. In line with the organisation's EPRR work programme, compliance will not be reached within the next 12 months.<br><br>Amber = Not compliant with core standard. The organisation's EPRR work programme demonstrates evidence of progress and an action plan to achieve full compliance within the next 12 months.<br><br>Green = Fully compliant with core standard. | Action to be taken | Lead | Timescale | Comments (including organisational evidence) |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Governance | Appointed AEO | The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director, and have the appropriate authority, resources and budget to direct the EPRR portfolio.<br><br>A non-executive board member, or suitable alternative, should be identified to support them in this role. | Y | • Name and role of appointed individual | Fully compliant | | Chris Evans - Chief Operating Officer. Supported by Resilience Manager | | Chris Evans - Chief Operating Officer and Executive Officer is the Trust Accountable Emergency Officer. (AEO) . The Non Executive Board Member is Mr. Terry Atherton |
| 2 | Governance | EPRR Policy Statement | The organisation has an overarching EPRR policy statement.<br><br>This should take into account the organisation's:<br>• Business objectives and processes<br>• Key suppliers and contractual arrangements<br>• Risk assessment(s)<br>• Functions and / or organisation, structural and staff changes.<br><br>The policy should:<br>• Have a review schedule and version control<br>• Use unambiguous terminology<br>• Identify those responsible for making sure the policies and arrangements are updated, distributed and regularly tested<br>• Include references to other sources of information and supporting documentation. | Y | Evidence of an up to date EPRR policy statement that includes:<br>• Resourcing commitment<br>• Access to funds<br>• Commitment to Emergency Planning, Business Continuity, Training, Exercising etc. | Fully compliant | | Chris Evans - Chief Operating Officer. Supported by Resilience Manager | | The AEO is a Trust Executive Officer and oversees all matters of EPRR Policy and procedure. For the previous 12 months he has been supported by an Interim experienced part time EPRR Co-ordinator. In September. 2018 the regular Trust experienced Resilience Manager will return to her post for a structured hand over and will work 3 days a week . Overall Trust EPRR Policy is set out in the Trust Major Incident Plan and the Terms of reference of the Events Planning Group. (EPG). The EPG oversees all EPRR matters and is the means of cascading appropriate information and policy to staff, communicating upwards to the Trust Quality Committee and The Board. |
| 3 | Governance | EPRR board reports | The Chief Executive Officer / Clinical Commissioning Group Accountable Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board / Governing Body, no less frequently than annually.<br><br>These reports should be taken to a public board, and as a minimum, include an overview on:<br>• training and exercises undertaken by the organisation<br>• business continuity, critical incidents and major incidents<br>• the organisation's position in relation to the NHS England EPRR assurance process. | Y | • Public Board meeting minutes<br>• Evidence of presenting the results of the annual EPRR assurance process to the Public Board | Fully compliant | | Chris Evans - Chief Operating Officer. Supported by Resilience Manager | | The AEO reports on EPRR matters annually to The Trust Board. Most recently September 2018. The EPRR Board report is also included in the Trust Annual General Meeting |
| 4 | Governance | EPRR work programme | The organisation has an annual EPRR work programme, informed by lessons identified from:<br>• incidents and exercises<br>• identified risks<br>• outcomes from assurance processes. | Y | • Process explicitly described within the EPRR policy statement<br>• Annual work plan | Fully compliant | | Chris Evans - Chief Operating Officer. Supported by Resilience Manager | | The EPG Group determines and approves an annual EPRR Work plan incorporating Planning & Review, Exercises and Debriefing. Last updated August 2018 and reviewed monthly |
| 5 | Governance | EPRR Resource | The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource, proportionate to its size, to ensure it can fully discharge its EPRR duties. | Y | • EPRR Policy identifies resources required to fulfill EPRR function; policy has been signed off by the organisation's Board<br>• Assessment of role / resources<br>• Role description of EPRR Staff<br>• Organisation structure chart<br>• Internal Governance process chart including EPRR group | Fully compliant | | Chris Evans - Chief Operating Officer. Supported by Resilience Manager | | The AEO is supported by an experienced part time Resilience Manager, and the members of the Events Planning Group (EPG). The EPG meets monthly and has a remit to oversee and provide scrutiny on EPRR issues. Also to ensure compliance with the Civil Contingencies Act 2004 and EPRR Core Standards. Membership is representative of all key areas clinical and non clinical. The group reports to The Quality |
| 6 | Governance | Continuous improvement process | The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the development of future EPRR arrangements. | Y | • Process explicitly described within the EPRR policy statement | Fully compliant | | Chris Evans - Chief Operating Officer. Supported by Resilience Manager | | The Trust has a corporate approach to continuous improvement. In the field of EPRR this is demonstrated by actions arising from Exercises and lessons learned from recent incidents. Examples are improvements to Silver Control Room and Major Incident notification systems. |
| 7 | Duty to risk assess | Risk assessment | The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider community and national risk registers. | Y | • Evidence that EPRR risks are regularly considered and recorded<br>• Evidence that EPRR risks are represented and recorded on the organisations corporate risk register | Fully compliant | | Chris Evans - Chief Operating Officer. Supported by Resilience Manager | | The Resilience Manager monitors and receives updates on the Local Resilience Forum (LRF) Risk Register. Relevant information is cascaded to the AEO and Trust wide via the EPG. i.e..August 2018 Suspicious packages, changes in the future response to Terrorism Risk Threat Assessment and multi agency planning for the Creamfields festival |
| 8 | Duty to risk assess | Risk Management | The organisation has a robust method of reporting, recording, monitoring and escalating EPRR risks. | Y | • EPRR risks are considered in the organisation's risk management policy<br>• Reference to EPRR risk management in the organisation's EPRR policy document | Fully compliant | | Chris Evans - Chief Operating Officer. Supported by Resilience Manager | | EPRR Risks are identified by the Local Health Resilience Partnership (LHRP),the LRF and assessing local events. Trust plans are created or updated as necessary i.e. Warrington Neighbourhood Event May 2018 |
| 9 | Duty to maintain plans | Collaborative planning | Plans have been developed in collaboration with partners and service providers to ensure the whole patient pathway is considered. | Y | Partners consulted with as part of the planning process are demonstrable in planning arrangements | Fully compliant | | Chris Evans - Chief Operating Officer. Supported by Resilience Manager | | The Resilience Manager actively engages in partnership working with the NHSE Area Team. Also with local area Acute Trusts, Ambulance Trusts, Mental Health Trusts and CCG partners, to seek common solutions and share best practice. In addition Cheshire Police and Warrington Borough Council Emergency Planning professionals are both liaison partners in event planning i.e. Annual Warrington Cream fields festival. Also attendance at Multi Agency JESIP workshops |
| 11 | Duty to maintain plans | Critical incident | In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a critical incident (as per the EPRR Framework). | Y | Arrangements should be:<br>• current<br>• in line with current national guidance<br>• in line with risk assessment<br>• tested regularly<br>• signed off by the appropriate mechanism<br>• shared appropriately with those required to use them<br>• outline any equipment requirements<br>• outline any staff training required | Fully compliant | | Chris Evans - Chief Operating Officer. Supported by Resilience Manager | | Trust EPRR planning and training outlines the different incident descriptions and categories. There is commonality in incident management assessment and approach. Given the learning from many of the recent incidents in the UK i.e. London and Manchester Arena, Trust management are trained and encouraged to be pro active in assessing incidents within and beyond our own catchment area, in order to maximise preparation time. |
| 12 | Duty to maintain plans | Major incident | In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a major incident (as per the EPRR Framework). | Y | Arrangements should be:<br>• current<br>• in line with current national guidance<br>• in line with risk assessment<br>• tested regularly<br>• signed off by the appropriate mechanism<br>• shared appropriately with those required to use them<br>• outline any equipment requirements<br>• outline any staff training required | Fully compliant | | Chris Evans - Chief Operating Officer. Supported by Resilience Manager | | Trust EPRR planning and training outlines the different incident descriptions and categories. The aim is to bring consistency in incident management, assessment and approach. Given the learning from many of the recent incidents in the UK i.e. London and Manchester Arena Trust management are trained and encouraged to be pro active in assessing incidents within and wider than our own catchment area in order to maximise preparation time. A training update for Senior Management is ongoing |
| 13 | Duty to maintain plans | Heatwave | In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of heat wave on the population the organisation serves and its staff. | Y | Arrangements should be:<br>• current<br>• in line with current national guidance<br>• in line with risk assessment<br>• tested regularly<br>• signed off by the appropriate mechanism<br>• shared appropriately with those required to use them<br>• outline any equipment requirements<br>• outline any staff training required | Fully compliant | | Chris Evans - Chief Operating Officer. Supported by Resilience Manager | | Heat wave plans have been activated in June, July and August 2018. Additional contingencies have been implemented through the hire of additional air conditioning units and an emphasis on staff and patient welfare. Estates maintenance response has been escalated to deal with urgent repairs. The learning from the ongoing 2018 heat wave experience will be used to update the Trust Heat wave plan for subsequent years |
| 14 | Duty to maintain plans | Cold weather | In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of snow and cold weather (not internal business continuity) on the population the organisation serves. | Y | Arrangements should be:<br>• current<br>• in line with current national guidance<br>• in line with risk assessment<br>• tested regularly<br>• signed off by the appropriate mechanism<br>• shared appropriately with those required to use them<br>• outline any equipment requirements<br>• outline any staff training required | Fully compliant | | Chris Evans - Chief Operating Officer. Supported by Resilience Manager and Emergency Care BCU Manager | | Winter planning for 2018-19 is ongoing and commenced in July 2018. In September 2018 Winter Planning was included as joint element of The Patient Flow committee meeting under the chair of the COO. The revised Trust Winter Plan will be published, circulated and briefed in October 2018 . The plan will cover all of the required criteria and include lessons learned from 2017-18 |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| 15 | Duty to maintain plans | Pandemic influenza | In line with current guidance and legislation, the organisation has effective arrangements in place to respond to pandemic influenza as described in the National Risk Register. | Y | Arrangements should be:<br>• current<br>• in line with current national guidance<br>• in line with risk assessment<br>• tested regularly<br>• signed off by the appropriate mechanism<br>• shared appropriately with those required to use them<br>• outline any equipment requirements<br>• outline any staff training required | Fully compliant | | Chris Evans - Chief Operating Officer. Supported by Resilience Manager and Associate Director of Infection Control | | The Trust Pandemic Flu Plan was updated in March 2018. Since that time we have waited new national PHE guidance . Once this is received the Trust plans will be further updated |
| 16 | Duty to maintain plans | Infectious disease | In line with current guidance and legislation, the organisation has effective arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including Viral Haemorrhagic Fever. These arrangements should be made in conjunction with Infection Control teams; including supply of adequate FFP3. | Y | Arrangements should be:<br>• current<br>• in line with current national guidance<br>• in line with risk assessment<br>• tested regularly<br>• signed off by the appropriate mechanism<br>• shared appropriately with those required to use them<br>• outline any equipment requirements<br>• outline any staff training required | Fully compliant | | Chris Evans - Chief Operating Officer. Supported by Resilience Manager and Associate Director of Infection Control | | Trust Infectious disease policies are embedded in day to day policy and procedure. Updates are the responsibility of The Associate Director of Infection Control, who is a member of the EPG. Planning includes availability and training in the use of FFP3 protective masks |
| 17 | Duty to maintain plans | Mass Countermeasures | In line with current guidance and legislation, the organisation has effective arrangements in place to distribute Mass Countermeasures - including the arrangement for administration, reception and distribution, eg mass prophylaxis or mass vaccination.<br><br>There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop Mass Countermeasure distribution arrangements. These will be dependant on the incident, and as such requested at the time.<br><br>CCGs may be required to commission new services dependant on the incident. | Y | Arrangements should be:<br>• current<br>• in line with current national guidance<br>• in line with risk assessment<br>• tested regularly<br>• signed off by the appropriate mechanism<br>• shared appropriately with those required to use them<br>• outline any equipment requirements<br>• outline any staff training required | Fully compliant | | Chris Evans - Chief Operating Officer. Supported by Resilience Manager | | The means to access mass countermeasures is included in the Trust Major Incident Plan. In all cases the Trust would seek the involvement and instructions of NHS England, and Public Health England, as the need for countermeasures is recognised as being likely to be a regional issue and subject to wider NHS co-ordination. |
| 18 | Duty to maintain plans | Mass Casualty - surge | In line with current guidance and legislation, the organisation has effective arrangements in place to respond to mass casualties. For an acute receiving hospital this should incorporate arrangements to increase capacity by 10% in 6 hours and 20% in 12 hours. | Y | Arrangements should be:<br>• current<br>• in line with current national guidance<br>• in line with risk assessment<br>• tested regularly<br>• signed off by the appropriate mechanism<br>• shared appropriately with those required to use them<br>• outline any equipment requirements<br>• outline any staff training required | Fully compliant | | Chris Evans - Chief Operating Officer. Supported by Medical Director Emergency Care and Resilience Manager | | The Trust has committed to the Cheshire and Merseyside joint doctrine for management of mass casualties. 40 Trust Staff took an active role in Exercise Golden Eagle in June 2018 to test the plan and exercises Trust capability. The exercise provided a superb opportunity to test a large number of EPRR systems and procedures . On the day the Trust was able to meet and exceed the surge levels expected. However it is acknowledged that this level of surge capacity management will always be challenging and dependent on the existing particular pressures of the day/year. Management EPRR briefings refer to planning and experience of recent UK mass casualty incidents and the main findings of The Kerslake report |
| 19 | Duty to maintain plans | Mass Casualty - patient identification | The organisation has arrangements to ensure a safe identification system for unidentified patients in emergency/mass casualty incident. Ideally this system should be suitable and appropriate for blood transfusion, using a non-sequential unique patient identification number and capture patient sex. | Y | Arrangements should be:<br>• current<br>• in line with current national guidance<br>• in line with risk assessment<br>• tested regularly<br>• signed off by the appropriate mechanism<br>• shared appropriately with those required to use them<br>• outline any equipment requirements<br>• outline any staff training required | Fully compliant | | Chris Evans - Chief Operating Officer. Supported by Medical Director Emergency Care and Resilience Manager | | The Trust Emergency Dept has systems in place to record and track patients arriving from a mass casualty incident. These systems were successfully practiced in Exercise Golden Eagle- June 2018. |
| 20 | Duty to maintain plans | Shelter and evacuation | In line with current guidance and legislation, the organisation has effective arrangements in place to place to shelter and / or evacuate patients, staff and visitors. This should include arrangements to perform a whole site shelter and / or evacuation. | Y | Arrangements should be:<br>• current<br>• in line with current national guidance<br>• in line with risk assessment<br>• tested regularly<br>• signed off by the appropriate mechanism<br>• shared appropriately with those required to use them<br>• outline any equipment requirements<br>• outline any staff training required | Fully compliant | | Chris Evans - Chief Operating Officer. Supported by Resilience Manager | | The Trust has comprehensive Fire evacuation plans based on progressive containment, compartmentalisation and lateral / vertical evacuation. Fire /evacuation training is a core subject for all staff. The challenge of whole site evacuation is recognised as a Major Incident, and full Trust and Police led Multi Agency Command and Control, with NHSE EPRR Team overall co-ordination. The Trust welcomes the opportunity to test such a scenario with a challenging multi agency desk top exercise. |
| 21 | Duty to maintain plans | Lockdown | In line with current guidance and legislation, the organisation has effective arrangements in place safely manage site access and egress of patients, staff and visitors to and from the organisation's facilities. This may be a progressive restriction of access / egress that focuses on the 'protection' of critical areas. | Y | Arrangements should be:<br>• current<br>• in line with current national guidance<br>• in line with risk assessment<br>• tested regularly<br>• signed off by the appropriate mechanism<br>• shared appropriately with those required to use them<br>• outline any equipment requirements<br>• outline any staff training required | Fully compliant | | Chris Evans - Chief Operating Officer. Supported by Head of Estates. Head of Security and Resilience Manager | | ED Access control is now in place and operational. This will assist with an effective and prompt lockdown of that key area. For the remainder of the Trust a lock down policy is in place which has been tested with actual events |
| 22 | Duty to maintain plans | Protected individuals | In line with current guidance and legislation, the organisation has effective arrangements in place to respond to manage 'protected individuals'; including VIPs, high profile patients and visitors to the site. | Y | Arrangements should be:<br>• current<br>• in line with current national guidance<br>• in line with risk assessment<br>• tested regularly<br>• signed off by the appropriate mechanism<br>• shared appropriately with those required to use them<br>• outline any equipment requirements<br>• outline any staff training required | Fully compliant | | Chris Evans - Chief Operating Officer. Supported by Head of Security and Resilience Manager | | The Major Incident Plan Communication Team Action Card sets out arrangements for managing the media response and enquiries. The Incident Command Structure would assess the impact of any planned VIP visits /patients, and work in conjunction with Cheshire Police to implement any appropriate additional VIP arrangements. The Trust Consent to treatment plan contains a section on celebrity/VIP patients |
| 23 | Duty to maintain plans | Excess death planning | Organisation has contributed to and understands its role in the multiagency planning arrangements for excess deaths, including mortuary arrangements. | Y | Arrangements should be:<br>• current<br>• in line with current national guidance<br>• in line with risk assessment<br>• tested regularly<br>• signed off by the appropriate mechanism<br>• shared appropriately with those required to use them<br>• outline any equipment requirements<br>• outline any staff training required | Fully compliant | | Chris Evans - Chief Operating Officer. Supported by Resilience Manager | | Through the LHRP, the Trust contributes to the daily monitoring of mortuary capacity in the region. The LRF Mass fatalities plans are known and we keenly await progress on the Cheshire Halton and Warrington LRF Front . In September 2017 the Trust supported a Police Mass fatalities /mortuary exercise by providing a venue at Halton Hospital. |
| 24 | Command and control | On call mechanism | A resilient and dedicated EPRR on call mechanism in place 24 / 7 to receive notifications relating to business continuity incidents, critical incidents and major incidents.<br><br>This should provide the facility to respond or escalate notifications to an executive level. | Y | • Process explicitly described within the EPRR policy statement<br>• On call Standards and expectations are set out<br>• Include 24 hour arrangements for alerting managers and other key staff. | Fully compliant | | Chris Evans - Chief Operating Officer. Supported by Resilience Manager | | The Trust has an established Senior Manager & Executive On Call rota facilitating 24/7 access to Silver/ Tactical Control On Call Manager and Gold/Strategic On Call Executive. Immediate access is available through the Hospital Switchboard. On Call Managers receive training in EPRR matters and challenges . In addition NHS England Area Team have contact details for both the AEO and Resilience Manager. Although not formally 'On Call' both are fully prepared to provide specialist advice and respond in person if required attend to support Incident Management . I.e. 2017 Creamfields Drugs arrests and hospital admissions and 2018 Creamfields event. |
| 25 | Command and control | Trained on call staff | On call staff are trained and competent to perform their role, and are in a position of delegated authority on behalf on the Chief Executive Officer / Clinical Commissioning Group Accountable Officer.<br><br>The identified individual:<br>• Should be trained according to the NHS England EPRR competencies (National Occupational Standards)<br>• Can determine whether a critical, major or business continuity incident has occurred<br>• Has a specific process to adopt during the decision making<br>• Is aware who should be consulted and informed during decision making<br>• Should ensure appropriate records are maintained throughout. | Y | • Process explicitly described within the EPRR policy statement | Fully compliant | | Chris Evans - Chief Operating Officer. Supported by Resilience Manager | | On Call Senior Managers at Gold and Tactical levels receive training on EPRR responsibilities, incident classification, decision making and notification cascade. Personal logging of actions and decisions feature prominently in the training. The current EPRR training initiative commenced in July 2018 and will be complete in September 2018 |
| 26 | Training and exercising | EPRR Training | The organisation carries out training in line with a training needs analysis to ensure staff are competent in their role; training records are kept to demonstrate this. | Y | • Process explicitly described within the EPRR policy statement<br>• Evidence of a training needs analysis<br>• Training records for all staff on call and those performing a role within the ICC<br>• Training materials<br>• Evidence of personal training and exercising portfolios for key staff | Fully compliant | | Chris Evans - Chief Operating Officer. Supported by Resilience Manager | | The Resilience Manager co-ordinates EPRR training and exercising. Training focuses on staff with key roles in the Emergency response. i.e. Switchboard. ED ,On Call Managers, Executives, . In September /October 2018 EPRR training is planned to extend to the Night Nurse Practitioners |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| 27 | Training and exercising | EPRR exercising and testing programme | The organisation has an exercising and testing programme to safely test major incident, critical incident and business continuity response arrangements.<br><br>Organisations should meet the following exercising and testing requirements:<br>• a six-monthly communications test<br>• annual table top exercise<br>• live exercise at least once every three years<br>• command post exercise every three years.<br><br>The exercising programme must:<br>• identify exercises relevant to local risks<br>• meet the needs of the organisation type and stakeholders<br>• ensure warning and informing arrangements are effective.<br><br>Lessons identified must be captured, recorded and acted upon as part of continuous improvement. | Y | • Exercising Schedule<br>• Evidence of post exercise reports and embedding learning | Fully compliant | | Chris Evans - Chief Operating Officer. Supported by Resilience Manager | | The Resilience Manager co-ordinates EPRR training and exercising. The last 12 months has seen a number of exercise events . November 2018 **'Exercise Checker'** - Communications Exercise. December 2018 **'Exercise Concourse' -** ED Mass Casualty Exercise. June 2018 - **'Exercise Golden Eagle'** - Regional Mass Casualty Exercise In May 2018 the Interim Emergency Planning Co-ordinator qualified as an 'EMERGO Senior Instructor with full access to the nationally accredited EMERGO Exercise resources. Exercise Eagle was successfully run as a full EMERGO Major Live Exercise. Consideration will be given to using the format in similar exercises for key staff. Full reports are produced following each exercise and actions identified for improvement. In addition learning outcomes are referenced in subsequent training sessions. |
| 28 | Training and exercising | Strategic and tactical responder training | Strategic and tactical responders must maintain a continuous personal development portfolio demonstrating training in accordance with the National Occupational Standards, and / or incident / exercise participation | Y | • Training records<br>• Evidence of personal training and exercising portfolios for key staff | Fully compliant | | Chris Evans - Chief Operating Officer. Supported by Resilience Manager | | The July-August 2018 Strategic and Tactical responder training has progressed well. Attendance is recorded in staff personal development records |
| 30 | Response | Incident Co-ordination Centre (ICC) | The organisation has a preidentified an Incident Co-ordination Centre (ICC) and alternative fall-back location.<br><br>Both locations should be tested and exercised to ensure they are fit for purpose, and supported with documentation for its activation and operation. | Y | • Documented processes for establishing an ICC<br>• Maps and diagrams<br>• A testing schedule<br>• A training schedule<br>• Pre identified roles and responsibilities, with action cards<br>• Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazards | Fully compliant | | Chris Evans - Chief Operating Officer. Supported by Resilience Manager | | The Trust Conference room at Warrington Hospital is the designated Tactical/Silver Control Room -(ICC). The room has recently (June 2018) had investment in equipment for Major Incidents. Cupboards, Signage, Role boxes, Stationery, Log books, Whiteboards, new Video conferencing equipment. A new 3 screen display and additional computer. The electrical supply to the room is covered by UPS and a back up generator. A conventional telephone link is available in the room. The fall back room is in the Bed Bureau. which has ready access to key support documents to support Senior Managers in the early stages of an Incident . Familiarisation with ICC is included in management briefings and used as the training venue |
| 31 | Response | Access to planning arrangements | Version controlled, hard copies of all response arrangements are available to staff at all times. Staff should be aware of where they are stored; they should be easily accessible. | Y | Planning arrangements are easily accessible - both electronically and hard copies | Fully compliant | | Chris Evans - Chief Operating Officer. Supported by Resilience Manager | | Hard copies of the Trust Major Incident Plan are available in the Silver Control Room and also readily available on the Trust network -policy data base. Action cards for key responders are available in hard copy in individual role boxes for ready access. On Call Managers are encouraged to hold and have their respective Action Cards readily available. The equipment in the secondary ICC within the Bed Bureau is staffed / used/tested on a daily basis |
| 32 | Response | Management of business continuity incidents | The organisations incident response arrangements encompass the management of business continuity incidents. | Y | • Business Continuity Response plans | Fully compliant | | Chris Evans - Chief Operating Officer. Supported by Resilience Manager | | Strategic and Tactical Incident Management training encompasses a range of Business Continuity challenges and the benefits/ requirements of establishing an early Incident Management Team and ICC. |
| 33 | Response | Loggist | The organisation has 24 hour access to a trained loggist(s) to ensure decisions are recorded during business continuity incidents, critical incidents and major incidents. | Y | • Documented processes for accessing and utilising loggists<br>• Training records | Partially compliant | A cadre of administration staff to undertake an internal Loggist training course. A documented process of how to access and utilise a Loggist in the event of a major incident | Emma Blackwell, Resilience Manager | Dec-18 | The Trust has previously engaged in a training programme for Incident Loggist resulting in a cadre of trained staff. Some staff have now moved deparment, left the Trust or require refreshser training. It is recognised that this is an area for urgent review and update, this is a priority task. |
| 34 | Response | Situation Reports | The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to business continuity incidents, critical incidents and major incidents. | Y | • Documented processes for completing, signing off and submitting SitReps<br>• Evidence of testing and exercising | Fully compliant | | Chris Evans - Chief Operating Officer. Supported by Resilience Manager | | The Trust Major Incident Plan includes a SITREP template. A similar template was utilised successfully throughout Exercise Golden Eagle. Incident Managers are responsive to bespoke reporting arrangement often implemented in the course of an incident |
| 35 | Response | Access to 'Clinical Guidance for Major Incidents' | Emergency Department staff have access to the NHSE 'Clinical Guidance for Major Incidents' handbook. | Y | Guidance is available to appropriate staff either electronically or hard copies | Fully compliant | | Chris Evans - Chief Operating Officer. Supported by Resilience Manager | | ED Staff have ready access to Toxbase, Public Health England On Call advice and daily used clinical reference sources |
| 36 | Response | Access to 'CBRN incident: Clinical Management and health protection' | Clinical staff have access to the PHE 'CBRN incident: Clinical Management and health protection' guidance. | Y | Guidance is available to appropriate staff either electronically or hard copies | Fully compliant | | Chris Evans - Chief Operating Officer. Supported by Resilience Manager | | ED Staff have ready access to Toxbase, Public Health England On Call advice and daily used clinical reference sources |
| 37 | Warning and informing | Communication with partners and stakeholders | The organisation has arrangements to communicate with partners and stakeholder organisations during and after a major incident, critical incident or business continuity incident. | Y | • Have emergency communications response arrangements in place<br>• Social Media Policy specifying advice to staff on appropriate use of personal social media accounts whilst the organisation is in incident response<br>• Using lessons identified from previous major incidents to inform the development of future incident response communications<br>• Having a systematic process for tracking information flows and logging information requests and being able to deal with multiple requests for information as part of normal business processes<br>• Being able to demonstrate that publication of plans and assessments is part of a joined-up communications strategy and part of your organisation's warning and informing work | Fully compliant | Trust to closely monitor national guidance and update plans accordingly | Chris Evans - Chief Operating Officer. Supported by Associate Director of Communications and Resilience Manager | | Major Incident Plan details communications arrangements. The Trust has an Information Sharing agreement with Cheshire Resilience Forum. The Agreement sets out the Police co-ordinating role and the types and extent of information to be shared with other responders and released to the media. There is Senior Communications representative on call and would attend n the Major Incident Control Room to lead on internal and external communications format and content. |
| 38 | Warning and informing | Warning and informing | The organisation has processes for warning and informing the public and staff during major incidents, critical incidents or business continuity incidents. | Y | • Have emergency communications response arrangements in place<br>• Be able to demonstrate consideration of target audience when publishing materials (including staff, public and other agencies)<br>• Communicating with the public to encourage and empower the community to help themselves in an emergency in a way which compliments the response of responders<br>• Using lessons identified from previous major incidents to inform the development of future incident response communications<br>• Setting up protocols with the media for warning and informing | Fully compliant | Trust to closely monitor national guidance and update plans accordingly | Chris Evans - Chief Operating Officer. Supported by Associate Director of Communications and Resilience Manager | | The Major Incident Plan details the options for communications, ranging from IT, telephony, Internet, Intranet, Mobile phones , radios, signage and in person. The Communications specialist would lead on this area in conjunction with the Executive Incident Commander. Exercise Golden Eagle enabled a trial of these systems as did the recent fire and business continuity challenge in the Warrington Hospitals Kendrick Wing |
| 39 | Warning and informing | Media strategy | The organisation has a media strategy to enable communication with the public. This includes identification of and access to a trained media spokespeople able to represent the organisation to the media at all times. | Y | • Have emergency communications response arrangements in place<br>• Using lessons identified from previous major incidents to inform the development of future incident response communications<br>• Setting up protocols with the media for warning and informing<br>• Having an agreed media strategy which identifies and trains key staff in dealing with the media including nominating spokespeople and 'talking heads' | Fully compliant | Trust to closely monitor national guidance and update plans accordingly | Chris Evans - Chief Operating Officer. Supported by Associate Director of Communications and Resilience Manager | | The Trust has a media strategy which is regularly exercised i.e. Winter pressure Trust Major Incident Plan details communications arrangements. The Trust has an Information Sharing agreement with Cheshire Resilience Forum. The Agreement sets out the Police co-ordinating role and the types and extent of information to be shared with other responders and released to the media. There is Senior Communications representative on call who would attend the Major Incident Control Room to lead on internal and external communications format and content. |
| 40 | Cooperation | LRHP attendance | The Accountable Emergency Officer, or an appropriate director, attends (no less than 75%) of Local Health Resilience Partnership (LHRP) meetings per annum. | Y | • Minutes of meetings | Fully compliant | Trust to closely monitor national guidance and update plans accordingly | Chris Evans - Chief Operating Officer. Supported by Resilience Manager | | Over the last 12 months the AEO post has been filled on a temporary basis for 8 months and by the current AEO for the last 4 months. Throughout the period either the AEO or Deputy has attended all LHRP meetings and all LHRP Practitioner meetings. In all cases Trust representatives are active contributors to debate, initiatives and actions. The AEO supports the recent move to reduce the number of LHRP Strategic meeting to 2 per anum and a more Strategic agenda |
| 41 | Cooperation | LRF / BRF attendance | The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with other responders. | Y | • Minutes of meetings<br>• Governance agreement if the organisation is represented | Fully compliant | | Chris Evans - Chief Operating Officer. Supported by Resilience Manager | | In Cheshire NHS attendance at Local Resilience Forum meetings is the responsibility of the NHSE EPRR Are Team Manager. Information and tasks are cascaded out via the LHRP. This arrangement works well |
| 42 | Cooperation | Mutual aid arrangements | The organisation has agreed mutual aid arrangements in place outlining the process for requesting, co-ordinating and maintaining resource eg staff, equipment, services and supplies.<br><br>These arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA). | Y | • Detailed documentation on the process for requesting, receiving and managing mutual aid requests<br>• Signed mutual aid agreements where appropriate | Fully compliant | Trust to closely monitor national guidance and update plans accordingly | Chris Evans - Chief Operating Officer. Supported by Resilience Manager | | There are several mutual aid arrangements. They include Ambulance deflections and diversions & The Critical Care Network. All other mutual aid arrangements would be dealt with at the time by an Executive Director at Strategic level and dependent on the nature of the request /requirement . It is envisaged that in such circumstances in the first instance contact would be |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| 46 | Cooperation | Information sharing | The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders. | Y | • Documented and signed information sharing protocol<br>• Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation and the Civil Contingencies Act 2004 'duty to communicate with the public'. | Fully compliant | Trust to closely monitor national guidance and update plans accordingly | | | The Trust Major Incident Plan details communications arrangements. The Trust has an Information Sharing agreement with Cheshire Resilience Forum. The Cheshire LHRP EPRR Practitioner Group is vibrant and meet regularly. Members freely share initiatives, experiences and good practice. i.e Exercise and Notification initiatives |
| 47 | Business Continuity | BC policy statement | The organisation has in place a policy statement of intent to undertake Business Continuity Management System (BCMS). | Y | Demonstrable a statement of intent outlining that they will undertake BC - Policy Statement | Fully compliant | | Chris Evans - Chief Operating Officer. Supported by Resilience Manager | | The Trust has a comprehensive overall Business Continuity (BC) Plan. The plan includes guidance and policy for identifying, responding to and managing a wide range of BC challenges and sets out expectations and templates for CBU/Departmental BC plans. |
| 48 | Business Continuity | BCMS scope and objectives | The organisation has established the scope and objectives of the BCMS, specifying the risk management process and how this will be documented. | Y | BCMS should detail:<br>• Scope e.g. key products and services within the scope and exclusions from the scope<br>• Objectives of the system<br>• The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties<br>• Specific roles within the BCMS including responsibilities, competencies and authorities.<br>• The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process<br>• Resource requirements<br>• Communications strategy with all staff to ensure they are aware of their roles<br>• Stakeholders | Fully compliant | | Chris Evans - Chief Operating Officer. Supported by Resilience Manager | | BC Incidents and exercises are referred to the Trust Events Planning Group. i.e. Kendrick building fire. BC incidents and challenges are included in the annual EPRR report to The Board. |
| 49 | Business Continuity | Business Impact Assessment | The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(s). | Y | Documented process on how BIA will be conducted, including:<br>• the method to be used<br>• the frequency of review<br>• how the information will be used to inform planning<br>• how RA is used to support. | Fully compliant | | Chris Evans - Chief Operating Officer. Supported by Resilience Manager | | A BIA has been completed for the Trust as the foundation for the Trust Business Continuity plan. The Trust BIA can be found within the BCP.<br>A generic BIA has been completed by all the newly formed Clinical Business Units using the Trust BIA guidance document. BIA's have previously been completed by all Corporate services.<br>Any issues identified as being a risk to the continuity of services that the Trust provides are registered on the Corporate Risk Register. |
| 50 | Business Continuity | Data Protection and Security Toolkit | Organisation's IT department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis. | Y | Statement of compliance | Fully compliant | | Chris Evans - Chief Operating Officer. Supported by Head of IT and Resilience Manager | | Historically we have been compliant with the Information Governance Toolkit standards at level 2 standard and the 2018 audit of this submission returned a significant assurance level. The Data Protection and Security Toolkit return will be submitted at the October 2018 requirement. |
| 51 | Business Continuity | Business Continuity Plans | The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to:<br>• people<br>• information and data<br>• premises<br>• suppliers and contractors<br>• IT and infrastructure<br><br>These plans will be updated regularly (at a minimum annually), or following organisational change. | Y | • Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation | Partially compliant | Trust BCP to be reviewed and updated.<br>BCP's to be developed in 2 Clinical Business Units.<br>Corporate BCP's need updating<br>Service level plans require updating. | Resilience Manager | Dec-18 | It is a priority task to take stock and audit CBU and Departmental BC plans and update as appropriate with organisational changes. |
| 52 | Business Continuity | BCMS monitoring and evaluation | The organisation's BCMS is monitored, measured and evaluated against the Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board. | Y | • EPRR policy document or stand alone Business continuity policy<br>• Board papers | Fully compliant | | | | BC Challenges and incidents are included in the annual EPRR report to The Board and updates to represent organisational changes are programmed through the Event Planning Group. |
| 53 | Business Continuity | BC audit | The organisation has a process for internal audit, and outcomes are included in the report to the board. | Y | • EPRR policy document or stand alone Business continuity policy<br>• Board papers<br>• Audit reports | Fully compliant | | | | A significant piece of work was carried out in 2017 to enhance and bring consistency to BC planning across the Trust . |
| 54 | Business Continuity | BCMS continuous improvement process | There is a process in place to assess and take corrective action to ensure continual improvement to the BCMS. | Y | • EPRR policy document or stand alone Business continuity policy<br>• Board papers<br>• Action plans | Fully compliant | | | | Business Continuity is a standard agenda item on the Event Planning Group (see minutes for evidence) |
| 55 | Business Continuity | Assurance of commissioned providers / suppliers BCPs | The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers arrangements work with their own. | Y | • EPRR policy document or stand alone Business continuity policy<br>• Provider/supplier assurance framework<br>• Provider/supplier business continuity arrangements | Partially compliant | Deputy Head of Procurement to update the Supplies department BCP. | Simon Bennett, Supply Chain Manager | Nov-18 | The NHS Supply Chain has a comprehensive BCP. Within the Trust the Supplies department has a BCP in place, it is acknowledged that the BCP needs to be reviewed. |
| 56 | CBRN | Telephony advice for CBRN exposure | Staff have access to telephone advice for managing patients involved in CBRN exposure incidents. | Y | Staff are aware of the number / process to gain access to advice through appropriate planning arrangements | Fully compliant | | Chris Evans - Chief Operating Officer. Supported by Resilience Manager & Matron ED | | Telephone contact numbers readily available in Trust Hazmat/CBRN e Plan. Staff also have access to Toxbase and 24/7 On Call contact details for Public Health England specialist advice |
| 57 | CBRN | HAZMAT / CBRN planning arrangement | There are organisation specific HAZMAT/ CBRN planning arrangements (or dedicated annex). | Y | Evidence of:<br>• command and control structures<br>• procedures for activating staff and equipment<br>• pre-determined decontamination locations and access to facilities<br>• management and decontamination processes for contaminated patients and fatalities in line with the latest guidance<br>• interoperability with other relevant agencies<br>• plan to maintain a cordon / access control<br>• arrangements for staff contamination<br>• plans for the management of hazardous waste<br>• stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes<br>• contact details of key personnel and relevant partner agencies | Fully compliant | | Chris Evans - Chief Operating Officer. Supported by Resilience Manager & Matron ED | | The Trust has a dedicated and comprehensive Hazmat and CBRNE plan. The plan is available on the Trust data base and underpins awareness training in ED. The plan covers all the key areas and roles and includes references and guidance on Initial Operational Response (IOR) methods. IOR Equipment is also readily available at Halton Hospital Urgent Care Centre. |
| 58 | CBRN | HAZMAT / CBRN risk assessments | HAZMAT/ CBRN decontamination risk assessments are in place appropriate to the organisation.<br><br>This includes:<br>• Documented systems of work<br>• List of required competencies<br>• Arrangements for the management of hazardous waste. | Y | • Impact assessment of CBRN decontamination on other key facilities | Fully compliant | | Chris Evans - Chief Operating Officer. Supported by Resilience Manager & Matron ED | | The Trust Hazmat /CBRNe plan and Manager/ Security/ED Staff training highlight the importance of preventing contaminated casulatiues entering the Trust buildlings |
| 59 | CBRN | Decontamination capability availability 24 /7 | The organisation has adequate and appropriate decontamination capability to manage self presenting patients (minimum four per hour), 24 hours a day, 7 days a week. | Y | Rotas of appropriately trained staff availability 24 /7 | Partially compliant | Trust trainers have been identified and will be booked onto Train the Trainer courses as soon as they become available. In the interim, staff awareness sessions will take place to ensure all staff are aware of the IOR for decontamination. | Chris Evans - Chief Operating Officer. Supported by Resilience Manager & Matron ED | Ongoing | There are CBRN Leads on both the Warrington and Halton site. However Leads need refresher training and not all ED staff have recieved Decontamination training. This is an area of work to be progressed. A programme of staff training on basic Initial Operational Response (IOR) is recommended. The aim is to have a minimum level of casualty decontamination staffing available in ED at all times. In the future once staff are trained then records should be maintained and made accessible . NWAS have failed to provide the necessary and scheduled Decontamination/CBRN Train the Trainer courses. The last was cancelled at short notice . |
| 60 | CBRN | Equipment and supplies | The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients.<br><br>• Acute providers - see Equipment checklist: https://www.england.nhs.uk/ourwork/eprr/hrn/<br>• Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011) (found at: http://www.londonccn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf)<br>• Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ | Y | Completed equipment inventories; including completion date | Fully compliant | | Chris Evans - Chief Operating Officer. Supported by Resilience Manager & Matron ED | | MDU and IOR equipment stored within ED and UCC and available for rapid deployment. |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **61** | **CBRN** | **PRPS availability** | The organisation has the expected number of PRPS (sealed and in date) available for immediate deployment.<br><br>There is a plan and finance in place to revalidate (extend) or replace suits that are reaching their expiration date. | Y | Completed equipment inventories; including completion date | Partially compliant | All out of date suits are to be removed from the operational store and destroyed by Respirex. The Trust only has 9 in date Operational PRPS suits, Request made to NHS England for 3 more from Central Store (29.8.18) | Chris Evans - Chief Operating Officer. Supported by Resilience Manager & Matron ED | Awaiting roll out of new suits from DH | The Trust has a total of 9 in date PRPS suits which below the minimum level of 12 needed to mount a response. All of these suits are on loan from Central Store pending national role out of new suits. A further 6 suits were mislaid in delivery and never arrived. Despite efforts of Trust and NHSE they have not been located . Out of date suits are scheduled to be disposed of in accordance with national guidance. |
| **62** | **CBRN** | **Equipment checks** | There are routine checks carried out on the decontamination equipment including:<br>• Suits<br>• Tents<br>• Pump<br>• RAM GENE (radiation monitor)<br>• Other decontamination equipment.<br><br>There is a named individual responsible for completing these checks | Y | Record of equipment checks, including date completed and by whom. | Fully compliant | | Chris Evans - Chief Operating Officer. Supported by Resilience Manager & Matron ED | | The Practice Development Nurse currently has this responsibility, however in the near future it is intended to allocate the HAZMAT/CBRNe maintenance , training and exercising to a Band 7 nurse within ED. |
| **63** | **CBRN** | **Equipment PPM** | There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date decontamination equipment for:<br>• Suits<br>• Tents<br>• Pump<br>• RAM GENE (radiation monitor)<br>• Other equipment | Y | Completed PPM, including date completed, and by whom | Fully compliant | | Chris Evans - Chief Operating Officer. Supported by Resilience Manager & Matron ED | | Checklist completed. |
| **64** | **CBRN** | **PPE disposal arrangements** | There are effective disposal arrangements in place for PPE no longer required, as indicated by manufacturer / supplier guidance. | Y | Organisational policy | Partially compliant | Quote obtained from RESPIREX for disposal of suits, funding has been identified and purchase order raised. | Resilience Manager & Matron ED | Oct-18 | Communications from Respirex and EPRR co-ordinator. |
| **65** | **CBRN** | **HAZMAT / CBRN training lead** | The current HAZMAT / CBRN Decontamination training lead is appropriately trained to deliver HAZMAT / CBRN training | Y | Maintenance of CPD records | Partially compliant | This is an area of work to be urgently progressed . NWAS have failed to provide the necessary and scheduled Decontaninatio/CBRN Train the Trainer courses. The last was cancelled at short notice . Trust trainers are very much out of date and need refresher training before internal training can commence. ED have identified 8 staff to attend the NWAS training as soon as the dates become available. | Resilience Manager & Matron ED | Awaiting dates from NWAS | Late 2017 NWAS cancelled at short notice all 8 places the Trust had booked for Training of Trainers for decontamnition/ Hazmat . This has led to a hold on training for staff. Trust staff are anxious for the regiaonl NWAS training to be rescheduled, as current trained staff need a refresher/update |
| **66** | **CBRN** | **Training programme** | Internal training is based upon current good practice and uses material that has been supplied as appropriate. Training programme should include training for PPE and decontamination. | Y | Evidence training utilises advice within:<br>• Primary Care HAZMAT/ CBRN guidance<br>• Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/<br><br>• A range of staff roles are trained in decontamination techniques<br>• Lead identified for training<br>• Established system for refresher training | Partially compliant | A newly appointed ED Practice Based Educator will overseee the decontamination training. Until dates can be provided for train the trainer courses the IOR will be ciruclated to staff for awareness. | Resilience Manager & Matron ED | October 2018 for staff awareness | This is is an area of work to be progressed . A programme of staff training on basic Initial Operational Response (IOR) is required. The aim is to have a minimum level of casualty decontamination staffing available in ED at all times. In the future once staff are trained then records should be maintained and made accessible . NWAS have failed to provide the necessary and scheduled Decontamination/CBRN Train the Trainer courses. The last was cancelled at short notice . Trust trainers are very much out of date and need refresher training. Representation has been made to NHSE to secure this training urgently. |
| **67** | **CBRN** | **HAZMAT / CBRN trained trainers** | The organisation has a sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme. | Y | Maintenance of CPD records | Partially compliant | Staff have been identified to attend the CBRN train the trainer course. This will then be rolled out to ED staff. | Resilience Manager & Matron ED | Awaiting dates from NWAS | This is is an area of work to be progressed . A programme of staff training on basic Initial Operational Response (IOR) is required. The aim is to have a minimum level of casualty decontamination staffing available in ED at all times. In the future once staff are trained then records should be maintained and made accessible . NWAS have failed to provide the necessary and scheduled Decontamination/CBRN Train the Trainer courses. The last was cancelled at short notice . Trust trainers are very much out of date and need refresher training. Representation has been made to NHSE to secure this training urgently. |
| **68** | **CBRN** | **Staff training - decontamination** | Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant. | Y | Evidence training utilises advice within:<br>• Primary Care HAZMAT/ CBRN guidance<br>• Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/<br>• Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011). Found at: http://www.londoncn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf<br>• A range of staff roles are trained in decontamination technique | Partially compliant | Staff will receive training based on the CBRN guidance and IOR as described in the Trust CBRN plan. | Resilience Manager & Matron ED | Ongoing | Training detailed in Trust CBRN Plan and Power Point presentations of previous staff training. |
| **69** | **CBRN** | **FFP3 access** | Organisations must ensure staff who may come into contact with confirmed infectious respiratory viruses have access to FFP3 mask protection (or equivalent) 24 / 7. | Y | | Fully compliant | | Chris Evans - Chief Operating Officer. Supported by Resilience Manager & Matron ED | | FFP3 masks are available in ED. There is an ongoing programme of training and fit testing and records are maintained |

| Ref | Domain | Standard | Detail | Acute Providers | Evidence - examples listed below | Self assessment RAG<br><br>Red = Not compliant with core standard. In line with the organisation's EPRR work programme, compliance will not be reached within the next 12 months.<br><br>Amber = Not compliant with core standard. The organisation's EPRR work programme demonstrates evidence of progress and an action plan to achieve full compliance within the next 12 months.<br><br>Green = Fully compliant with core standard. | Action to be taken | Lead | Timescale | Comments |
|---|---|---|---|---|---|---|---|---|---|---|
| **Deep Dive - Command and control** | | | | | | | | | | |
| **Domain: Incident Coordination Centres** | | | | | | | | | | |
| 1 | Incident Coordination Centres | Communication and IT equipment | The organisation has equipped their ICC with suitable and resilient communications and IT equipment in line with NHS England Resilient Telecommunications Guidance. | Y | | Fully compliant | | | | Incident Control Room facilities enhanced and upgraded May 2018. 6 additional telephone lines, retention of conventional fallback line. 3 new wall mounted display screens and multi display system. Role specific equipment boxes and tabards. New colour printer. New large whiteboards . IT Power have Generatorr back up and UPS |
| 2 | Incident Coordination Centres | Resilience | The organisation has the ability to establish an ICC (24/7) and maintains a state of organisational readiness at all times. | Y | Up to date training records of staff able to resource an ICC | Fully compliant | | | | July & August 2018. 30 On Call Managers given in Major Incident and Business Continuity Incident Co-ordination in ICC. Including familiarisation with equipment |
| 3 | Incident Coordination Centres | Equipment testing | ICC equipment has been tested every three months as a minimum to ensure functionality, and corrective action taken where necessary. | Y | Post test reports<br>Lessons identified<br>EPRR programme | Fully compliant | | | | ICC equipment and room functionality tested during Exercise Golden Eagle - 5 June 2018. Resilience Manager checks , audits and test equipment and preparedness monthly to coincide with Events Planning Group meetings |
| 4 | Incident Coordination Centres | Functions | The organisation has arrangements in place outlining how it's ICC will coordinate it's functions as defined in the EPRR Framework. | Y | Arrangements outline the following functions:<br>Coordination<br>Policy making<br>Operations<br>Information gathering<br>Dispersing public information. | Fully compliant | | | | Major Incident Plan covers the use and functions of the ICC. Recent (July and August 2018 ) On Call Manager training for Major Incident Management focussed on the role and function n of the room and the Incident Management Team |
| **Domain: Command structures** | | | | | | | | | | |
| 5 | Command structures | Resilience | The organisation has a documented command structure which establishes strategic, tactical and operational roles and responsibilities 24 / 7. | Y | Training records of staff able to perform commander roles<br>EPRR policy statement - command structure<br>Exercise reports | Fully compliant | | | | Strategic/Tactical and Bronze command structure embedded in hospital management. Recently enhanced with daily designated Silver Commander and overview . 24/7 Rotas for Manager and Executives. |
| 6 | Command structures | Stakeholder interaction | The organisation has documented how its command structure interacts with the wider NHS and multi-agency response structures. | Y | EPRR policy statement and response structure | Fully compliant | | | | Trust Major Incident Plan documents roles, functions and interaction with wider NHSE and CCG Incident Management and reporting requirements |
| 7 | Command structures | Decision making processes | The organisation has in place processes to ensure defensible decision making; this could be aligned to the JESIP joint decision making model. | Y | EPRR policy statement inclusive of a decision making model<br>Training records of those competent in the process | Fully compliant | | | | Section 8 of the Trust Major Incident Plan has full reference to JESIP Joint Decision Making Model. This is an element of management training sessions |
| 8 | Command structures | Recovery planning | The organisation has a documented process to formally hand over responsibility from response to recovery. | Y | Recovery planning arrangements involving a coordinated approach from the affected organisation(s) and multi-agency partners | Fully compliant | | | | Section 19 of the Trust Major Incident Plan outlines the approach and policy guidance on the transition from Response to a Recovery Phase |

| Overall assessment: | | | Partially compliant | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Ref** | **Domain** | **Standard** | **Detail** | Evidence - examples listed below | **Self assessment RAG**<br><br>Red = Not compliant with core standard. In line with the organisation's EPRR work programme, compliance will not be reached within the next 12 months.<br><br>Amber = Not compliant with core standard. The organisation's EPRR work programme demonstrates an action plan to achieve full compliance within the next 12 months.<br><br>Green = Fully compliant with core standard. | **Action to be taken** | **Lead** | **Timescale** | **Comments** |
| **33** | **Response** | **Loggist** | The organisation has 24 hour access to a trained loggist(s) to ensure decisions are recorded during business continuity incidents, critical incidents and major incidents. | • Documented processes for accessing and utilising loggists<br>• Training records | Partially compliant | A cadre of administration staff to undertake an internal Loggist training course. A documented process of how to access and utilise a Loggist in the event of a major incident | Emma Blackwell, Resilience Manager | Dec-18 | The Trust has previously engaged in a training programme for Incident Loggist resulting in a cadre of trained staff. Some staff have now moved deparment, left the Trust or require refresher training. It is recognised that this is an area for urgent review and update, this is a priority task. |
| **51** | **Business Contin** | **Business Continuity Plans** | The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to:<br>• people<br>• information and data<br>• premises<br>• suppliers and contractors<br>• IT and infrastructure<br><br>These plans will be updated regularly (at a minimum annually), or following organisational change. | • Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation | Partially compliant | Trust BCP to be reviewed and updated.<br>BCP's to be developed in 2 Clinical Business Units.<br>Corporate BCP's need updating<br>Service level plans require updating. | Resilience Manager | Dec-18 | It is a priority task to take stock and audit CBU and Departmental BC plans and update as appropriate with organisational changes. |
| **55** | **Business Contin** | **Assurance of commissioned providers / suppliers BCPs** | The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers arrangements work with their own. | • EPRR policy document or stand alone Business continuity policy<br>• Provider/supplier assurance framework<br>• Provider/supplier business continuity arrangements | Partially compliant | Deputy Head of Procurement to update the Supplies department BCP. | Simon Bennett, Supply Chain Manager | Nov-18 | The NHS Supply Chain has a comprehensive BCP. Within the Trust the Supplies department has a BCP in place, it is acknowledged that the BCP needs to be reviewed. |
| **59** | **CBRN** | **Decontamination capability availability 24 /7** | The organisation has adequate and appropriate decontamination capability to manage self presenting patients (minimum four per hour), 24 hours a day, 7 days a week. | Rotas of appropriately trained staff availability 2 | Partially compliant | Trust trainers have been identified and will be booked onto Train the Trainer courses as soon as they become available. In the interim, staff awareness sessions will take place to ensure all staff are aware of the IOR for decontamination. | Chris Evans - Chief Operating Officer. Supported by Resilience Manager & Matron ED | Ongoing | There are CBRN Leads on both the Warrington and Halton site. However Leads need refresher training and not all ED staff have recieved Decontamination training. This is an area of work to be progressed. A programme of staff training on basic Initial Operational Response (IOR) is recommended. The aim is to have a minimum level of casualty decontamination staffing available in ED at all times. In the future once staff are trained then records should be maintained and made accessible . NWAS have failed to provide the necessary and scheduled Decontamination/CBRN Train the Trainer courses. The last was cancelled at short notice . |
| **61** | **CBRN** | **PRPS availability** | The organisation has the expected number of PRPS (sealed and in date) available for immediate deployment.<br><br>There is a plan and finance in place to revalidate (extend) or replace suits that are reaching their expiration date. | Completed equipment inventories; including con | Partially compliant | All out of date suits are to be removed from the operational store and destroyed by Respirex. The Trust only has 9 in date Operational PRPS suits, Request made to NHS England for 3 more from Central Store (29.8.18) | Chris Evans - Chief Operating Officer. Supported by Resilience Manager & Matron ED | Awaiting roll out of new suits from DH | The Trust has a total of 9 in date PRPS suits which below the minimum level of 12 needed to mount a response. All of these suits are on loan from Central Store pending national role out of new suits. A further 6 suits were mislaid in delivery and never arrived. Despite efforts of Trust and NHSE they have not been located . Out of date suits are scheduled to be disposed of in accordance with national guidance. |
| **64** | **CBRN** | **PPE disposal arrangements** | There are effective disposal arrangements in place for PPE no longer required, as indicated by manufacturer / supplier guidance. | Organisational policy | Partially compliant | Quote obtained from RESPIREX for disposal of suits, funding has been identified and purchase order raised. | Resilience Manager & Matron ED | Oct-18 | Communications from Respirex and EPRR co-ordinator. |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **65** | **CBRN** | **HAZMAT / CBRN training lead** | The current HAZMAT / CBRN Decontamination training lead is appropriately trained to deliver HAZMAT / CBRN training | Maintenance of CPD records | Partially compliant | This is an area of work to be urgently progressed . NWAS have failed to provide the necessary and scheduled Decontaninatio/CBRN Train the Trainer courses. The last was cancelled at short notice . Trust trainers are very much out of date and need refresher training before internal training can commence. ED have identified 8 staff to attend the NWAS training as soon as the dates become available. | Resilience Manager & Matron ED | Awaiting dates from NWAS | Late 2017 NWAS cancelled at short notice all 8 places the Trust had booked for Training of Trainers for decontamnition/ Hazmat . This has led to a hold on training for staff. Trust staff are anxious for the regiaonl NWAS training to be rescheduled, as current trained staff need a refresher/update |
| **66** | **CBRN** | **Training programme** | Internal training is based upon current good practice and uses material that has been supplied as appropriate. Training programme should include training for PPE and decontamination. | Evidence training utilises advice within:<br>• Primary Care HAZMAT/ CBRN guidance<br>• Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/<br><br>• A range of staff roles are trained in decontamination techniques<br>• Lead identified for training<br>• Established system for refresher training | Partially compliant | A newly appointed ED Practice Based Educator will overseee the decontamination training. Until dates can be provided for train the trainer courses the IOR will be ciruclated to staff for awareness. | Resilience Manager & Matron ED | October 2018 for staff awarenes ss | This is is an area of work to be progressed . A programme of staff training on basic Initial Operational Response (IOR) is required. The aim is to have a minimum level of casualty decontamination staffing available in ED at all times. In the future once staff are trained then records should be maintained and made accessible . NWAS have failed to provide the necessary and scheduled Decontamination/CBRN Train the Trainer courses. The last was cancelled at short notice . Trust trainers are very much out of date and need refresher training. Representation has been made to NHSE to secure this training urgently. |
| **67** | **CBRN** | **HAZMAT / CBRN trained trainers** | The organisation has a sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme. | Maintenance of CPD records | Partially compliant | Staff have been identified to attend the CBRN train the trainer course. This will then be rolled out to ED staff. | Resilience Manager & Matron ED | Awaiting dates from NWAS | This is is an area of work to be progressed . A programme of staff training on basic Initial Operational Response (IOR) is required. The aim is to have a minimum level of casualty decontamination staffing available in ED at all times. In the future once staff are trained then records should be maintained and made accessible . NWAS have failed to provide the necessary and scheduled Decontamination/CBRN Train the Trainer courses. The last was cancelled at short notice . Trust trainers are very much out of date and need refresher training. Representation has been made to NHSE to secure this training urgently. |
| **68** | **CBRN** | **Staff training - decontamination** | Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant. | Evidence training utilises advice within:<br>• Primary Care HAZMAT/ CBRN guidance<br>• Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/<br>• Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011). Found at: http://www.londoncn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf<br>• A range of staff roles are trained in decontamination technique | Partially compliant | Staff will receive training based on the CBRN guidance and IOR as described in the Trust CBRN plan. | Resilience Manager & Matron ED | Ongoing | Training detailed in Trust CBRN Plan and Power Point presentations of previous staff training. |

**Cheshire & Merseyside Local Health Resilience Partnership (LHRP)**
**Emergency Preparedness, Resilience and Response (EPRR) assurance 2018-2019**

## 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 Partial 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 | Standards rated as Red | Standards rated as Amber | Standards rated as Green |
|---|---|---|---|
| **65** | 0 | 8 | 57 |
| Acute providers: **64**<br>Specialist providers: **55**<br>Community providers: **54**<br>Mental health providers:**54**<br>CCGs: **43** | | | |

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 and governance deep dive responses.

Sign Name

CHRIS EVANS

Print Name

The organisation's Accountable Emergency Officer

Trust Board 28/11/18

Date of board / governing body meeting

3/10/18

Date signed

| Core Standard reference | Core Standard description | Current Trust Position | Improvement required to achieve compliance | Action to deliver improvement | Deadline | Progress to date |
|---|---|---|---|---|---|---|
| **Response 33** | The organisation has 24 hour access to a trained Loggist(s) to ensure decisions are recorded during business continuity incidents, critical incidents and major incidents. | The small group of Loggist that were trained in the Trust are either no longer employed by the Trust or are out of date with their training.<br>3 members of staff (including the Resilience Manager) would currently be able to fulfil the role. | A cadre of administration staff to undertake an internal Loggist training course.<br><br>A documented process of how to access and utilise a loggist in the event of a major incident. | A group of administration staff to be identified who would be willing and able to undertake the Loggist role as part of the Incident Co-ordination Team in the event of a Major Incident. | December 2018 | 12.09.18 discussed at EPG, Band 5 administration staff identified. A training plan is being developed.<br>18.10.18 EB attended train the trainer course.<br>30.10.18 Flyer currently being produced by the Comms team.<br>Training scheduled for the 06.12.18. |
| **Business Continuity 51** | The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to:<br>• people<br>• information and data<br>• premises<br>• suppliers and contractors<br>• IT and infrastructure<br><br>These plans will be updated regularly (at a minimum annually), or following organisational change. | The Trust Business Continuity Plan was due for review in February 2018.<br><br>Clinical Business Unit and Service level plans were developed early in 2017 for some but not all areas. 2 CBU's do not have BCP's in place. The remaining service level plans are overdue their annual review. | Review and updates to the Trust Business Continuity Plan.<br><br>Review of CBU and Service level BCPs.<br><br>Development of BCP's for Musculoskeletal Care and Airways, Breathing and Circulation.<br><br>Corporate service plans to be reviewed. | Resilience Manager to update Trust Business Continuity Plan and table at the November Event Planning Group.<br><br>BCP's to be sent to CBU's for review and updates.<br><br>Resilience Manager to work with the 2 CBU's to ensure BCP's in place.<br><br>Resilience Manager to link in with HR, Finance and Estates for | November 2018<br><br>November 2018<br><br>November 2018<br><br>December 2018 | September 2018 Trust wide review of current BCP status.<br><br>September 2018<br>IM&T completed update of their BIA and BCP.<br><br>October 2018<br>Updated BCP's received from Estates and Finance<br><br>October 2018<br>CBU's currently working on BCP's to be completed by the end of November.<br><br>November 2018<br>Trust BCP has been updated and approved at EPG.<br><br>CBU's all provided update on current position of BCP's. |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Business Continuity 55** | The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers arrangements work with their own. | The Business Continuity Plan for Supplies is out of date. | Supplies BCP to be updated to incorporate requirements of the core standard. | BCP to be updated by the Deputy Head of Procurement. | November 2018 | November 2018 Supplies Manager confirmed BCP currently being updated. |
| **CBRN 59** | The organisation has adequate and appropriate decontamination capability to manage self-presenting patients (minimum four per hour), 24 hours a day, 7 days a week. | There are CBRN leads on both the Warrington and Halton site. However, not all ED staff have received decontamination training.<br><br>Some staff require an update and refresher training.<br><br>NWAS have failed to provide the necessary and scheduled Decontamination/CBRN Train the Trainer courses. The last was cancelled at short notice.<br><br>Unable to obtain training records from previous ED Practice Educator. | 8 ED staff have been identified to attend the NWAS train the trainer course once the dates are released.<br><br>Training will then be rolled out in the department. | Identified CBRN Leads to attend NWAS Decontamination/CBRN Train the Trainer course.<br><br>Training to be rolled out within the ED department. | Awaiting dates from NWAS | October 2018 Resilience Manager and ED Practice Education to provide awareness briefing to staff. |
| **CBRN 61** | The organisation has the expected number of PRPS (sealed and in date) available for | The Trust has a total of 9 in date PRPS suits which below the minimum level of 12 needed to mount a | A further 3 PRPS suits need to be provided from the Central store. | NHS England to liaise with DH Central Store | January 2019 | 31.10.18 – 6 new PRPS suits have been delivered to ED. The Trust currently has 15 PRPS |

| | | | | | | |
|---|---|---|---|---|---|---|
| | immediate deployment.<br><br>There is a plan and finance in place to revalidate (extend) or replace suits that are reaching their expiration date. | response. All of these suits are on loan from Central Store pending national role out of new suits. A further 6 suits were mislaid in delivery and never arrived. Despite efforts of Trust and NHSE they have not been located . Out of date suits are scheduled to be disposed of in accordance with national guidance. | | | | available for deployment. |
| **CBRN 64** | There are effective disposal arrangements in place for PPE no longer required, as indicated by manufacturer / supplier guidance. | The Trust currently has 14 expired PRPS suits that need to be disposed of. | 14 suits to be destroyed. | Funding to be identified for external company Respirex to collect suits. | October 2018 | September 2018 – Funding has been authorised by ED. Purchase order has been raised and suits to be collect w/c 12/12/18. |
| **CBRN 65** | The current HAZMAT / CBRN Decontamination training lead is appropriately trained to deliver HAZMAT / CBRN training. | Late 2017 NWAS cancelled at short notice all 8 places the Trust had booked for Training of Trainers for decontamination/ Hazmat . This has led to a hold on training for staff. The Current training leads on both sites need a refresher/update. | CBRN Leads to attend NWAS training as soon as dates are released. | Staff to be released from department to attend training once dates are released | Regional issues – dependant on NWAS | August 2018 – update from CBRNE Manager for NWAS, still in negotiation with NARU to deliver training sessions.<br><br>October 2018<br>NHS England confirmed dates are being scheduled for early in the new year, |
| **CBRN 66** | Internal training is based upon current good practice and uses material that has been supplied as appropriate. | Previously, Decontamination Leads who attended the NWAS CBRN Train the trainer courses have trained staff | 8 ED staff have been identified to attend the NWAS train the trainer course once the dates are released. | Staff to be released from department to attend training once dates are released. | Regional issues – dependant on NWAS | October 2018 Resilience Manager and ED Practice Education to provide awareness briefing to staff based on IOR. |

| | | | | | | |
|---|---|---|---|---|---|---|
| | Training programme should include training for PPE and decontamination. | within the department using the material given.<br><br>Current staff are in need of refresher training. | Training plans will then be developed using the materials they have been provided. | | | |
| **CBRN 67** | The organisation has a sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme. | Previously, Decontamination Leads who attended the NWAS CBRN Train the trainer courses have trained staff within the department using the material given.<br><br>Current staff are in need of refresher training. | 8 ED staff to attend the NWAS train the trainer course once the dates are released.<br><br>The trainers will then provider CBRN/Decontamination training sessions within the department. | Staff to be released from department to attend training once dates are released. | Regional issues – dependant on NWAS | October 2018 Resilience Manager and ED Practice Education to provide awareness briefing to staff based on IOR. |
| **CBRN 68** | Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant. | The Trust CBRN plan details the process to be followed in the event of self-presenting casualties.<br><br>All staff including Reception and Triage require refresher training. | Refresher training sessions to be undertaken by Reception staff.<br><br>Clinical staff will need to attend the full decontamination training once available. | Staff to be released from department to attend training once dates are released. | Reception training – December 2018<br><br>Clinical training – dependent on NWAS | October 2018 - Resilience Manager and ED Practice Education to provide awareness briefing to staff based on IOR<br><br>October 2018 – Reception action card updated and staff aware of procedure to follow. |

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

**BOARD OF DIRECTORS**

| | |
|---|---|
| **AGENDA REFERENCE:** | **BM/18/11/187** |
| **SUBJECT:** | **Guardian Quarterly Report on Safe Working Hours for Junior Doctors in Training July – September 2018** |
| **DATE OF MEETING:** | 28 November 2018 |
| **ACTION REQUIRED** | **The Board are requested to note the report and progress made with implementing the junior doctor contract and the level of assurance given that the junior doctors are working safely for their own health and wellbeing and the safety of patients.** |
| **AUTHOR(S):** | Mark Tighe, Guardian of Safe Working Hours and Mick Curwen, Head of HR Strategic Projects |
| **EXECUTIVE DIRECTOR SPONSOR:** | Alex Crowe, Deputy Medical Director |
| | |
| **LINK TO STRATEGIC OBJECTIVES:** | SO2: To have a committed, skilled and highly engaged workforce who feel valued, supported and developed and who work togther to care for our patients |
| **LINK TO BOARD ASSURANCE FRAMEWORK (BAF):** | BAF1.2: Health & Safety |
| | BAF2.1: Engage Staff, Adopt New Working, New Systems |
| | BAF2.3: Medical Staffing |
| | |
| **STRATEGIC CONTEXT** | The junior doctor contract was implemented in the trust on 7.12.16 but with national safeguards that the junior doctors should not be working excessive hours which could affect their health and wellbeing and the service they deliver to patients.<br><br>Each trust was required to appoint a Guardian of Safe Working whose primary role is to ensure that junior doctors do work safely and are able to access appropriate training and development opportunities.<br><br>A system of Exception Reports allows junior doctors to report areas of non-compliance and provides the opportunity for the Guardian to monitor trends and issues.<br><br>It is a requirement of the national contract that the Guardian submits a quarterly and annual report to the Board so that the Board can gain this level of assurance. |

| | |
|---|---|
| | The Board has previously received reports covering:<br><br>- December 2016 to May 2017<br>- June to September 2017<br>- October to December 2017<br>- January to March 2018 but also incorporating the Annual Report from April 2017 to March 2018.<br>- April – June 2018<br><br>This report covers the quarter from July – September 2018. |
| **EXECUTIVE SUMMARY** (KEY ISSUES): | The new Junior Doctors Contract has been in place since August 2016, and now all our Foundation Doctors are on this new contract, as well as the newer appointments on the CT and ST grade. Integration of the new rota has been achieved successfully between the rota managers, HR, postgraduate department, and the Clinical and Educational Supervisors.<br><br>There has been a slight rise in the number of exception reports filed in Q2 (35 vs 27), and in total number of incidents (58 vs 33). This was a crossover period between the outgoing Foundation Doctors and the new starters, so is a little difficult to interpret. The new Foundation Doctors had 3 induction tutorials on Exception Reporting and the New Junior Doctors Contract in August, so I was pleased to see they were able to start reporting in early August.<br><br>The majority of ERs still relate to juniors working past their allocated hours. The more senior trainees seem to be more concerned with loss of educational and training opportunities, when being asked to cover understaffed areas. This is apparent on one or two of the medical wards, for example cardiology on C21, where the Foundation Doctors feel there is medical understaffing, and the senior trainees feel unable to get to their teaching opportunities due to the inpatient clinical workload. This is now being addressed by the Medical Director and Chief Registrar.<br><br>We still have problems with the sign-off meetings between |

| | | |
|---|---|---|
| | the Educational Supervisors and the trainees, with large numbers of ERs having not been closed. I feel this has improved however, now that the trainees and Educational Supervisors are more accustomed to using the Allocate system. I do continue to push for closure of the ERs with both trainees and consultants.<br><br>We continue to see many more requests for time-off in lieu (TOIL), rather than compensatory payment. This is reassuring as it will hopefully prevent them exceeding their recommended maximum hours. | |
| **RECOMMENDATION:** | The Board are requested to note the report and progress made with implementing the junior doctor contract and the level of assurance given that the junior doctors are working safely for their own health and wellbeing and the safety of patients.<br><br>Any concerns that the Board have should be reported back to the Guardian for his attention. | |
| **PREVIOUSLY CONSIDERED BY:** | **Committee** | Not Applicable |
| | **Agenda Ref.** | SPC/18/11/126 |
| | **Date of meeting** | 21 November 2018 |
| | **Summary of Outcome** | Noted |
| **FREEDOM OF INFORMATION STATUS (FOIA):** | Release Document in Full | |
| **FOIA EXEMPTIONS APPLIED:** *(if relevant)* | None | |

**BOARD OF DIRECTORS**

| SUBJECT | Guardian Quarterly Report on Safe Working Hours for Junior Doctors in Training covering Q2: 1 July 2018 – 30 September 2018 | AGENDA REF: | BM/18/11/187 |
|---|---|---|---|

## 1. Executive Summary

The New Junior Doctor Contract is well established at WHH. All our rotas remain compliant, and in general the juniors are happy with their allocations. Our Junior Doctors' Forum remains very well attended and enjoys robust discussion. The collaboration of the Medical Director, HR and the Guardian into a single meeting for the JDF seems to work well, to identify and correct persistent ongoing concerns from the juniors. In addition, the juniors seem happy to engage with their consultants, Educational Supervisors and Guardian, if any new issues develop.

We are averaging around 10 exception reports (ERs) per month in Q1 and Q2), which is obviously down compared with the difficult times over the winter months. Thirty-five new ERs were submitted during this time, with 4 documented as immediate safety concerns (ISC).

The vast majority of ERs (29) still relate to our F1 doctors working past their allocated time, usually on an ad hoc basis, but there has been a cluster from two areas, which have prompted work schedule reviews.

Only two ERs relate to missed educational or training opportunities, both from ST grades, but this has improved from the previous quarters. Four ERs relate to a lack of senior support on their wards.

Most ERs are submitted by juniors working on the medical wards, but this reflects the busier nature of their jobs. I have been impressed with the attempts to resolve the staffing shortages on the acute medical wards, but despite this, the F1s appear to be getting good support and teaching there. The spike in orthopaedic ERs relate to time management, and a lack of awareness of the correct finishing time after nights. This has been addressed.

Although there has been some improvement, I still have issues with the timeliness of the review meetings between ES and trainee, once an ER has been submitted. I have encouraged the F1s to contact me as Guardian, if they are struggling to meet with their ES. I have contacted a number of supervisors, both individually and collectively, to try and address this.

We are seeing far more request for time-off in lieu rather than compensatory payment (17 vs 7 episodes), which is reassuring to ensure maintenance of safe working hours.

Again, there has again been no escalation of an ER to a level 2 review or fine to the trust since the last Report.

## 2. Introduction

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

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

This Report covers the period from 1 July 2018 to 30 September 2018 and follows the format as recommended by NHS Employers.

High level data

| | |
|---|---|
| Number of doctors / dentists in training (total): | 72 |
| Number of doctors / dentists in training on 2016 TCS (total): | 70 |
| Amount of time available in job plan for guardian to do the role: | 1.5 PAs / 6 hours per week |
| Admin support provided to the guardian (if any): | Nil WTE |
| Amount of job-planned time for educational supervisors: | 0.25 PAs per trainee up to a maximum of 0.5 PAs for further trainees |

The 72 doctors in training at the trust are made up of 36 FY1 trainees and 36 FY2 trainees, all of which are on the new contract (2 appointments on the FY2 intake were initially vacant but one was filled on a locum basis).

In addition, the Lead Employer (St Helens and Knowsley) employ trainees at ST1+ and CT1+ who rotate to different trusts as part of their training. At any one time, the trust usually has c90 trainees from the Lead Employer and the most recent rotations now include the vast majority of trainees on the new contract. The Lead Employer is responsible for their own monitoring and Quarterly Report for the trainees they employ.

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

| Specialty | No. exceptions raised Q1 | No. Exceptions raised Q2 | No. exceptions closed in Q2 | No. exceptions outstanding in Q2 |
|---|---|---|---|---|
| **General Medicine – FY1** | **18 (21)** | **16 (26)** | **8 (13)** | **8 (13)** |

| | | | | |
|---|---|---|---|---|
| **General Surgery – FY1** | **3 (6)** | **2** | **0** | **2** |
| **Trauma and Orthopaedics – FY1** | **0** | **1 (3)** | **0** | **1 (3)** |
| **Medicine - JST** | **0** | **7 (8)** | **5 (6)** | **2 (2)** |
| **Trauma and Orthopaedics – ST3** | **5** | **6 (15)** | **3 (7)** | **3 (8)** |
| **ENT – ST3** | **0** | **3 (4)** | **0** | **3 (4)** |
| **Emergency Medicine FY2** | **1** | **0** | **0** | **0** |
| **Total** | **27 (33)** | **35 (58)** | **16 (26)** | **19 (32)** |

NB.

1. The figures in brackets denote the total number of reported incidents. In some instances one Exception Report has been used to report more than one incident/issue. Therefore, a total of 35 exception reports were completed but these cover 58 incidents. The previous quarter was 27 exception reports and 33 incidents so whilst there has a slight increase in the number of exception reports there has been more of an increase in the number of actual incidents.
2. The 58 incidents were submitted from a total of 17 trainees covering 13 Educational Supervisors, 8 of which do not appear to have yet engaged in the process over this period which is of concern.
3. There were four exception reports completed covering 6 incidents, which were classified as an 'Immediate Safety Concerns' (ISCs). These relate to staffing levels caused by sickness and rota gaps in the medical wards (2 ERs). In ENT, there was an acute shortage of consultants, with a retirement and short-notice leaver, leaving the HST somewhat unsupported and with a lack of training opportunities (3 ERs). One of the medical ISCs was due to understaffing (and agency staff not turning up), and the other was a typing error on the ER! There has been a good response when I have escalated the ISCs to the relevant teams.
4. 19 (32) exception reports remain open from Q2 and need resolving. However, it should also be noted, that in one instance the trainee and Educational Supervisor have met to discuss the exception reports, but the trainee has not yet accepted the proposed outcome from the Educational Supervisor, but neither have they escalated this to the next stage.
5. I have communicated the need to close these ERs to both the trainee and educational supervisors on a number of occasions and covered this issue again at a Grand Round session on 13.7.18. This was a common theme at our recent Regional Guardian meeting, and has proved a difficult problem to correct among many trusts. The issue was covered at the induction of the new F1s and Lead Employer trainees in August.

Guidelines for exception reports state that reports should be completed by the doctor as soon as possible, but no later than 14 days of the exception. 34 (57) Exception Reports were submitted within 14 days and just one was outside this limit. This is an improvement from Q1 to Q2 of 8% to 97%. If the doctor is seeking payment as compensation, the report should be submitted within 7 days. Upon receipt of a report, the Educational Supervisor should respond within 7 days. We have allowed some flexibility in the time allowed after submission of an ER, to claim for payment or TOIL. However, we have put a provisional limit at 3 months, and whenever possible, to only allow TOIL within their current placement.

| Exception reports (response time) | | | | |
|---|---|---|---|---|
| | Addressed within 48 hours | Addressed within 7 days | Addressed in longer than 7 days | Still open |
| FY1 | 1 (1) | 0 | 7 (12) | 11 (18) |
| JST | 0 | 0 | 5 (6) | 2 (2) |
| ST3 | 1 (5) | 0 | 2 | 6 (12) |

The above table shows that 2 (6) reports (6%) have been addressed by the Educational Supervisor within 7 days, and 14 (20) reports (40%) were addressed in more than 7 days and 19 (32) reports (54%) still remain open. This latter figure is of some concern as the Educational Supervisors should have met to resolve the incidents. The exception reports which have been resolved were largely resolved at the 'Initial Stage' but 4 Exception Report have been escalated to 'Level 1 Review Stage'.

| **Exception reports (type of issue)** | | | | |
|---|---|---|---|---|
| | **Hours** | **Education** | **Service Support** | **Working Pattern** |
| **FY1** | **18 (30)** | **0** | **0** | **0** |
| **JST** | **5 (6)** | **1** | **0** | **0** |
| **ST3** | **6 (15)** | **1** | **4 (5)** | **0** |
| **Total** | **29 (51)** | **2** | **4(5)** | **0** |

Clearly the overwhelming number of issues relate to the number of 'hours' (83%) that the trainees are being asked to work in addition to their contracted hours.

| **Exception Reports (Outcome)** | | | | |
|---|---|---|---|---|
| | **Overtime Payment** | **Compensation and Work Schedule Review** | **Compensation: Time Off in lieu** | **No Further Action** |
| **FY1** | **0** | **2** | **6 (11)** | **0** |
| **JST** | **0** | **0** | **5 (6)** | **0** |

| | | | | |
|---|---|---|---|---|
| **ST3** | **3 (7)** | **0** | **0** | **0** |
| **Total** | **3 (7)** | **2** | **11 (17)** | **0** |

The increasing trend to time off in lieu as an outcome continues with 69% being resolved in this way and only 31% resulting in an overtime payment. This is consistent with the national position taken from feedback at Guardian meetings, and is reassuring to us regarding safe working hours.

Another interesting observation is that from just having 5 exception reports from Lead Employer trainees in Q1, this has increased to 16 (26) exception reports in Q2. There were no exception reports raised by FY2 trainees.

Junior Doctors on the 2002 Contract

It is important to remember that some junior doctors (employed by the Lead Employer) will remain on the 2002 contract for a number of years and will require their rotas to be monitored in line with their terms and conditions so that assurance can be given for all doctors in training and not just those on the new contract. A monitoring exercise has been completed on these doctors and the results are still being analysed. A new exercise has also commenced in November 2018.

## 4. Work Schedule Reviews

There have been two Work Schedule Reviews (WSR) recommended by the Education Supervisors at their initial meeting following submission of an exception report, which have been addressed by the relevant rota managers.

## 5. Locum Bookings

Bank and Agency

The normal arrangements for covering gaps on the rotas are for the trainees to be approached first to see what cover they can provide. Where gaps still remain, the shifts which need covering are submitted via the CBUs to the Medical bank. For the period from 1 July 2018 – 12 August 2018 the trust used the TempRe system for filling shifts but from 13 August 2018 – 30 September 2018 the trust has moved to a new system developed by 'Brookson'.

The tables below show the shifts which were escalated to the Medical bank for filling on the Medical Bank but because the trust has used two systems there are some discrepancies with the figures over this time period and it is possible that there are some duplicates but the numbers are thought to be low. The first table shows the total shifts by specialty and the second table shows the reason. All of the shifts relate to FY2 trainees.

Locum Bookings (Bank and Agency) by Department/Specialty

| Specialty | Requested Shifts | Paid Shifts | Shifts to Agency | Total Hours Requested | Paid Hours |
|---|---|---|---|---|---|
| Acute Medicine | 72 | 26 | 29 | 623.5 | 93 |
| A & E | 6 | 0 | 0 | 73 | 0 |
| Cardiology | 33 | 21 | 21 | 1600 | 117 |
| Care of the Elderly | 478 | 216 | 263 | 3822 | 1788 |
| General Surgery | 3 | 0 | 0 | 37.5 | 0 |
| Orthopaedic | 734 | 61 | 60 | 6843 | 734 |
| Total | 1326 | 324 | 373 | 12,999 | 2732 |

Locum Bookings (Bank) by Reason

| Booking Reason | Requested Shifts | Paid Shifts | Shifts to Agency | Total Hours Requested | Paid Hours |
|---|---|---|---|---|---|
| Annual Leave | 14 | 2 | 2 | 1470.5 | 23 |
| Extra | 30 | 29 | 30 | 240 | 230.5 |
| Sickness | 8 | 1 | 1 | 98 | 12 |
| Vacancy | 963 | 146 | 192 | 8453.5 | 1321.5 |
| Additional Service Requirement | 28 | 27 | 27 | 352 | 329 |
| On Call | 1 | 0 | 0 | 39 | 0 |
| Brookson Migration | 230 | 94 | 94 | 1785 | 755 |

| | | | | | |
|---|---|---|---|---|---|
| Total | 1274 | 299 | 346 | 12,438 | 2671 |

1. The above tables show that the main reason, by far, for requesting cover was due to vacancies.
2. Two specialties stand out in terms of requiring cover and these relate to Care of the Elderly and Trauma and Orthopaedics with the prime reason known to be other vacancies with the specialties. Not surprisingly, these two specialties also account for the highest use of bank/agency staff.
3. The number of shifts requested to be covered this quarter has fallen significantly from 2650 shifts to c1300 shifts but there had been a significant rise in the previous quarter.
4. The reason for the difference between requested shifts and the number of shifts given to agencies is due to subsequent cancellations from the CBUs.

## 6. Locum Work Carried Out by Trainees

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

| **Locum work by trainee** | | | | | | |
|---|---|---|---|---|---|---|
| **Specialty** | **Grade** | **Number of shifts worked** | **Number of hours worked** | **Number of hours rostered per week** | **Actual hours worked per week** | **Opted out of WTR?** |
| **General Medicine** | **FY1** | **c5** | **41** | **757** | **757** | **N/K** |
| **General Surgery** | **FY1** | **c6** | **50.5** | **544** | **534** | **N/K** |
| **TOTAL** | **FY1** | **C11** | **91.5** | **1301** | **1281** | **N/K** |
| **Psychiatry – NW Boroughs** | **FY2** | **c1.5** | **12.5** | **1468** | **1468** | **N/k** |
| **Accident and Emergency** | **FY2** | **c16** | **129.5** | **352** | **339** | **N/K** |
| **General Medicine** | **FY2** | **c12** | **96.5** | **464.5** | **464.5** | **N/K** |
| **General Surgery/Urology** | **FY2** | **c28** | **222** | **464.5** | **464.5** | **N/K** |
| **T & O** | **FY2** | **c11** | **86** | **325.15** | **325.15** | **N/K** |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Anaesthetics/ICU** | **FY2** | **c2.5** | **20.5** | **45** | **45** | **N/K** |
| **O & G** | **FY2** | **c1.5** | **12.5** | **352** | **352** | **N/K** |
| **GP** | **FY2** | **c2** | **19** | **480** | **406** | **N/K** |
| **Total** | **FY2** | **c75** | **598.5** | **3951.15** | **3864.15** | **N/K** |

NB.

1. The number of shifts worked has been estimated as records only show the number of hours worked and have been based on 8 hour shifts
2. The number of hours worked per week takes account of vacancies and trainees on maternity leave but excludes sickness or other absences such as annual leave.
3. It is not known whether any of the trainees exceeded an average of 48 hours per week under WTR and whether they completed an opt-out form.
4. In comparison with the previous quarter, the number of hours/shifts covered has reduced substantially from 169 shifts/1346.5 hours in Q1 to 75 shifts/598.5 hours in Q2. The previous two quarters were undoubtedly affected by the 'winter pressures' effect, where increased activity combined with some gaps in service increased the need for more shifts to be covered. However in comparison with Q3 in 2017/18 (Oct – Dec 2017) where c90 shifts were covered, the number of hours/shifts covered has reduced to more 'normal' levels.
5. The main areas where additional hours/shifts have been worked are general medicine, surgery, T&O and AED.
6. None of the extra hours worked related to Exception Reports which would suggest that TOIL is being used to compensate the trainees for working additional hours. All of the trainees have received information on how to make claims and this has been reiterated at the Junior Doctors Forum meetings.

## 7. Vacancies

The table below shows the vacancies at **FY1 level only** from **July – Sept 2018**:

| Specialty | Grade | July 18 | Aug 18 | Sept 18 | Total gaps (average) | Number of shifts uncovered |
|---|---|---|---|---|---|---|
| **General Surgery** | **FY1** | **0.4** | **0.4** | **0** | **0.26** | **16** |
| **Total** | **FY1** | **0.4** | **0.4** | **0** | **0.26** | **16** |

NB.

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

The table below shows the vacancies at **FY2 level only** from **July – Sept 2018:**

| Specialty | Grade | July 18 | Aug 18 | Sept 18 | Total gaps (average) | Number of shifts uncovered |
|---|---|---|---|---|---|---|
| **GP** | **FY2** | **3.0** | **3.0** | **0** | **2.0** | **120** |
| **A&E** | **FY2** | **0** | **0** | **1.0** | **0.33** | **20** |
| **Total FY2** | **FY2** | **3.0** | **3.0** | **1.0** | **2.3** | **195** |

NB.

1. During this period the three gaps in July and August on the rota all coincided to be at GP surgeries and did not affect any of the hospital services. It was not possible to cover any of these gaps.
2. The gap in A&E in Sept was due to a trainee having to extend their FY1 training but this was offset by another FY2 having their training extended.
3. There were no trainees on maternity leave or on long term sickness.

## 8. Fines

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

## 9. Qualitative Information

**Junior Doctors Forum**: The JDF continues to be very well attended, and there is excellent engagement and debate during the meeting. The joint meeting with Medical Director, Guardian and HR appears to be appreciated by the juniors and the chief registrar.

**Education supervisors**: Our ES are improving with their response to ERs, although this has involved a lot of "encouragement" from me. It is of concern that a number of ERs remain outstanding at the current time, and at the Regional meeting, we are all looking at strategies

to attempt to sort this problem. I have met with trainees on several occasions, to emphasise the importance of early sign-off of ERs.

**Exception reports**: Steady number coming through, around 10 per month this year. All ISCs have been addressed and closed expeditiously. Volume comparable with trusts our size at the Regional Guardian meeting.

**Compensation for extra duties worked**: Our juniors continue to favour compensation by TOIL, rather than payment. This is more reassuring for us, to ensure none of our trainees are exceeding their permitted hours. There have been 2 work schedule reviews, following immediate safety concerns, which were useful to correct problems for future F1s in the post.

**Allocate training**: There has been drop-in sessions available for Educational Supervisors to assist in completion of ER reviews. The PowerPoint presentation from Allocate is pretty self-explanatory and comprehensive too.

## 10. Issues Arising

Our volume of exception reports (ER) have stayed at a reasonable level during Q2. However, it is vital the juniors still engage with the process, to ensure they are working safely within their allocated rotas.

The 4 immediate safety concerns in this 3 month period were addressed and closed rapidly.

We have seen a positive shift in this 3 month period for compensation towards time-off in lieu, rather than supplementary payment, following submission of an Exception Report. This will lead to some reassurance that trainees are not exceeding their maximum safe hours

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

We need to ensure continued engagement of our Education Supervisors with our junior doctors, and continue to address the problem of persistent delays in participation of review meetings.

## 11. Action Taken to Resolve Issues

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

## 12. Summary

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

Apart from sporadic occasions, our juniors have been able to attend educational and teaching sessions, without recall to ward duty during this time frame.

Although there is still an issue with sign-off of outstanding ERs, there has been notable improvement in Q2. In addition, all completed reports have been signed off without resort to level 2 or guardian reviews. This was one of the main concerns from the BMA prior to implementation of the contract, and it is pleasing to see this continuing in our trust.

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

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

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

## 13. Questions for Consideration

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

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

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

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

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

**BOARD OF DIRECTORS**

| | |
|---|---|
| **AGENDA REFERENCE:** | **BM/18/11/120** |
| **SUBJECT:** | **Board Assurance Framework and Strategic Risk Register report** |
| **DATE OF MEETING:** | 28th November 2018 |
| **ACTION REQUIRED** | **Review, Discuss and approve** |
| **AUTHOR(S):** | John Culshaw, Head of Corporate Affairs |
| **EXECUTIVE DIRECTOR SPONSOR:** | Simon Constable, Medical Director & Deputy CEO |
| | |
| **LINK TO STRATEGIC OBJECTIVES:** | All |
| | |
| **STRATEGIC CONTEXT** | Risk Management is a mechanism for managing exposure to risk that enables the Trust to recognise the events that may result in harm and/or loss. The Trust has a legal and moral duty to patients, visitors and staff to ensure that their safety and wellbeing is not compromised as a result of hospital activities, processes or procedures, as well as regulatory implications. |
| **EXECUTIVE SUMMARY** (KEY ISSUES): | Since the last meeting, three new risks have been added to the BAF.<br><br>• *Failure to provide HCAI surveillance data and take timely action, caused by lack of IT software resulting in a risk of outbreaks of healthcare associated infection.*<br>• *Failure to provide continuity of palliative care caused by remaining consultant leaving the trust on 23.2.18 resulted in no consultant in palliative care*<br>• *Failure to provide an adequate level of Consultant Microbiology cover caused by insufficient numbers of Consultant staff (as advised in RCPath guidelines),resulting in delays in patient management due to delayed communication of results, inability to attend ward rounds, inability to complete required workload & attend infection control meetings as required.*<br><br>Furthermore, one risk has been removed from the |

| | |
|---|---|
| | BAF as all the action have been completed:<br>• *Failure to provide assurance regarding complaints handling within the Trust, caused by ineffective systems and processes, resulting in a poor experience for complainants, the Trust not meeting statutory and contractual complaints targets and not having effective systems in place to learn lessons from complaints*<br><br>Also included in the report are notable updates to existing risks |
| **RECOMMENDATION:** | Discuss and approve the changes and updates to the Board Assurance Framework and Strategic Risk Register |
| **FREEDOM OF INFORMATION STATUS (FOIA):** | Release Document in Full |
| **FOIA EXEMPTIONS APPLIED:** ***(if relevant)*** | None |

**BOARD OF DIRECTORS**

| SUBJECT | Board Assurance Framework | AGENDA REF: | BM/18/11/120 |
|---|---|---|---|

## 1. BACKGROUND/CONTEXT

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

The latest updates have been mapped into the Board Assurance Framework (BAF) (Appendix 1).

## 2. KEY ELEMENTS

### 2.1 New Risks

Since the last meeting three new risks have been added to the register.

| | |
|---|---|
| Risk #186 | **Risk: Failure to provide HCAI surveillance data and take timely action, caused by lack of IT software resulting in a risk of outbreaks of healthcare associated infection.** |
| Controls and Assurances | ▪ MIC-STAT MOLIS function to extract data retrospectively.<br>▪ Local spread sheet for cases of 'alert' organisms. |
| Gaps | ▪ No prospective data available.<br>▪ Manual input of data into local spread sheet - data entry risk of errors. |
| Initial Risk Rating | 16 (4x4) |
| Residual Risk Rating | 16 (4x4) |
| Actions | 1.1 To implement an IT software solution.<br>• Review off the shelf surveillance packages available.<br>• Review existing functionality with MOLIS<br><br>1.2 Implement IT software for surveillance.<br>• Develop business case or optional appraisal.<br><br>**Progress notes:**<br><br>Additional meeting held with IT on 30/08/18 to review development on in house surveillance system including:<br>MRSA screening compliance<br>Alerts for patients admitted and not screened<br>twice daily email for all patients with an Infection control clinical alert |

| | |
|---|---|
| | in Lorenzo<br>Patient movements if contact tracing is required<br>Auto flagging in Lorenzo from laboratory results - alert organisms<br>alerts for cluster of the same organism results in a defined clinical area |

| | |
|---|---|
| Risk **#261** | **Risk: Failure to provide continuity of palliative care caused by remaining consultant leaving the trust on 23.2.18 resulted in no consultant in palliative care** |
| Controls and Assurances | ▪ Consultant left 23.03.18. Palliative care Matron currently running OP clinics and helping to cover workload. Discussions taking place with St Rocco's to identify service requirements before advertising permanently. Advert out for temporary consultant cover.<br>▪ June update - interviewing for new palliative care consultant 19th June<br>▪ August update: some cover agreed by local Palliative care specialist for Fridays from September.<br>▪ Consultant advice available for team through St Roccos advice line.<br>▪ September update: awaiting start of Friday cover. Reviewing job description/options around palliative care consultant. Due to previous unsuccessful recruitment considering different ways of working. |
| Gaps | ▪ There remains no consultant in this position although cover in place |
| Current Risk Rating | 9 (3x3) |
| Suggested Risk Rating | 16 (4x4) |
| Actions | ▪ Discussions taking place with St Rocco's to identify service requirements before advertising permanently.<br>▪ completion of service requirements for both areas |

| | |
|---|---|
| Risk **#280** | **Risk: Failure to provide an adequate level of Consultant Microbiology cover caused by insufficient numbers of Consultant staff (as advised in RCPath guidelines),resulting in delays in patient management due to delayed communication of results, inability to attend ward rounds, inability to complete required workload & attend infection control meetings as required.** |
| Controls and Assurances | ▪ As an interim measure, a locum Consultant Microbiologist will be required if one of current Consultant Microbiologist were away on leave for 1 week or more.<br>▪ Business case in progress |
| Gaps | ▪ There remains no consultant in this position although cover in place |
| Current Risk Rating | 16 (4x4) |
| Suggested Risk Rating | 16 (4x4) |
| Actions | ▪ A business case to be submitted for an additional (third) Consultant Microbiologist to be contracted to fulfil the current clinical needs |

### 2.2 Removal of Risks

Following a review at the Risk Review Group on 8th October 2018, and subsequent approval at the Quality Assurance Committee on 8th November 2018, the following risk was removed from the BAF as all the actions have been completed:

*Failure to provide assurance regarding complaints handling within the Trust, caused by ineffective systems and processes, resulting in a poor experience for complainants, the Trust not meeting statutory and contractual complaints targets and not having effective systems in place to learn lessons from complaints*

### 2.3 Existing Risks - Updates

| Risk ID | Strategic Risk | Update since last Risk review | Impact of update on risk rating |
|---|---|---|---|
| 134 | Risk: Financial Sustainability<br>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.<br>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. | • CCG have made the Trust aware of their M6 financial position. After mitigations, they are currently working to close a potential gap. This may impact on the financial support available to the Trust to achieve our revised control total.<br>• Extended Loan repayment due Nov 2018, awaiting confirmation of further extension from NHSi..<br>• Sub group established for OT payments reporting through premium pay spend and review group<br>• Commissioned an audit review of OT processes subject to Chair of Audit Chair Approval<br>• Recommendation for internal OT processes to be presented to Exec Team | No impact on risk rating |
| 120 | Failure to identify and manage patients' risk of sustaining a fall; caused by inadequate risk assessment and implementation of appropriate care plans. This may cause patient harm, has a negative effect on the patient's experience, may prolong their length of stay, and give rise to complaints and claims against the trust. | • Two moderate harms falls occurred in September 2018<br>• One serious harm fall occurred in October 2018.<br><br>The financial impact associated with falls is great, the average cost of a no harm fall is approximately £2,600 for people over the age of 65 and for a severe harm fall £14,100.<br><br>• Bathroom review programme near completion, findings to report in November 2018.<br>• Falls alarms and sensor pads ordered following a donation form the League of Friends<br>• Enhanced Care Policy Rollout - Training underway in November<br>• NHSi collaborative completed with two wards | No impact on risk rating |

| Risk ID | Strategic Risk | Update since last Risk review | Impact of update on risk rating |
|---|---|---|---|
| | | • Multi-factorial falls documentation to be on wards by the end of November. | |
| 116 | Failure to deliver national and local performance targets will result in an impact on patient care, reputation and financial position. | • STP bid successful for FAU substantive Recruitment - In progress to support 5 day delivery model.<br>• The first meeting of the Performance Review Group will take place w/c 29th October 2018.<br>• Venn System Capacity & Demand due to report in October 2018.<br>• Venn System Event taking place 5th November 2018<br>• Discharge Lounge due to open on 26th November 2018<br>• Full business case to be presented to the Exec Team for works to be undertaken on A3 (for completion in Dec 2018) creating assessment capacity. | No impact 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. | • Completed a staffing escalation audit in Oct to review the effectiveness of the staffing escalation plans<br>• Asked to join cohort 4 of the NHSi retention improvement programme which commences in Nov 2018.<br>• 13 RNs & 15 HCAs recruited in September 2018<br>• 26 RNs & 12 HCAs due to commence with the Trust in October 2018.<br>• 17 new starter commenced on Monday 12th November<br>• HCA Recruitment event taking place on 4th December for which there are 75 applicants<br>• 'Keeping in touch' day scheduled for 22nd November for new starters<br>• First meeting of the NHSi Retention Collaborative on 22nd November 2018 | No impact on risk rating |
| 512 | Failure to have robust processes in place across the Trust relating to Medical devices, caused by inconsistency in applying policies and procedures and inability to provide assurance, resulting in potential for patient safety incidents, service disruption and non-compliance of regulatory standards. | • An improvement plan is in place within the Trust aligned to CQC action plan. This will ensure that:<br>o By end October all competency assessments will be in place for High, Medium, Low risk devices and that all system work on E-quip will be completed for staff to input details of training and competency<br>o By end October – all inventories will be reconciled on the E-quip | No impact on risk rating |

| Risk ID | Strategic Risk | Update since last Risk review | Impact of update on risk rating |
|---|---|---|---|
| | | system and the Trust will have a centralised inventory<br>By end December – all training and competency records for medical devices/equipment will be uploaded onto the E-quip system | |
| 138 | Failure to provide timely information caused by increasing internal and external demands for datasets, implementation of new systems and a lack of skilled staff with capacity to respond. Resulted in a financial impact, external reputation damage and poor management decision making due to lack of quality data. | • BI Manager commenced and work on the new Emergency Care Flow Dashboard has started in collaboration with an external supplier.<br>• Data Quality checks on patient demographics and completeness and timely discharge letters continue with real time daily routines to ensure letters stranded in interfaces are submitted timely. | No impact on risk rating |
| 143 | Failure to deliver essential services, caused by a Cyber Attack, resulting in loss of data and vital IT systems, resulting in potential patient harm, loss in productivity and Trust reputation | • Windows XP are not off our network and only XP left are radiology machines which are hardened so they cannot be changed (minimal risk)<br>• Critical Systems Patching Schedule has been ratified by the Digital Board and will be going to the Event Planning Group the same week. Patching is continuing.<br>• Event Log Retention Policy has been added to the ISMS (Part of Cyber Essentials +)<br>• All CareCERT's are now completed and sent back to NHS England. | |
| 123 | Failure to prevent harm to patients, caused by lack of timely and quality discharge summaries being sent to primary care, resulting in a lack of appropriate handover of care, with patient safety, operational, financial and reputational consequences. | • A daily report tracking discharge summary performance is in place and sent out to Clinical Directors<br>• E-Discharge Task and Finish Group has been set up to oversee a review of the Trust's E-Discharge policies and processes, to ensure that they are robust and that there is effective clinical review and escalation processes in place. The Task & Finish group reports to the Patient Safety & Clinical Effectiveness Sub Committee. | No impact on risk rating |
| 135 | Failure to provide adequate and timely IMT system implementations & systems optimisation caused by either increasing demands and enhanced system functionality which results | • A business case for ICE resilience has been approved by the Executive Team with the installation and configuration will be completed by the end of Oct 2018.<br>• A training needs and plan is currently being developed for critical systems. | No impact on risk rating |

| Risk ID | Strategic Risk | Update since last Risk review | Impact of update on risk rating |
|---|---|---|---|
| | in pressure on staff; potential in systems being poorly used resulting in poor data quality. Impact on patient access to services, quality of care provided, potential patient harm and financial & performance targets. | | |
| 145 | Failure to influence sufficiently within the Cheshire & Merseyside Healthcare Partnership 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. | • Draft Clinical Strategy in place and individual specialty level strategies being developed.<br>• Memorandum of Understanding and work plan with Bridgewater Community Healthcare NHS FT approved.<br>• Working in partnership with GP Federation in Halton on relation to improving joint clinical pathways.<br>• Council and CCG in both Warrington & Halton supportive of development of new hospitals.<br>• Agreement of sustainability contract with Warrington CCG.<br>• GP engagement event held for Warrington & Halton GPs.<br>• Work plan agreed with StHK<br>• Shared a presentation demonstrating Halton Hospital's suitability to host the Eastern Sector Cancer Hub with Clatterbridge and other stakeholders. This forms part of the formal decision making process on the location of the hub<br>• Two more GP engagement events planned.<br>• Regular Strategy updates are provided to the Council of Governors. | No impact on risk rating |
| 133 | Failure to successfully engage the Workforce, caused by the potential for a negative working environment which resulted in the consequential loss of discretionary effort and productivity, or loss of talented colleagues to other organisations, which would impact patient care, staff morale and delivery of the Trust's strategic objectives | • The Trust is moving forward with phases 2,3 and 4 of LIA<br>• The new People Strategy has been ratified - with a key focus on Engagement<br>• National Staff Survey currently out for completion. | No impact on risk rating |

| Risk ID | Strategic Risk | Update since last Risk review | Impact of update on risk rating |
|---|---|---|---|
| 414 | Failure to implement best practice information governance and information security policies and procedures caused by lack of resources or ineffective communication of key information governance messages to WHH staff | • Audits on wards underway to establish whether IG best practice is in place<br>• New Director of IT appointed.<br>• Options for improving security of access to Lorenzo other than smartcards being reviewed. A paper will be presented to the Digital Board by 31/12/18. | No impact on risk rating |
| 88 | Failure to implement the requisite GDPR (General Data Protection Regulation) policies, procedures and processes caused by lack of resources resulting in areas of data protection non-compliance | • Populating Information Asset Register developed by the Walton Centre with information about electronic assets which will form the basis of systems mapping and best practice mechanisms around IT system risks, business continuity and IAO training.<br>• Identification of assistance for IG Manager in mapping information flows is underway. | No impact on risk rating |
| 141 | Failure to achieve the highest level of corporate governance, caused by the requirement to review and embed new structures, which may impact on statutory and regulatory requirements | • Previous Well-Led Action plan closed and residual risks transferred to new action plan.<br>• Evidence being completed for each KLOE in preparation for self-assessment | No impact on risk rating |
| 153 | Failure to attend mandatory resuscitation training caused by operational pressures resulting in low compliance rates and risk to patient and staff safety | • Liaised with managers to provide targeted training where appropriate<br>• Identified specific admin support throughout Sept & Oct to support Resus training & is contacting non-compliant staff and managers regularly to promote attendance.<br>• All CBU triumvirates contacted by Director of HR & OD regarding low compliance.<br>• All non-compliant staff have received a letter from the Director of HR & OD setting out requirements for compliance by 31 Oct 2018<br>• Weekly task and finish group set up to meet throughout October 2018, with senior leaders from key staff groups. Purpose to micro-manage attendance at training. | No impact on risk rating |

### 2.3 Risk Management Strategy Updates

We will be undertaking a stocktake of our risk process and maturity. The Risk review Group continues to meet monthly with the next meeting due to be held on 10th December 2018

## 3 RECOMMENDATIONS

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

APPENDIX 1

| ID | Risk description | Rating (initial) | Rating (current) | Please provide assurance details | Please provide any gaps in assurance | Monitoring Committee | Monitoring Sub Committee |
|---|---|---|---|---|---|---|---|
| 88 | Failure to implement the requisite GDPR (General Data Protection Regulation) policies, procedures and processes caused by lack of resources resulting in areas of data protection non-compliance | 9 | 12 | 1. Controls and assurance identified in readiness assessment and action plan.<br>2. Progress Reporting to Quality Committee<br>16.03.2018 - DPO Appointed<br>14.06.2018 - Information Asset Register System procured and being populated<br>05.09.2018 - Continued reporting of GDPR action plan to Quality Assurance Committee and plan updated in August 2018.<br><br>03/10/2018 -Populating Information Asset Register developed by the Walton Centre with information about electronic assets which will form the basis of systems mapping and best practice mechanisms around IT system risks, business continuity and IAO training.<br><br>03/10/2018 Identification of assistance for IG Manager in mapping information flows is underway. | Gaps in assurance include:<br><br>1. Incomplete Information flow mapping, difficulties in maintaining data asset registers and lack of resources (1 staff member) to maintain compliance with requirements of general data protection regulations on a long term basis.<br><br>2. Difficulty identifying all data processors in order to vary contracts | Quality & Assurance Committee | Informatics Sub-Committee |
| 115 | Failure to provide adequate staffing levels in some specialities and wards. Caused by inability to fill vacancies, sickness.<br>Resulting in pressure on ward staff , potential impact on patient care and impact on Trust access and financial targets. | 20 | 20 | 14.08.2018<br>45 HCAs have been recruited against the Nurse Staffing Business Case, due to start in August/September.<br>26 RNs commencing in September 2018<br>Daily staffing report which =forms part of the bed management reporting framework, underpinned with the staffing escalation process. This was audited in April 2018 with further Audit due October 2018.<br>Sickness pilot commenced in August 2018 for a period of three months.<br>Red Flag Events which relate to unmet care need due to staffing are now in place across the Trust and are responded to by the Lead Nurse or Matron on a daily basis.<br>11.09.2018<br>RCN Recruitment Day taking place on 13th September for trained nurses.<br>Recruited HCAs & RNs currently on Induction.<br>04.10.2018<br>•RCN event successfully recruited a further 9 registered nurses.<br>•Undertaking 'itchy feet' conversations with staff who are thinking of leaving to improve retention.<br>•Undertaking a staffing escalation audit in Oct to review the effectiveness of the staffing escalation plans.<br>23.10.2018<br>- Staffing Audit completed.<br>- Asked to join cohort 4 of the NHSi retention improvement programme which commences in Nov 2018.<br>- 13 RNs & 15 HCAs recruited in September 2018<br>- 26 RNs & 12 HCAs due to commence with the Trust in October 2018.<br>14.11.2018<br>- 17 new starter commenced on Monday 12th November<br>- HCA Recruitment event taking place on 4th December for which there are 75 applicants<br>- 'Keeping in touch' day scheduled for 22nd November for new starters<br>- First meeting of the NHSi Retention Collaborative on 22nd November 2018 | 6 monthly nursing acuity & dependency review undertaken, Results being collated<br>Recruitment and Retention Strategy developed December 2016 and in being operationalised and implemented<br>The Trust has had concerns raised by Health Education North West/Deanery regarding supervision and education of junior doctors in some medical specialities (acute medicine and geriatric care)<br><br>23.10.2018<br>- staff turnover has increased; therefore, more detailed analysis is being undertaken to look at measures to address the problem. | Operational Board | Workforce Sub-Committee |
| 116 | Failure to deliver national and local performance targets will result in an impact on patient care, reputation and financial position. | 20 | 20 | 06.08.2018<br>ECIP Review undertaken JULY 2018<br><br>05.09.2018<br>Frailty Hub Business Case to be submitted 07.09.2018 for STP Bids; however, IBCF contingency plan in place to support 1 year full funding to allow recruitment to start.<br><br>Assurance provided to regional NHSi Director in relation to Elective Care expectations and performance between Sept 2018 - March 2019.<br><br>Winter planning sessions commenced in July 2018 which have moved to weekly meeting in Sept 2018. Internal & System plans referencing peer reviews and GIRFT documentation.<br><br>16.10.2018<br>STP bid successful for FAU substantive Recruitment - In progress to support 5 day delivery model.<br><br>The first meeting of the Performance Review Group will take place w/c 29th October 2018.<br><br>Venn System Capacity & Demand due to report in October 2018.<br><br>05.11.2018<br>- Venn System Event taking place 5th November 2018<br>- Discharge Lounge due to open 26th November 2018<br>- Full business case to be presented to the Exec Team for works to be undertaken on A3 (for completion in Dec 2018) creating assessment capacity. | Electronic solution to data reporting including e outcomes<br><br>CBU teams to embed capacity and demand work throughout specialities and link to annual business plan cycles. | Operational Board | QPS Meeting |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 117 | Failure to provide a spinal service for the local population, caused by a voluntary suspension of the service amid potential governance concerns, resulting in poor patient experience, potential safety concerns for those patients with delayed procedures or follow ups, reputation damage and potential regulatory and contractual issues. | 20 | 16 | Controls:<br>The Trust proposed a voluntary suspension of the service whilst jointly commissioning (with commissioners) the Royal College of Surgeons to undertake a review of the service<br>There are a number of Serious Incidents (4) that have occurred since January – these incidents have been/are being externally reviewed<br>A weekly spinal meeting has been established by the Medical Director to ensure there is an oversight of operational, patient experience, regulatory and contractual impacts.<br>The Trust is working with commissioners and other spinal providers to ensure that there is alternative arrangements in place regarding patient procedures.<br>Most inpatient procedures have had alternate providers identified. Currently reviewing outpatient procedures and follow up clinics.<br>Communications team working across commissioning and regulators to ensure patients and the public are kept up to date.<br>Assurances:<br>The service remains in suspension<br>Ongoing discussions with commissioners regarding management of patients<br><br>06.09.2018<br>a) The patients have now all been moved to alternative providers<br>b) The Trust is working with Commissioners and other providers on a single service.<br>c) The residual risk is reputational and from a regulatory (CQC) perspective | Currently working with commissioners regarding those patients who have follow up procedures and spinal injections, to ensure suitable alternative providers are found.<br>CQC is investigating one of the Serious Incident Cases – this is awaited<br>The Trust is starting to see increased concerns from patients raised through PALS/Complaints regarding having notification of delay to their procedures.<br>Significant financial pressures emerging regarding the suspension and associated costs<br>On-call/review arrangements for patients attending A&E to be clarified | Board of Directors | Executive Directors |
| 118 | Failure to have sufficient anaesthetic cover on critical care, caused by insufficient middle grade/registrar doctors to cover the 2nd and 3rd tier on calls, resulting in potential patient safety issues, operational impact and financial pressures due to locum costs. | 20 | 16 | Controls:<br>Electronic Rota in place<br>Staffing escalation processes in place<br>Critical Care Network Standards/Royal College of Anaesthetists Standards<br>Assurance:<br>The rota is reviewed weekly and populated – internal staff are offered locum shifts before agency cover is sought<br>Assurance is weak – the rota is heavily dependent on goodwill of existing staff and agency staff<br>18.9.18:<br>3 WTE Trainee ACCPS's in place - qualify summer 2020<br>Recruitment for 2 WTE ACCPS<br>1 Trust grade in place from October 18 | Insufficient medical staff at each level<br>Inability to recruit SAS doctors , 18.9.18 - new campaign interviews listed for 19.9.18. | Quality & Assurance Committee | Patient Safety & Effectiveness Sub-Committee |
| 119 | Failure to have sufficient assurance in place regarding contractual and governance requirements in Sexual Health Services, resulting in potential patient safety issues, organisational and reputational risk. | 16 | 12 | Controls:<br>Policies and procedures in place<br>Implied contracts in place with Bridgewater, STHK and HBC as Commissioner<br>Governance lead in place<br>GUM meeting set up, chaired by Medical Director, to oversee risk<br>Assurances:<br>Process put in place regarding reporting on results which have been reviewed<br>Governance model review commenced by incoming CBU Manager | Governance arrangements in place – need to be reviewed<br>Lack of assurance regarding results reporting systems in the service<br>Serious Incident been declared regarding the service | Quality & Assurance Committee | Patient Safety & Effectiveness Sub-Committee |
| 120 | Failure to identify and manage patients' risk of sustaining a fall; caused by inadequate risk assessment and implementation of appropriate care plans. This may cause patient harm, has a negative effect on the patients experience, may prolong their length of stay, and give rise to complaints and claims against the trust. | 20 | 16 | 06.09.2018<br>First wave of the bed replacement programme has been completed<br>Falls are discussed at the daily Trust-Wide Safety Briefing and themes identified.<br>Reviewed the current enhanced care process and re-written the policy and process as is currently being piloted on A4 & A7. This pilot is part of the improvement work from the NHSi Falls Collaborative. Enhanced Care Policy to be ratified at PSCESC Sept 2018<br>A review of the Trust falls equipment in relation to alarms and sensor pads has taken place. An Inventory list is held by the moving & handling co-ordinator and a plan to purchase additional falls equipment is in place.<br>Reviewed the current falls documentation and revised a number of elements and is currently being piloted on A4 & A7.<br><br>04.10.2018<br>•Updated Trust wide care plan -September<br>•Approved Enhanced care policy PSCEC ( September) with plan for formal rollout November<br>•Falls alarms and sensor pads ordered<br><br>23.11.2018<br>• Bathroom review programme near completion, findings to report in November 2018.<br>• Falls alarms and sensor pads ordered following a donation form the League of Friends<br>• Enhanced Care Policy Rollout - Training underway in November<br>• NHSi collaborative completed with two wards | There have been a number of falls within the Trust causing Serious Harm<br>There is a requirement to review falls prevention equipment<br>Falls training is core skills training for staff - data on falls training needs to improve<br>MIAA audit into falls showed limited assurance | Quality & Assurance Committee | Patient Safety & Effectiveness Sub-Committee |
| 122 | Failure to provide assurance regarding the Trust's safeguarding agenda being implemented across the Trust caused by gaps highlighted during external review may result in having an impact on patient safety and cause the Trust to breach regulations | 16 | 16 | WRAP Training - Completed - delivered daily across the Trust. In excess of 1000 staff trained face to face and achieved 85% target<br>LD Training programme introduced - Delivered daily until the end of July, now fortnightly.<br>Awaiting delivery of safeguarding adult resource folders for all wards and depts., detailing all aspects of adult safeguarding for wards to access.<br>Safeguarding Adults Website updated to include additional training resources and videos.<br>Further MCA Audit completed. | Review of safeguarding governance structure required<br>Review of the safeguarding team and functions<br>Requirement to review practices of chemical restraint<br>A review of safeguarding training required<br>A policy review<br>Representation at Local Safeguarding Boards to be reviewed<br>A review of policies to be undertaken<br>Development of an electronic system for use by the safeguarding team<br>Lack of LD specialist support<br>CQC raised issues regarding mental capacity assessments and DOLS | Quality & Assurance Committee | Safeguarding Sub-Committee |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 123 | Failure to prevent harm to patients, caused by lack of timely and quality discharge summaries being sent to primary care, resulting in a lack of appropriate handover of care, with patient safety, operational, financial and reputational consequences. | 16 | 12 | Controls:<br>Discharge summary performance, both the 95% and 7 day standard, is now monitored through an electronic dashboard, and is overseen by the monthly Clinical Operational Board (and also Finance and Sustainability Committee).<br>Performance is managed at ward level, with an escalation protocol through the Clinical Business Unit and division.<br>Discharge Policy and processes in place to support staff<br>Training provided to staff, including junior doctors on induction, on Lorenzo<br>Assurance:<br>The current performance shows that we meet the 95% target for sending discharge summaries within seven days, whilst recognizing that improvement needs to continue to improve regarding sending discharge summaries within 24 hours. Current performance is 88% within 24 hours.<br>Sample audit work undertaken with regard to the backlog to date (June 23rd 2017) has not revealed that a patient has been harmed<br>A review of incidents and complaint information in the timeframe of the backlog has not identified that a patient has come to harm or that a patients has complained<br><br>18.10.2018<br>E-Discharge Task and Finish Group has been set up to oversee a review of the Trust's E-Discharge policies and processes, to ensure that they are robust and that there is effective clinical review and escalation processes in place. The Task & Finish group reports to the Patient Safety & Clinical Effectiveness Sub Committee. | In Q1 of 17/18, there is a backlog of c160 discharge summaries, which suggests more work is needed<br>Communication meeting with primary care (June 2017) suggest improvement still needed in handover of care and discharge summaries | Quality & Assurance Committee | Patient Safety & Effectiveness Sub-Committee |
| 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. | 20 | 9 | Controls:<br>Estates strategy<br>PLACE assessment action plan<br>Risk Management systems and incident reporting<br>General capital investment<br>Compass reporting re: water flushing<br>Matron and estates walkabouts<br>Reporting structure for maintenance<br>On call service for OOH issues<br>Maintenance log<br>Assurance:<br>Water quality group<br>Fire safety group<br>Medical gases group<br>Estates safety<br>Medical Equipment group<br>Capital Planning group<br>Six Facet survey – condition appraisal of estate (annually) 5 Year program 20% each year<br>Asbestos survey annually<br>Premises Assurance model (PAM) Self-assessment tool estate compliance<br>Good Corporate Citizen self-assessment (review of sustainability ) | Maintenance improvement program<br>Medical equipment maintenance is managed by a risk assessed approach whereby equipment is identified as:<br>High<br>Medium<br>Medium/Low<br>Low<br>All high and medium is fully maintained. Medium/low and low is operator assessed and reported to medical equipment engineering as required.<br>A significant gap in control and assurance relates to breach of fire regulations regarding emergency lighting in some of the areas. There are mitigation's in place, Cheshire Fire and Rescue Service are aware and the Trust has no enforcements in place.<br>There is also a significant risk regarding the age and repair of generators in the Trust, for which there are mitigation and continuity plan in place for- which are under review. | Operational Board | Estates Sub-Committee |
| 128 | Failure to comply with the Thromboprophylaxis procedure/policy caused by poor completion of thromboprophylaxis risk assessments and follow up investigation (Root Cause Analysis) of hospital associated VTE in some areas, resulting in the risk of patients not receiving the appropriate, preventative treatment for VTE in hospital. | 20 | 12 | Controls:<br>Policy and guidelines in place regarding VTE<br>Process in place regarding VTE investigations<br>Assurance:<br>Monitor of progress by Patient Safety and Clinical Effectiveness committee, Quality Committee; monthly assessment of progress with number of RCAs<br>Harm free care figures<br>Mortality/coroners data does not suggest that the Trust is an outlier in terms of harm being caused to patients | Performance report shows numbers of VTE RCAs outstanding and poor compliance in some areas with risk assessments<br>Lack of assurance that that numbers of hospital associated VTEs are being monitored within clinical governance processes within Divisions/CBUs and being fed back to individuals<br>Thrombosis Committee terms of reference need to be reviewed | Quality & Assurance Committee | Patient Safety & Effectiveness Sub-Committee |
| 129 | Failure to stop Clinical variation, caused by lack of systems/process or failure of systems/to follow process resulted in lack of evidence based practice, potential patient harm and reputational impact. | 16 | 12 | 02.08.2018<br>Assessment of NICE Guidance against Trust Compliance is ongoing, an action plan has been produced where there are gaps in compliance, both Trustwide and at Specialty level. The Speciality level action plans are monitored at CBU Governance meetings.<br><br>NICE Guidance compliance is incorporated in Specialty Dashboards.<br><br>GIRFT programme looks at clinical variation across specialities and where variation is identified, actions are recommended to rectify these. Performance is monitored at Quality Academy Board. | Clinical Governance systems within the Trust need to be reviewed e.g. Lack of integrated effectiveness agenda corporately<br>Clinical/CBU leadership model still embedding<br>Further work to develop integrated performance report, dashboards and cross referencing / escalation of issues<br>The Trust is reporting higher than expected mortality rates in HSMR, although SHMI showing a significant downward trend.<br>UTI outlier in term of mortality<br>Lack of co-ordinated learning framework within the Trust<br>Lack of assurance regarding NICE guidance compliance within the Trust<br>Inpatient survey showed significant decrease in performance in some areas<br>Concerns regarding spinal surgery services raised internally and externally by NHSE | Quality & Assurance Committee | Patient Safety & Effectiveness Sub-Committee |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 133 | Failure to successfully engage the Workforce, caused by the potential for a negative working environment which resulted in the consequential loss of discretionary effort and productivity, or loss of talented colleagues to other organisations, which would impact patient care, staff morale and delivery of the Trust's strategic objectives | 20 | 12 | Controls:<br>Communications: We have developed a Communications and Engagement Work plan 2017-18 which is being delivered across the WHH workforce<br>We have merged the Communications and Staff Engagement teams to consolidate and maximise staff engagement<br>There is a revised leadership model in place within the Trust<br>Priorities for the Trust are promoting learning and development, driving clinical leadership, having efficient job plans, celebrating success through staff awards and supporting innovation and working with partner organisations<br>There is an established Strategic People Committee of the Board<br>Investment in training and Support for staff<br>Open Mic sessions/Team Talk in place to engage staff and offer them a voice<br>Established weekly planning meetings with the Transformation team to identify any possible schemes that could negatively impact staff and take pre-emptive planning action<br>Assurance:<br>Engagement Dashboard reported to Trust Board (includes monitoring of Team Brief attendance)<br>Staff FFT and Annual NHS Staff Survey (published March each year) both reported to SPC<br><br>30.07.2018<br>Annual NHS Staff Survey showed an engagement score of 3.74/5 against a national average of 3.79/5<br><br>28.09.2018<br>The Trust is moving forward with phases 2,3 and 4 of LIA<br>The new People Strategy has been ratified - with a key focus on Engagement<br><br>23.10.18<br>National Staff Survey currently out for completion. | Delivery plans against People Strategy to be finalised | Operational Board | Workforce Sub-Committee |
| 134 | Financial Sustainability<br>a) Failure to sustain financial viability, caused by internal and external factors, resulted in potential impact to patient safety, staff morale and enforcement/regulatory action being taken.<br>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. | 20 | 20 | 06.09.2018<br>•Work with the Commissioners on QIPP and CIP schemes through the Collaborative and Sustainability Group to ensure the schemes have a positive impact on sustainability across the whole health economy<br>•Monthly FRG meeting with CBU led by Dof<br>•Fortnightly CIP monitoring with NHSI<br>•Transformation structure being reviewed to strengthened accountability<br><br>06.09.2018<br>•Transformation structure being reviewed to strengthened accountability<br>•Trust teams are working within the place based teams to bid for additional STP monies to improve sustainability<br>•Recruited agency staff and additional substantive staff to support clinical coding recovery. Trajectories have been set and are being monitored and are being overachieved.<br>•Regarding the aged debt in dispute, the Commissioners have requested MIAA to undertake due diligence review in to the debtors accounts. Furthermore, regular meetings are taking place between the Trust, CCGs and NHSE to consider future service provision and resolution of financial liabilities.<br><br>23.10.18<br>Control re employment legislation<br>- Sub group established for OT payments reporting through premium pay spend and review group<br>- Commissioned an audit review of OT processes subject to Chair of Audit Chair Approval<br>- Recommendation for internal OT processes to be presented to Exec Team | 13.09.2018<br>•Following recent letter relating to no confidence in Warrington CCG and resignation of the Chair, potential to destabilise the current sustainability and transformational work that is being undertaken. This could have negative effect on the Trust's and Health Economy's financial position due to the potential impact on collaborative schemes.<br><br>11.10.2018<br>- CCG have made the Trust aware of their M6 financial position. After mitigations, they are currently working to close a potential gap. This may impact on the financial support available to the Trust to achieve our revised control total.<br><br>- Extended Loan repayment due Nov 2018, awaiting confirmation of further extension from NHSi.<br><br>23.10.18<br>Failure to fully comply with emerging national employment litigation resulting in additional pay costs or the trust receiving potential claims<br>- National steer required from NHSi & NHS employers<br>- Due to current financial position, the Trust does not hold sufficient reserves.<br>- the specific case law could go back up to 6 years; however, employment history recorded on ESR is unreliable due to the use of paper records for a potential backdated 6 year period.<br>- | Finance & Sustainability Committee | |
| 135 | Failure to provide adequate and timely IMT system implementations & systems optimisation caused by either increasing demands and enhanced system functionality which results in pressure on staff; potential in systems being poorly used resulting in poor data quality. Impact on patient access to services, quality of care provided, potential patient harm and financial & performance targets. | 20 | 16 | 12.10.18<br>A business case for ICE resilience has been approved by the Executive Team with the installation and configuration will be completed by the end of Oct 2018.<br><br>A TNA analysis and plan is currently being developed for critical systems. | Failure to provide IMT system support caused by lack of staff or single points of expertise in the structure; resulting in systems being unavailable for longer periods of time in the event of a failure. Impact on trust access, quality of care and financial targets with potential for reputation al damage.<br>• Failure to secure trust's IMT systems from cyber-attacks due to poor end user training and awareness, limited and out of date security systems and increasing complexity of attacks. Impact is loss of patient data resulting in fines, organisational reputation al damage or extended downtime of systems, resulting in loss of financial information and loss of ability to treat patients.<br>• Failure of IMT infrastructure to be available 24*7 due to increasing demands requiring additional hardware which cannot be purchased due to funding restraints.<br>• Assurance that DQ reports available within the BIS are being accessed and acted upon by operational staff<br>• Sufficient time for engagement from Cubs around system management<br>• Certification to the Cyber Essentials standard in quarter 1 Financial year 2017/18 is required. This was recommended in the National Data Guardian/CQC report of 2016 | Operational Board | Informatics Sub-Committee |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 138 | Failure to provide timely information caused by increasing internal and external demands for datasets, implementation of new systems and a lack of skilled staff with capacity to respond. Resulted in a financial impact, external reputation damage and poor management decision making due to lack of quality data. | 16 | 16 | 02.08.2018<br>Recruited 4 Information analysts as part of business case who are supporting with timely statutory reporting and key Trust workstreams including maternity, theatres, delayed discharges, urgent care.<br><br>Business Intelligence Development Roadmap produced and priorities will be agreed with key Execs to ensure prioritisation and Trust focused workstreams.<br><br>07/09/18<br><br>Recruited to a Band 8a Business Intelligence Manager, who commenced with the Trust on 03/09/2018.<br>Recruited to a Band 2 Data Quality Clerk, who commenced with the Trust on 20/08/2018.<br>26/10/18<br>BI Manager commenced and work on the new Emergency Care Flow Dashboard has started in collaboration with an external supplier. This will provide automated, timely, current performance data for urgent care operational staff, CBU leads and Executives to monitor service demands and track adverse variances with a view to deploying measures to improve services accordingly. Data Quality checks on patient demographics and completeness and timely discharge letters continue with real time daily routines to ensure letters stranded in interfaces are submitted timely. | The new Head of Information will be joining end of March who will review the overall strategy for delivering information services, she has already started to look at this following a meeting on 15/02/17 – on going<br>New interactive tools to allow users to manually 'data mine' the reports is in pilot.<br><br>07/09/18<br><br>The advert has just closed for the latest round of recruitment for 2 x Band 7 Principal Information Analyst posts, shortlisting will take place week commcing 10/09/2018, interview 26/09/2018.<br>The advert for a Band 7 Business Intelligence Developer post and a Band 5 Information Analyst post will go out week commencing 10/09/2018.<br><br>02.08.2018<br>Recruitment ongoing for 3 principal information analysts and developers and an additional information analysts as part of the business case. | Operational Board | Informatics Sub-Committee |
| 141 | Failure to achieve the highest level of corporate governance, caused by the requirement to review and embed new structures, which may impact on statutory and regulatory requirements | 16 | 12 | Controls:<br>Compliance with license conditions – reportable quarterly via Audit Committee<br>Appointment of Adviser to Board<br>Re-establishment of Foundation Trust Office<br>Recruitment of Secretary to Board and support<br>Assurance:<br>Well Led Review and CQC inspection 2017<br>NHS Improvement Assessment<br>Board Evaluation Surveys<br>Well-led Self-Assessment<br>Assurance has been received following the Well Led review commissioned by the Trust from Delta. Actions from this review will be monitored by the Board.<br>A restructure of the corporate meetings has taken place<br><br>August 2018<br>Well-Led Steering Group set up and individual leads assigned to each KLOE<br>BAF held on Datix and linked with departmental Risk Registers.<br><br>Sept 2018<br>LiA linked in with Well-Led Steering Group<br><br>October 2018<br>Previous Well-Led Action plan closed and residual risks transferred to new action plan.<br>Evidence being completed for each KLOE in preparation for self assessment | Need to re launch the Board Assurance Framework and align to the Strategic Risk Register<br>Lack of ongoing regular review of Well Led standards<br>Completion of Declaration of Interest by ALL staff Band 7 and above | Audit Committee | Executive Directors |
| 143 | Failure to deliver essential services, caused by a Cyber Attack, resulting in loss of data and vital IT systems, resulting in potential patient harm, loss in productivity and Trust reputation | 12 | 12 | 14/09/2018<br>Phase 2 of the additional cyber security has been completed<br><br>10/10/2018<br>Windows XP are not off our network and only XP left are radiology machines which are hardened so they can not be changed (minimal risk)<br><br>Critical Systems Patching Schedule has been ratified by the Digital Board and will be going to the Event Planning Group the same week. Patching is continuing.<br><br>Event Log Retention Policy has been added to the ISMS (Part of Cyber Essentials +)<br><br>07/11/2018<br>Been using the trial version of Solar Winds patching software to test the process with our backend servers. Senior IT staff are happy with the software and now have raised a purchase order to purchase the full software. We have also pushed back to the organisation around patching servers in hours to help fix any potential issues resulting from a patch breaking a system. So far a positive response from asset owners helping to bring in as many server patching in hours.<br><br>All CareCERT's are now completed and sent back to NHS England. | 07/11/2018<br>Trust only has a handful of Windows XP in Radiology which are hardened which means their code cannot be altered by an attack, we are happy from a desktop point of view all Windows unsupported operating systems are now been cleared. We are working on migrating all desktops to Windows 10, removing Windows 7 and 8 from the desktops.<br><br>The cyber business case is in draft and Director of IT and Information at the Wirral has asked for feedback from the other two trusts. WHHT have feedback to Wirral. | Operational Board | Informatics Sub-Committee |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 145 | Failure to influence sufficiently within the STP and LDS may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position. | 20 | 15 | 05.10.2018<br>- Draft Clinical Strategy in place and individual specialty level strategies being developed.<br>- Memorandum of Understanding and work plan with Bridgewater Community Healthcare NHS FT approved.<br>- Working in partnership with GP Federation in Halton on relation to improving joint clinical pathways.<br>- Council and CCG in both Warrington & Halton supportive of development of new hospitals.<br>- Agreement of sustainability contract with Warrington CCG.<br>- GP engagement event held for Warrington & Halton GPs.<br><br>19.11.2018<br>- Work plan agreed with StHK<br>- Shared a presentation demonstrating Halton Hospital's suitability to host the Eastern Sector Cancer Hub with Clatterbridge and other stakeholders. This forms part of the formal decision making process on the location of the hub<br>- Two more GP engagement events planned.<br>- Regular Strategy updates are provided to the Council of Governors. | Our CQC rating may impact our ability to influence<br>Organisational sovereignty and the need for individual Trusts, CCGs and others to meet performance targets at an organisational level have the potential to slow or block progress.<br>Failure to successfully engage with all of our stakeholders across our catchment population<br>Limitations of the size of the catchment area. | Operational Board | Strategic Development Sub-Committee |
| 153 | Failure to attend mandatory resuscitation training caused by operational pressures resulting in low compliance rates and risk to patient and staff safety | 15 | 15 | Update 5.9.18<br>Action has been agreed to stop competency assessments of AEDs and an analysis will be undertaken on best times of the day to provide training. Early morning sessions will continue. Throughout the months September and October 1,300 places will be offered.<br><br>08.10.2018<br>-Liaised with managers to provide targeted training where appropriate<br>-Identified specific admin support throughout Sept & Oct to support Resus training & is contacting non-compliant staff and managers regularly to promote attendance.<br>-all CBU triumvirates contacted by Director of HR & OD regarding low compliance.<br>- All non-compliant staff have received a letter from the Director of HR & OD setting out requirements for compliance by 31 Oct 2018<br>- Weekly task and finish group set up to meet throughout October 2018, with senior leaders from key staff groups. Purpose to micro-manage attendance at training. | Low training compliance for specific staff groups.<br><br>Level 2 training compliance remains low (60.8%) in July 2018.<br><br>08.10.2018<br>- releasing staff to attend training remains a challenge and as at 28.09.2018 only approx. 230 staff had attended training. | Operational Board | Workforce Sub-Committee |
| 186 | Failure to provide HCAI surveillance data and take timely action.<br><br>Caused by lack of IT software.<br><br>Resulting in a risk of outbreaks of healthcare associated infection. | 16 | 16 | MIC-STAT MOLIS function to extract data retrospectively.<br><br>Local spread sheet for cases of 'alert' organisms. | No prospective data available.<br><br>Manual input of data into local spread sheet - data entry risk of errors. | Quality & Assurance Committee | Patient Safety & Effectiveness Sub-Committee |
| 261 | Failure to provide continuity of palliative care caused by remaining consultant leaving the trust on 23.2.18 resulted in no consultant in palliative care | 12 | 9 | Consultant left 23.03.18. Palliative care Matron currently running OP clinics and helping to cover workload. Discussions taking place with St Rocco's to identify service requirements before advertising permanently. Advert out for temporary consultant cover.<br><br>June update - interviewing for new palliative care consultant 19th June<br><br>August update: some cover agreed by local Palliative care specialist for Fridays from September.<br>Consultant advice available for team through St Roccos advice line.<br><br>September update: awaiting start of Friday cover. Reviewing job description/options around palliative care consultant. Due to previous unsuccessful recruitment considering different ways of working. | There remains no consultant in this position although cover in place | Quality & Assurance Committee | Patient Safety & Effectiveness Sub-Committee |
| 280 | Failure to provide an adequate level of Consultant Microbiology cover caused by insufficient numbers of Consultant staff (as advised in RCPath guidelines),resulting in delays in patient management due to delayed communication of results, inability to attend ward rounds, inability to complete required workload & attend infection control meetings as required. | 16 | 16 | As an interim measure, a locum Consultant Microbiologist will be required if one of current Consultant Microbiologist were away on leave for 1 week or more.<br>Business case in progress | Likely to happen as consultants will require annual leave, and there may be unexpected sickness.<br>There is difficulty in accessing suitable locum cover. | Quality & Assurance Committee | Patient Safety & Effectiveness Sub-Committee |
| 414 | Failure to implement best practice information governance and information security policies and procedures caused by lack of resources or ineffective communication of key information governance messages to WHH staff | 12 | 12 | 02.08.2018<br>Information Governance Manager now reports to IT Services Manager for support & guidance and cross-cover, which reduces the risk of single point dependency.<br><br>A draft re-structure that includes an Information Security Manager has been produced and will be presented to the newly appointed CIO in due course.<br><br>05-09-18--New Director of IT not in post until 01/12/18 at which time any extra resources will be discussed.<br><br>03/10/18--Audits on wards underway to establish whether IG best practice is in place<br>26/10/18<br>Options for improving security of access to Lorenzo other than smartcards, which will include deploying VDI Trustwide (currently in ED Department) will be formulated and submitted to the Digital Optimisation Group and Digital Board for consideration regards costs vs risks and benefits in advance of NHS Digital deploying any security solutions in the future. Steve Deacons and Howard Gray to prepare and present the paper to the Group and the Digital Board by 31/12/18. | •Ongoing effectiveness of GDPR related processes and policies in response to MIAA GDPR readiness assessment<br>•Effectiveness of Trust server estate patching in response to security alerts<br>•Effectiveness of controls in relation to the resilience of the Trust's IT infrastructure, particularly in light of the demands of the 2018 EU NIS Directive<br>•Ongoing audit of information governance and application of IG controls in the general environment including storage of records and training requirements | Quality & Assurance Committee | Informatics Sub-Committee |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 469 | Failure to ensure timely delivery of Getting to Good action plan, caused by potential lack of capacity and resource resulting in an organisational risk of not attaining a rating of 'Good' | 16 | 12 | Development of a getting to Good Action plan<br>Getting to Good Steering Group chaired by CEO, reporting to Quality Assurance Committee and Audit Committee<br>All core services rated Requires Improvement being overseen by an allocated Executive Director<br>Improvement workstreams in place, engaging clinical staff<br>Enabling strategies in place e.g. Organisational Development<br>Ring fencing capital monies to ensure support for CQC actions (c£0.5 million)<br>Getting to Good Steering Group meetings scheduled monthly<br>Reporting function in place- led by Clinical Governance, supported by Transformation team<br>Triangulated data being scrutinised – NHSI/CQC Insight report<br>Trust Board have approved a business case to increase establishment of nurse staffing in the Trust following an acuity review, which will ensure must do actions regarding staffing are delivered | Capacity in the system to deliver a high number of actions – linked to significant operational pressures and competing priorities<br>Financial pressures<br>Staffing pressures<br>Cultural change required in some areas<br>Gaps in compliance in Must Do/Should Do actions<br>Use of Resource assessment may be difficult with current financial pressures<br>Specific 'Must Do' Action relating to MLU | Quality & Assurance Committee | Getting to Good, Moving to Outstanding Steering Group |
| 512 | Failure to have robust processes in place across the Trust relating to Medical devices, caused by inconsistency in applying policies and procedures and inability to provide assurance, resulting in potential for patient safety incidents, service disruption and non compliance of regulatory standards. | 16 | 12 | 17.08.2018<br>Medical Devices have been audited at ward and department level and a centrally held inventory is nearly finalised – we have allocated resources for admin support to ensure this is logged electronically on the E-Quip system<br>A new Medical Devices Safety Group has been established with clinical representation – this will have roles and responsibilities regarding advising on purchasing and procurement of equipment as well as ensuring robust policies, procedures and incident reviews are in place<br>Training competencies are being put in place for all medical devices in the Trust – aligned to whether they are high risk, medium risk or low risk<br>Medical devices has been flagged at the Getting to Good meeting as a risk area for the CQC assessment and an update of the improvement plan in place will be presented to the September meeting.<br>Work is being undertaken on the E-quip database systems so that staff can record training<br><br>04.10.2018<br>An improvement plan is in place within the Trust aligned to CQC action plan. This will ensure that<br>-By end October all competency assessments will be in place for High, Medium, Low risk devices and that all system work on E-quip will be completed for staff to input details of training and competency<br>-By end October – all inventories will be reconciled on the E-quip system and the Trust will have a centralised inventory<br>-By end December – all training and competency records for medical devices/equipment will be uploaded onto the E-quip system | CQC has flagged 'Must do' actions regarding medical devices in maternity, critical care and paediatrics<br>An in-house review has raised issues with regard to<br>Implementing new policy and procedures<br>Ensuring there is a clear inventory of devices in place within the Trust – as currently there are different systems on which to log devices<br>Ensuring that there is visibility of all risks with regard to medical devices within the Trust and we have assurance that there is appropriate replacement programmes in place Trustwide<br>Ensuring that we have assurance that staff have been trained on medical devices within the Trust. | Quality & Assurance Committee | Patient Safety & Effectiveness Sub-Committee |

We are WHH

Warrington and Halton Hospitals NHS Foundation Trust

# REPORT TO BOARD OF DIRECTORS

| | | |
|---|---|---|
| **AGENDA REFERENCE:** | **BM/18/11/121** | |
| **SUBJECT:** | **Changes to the Scheme of Reservation and Delegation Table B** | |
| **DATE OF MEETING:** | 28 November 2018 | |
| **ACTION REQUIRED** | **Approval** | |
| **AUTHOR(S):** | Karen Spencer, Head of Financial Services | |
| **EXECUTIVE DIRECTOR SPONSOR:** | Simon Constable, Executive Medical Director/ Deputy CEO | |
| | | |
| **LINK TO STRATEGIC OBJECTIVES:** | All | |
| **LINK TO BOARD ASSURANCE FRAMEWORK (BAF):** | BAF1.3: National & Local Mandatory, Operational Targets | |
| | BAF1.4: Business Continuity | |
| | BAF3.2: Monitor Undertakings: Corporate Governance & Financial Management | |
| | | |
| **STRATEGIC CONTEXT** | To ensure Table B of the Scheme of Delegation and Reservation (SORD) is comprehensive, clear and robust a complete review has been undertaken and updated as appropriate. | |
| **EXECUTIVE SUMMARY** (KEY ISSUES): | In reviewing Table B the following documents have been consulted:<br><br>• HM Treasury Guidance, Managing Public Money.<br>• NHS Improvement Trust Accounts Consolidation schedule 29 on Losses and Special Payments.<br>• Managing Conflicts of Interest in the NHS. | |
| **RECOMMENDATION:** | The Board is asked to approve the revised Table B of the SORD. | |
| **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. | |

**TRUST BOARD**

| SUBJECT | Changes to the Scheme of Reservation and Delegation Table B | AGENDA REF: | BM/11/121 |
|---|---|---|---|

## 1. PURPOSE

The purpose of this report is to seek approval from the Board of Directors for the proposed amendments to Table B of the Scheme of Delegation and Reservation (SORD).

## 2. KEY ELEMENTS

The SORD states how powers are reserved to the Board of Directors, whilst at the same time delegating to the appropriate level detailed in the application of the Trust's policies and procedures.

To ensure Table B of the Scheme of Delegation and Reservation (SORD) is comprehensive, clear and robust a complete review has been undertaken and updated as appropriate.

In reviewing Table B the following documents have been consulted:

- HM Treasury Guidance, Managing Public Money.
- NHS Improvement Trust Accounts Consolidation schedule 29 on Losses and Special Payments.
- Managing Conflicts of Interest in the NHS.

A copy of the revised Table B is included (Appendix A).

## 3. RECOMMENDATIONS

The Board is asked to approve the revised Table B of the SORD.

## Appendix A

| DELEGATED MATTER | DELEGATED LIMIT | OPERATIONAL RESPONSIBILITY |
|---|---|---|
| **1. CHARITABLE FUNDS** | | |
| Charitable Spend (designated, restricted and unrestricted) | Up to £1,000 | Head of Financial Services and Fundraising Manager |
| | £1,001 - £5,000 | Director of Finance & Commercial Development and Director of Nursing |
| | Over £,5000 | Charitable Funds Committee |
| **2. GIFTS AND HOSPITALITY** | | |
| **2.1 Cash & Vouchers** | | |
| **Cash and vouchers** Should always be declined. | any value | All Staff |
| **2.2 Gifts** | | |
| **Gifts** do not need to be declared | up to £50 (Single) | All Staff |
| **Gifts Multiple** Multiple gifts from the same source over a 12 month period should be treated the same as single gifts **over £50 (see below)** | up to £50 (Multiple) | |
| **Gifts** should be accepted on behalf of the Trust (not in a personal capacity) They should be recorded on the register and delivered to the WHH Charity as 'Gifts in Kind' to be used for the benefit of patients | Over £50 | |
| **2.3 Hospitality** | | |
| **Meal and refreshments** May be accepted and need not be declared | up to £25 | All Staff |
| **Meal and refreshments** May be accepted and must be declared | £25 - £75 | |
| **Meal and refreshments** should be refused unless (in exceptional circumstances) senior approval is given. | Over £75 | |

## Appendix A (continued)

| DELEGATED MATTER | DELEGATED LIMIT | OPERATIONAL RESPONSIBILITY |
|---|---|---|
| **3. LITIGATION CLAIMS** | | |
| Clinical Negligence scheme for the Trust (CNST) and Clinical Risk Pooling Scheme (LTPS & PES - above excess only) for the Trust | | NHS Recovery (NHSR) on behalf of the Trust |
| Employers Liability (EL) claims within excess | up to £3,000 | Litigation & Risk Manager |
| Public Liability (PL) claims within excess | up to £10,000 | |
| **4. LOSSES AND SPECIAL PAYMENTS** | | |
| **Losses:** | | |
| **1. Losses of cash due to:** | | |
| a. theft, fraud etc.<br>b. overpayment of salaries etc.<br>c. other causes | up to £2,500 | Head of Financial Services |
| | £2,501 - £5,000 | Deputy Director of Finance |
| | £5,001 - £10,000 | Director of Finance and Commercial Development |
| | £10,001 - £250,000 | Chief Executive |
| | Over £250,000 | Board of Directors |
| **2. Fruitless payments and constructive losses** | up to £10,000 | Director of Finance and Commercial Development |
| | £10,001 - £250,000 | Chief Executive |
| | Over £250,000 | Board of Directors |
| **3. Bad debts and claims abandoned in relation to:** | | |
| a. private patients<br>b. overseas visitors<br>c. other | up to £2,500 | Head of Financial Services |
| | £2,501 - £5,000 | Deputy Director of Finance |
| | £5,001 - £10,000 | Director of Finance and Commercial Development |
| | £10,001 - £250,000 | Chief Executive |
| | Over £250,000 | Board of Directors |
| **4. Damage to buildings, property etc. (including stores losses) due to:** | | |
| a. theft, fraud etc.<br>b. stores losses<br>c. other | up to £500 | Ward Manager or Department Manager |
| | £500 - £1,500 | Head of Service/CBU Manager |
| | £1,501 - £2,500 | Head of Financial Services |
| | £2,501 - £5,000 | Deputy Director of Finance |
| | £5,001 - £10,000 | Director of Finance and Commercial Development |
| | £10,001 - £250,000 | Chief Executive |
| | Over £250,000 | Board of Directors |

## Appendix A (continued)

| 4. LOSSES AND SPECIAL PAYMENTS | | |
|---|---|---|
| **Special payments:** | | |
| **5. Compensation under court order or legally binding arbitration award** | up to £10,000 | Director of Finance and Commercial Development |
| | £10,001 - £250,000 | Chief Executive |
| | Over £250,000 | Board of Directors |
| **6. Extra contractual to contractors** | up to £10,000 | Director of Finance and Commercial Development |
| | £10,001 - £250,000 | Chief Executive |
| | Over £250,000 | Board of Directors |
| **7. Ex gratia payments in respect of:** | | |
| a. loss of personal effects<br>b. clinical negligence with advice c. personal injury with advice d. other negligence and injury<br>e. other employment payments (not including special severance payments which are disclosed below)<br>f. patient referrals outside the UK and EEA Guidelines<br>g. other<br>h. maladministration, no financial loss | up to £500 | Ward Manager or Department Manager |
| | £500 - £1,500 | Head of Service/CBU Manager |
| | £1,501 - £2,500 | Head of Financial Services |
| | £2,501 - £5,000 | Deputy Director of Finance |
| | £5,001 - £10,000 | Director of Finance and Commercial Development |
| | £10,001 - £250,000 | Chief Executive |
| | Over £250,000 | Board of Directors |
| **8. Special severance payments**<br>Special severance payments when staff leave a public sector employer should only rarely be considered. They will always require HM Treasury approval because they are usually novel, contentious and potentially repercussive: NHS bodies have no delegated authority to make such payments unless so approved. NHS Bodies must complete a template for submission to HMT for approval. | up to £10,000 | HM Treasury |
| | £10,001 - £250,000 | |
| | Over £250,000 | |

## Appendix A (continued)

| | | |
|---|---|---|
| **4. LOSSES AND SPECIAL PAYMENTS** | | |
| **Special payments:** | | |
| **9. Extra statutory and regulatory**<br>Extra statutory and regulatory are within the broad intention of the statute or regulation, respectively, but go beyond a strict interpretation of its terms. | up to £10,000 | Director of Finance and Commercial Development |
| | £10,001 - £250,000 | Chief Executive and Director of Finance and Commercial Development |
| | Over £250,000 | Board of Directors |
| **5. PETTY CASH DISBURSEMENTS & PATIENT MONIES (authority to pay cash)** | | |
| Petty Cash | up to £50 | Budget Holder |
| | Over £50 | Director of Finance & Commercial Development OR Nominated Deputy |
| Patients Monies | up to £100 | Cash & General Office Manager |
| | £101 - £5,000 | Deputy Director of Finance or Head of Financial Services |
| | Over £5,000 | Director of Finance & Commercial Development |
| **6. REQUISITIONING GOODS AND SERVICES AND APPROVING PAYMENTS** | | |
| **6.1** Revenue Expenditure - Delegated Authority (excluding consultancy services, capital and removal expenses) | up to £5,000 | Ward /Service/Theatre Managers/Divisional Administrator (or equivalent) |
| | up to £10,000 | Matron/Lead Nurse/Head of Service/Department Managers |
| | up to £25,000 | Associate Directors/Board Secretary/Deputy Chief Pharmacist/Deputy Clinical Business Manager/ Head of Service (or equivalent) |
| | up to £50,000 | Director of Medical Education/Deputy Directors/ Associate Director of Estates and Facilities / Chief Pharmacist/Clinical Business Unit Manager |
| | up to £100,000 | Deputy Chief Operating Officer |
| | up to £250,000 | Executive Directors |
| | over £250,000 | Chief Executive (delegated to Deputy Chief Executive in absence of CE) |

## Appendix A (continued)

| | | |
|---|---|---|
| **6. REQUISITIONING GOODS AND SERVICES AND APPROVING PAYMENTS** | | |
| **6.2** Consultancy Services | up to £50,000 | Chief Executive / Executive Directors |
| | Over £50,000 | NHS Improvement |
| **6.3** Capital Expenditure | n/a | Board of Directors following recommendation by Capital Planning Group supported by Finance and Sustainability Committee |
| Annual capital programme and amendments to the capital programme | | |
| Orders for schemes within the approved capital programme | | see section 6.1 Delegated Authority |
| Emergency schemes approved by | up to £250,000 | Director of Finance and Commercial Development or Deputy Director of Finance |
| | £250,000 - £500,000 | Chief Executive |
| | over £500,000 | Board of Directors |
| **6.4** Removal Expenses | up to £8,000 | Director of Human Resources and Organisational Development |
| **7. QUOTATIONS AND TENDERS** | | |
| **Quotations**: inviting minimum of 3 written quotations for goods/services | £10,000 - £60,000 | Associate Director of Procurement (except drugs) Chief Pharmacist (drugs only)* *only these two people can invite tenders or obtain quotes |
| **Competitive Tenders:** inviting a minimum of 3 written competitive tenders for goods/services (incompliance with EC directives as appropriate) EU limits and subsequent changes to be provided under separate correspondence by Associate Director of Procurement | over £60,000 | |

## Appendix A (continued)

| | | |
|---|---|---|
| **8. BUSINESS CASE APPROVAL (TRUST FUNDED)** | | |
| Revenue only | All | Executive Team (once approved delegated authority limits apply) |
| Revenue including capital | | |
| Revenue only | over £500,000 | Board of Directors (once approved delegated authority limits apply) |
| Revenue including capital | | |
| **9. REDESIGNATION** | | |
| Trust must still meet Financial Targets. Total trust budget remains under spent. Total divisional /departmental budget remains under spent | up to £25,000 | Deputy Director of Finance |
| | up to £100,000 | Director of Finance and Commercial Development |
| | up to £250,000 | Chief Executive |
| | over £250,000 | Trust Board |

**BOARD OF DIRECTORS**

| | | |
|---|---|---|
| **AGENDA REFERENCE:** | **BM/18/11/122** | |
| **SUBJECT:** | **Charitable Fund Annual Report and Accounts for year ending 31st March 2018** | |
| **DATE OF MEETING:** | **28th November 2018** | |
| **ACTION REQUIRED** | **For Decision** | |
| **AUTHOR(S):** | Katie Armstrong, Financial Accountant | |
| **EXECUTIVE DIRECTOR SPONSOR:** | Andrea McGee, Director of Finance & Commercial Development<br>Choose an item. | |
| | | |
| **LINK TO STRATEGIC OBJECTIVES:** | All | |
| **LINK TO BOARD ASSURANCE FRAMEWORK (BAF):** | BAF1.3: National & Local Mandatory, Operational Targets | |
| | BAF1.4: Business Continuity | |
| | BAF3.3: Clinical & Business Information Systems | |
| | | |
| **STRATEGIC CONTEXT** | The 2017/18 Annual Report and Accounts have been prepared in accordance with Part 8 of the Charities Act 2011, the Statement of Recommended Practice for charities and Financial Reporting Standard 102. | |
| **EXECUTIVE SUMMARY** (KEY ISSUES): | For the year ending 31st March 2018 the Charity generated income of £279k and incurred expenditure of £168k. This has increased the balance of funds by £111k. As at 31st March 2018 the balance of funds held was £608k. | |
| **RECOMMENDATION:** | The Board of Directors is requested to approve the Charitable Funds Annual Report and Accounts for year ending 31st March 2018. | |
| **PREVIOUSLY CONSIDERED BY:** | **Committee** | Charitable Funds Committee |
| | **Agenda Ref.** | CFC/18/11/39 |
| | **Date of meeting** | 15th November 2018 |
| | **Summary of Outcome** | Approved |
| **FREEDOM OF INFORMATION STATUS (FOIA):** | Release Document in Full | |
| **FOIA EXEMPTIONS APPLIED:** ***(if relevant)*** | None | |

## 1. BACKGROUND/CONTEXT

The purpose of the report is to provide the Board of Directors with the Annual Report and Accounts for the Charitable Fund for the year ending 31st March 2018.

## 2. KEY ELEMENTS

In accordance with the Charities Commission in England and Wales the Corporate Trustee is required to produce an annual report and accounts for the charity on a yearly basis and file with the Charities Commission within ten months of the financial year end. Therefore the 2017/18 Annual Report and Accounts need to be submitted to the Charities Commission by 31st January 2019.

The 2017/18 Annual Report and Accounts were submitted to the Charitable Funds Committee on 15th November 2018 for recommendation and have been reviewed by Voisey & Co, Independent Examiners. The Annual Report and Accounts have been prepared in accordance with Part 8 of the Charities Act 2011, the Statement of Recommended Practice for charities and Financial Reporting Standard 102.

For the year ending 31st March 2018 the Charity generated income of £279k and incurred expenditure of £168k. This has increased the balance of funds by £111k. As at 31st March 2018 the balance of funds held was £608k.

## 3. RECOMMENDATIONS

The Board of Directors is requested to approve the Charitable Funds Annual Report and Accounts for year ending 31st March 2018.

# Warrington and Halton Hospitals NHS Foundation Trust Charitable Fund

# Trustee's Annual Report & Independently Examined Financial Statements

**For the Year to 31st March 2018**

**Registered Charity No 1051858**

## Contents

## Reference and administrative details

| | |
|---|---|
| **Address of Charity:** | Lovely Lane<br>Warrington<br>Cheshire<br>WA5 1QG<br>Tel: 01925 662835 |
| **Registered Charity no:** | 1051858 |
| **Bankers:** | Government Banking Service<br>7th Floor, Southern House<br>Wellesley Grove<br>Croydon<br>CR9 1TR |
| **Independent examiners:** | Voisey & Co<br>8 Winmarleigh Street<br>Warrington<br>Cheshire<br>WA1 1JW |

# Report of the Trustee for the year ended 31st March 2018

## Foreword

Warrington and Halton Hospitals NHS Foundation Trust (the "Corporate Trustee") presents the Charitable Funds Annual Report together with the independently examined financial statements for the year ended 31st March 2018 of Warrington and Halton Hospitals NHS Foundation Trust Charitable Fund ("the Charity"). Under Part 8 section 145 of the Charities Act 2011, the Corporate Trustee has exercised the Charity's exemption from audit. External scrutiny through *independent examination* is permitted and deemed appropriate for the Charity as its gross income is below a statutory threshold.

The Charity's Annual Report and Accounts for the year ended 31st March 2018 have been prepared by the Corporate Trustee in accordance with Part 8 of the Charities Act 2011 and the Statement of Recommended Practice: Accounting and Reporting by Charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) issued on 16th July 2014. The Charity's report and accounts include all of the separately established funds for which the Warrington and Halton Hospitals NHS Foundation Trust is sole beneficiary.

# Structure, governance and management

## Corporate Trustee

The sole corporate trustee of the Charity is the Warrington and Halton Hospitals NHS Foundation Trust. The Charity was established in accordance with paragraph 16c of Schedule 2 of the NHS and Community Care Act 1990.

The Corporate Trustee is managed by its Board of Directors which consists of executive and non-executive directors. It has responsibility for planning, directing and controlling the activities of the entity, ensuring that the NHS body fulfils its duties in managing the charitable funds.

The members of the Board of Directors of the Corporate Trustee who served during the financial year and up to the date of compilation of this report were as follows.

| Name | Title | Notes |
|---|---|---|
| Steve McGuirk | Chairman | |
| Jean-Noel Ezingeard | Non-Executive Director | Commenced 26 April 2017 |
| Ian Jones | Non-Executive Director | |
| Terry Atherton | Non-Executive Director | |
| Anita Wainwright | Non-Executive Director | |
| Margaret Bamforth | Non-Executive Director | |
| Mel Pickup | Chief Executive | |
| Simon Constable | Deputy Chief Executive/Executive Medical Director | |
| Alex Crowe | Medical Director (1) | Commenced 18 September 2017 |
| Andrea McGee | Director of Finance and Commercial Development | |
| Sharon Gilligan | Chief Operating Officer | Left 28 April 2017 |
| Jan Ross | Acting Chief Operating Officer | From 1 May 2017 to 7 January 2018 |
| Chris Evans | Chief Operating Officer | Commenced 1 March 2018 |
| Kimberley Salmon-Jamieson | Chief Nurse | |
| Pat McLaren | Director of Community Engagement (1) | |
| Jason DaCosta | Director of Information Technology(1) | Left 30 June 2018 |
| Roger Wilson | Director of Human Resources and Organisational Development(1) | Left 4 May 2017 |
| Michelle Cloney | Director of Human Resources and Organisational Development(1) | |
| Lucy Gardner | Director of Transformation(1) | |

(1) Non-voting Executive Directors.

The Charity is established as an umbrella charity, registered with the Charity Commission (no. 1051858). The umbrella charity covers the existence of a single unrestricted general fund containing 5 (2016/17 4) designated funds as at 31st March 2018, and, currently, 12 restricted funds (2016/17 8). The Charity was first registered as both Halton General Hospital NHS Trust Charity and Warrington Hospital NHS Trust Charity in April 1996 under the Charities Act 1993, which is now been incorporated into the Charities Act 2011.

In April 2001, supplemental deeds were executed to amalgamate the administration, trustees, objects and powers of the two charities following merger of the two organisations, creating the single body known as North Cheshire Hospitals NHS Trust Charitable Fund. On 1st December 2008, the Trust changed its name to Warrington and Halton Hospitals NHS Foundation Trust, following its transition to Foundation Trust status. The name of the Charity was changed accordingly by way of a supplemental deed and registered with the Charity Commission on 16th March 2010.

**Charitable Funds Committee**

The Board of Directors (the Board) established a committee on 5th April 2001, known as the Charitable Funds Committee, (the Committee) reporting to the Board, in accordance with standing order 6 for the practice and procedure of the Board of Directors (annex 7 of the Trust's Constitution). The role of the Committee is to oversee the management of the affairs of the Charitable Fund. This is a delegated duty carried out on behalf of the Corporate Trustee. The role is to ensure that the Charity acts within the terms of its declaration of trust and appropriate legislation, and to provide information to the Audit Committee to enable it to provide assurance to the Board that the Charity is properly governed and well managed across its full range of activities.

Aside from any restricted funds held, the Charity holds a single general fund, within which designated funds have been created to acknowledge expressions of wish from donors about the particular department or ward which should ideally benefit from their generosity. The Trustee has an intention to use the income of designated funds in the areas indicated by donors. However the Committee may choose to apply the funds to general purpose in any area of the Trust's hospitals in accordance with the Health Service Act 1977.

**Membership of the Committee**

The Committee shall be composed of all independent Non-Executive Directors (excluding the Chairman), one of whom will be appointed as Chair of the Committee.

**Attendance**

The following individuals, or their nominated Deputy, shall normally be in attendance at the meetings:

- Director of Finance & Commercial Development or nominated deputy
- Chief Nurse or nominated deputy
- Director of Community Engagement and Corporate Affairs
- Fundraising Manager
- Head of Financial Services
- Publicly Elected Governor

During the year under review and up to the date of compilation of this Report, the members of the Charitable Funds Committee were as follows.

| Name | Position held | Notes |
|---|---|---|
| Jean-Noel Ezingeard | Non-Executive Director (Chair of Charitable Funds Committee) | Commenced 26 April 2017 |
| Ian Jones | Non-Executive Director (Interim Chair of Charitable Funds Committee) | From 1 December 2016 to 25 April 2017(1) |
| Terry Atherton | Non-Executive Director | |
| Anita Wainwright | Non-Executive Director | |
| Margaret Bamforth | Non-Executive Director | |

(1) Relates to time as Interim Chair, permanent member of Charitable Funds Committee.

The Head of Financial Services, in conjunction with the Fundraising Manager is able to approve expenditure on behalf of the Corporate Trustee with an upper limit of £1,000.

The Director of Finance and Commercial Development is responsible for day to day control of the administration of the charitable funds, and, in conjunction with the Director of Nursing, approves expenditure on behalf of the Corporate Trustee with an upper limit of £5,000.

Expenditure in excess of £5,000 is referred to the Charitable Funds Committee on a quarterly basis.

Members of the Trust Board and the Charitable Funds Committee are not individual Trustees under Charity Law, but act as agents on behalf of the Corporate Trustee.

**Corporate Trustee's appointments**

The methods of appointment to the key governance roles within the Board of Directors and Council of Governors of the Corporate Trustee are reported in the Corporate Trustee's Annual Report and Accounts 2017/18 and contained within the Corporate Trustee's Constitution. Copies of these documents can be obtained from the Corporate Trustee's website or from its Communications office, located at Warrington Hospital, Lovely Lane, Warrington, Cheshire WA5 1QG.

All appointments to the Charitable Funds Committee are made in accordance with the Charitable Funds Committee's approved Terms of Reference.

Trust staff including executive and non-executive directors, are required to complete the Trust's corporate induction programme, and are encouraged towards continuous professional development through the Trust's on-going performance management arrangements. Directors are able to seek individual professional advice or training at the Trust's expense in the furtherance of their duties.

Governors' knowledge is refreshed through a range of briefing sessions and workshops. The Board of Directors, Charitable Funds Committee and governors all have direct access to advice from the Board Secretary who is responsible for ensuring that the Corporate Trustee's procedures are followed and that applicable regulations are complied with.

**Administration**

The accounting records and day to day financial administration of the funds are dealt with by the Finance Department. Fund raising and promotion of the charity is administered by the Trust's Fundraising team located within the Communications office, both are located at Warrington Hospital, Lovely Lane, Warrington, Cheshire WA5 1QG.

## Risk management

The major risks to which the Charity is exposed have been identified and considered. A risk register has been compiled which is reviewed by the Charitable Funds Committee on a biannual basis. Income and expenditure is monitored as part of the risk management process, to avoid unforeseen calls on reserves.

The Charities Commission Checklist for Trustees is reviewed bi-annually by the Committee and submitted by the Chair to the Trust Board thereafter.

## Objectives and strategy

The objective of the Charity is to provide for any charitable purpose or purposes relating to the National Health Service wholly or mainly for the services provided by Warrington and Halton Hospitals NHS Foundation Trust.

The Charity raises funds to provide the additional comforts, care or experiences for the direct benefit of patients and their families beyond that which the NHS provides. This is achieved by:

- Providing state-of-the-art equipment, technology or training
- Funding WHH-related research
- Improving the hospital environment
- Providing enhancements to support the care and comfort of our patients

The Corporate Trustee attempts to balance the purchasing of essential equipment for essential services against expenditure which improves the general environment and facilities of the hospitals for its patients. In achieving this balance, the Corporate Trustee always has in mind the wishes of the donors to the Charity.

## Public interest benefit

The Corporate Trustee ensures that the *public interest benefit* criteria, as detailed in the Charities Act 2011, are met by critically assessing each funding application from sub-fund holders. Applications for funding can be made by any department within the hospitals, and applications are only restricted by the availability of funds and the quality of the application.

Where possible, funds are used to provide benefit to a wide range of patients, and funds used for staff enablement are allocated to projects that will directly benefit patients. A summary of major purchases made by the Charity during the year under review is contained in the Annual Review of Income and Expenditure Activities (page 8).

## Reserve policy

### Requirement

In accordance with Charity Commission guidance, the Corporate Trustee acknowledges that there is a requirement to hold reserves. The reserves policy should take into account future commitments from the general unrestricted funds held by the Charity. Assuming that funds have been designated appropriately and will be spent within a reasonable timescale the charity should not rely on the unrestricted designated funds for the absorption of overheads on a continuing basis. Therefore the level of reserves held in the general unrestricted funds of the charity should be sufficient to cover the annual support costs and overheads of the charity.

The charity approves expenditure on a case by case basis taking into account the level of funds available and the Corporate Trustee reserves the right to cancel any past delegation and transfer monies to the general unrestricted funds of the Charity. This may be considered where designated funds have not been spent within a reasonable timescale or where the original purpose of the designation no longer exists. Likewise the Corporate Trustee may choose to designate funds for a particular purpose.

### Level of reserves

As at 31st March 2018 the Corporate Trustee considers that a minimum reserve of £90,000 (£90,000 as at 31st March 2017) in the unrestricted general purpose fund should be permanently maintained.

### Monitoring

The Director of Finance and Commercial Development will report on the progress of the reserves and make recommendations to the Charitable Funds Committee in order to comply with the policy. The Charitable Funds Committee has authority to vary the minimum level of reserves.

At 31st March 2018 the unrestricted general purpose fund held reserves of £102,717 (£111,885 as at 31st March 2017).

## Investment policy

### Introduction

Where NHS charitable funds have surplus monies in excess of the minimum reserves plus those required to fund commitments that have not yet been realised, Trustees may elect to invest some or this entire surplus in order to generate additional income to fund future charitable activities.

### Investment criteria

The investment policy of the Corporate Trustee is to deposit the entire value of the fund with the Government Banking Service in an interest-bearing account. This decision is based upon the intention in the short term to spend the funds, such that long-term investment would not be appropriate.

### Interest receivable, interest payable and bank charges

It is the policy of the Corporate Trustee to apportion interest payable and bank charges across all funds, and to credit all funds with the proceeds of the Charity's investments based on the average balance of the funds held.

## Annual review of income and expenditure

### Income

During 2017/18, the Charity continued to support a wide range of charitable and health-related activities, by purchasing supplementary and complementary equipment or services which may not ordinarily have been provided from NHS sources.

Total income in was £279,783 (£132,538 in 2016/17) per the table below:

| | 2017/18 | 2016/17 |
|---|---|---|
| Legacies | £157,115 | £4,857 |
| Fundraising activities (see following page) | £95,240 | £44,067 |
| Donations | £26,236 | £82,627 |
| Income from investments | £1,192 | £987 |
| **Total Income** | **£279,783** | **£132,538** |

**Analysis of income from fundraising activities in 2017/18**

| | |
|---|---|
| • Income from the charity's own fundraising activities | £24,678 |
| • Donations In Memory | £23,178 |
| • Monies raised by individuals in support of the charity | £18,636 |
| • Grants from formal groups | £16,850 |
| • Amounts raised by community groups | £5,383 |
| • Small change boxes | £3,674 |
| • Income from recycling | £2,324 |
| • Other | £517 |
| **Total income from fundraising activities** | **£95,240** |

**Expenditure**

The Charity's unrestricted general fund contains a number of designated funds in order to assist the donors in matching their donation with a particular department. All donations are accepted taking into account the donors' intentions and are held in the general fund unless a restriction has been applied; in this case, a separate restricted fund may be created. Legacy income where subject to a legal trust is held as restricted funds.

The Corporate Trustee is committed to ensuring that all funds are directed to patient benefit as soon as possible. Total expenditure in 2017/18 was £169,430 (£244,304 in 2016/17) per the table below:

| | **2017/18** | **2016/17** |
|---|---|---|
| Expenditure on patient welfare and medical equipment (see following table) | £54,287 | £145,260 |
| Support costs and overheads | £28,695 | £21,274 |
| Staff costs | £48,804 | £45,191 |
| Governance costs | £24,669 | £18,990 |
| **Expenditure on charitable activities** | **£156,455** | **£230,715** |
| Fundraising activities | £12,975 | £13,589 |
| **Total expenditure** | **£169,430** | **£244,304** |

**Analysis of significant expenditure in 2017/18 (items costing more than £1,000) ***

| | |
|---|---|
| • Bladder scanner. | £8,545 |
| • Interactive entertainment system for patients with dementia. | £7,794 |
| • Foetal monitor for use in neonatal department. | £7,334 |
| • Over bed tables to enhance patient experience. | £4,488 |
| • Reclining chairs for use by visitors to seriously ill patients. | £3,366 |
| • Cuddle cots for use in neonatal department. | £3,295 |
| • Syringe drivers. | £3,258 |
| • Music licences for all sites. | £3,140 |

| | |
|---|---|
| • Equipment for the diabetes department at Halton. | £2,145 |
| • Thermometers for every cot in the neonatal department. | £1,650 |
| • Observation machine for ward A6. | £1,200 |
| **Total expenditure on individual items costing more than £1,000** | **£46,215** |
| Other Charitable purchases (under £1,000 per item) | £8,072 |
| **Total Charitable expenditure** | **£54,287** |

*Items listed relate to expenditure on patient welfare, medical equipment and staff welfare with direct benefit to patients contained within note 6 on page 18.

## Future plans

The Corporate Trustee does not expect significant changes in the objectives of the Charity in the forthcoming year and is committed to utilising funds to ensure that funds expended are directed to patient benefit as soon as is practicable. During the period under review the Charitable Funds Committee sought spending plans from holders of both restricted and designated income funds with the intention of significantly reducing reserves where suitable projects or programmes can be identified.

At the date of compilation of the financial statements, the following schemes, each involving commitments in excess of £1,000 have been approved.

| | |
|---|---|
| • Cooling blankets for the neonatal unit. | £18,936 |
| • Enhancements to the patient areas in the maternity unit. | £13,050 |
| • Video Laryngoscope for intensive care. | £7,672 |
| • Equipment for the diabetes department at Warrington. | £2,808 |
| • Mobile observation monitors. | £2,760 |
| • Enhancements to patient area in breast screening unit. | £1,770 |

In addition the Charity has commitments to fundraising for the following appeals.

| | |
|---|---|
| • Children's playground | £87,447 |
| • Serious Illness Care programme (SIC) | £35,000 |
| • Volunteer led shared reading programme | £11,600 |

## Acknowledgement

The Corporate Trustee would like to extend its sincere thanks on behalf of the patients and staff who have felt the impact of this year's donations and legacies, received at our charity offices at Warrington and Halton hospitals, through our Cash Offices, by post or through *Just Giving* or other gift making websites. Many of our donors have contributed in times of personal difficulty.

Gratitude is also extended to the Leagues of Friends at both Warrington and Halton Hospitals. These independent charities operate alongside the Charity, sharing similar objectives, and the Charity occasionally co-purchases items with them.

The Corporate Trustee would also like to acknowledge the increasing fundraising activities of our donors and our staff, who have been holding events and undertaking a variety of sponsored feats to generate awareness and funds for the Charity. Their contributions, imagination and enthusiasm are greatly appreciated.

Information regarding the independently examined accounts can be obtained from the Finance Department on 01925 662835.

Approved on behalf of the Corporate Trustee.

PAT MCLAREN …… Date: 28th November 2018
Director of Community Engagement

## Statement of Trustee's responsibilities

The law applicable to charities in England and Wales requires the Trustee to prepare financial statements for each financial year which give a true and fair view of the Charity's financial activities during the year, and of its financial position at the end of the year. In preparing financial statements that give a true and fair view, the Trustee should follow best practice and:

- select suitable accounting policies and then apply them consistently;
- make judgements and estimates that are reasonable and prudent;
- state whether applicable accounting standards and statements of recommended practice have been followed, subject to any departures disclosed and explained in the financial statements;
- prepare the financial statements on the going concern basis unless it is inappropriate to presume that the Charity will continue in operation;
- keep proper accounting records, which disclose with reasonable accuracy at any time the financial position of the Charity, and which enables the Trustee to ensure that the financial statements comply with the requirements in the Charities Act 2011, the Charity (Accounts and Reports) Regulations and the provisions of the trust deed; and
- Safeguard the assets of the Charity, therefore taking reasonable steps in the prevention and detection of fraud and other irregularities.

The Corporate Trustee confirms that it has met the responsibilities set out above and complied with the requirements for preparing the accounts. The financial statements set out on pages 13 to 23 attached have been compiled from, and are in accordance with, the financial records maintained by the Corporate Trustee.

Approved by the Corporate Trustee on 28th November 2018 and signed on its behalf by:

STEVE MCGUIRK ……Chairman

ANDREA MCGEE……Director of Finance and Commercial Development

**INDEPENDENT EXAMINER'S REPORT TO THE TRUSTEES OF WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST CHARITABLE FUND**

I report on the accounts for the year ended 31st March 2018 set out on pages 13 to 23

**Respective responsibilities of trustees and examiner**

The charity's trustees are responsible for the preparation of the accounts. The charity's trustees consider that an audit is not required for this year under section 144 of the Charities Act 2011 ("the Charities Act") and that an independent examination is needed.

It is my responsibility to:

- examine the accounts under section 145 of the Charities Act,
- to follow the procedures laid down in the general Directions given by the Charity Commission (under section 145(5)(b) of the Charities Act, and
- to state whether particular matters have come to my attention.

**Basis of independent examiner's statement**

My examination was carried out in accordance with general Directions given by the Charity Commission. An examination includes a review of the accounting records kept by the charity and a comparison of the accounts presented with those records. It also includes consideration of any unusual items or disclosures in the accounts, and seeking explanations from the trustees concerning any such matters. The procedures undertaken do not provide all the evidence that would be required in an audit, and consequently no opinion is given as to whether the accounts present a 'true and fair' view and the report is limited to those matters set out in the statement below.

**Independent examiner's statement**

In connection with my examination, no matter has come to my attention:

1. which gives me reasonable cause to believe that in, any material respect, the requirements:

- to keep accounting records in accordance with section 130 of the Charities Act; and
- to prepare accounts which accord with the accounting records and comply with the accounting requirements of the Charities Act have not been met; or

2. to which, in my opinion, attention should be drawn in order to enable a proper understanding of the accounts to be reached.

Philip Urmston BSc FCA
Voisey & Co, Chartered Accountants
8 Winmarleigh Street
Warrington, Cheshire WA1 1JW ……2018

# Statement of Financial Activities

| | Note | Unrestricted Funds | Restricted Funds | Endowment Funds | **Total Funds** | Prior Year Total Funds |
|---|---|---|---|---|---|---|
| | | 2017/18 | 2017/18 | 2017/18 | **2017/18** | 2016/17 |
| | | £000 | £000 | £000 | **£000** | £000 |
| **Incoming and endowments from:** | | | | | | |
| Incoming resources from generated funds | 2 | 70 | 25 | - | **95** | 44 |
| Donations and legacies | 3 | 52 | 131 | - | **183** | 87 |
| Other trading activities | | - | - | - | **-** | - |
| Income from Investments | 4 | - | 1 | - | **1** | 1 |
| **Total income and endowments** | | 122 | 157 | - | **279** | 132 |
| **Expenditure on:** | | | | | | |
| Raising funds | 5 | (11) | (2) | - | **(13)** | (14) |
| Charitable activities | 6 | (98) | (57) | - | **(155)** | (230) |
| **Total expenditure** | | (109) | (59) | - | **(168)** | (244) |
| Net income/(expenditure) | | 13 | 98 | - | **111** | (112) |
| Transfers between funds | 16 | (12) | 12 | - | **-** | - |
| **Net movement in funds** | | 1 | 110 | - | **111** | (112) |
| **Reconciliation of funds** | | | | | | |
| Total funds brought forward | | 139 | 358 | - | **497** | 609 |
| **Total funds carried forward** | | **140** | **468** | **-** | **608** | **497** |

# Balance Sheet as at 31st March 2018

| | Note | Unrestricted Funds | Restricted Funds | Endowment Funds | **Total Funds** | Prior Year Total Funds |
|---|---|---|---|---|---|---|
| | | 2017/18 | 2017/18 | 2017/18 | **2017/18** | 2016/17 |
| | | £000 | £000 | £000 | **£000** | £000 |
| **Fixed Assets** | | | | | | |
| Intangible assets | 9 | 11 | - | - | **11** | 14 |
| **Total fixed assets** | | 11 | - | - | **11** | 14 |
| **Current assets** | | | | | | |
| Cash at Bank and in hand | 10 | 116 | 375 | - | **491** | 511 |
| Debtors | 11 | 16 | 122 | - | **138** | 18 |
| **Total current assets** | | 132 | 497 | - | **629** | 529 |
| **Current liabilities** | | | | | | |
| Creditors: amounts falling due within one year | 12 | (3) | (29) | - | **(32)** | (46) |
| **Net current assets** | | 129 | 468 | - | **597** | 483 |
| **Total assets less current liabilities** | | 140 | 468 | - | **608** | 497 |
| **Non current liabilities** | | - | - | - | **-** | - |
| **Net assets** | | 140 | 468 | - | **608** | 497 |
| **The funds of the Charity** | | | | | | |
| Total Charity funds | 16 | 140 | 468 | - | 608 | 497 |
| **Total funds carried forward** | | **140** | **468** | **-** | **608** | **497** |

**The funds of the Charity:**

The notes on pages 15 to 23 form part of these accounts.

Signed:

Chairman……Date 28th November 2018

Director of Finance
and Commercial Development……Date 28th November 2018

# Notes to the accounts

## Note 1 Accounting policies

The financial statements have been prepared under the historical cost convention and in accordance with Statement of Recommended Practice: Accounting and Reporting by Charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) issued on 16th July 2014 and the Charities Act 2011.

The financial statements are presented in Pounds Sterling, rounded to the nearest thousand.

There is no requirement for the Charity to prepare a cash flow statement since it is exempt due to being a 'smaller' charity (i.e. income less than £500,000).

### 1.1 Accounting judgements and key sources of estimation uncertainty

In the application of the Charity's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amount of assets and liabilities that are not readily apparent from other sources.

The estimates and associated assumptions are based on historical experience and other factors considered of relevance. Actual results may differ from those estimates, and underlying assumptions are continually reviewed. Revisions to estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of revision and future periods if the revision affects both current and future periods.

The following are the areas of critical judgements that management have made in the process of applying the entity's accounting policies.

#### Going concern

After making enquiries, the Corporate Trustee has a reasonable expectation that the Charity has adequate resources to continue in operational existence for the foreseeable future. For this reason, it continues to adopt the going concern basis in preparing these financial statements.

There are currently no sources of estimation or uncertainty that are judged to cause a significant risk of material adjustment to the financial statements.

### 1.2 Funds structure

Restricted funds are to be used in accordance with the specific restrictions imposed by the donor. The Charity held 12 restricted funds at the end of the year under review.

The Charity did not hold any endowments, expendable or otherwise, during the year under review.

Unrestricted funds comprise those funds which the Corporate Trustee is free to use for any purpose in furtherance of the Charity's charitable objects. The Charity has a single unrestricted general fund containing several designated funds. These unrestricted designated funds are created to honour donors' expressions, or are created by the Trustee, at its discretion, to designate monies for specific future purposes. Any funds held within a designated fund can be merged or transferred within the general fund at any time, at the discretion of the Trustee, in accordance with the Health Service Act 1977 and the Charity's dormant funds policy.

**1.3 Incoming resources**

All incoming resources are recognised once the Charity has entitlement to the resources, it is probable that the resources will be received, and the monetary value of incoming resources can be measured with sufficient reliability.

The cost of donations in kind for charitable activities is deemed to be the fair value of those gifts at the time of their receipt. They are recognised on receipt as income from fundraising activities in the reporting period in which the goods are received.

Donations in kind are recognised as an expense at the carrying amount of the goods upon application to charitable activities.

**1.4 Incoming resources from legacies**

Legacies are accounted for as incoming resources either upon receipt, or where the receipt of the legacy is probable. This would require that confirmation has been received from the representatives of the estate(s) that payment of the legacy will be made or property transferred, and that all of the conditions attached to the legacy have been fulfilled.

**1.5 Resources expended**

All expenditure is accounted for on an accruals basis, and has been classified under the headings that aggregate all costs related to that category. All expenditure is recognised once there is a legal or constructive obligation committing the Charity to the expenditure.

The Charity does not make grants to third parties.

Contractual arrangements are recognised as goods or services are supplied.

**1.6 Costs of raising funds**

These are costs associated with generating incoming resources, and are recognised as per the Charity's other expenditure.

**1.7 Charitable activities**

The costs of charitable activities include all costs incurred in the pursuit of the charitable objects of the Charity. These costs comprise the direct costs of charitable purchases, support costs, overheads and governance costs as shown in Note 6.

Governance costs comprise all costs incurred in the governance of the Charity. These costs include fees pertaining to the provision of governance and financial papers to the Charitable Funds Committee, the creation of this Annual Report and Accounts, the audit or independent examination of the accounts, and any associated support costs.

### 1.8 Intangible fixed asset investments

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the Charity's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to or service potential be provided to, the Charity and where the cost of the asset can be measured reliably.

Intangible assets are initially recognised at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating.

Intangible assets are amortised over a useful economic life of 5 years using a straight line on cost method.

### 1.9 Realised gains and losses

All gains and losses are taken to the Statement of Financial Activities as they arise.

### 2. Analysis of income from generated funds (Fundraising activities)

| | Unrestricted Funds 2017/18 £000 | Restricted Funds 2017/18 £000 | **Total Funds 2017/18 £000** | Total Funds 2016/17 £000 |
|---|---|---|---|---|
| Income from fundraising events | 21 | 4 | **25** | 3 |
| Income from third party fundraisers | 10 | 8 | **18** | 23 |
| Donations in kind | - | - | **-** | 16 |
| Other | 39 | 13 | **52** | 2 |
| **Total** | 70 | 25 | **95** | 44 |

## 3. Analysis of voluntary income

| | Unrestricted Funds 2017/18 £000 | Restricted Funds 2017/18 £000 | **Total Funds 2017/18 £000** | Total Funds 2016/17 £000 |
|---|---|---|---|---|
| Donations | 16 | 10 | **26** | 82 |
| Legacies | 36 | 121 | **157** | 5 |
| **Total** | 52 | 131 | **183** | 87 |

## 4. Analysis of investment income

| | Unrestricted Funds 2017/18 £000 | Restricted Funds 2017/18 £000 | **Total Funds 2017/18 £000** | Total Funds 2016/17 £000 |
|---|---|---|---|---|
| Bank interest | 0.4 | 0.8 | **1.2** | 1.0 |
| **Total** | 0.4 | 0.8 | **1.2** | 1.0 |

## 5. Analysis of expenditure on raising funds (Fundraising activities)

| | Unrestricted Funds 2017/18 £000 | Restricted Funds 2017/18 £000 | **Total Funds 2017/18 £000** | Total Funds 2016/17 £000 |
|---|---|---|---|---|
| Expenditure on fundraising events | 8 | - | **8** | 1 |
| Promotional items and branding | 3 | 2 | **5** | 8 |
| Consultancy fees | - | - | **-** | 5 |
| **Total** | 11 | 2 | **13** | 14 |

## 6. Analysis of charitable activities

| | Unrestricted Funds 2017/18 £000 | Restricted Funds 2017/18 £000 | **Total Funds 2017/18 £000** | Total Funds 2016/17 £000 |
|---|---|---|---|---|
| Patient welfare | 20 | 7 | **27** | 102 |
| Staff enablement | (2) | - | **(2)** | 5 |
| Medical equipment | 15 | 14 | **29** | 38 |
| **Sub Total** | **33** | **21** | **54** | **145** |
| Support costs and overheads* | 21 | 7 | **28** | 21 |
| Staff costs | 36 | 13 | **49** | 45 |
| Governance costs | 8 | 16 | **24** | 19 |
| **Total** | 98 | 57 | **155** | 230 |

*Support costs and overheads comprise of an apportionment from the Trust's administration charge (Note 6) of £16,000 (£16,000 in 2016/17) plus other sundry items not categorised elsewhere.

**6.1 Governance costs**

| | Unrestricted Funds 2017/18 £000 | Restricted Funds 2017/18 £000 | **Total Funds 2017/18 £000** | Total Funds 2016/17 £000 |
|---|---|---|---|---|
| Independent examination/audit fees | 0.5 | 1.0 | **1.5** | 2.2 |
| Administration Charge | 5.3 | 10.7 | **16.0** | 16.0 |
| Fees and subscriptions | 2.4 | 4.7 | **7.1** | 0.8 |
| **Total** | 8.2 | 16.4 | **24.6** | 19.0 |

Independent examination/ audit fees consist of an accrual for the independent examination fee of £1,560 (£1,560 in 2016/17) for the period of this review.

**7. Staff Costs**

| | **2017/18 £000** | 2016/17 £000 |
|---|---|---|
| Salaries and wages | **39** | 37 |
| Social Security costs | **4** | 3 |
| Pension Costs | **6** | 5 |
| **Total** | **49** | 45 |

During the period under review no employees received employee benefits (excluding employee pension costs) of more than £60,000.

The Trustee is defined as the Corporate Trustee that does not constitute employment with the charity. Accordingly no Trustees are paid any remuneration nor receive any other benefits and expenses from employment with the charity.

**7.1. Average number of employees in the year (Whole time equivalent)**

| | **2017/18** | 2016/17 |
|---|---|---|
| Fundraising | **1.0** | 1.0 |
| Administration | **0.4** | 0.4 |
| **Total** | **1.4** | 1.4 |

**7.2. Pension Costs**

Employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded defined benefit scheme that covers NHS employers, General Practices and other bodies allowed under the direction of the Secretary of State in England and Wales. It is not possible for the Corporate Trustee to identify its share of the underlying scheme liabilities. Therefore the scheme is accounted for as a defined contribution scheme.

Employer's pension cost contributions are charged to the Statement of Financial Activities as and when they become due.

## 8. Allocation of administration charge

The costs of administering the Charity have been split between support costs and overheads (Note 6) governance costs (Note 6.1) and staff costs (Note 7).

During the year under review an administration charge was raised to cover the governance, financial and procurement resources of Warrington and Halton Hospitals NHS Foundation Trust. The charge for 2017/18 was £32,000 (£32,000 in 2016/17) the charge is apportioned equally between support costs and overheads and governance costs. The element of the administration charge that is attributed to governance costs pertains to the costs associated with the preparation of Committee papers and the Annual Report and Accounts.

During the year under review the Corporate Trustee considered the charity's policy on the allocation of overheads in conjunction with guidance as issued by the Charities Commission.

As at 31st March 2018 all shared costs for administration and governance costs have been apportioned across all funds using a combination of transactional and average balance techniques.

Overheads will continue to be apportioned on an annual basis. In the event that a restriction does not permit the allocation of overheads the costs will be met by way of a transfer from the unrestricted funds held by the charity.

## 9. Analysis of Intangible Fixed Assets

| | 2017/18 £000 Software |
|---|---|
| **Cost** | |
| Balance brought forward at 1st April 2017 | **17** |
| Additions in year | **0** |
| Disposals in year | **0** |
| Balance carried forward at 31st March 2018 | **17** |
| | |
| **Amortisation*** | |
| Balance brought forward at 1st April 2017 | **3** |
| Charge in year | **3** |
| Balance carried forward at 31st March 2018 | **6** |
| | |
| **Net Book Value at 31st March 2018** | **11** |
| | |
| **Net Book Value at 31st March 2017** | **14** |

*The cost of intangible fixed assets relates to the purchase of the Harlequin fund raising database and associated finance package. The asset was purchased in 2015/16 and came into use from 1st April 2016.

## 10. Analysis of cash at bank and in hand

| | **2017/18 £000** | 2016/17 £000 |
|---|---|---|
| Bank current account | **491** | 511 |
| **Total** | **491** | 511 |

## 11. Analysis of debtors

| | **2017/18 £000** | 2016/17 £000 |
|---|---|---|
| Prepayments and accrued income | **138** | 6 |
| Other debtors | **0** | 12 |
| **Total** | **138** | 18 |

During the year under review, and the prior year, other debtors represent amounts to be reclaimed by the Charity in respect of Gift Aid and VAT.

## 12. Analysis of current liabilities and long term creditors

| | **2017/18 £000** | 2016/17 £000 |
|---|---|---|
| Accruals and purchases made on behalf of the Charity | **32** | 46 |
| **Total** | **32** | 46 |

## 13. Related party transactions

The Charity is a subsidiary of the Trust and is therefore a related party. Warrington and Halton Hospitals NHS Foundation Trust is the sole beneficiary of the Charity. The Charity provides funding to the Trust for approved expenditure made on behalf of the Charity. During 2017/18 the Charity made payments to Warrington and Halton Hospitals NHS Foundation Trust totalling £171,327 (£185,156 in 2016/17).

At 31st March 2018 the Charity owed Warrington and Halton Hospitals NHS Foundation Trust £25,474 for purchases made by the Trust on behalf of the Charity. At 31st March 2017 Warrington and Halton Hospitals NHS Foundation Trust owed the Charity £38,199 for refunds relating to purchases made on behalf of the Charity which had been received into the Trust at 31st March 2017.

All transactions entered into during the year were conducted on an arm's length basis.

During the year, none of the members of the Trust Board or senior Trust staff, or parties related to them, were beneficiaries of the Charity. Neither the Corporate Trustee nor any member of the

Trust Board has received honoraria, emoluments or expenses in the year. The Corporate Trustee has not used the funds of the Charity to purchase trustee indemnity insurance.

Board members, and other senior staff, take decisions on both Charity and exchequer matters, but endeavour to keep the interests of each discrete, and do not seek to benefit personally from such decisions. Declarations of personal interest have been made in both capacities and are available to be inspected by the public in the Corporate Information section of the Trust's website.

From 1st April 2013 NHS charitable funds considered to be subsidiaries are to be consolidated within the Trust accounts in accordance with an accounting direction issued by Monitor, now NHS Improvement. For 2017/18 the Trust has opted not to consolidate charitable funds with the main Trust Accounts because they are immaterial. This will continue to be reviewed each year for appropriateness.

## 14. Events after the reporting period

There have been no events since the Balance Sheet date that would indicate that any revision to the accounts is necessary.

## 15. Legacies

Legacy income received between 31st March 2018 and the date of compilation of this Annual Report and Accounts has been recognised within the legacy income figure for 2017/18 on the basis that the income was probable as at 31st March 2018. Such income is included within note 3 on page 18 and is included within accrued income in note 11 on page 21.

## 16. Fund structure and summary of movements

### Charitable funds

The Charity has 13 funds. These are the (unrestricted) General Fund, and 12 Restricted Funds. The restriction has arisen due to the legacy donor's stipulation that the monies be spent within a particular department.

During the year under review the maternity fund received income for which a restriction was applied. Overheads allocated to the fund were met by way of a transfer from the unrestricted funds held by the charity.

Overheads allocated to the Halton legacy fund were met in part by way of a transfer from the unrestricted funds held by the Charity. The transfer represented the residual balance of the fund once all committed expenditure had been applied to the benefit of service users at Halton Hospital.

A summary of fund movements is given in the following table:

| Fund | Balance as at 1st April 2017 | Incoming resources | Outgoing resources | Transfers | Balance as at 31st March 2018 |
|---|---|---|---|---|---|
| | £ | £ | £ | £ | £ |
| Unrestricted Funds | 139,827 | 122,535 | (110,327) | (12,409) | 139,626 |
| Breast Screening | 34,951 | 77 | (1,600) | - | 33,428 |
| Cancer Patient Support | 10,897 | 5,275 | (2,691) | - | 13,481 |
| Diabetes | - | 85,000 | - | - | 85,000 |
| Garden Enhancement | - | 2,002 | (556) | - | 1,446 |
| Halton Hospital Legacy | - | (9) | (12,400) | 12,409 | - |
| Heart Unit | 19,051 | 807 | (1,085) | - | 18,773 |
| Intensive Care | 187,773 | 10,842 | (24,870) | - | 173,745 |
| Maternity | 9,160 | 13,895 | (4,800) | - | 18,255 |
| Neonatal | 83,301 | 3,541 | (9,342) | - | 77,500 |
| Ophthalmology | 2,592 | 693 | (1,073) | - | 2,212 |
| Radiology | - | 34,263 | - | - | 34,263 |
| Stroke Unit | 9,889 | 862 | (686) | - | 10,065 |
| **Total Funds** | **497,441** | **279,783** | **(169,430)** | **-** | **607,794** |

**Unrestricted general fund: sub-fund balances**

| Fund | Balance as at 1st April 2017 | Incoming resources | Outgoing resources | Transfers | Balance as at 31st March 2018 |
|---|---|---|---|---|---|
| | £ | £ | £ | £ | £ |
| General Unrestricted | 111,885 | 70,482 | (67,241) | (12,409) | 102,717 |
| Children's Unit Appeal | 3,751 | 43,537 | (28,263) | - | 19,025 |
| Children's Respiratory Fund | 1,774 | 4 | (81) | - | 1,697 |
| Forget Me Not Appeal | 13,118 | 8,439 | (14,838) | - | 6,719 |
| Heartbeat Halton Appeal | 2,341 | 58 | 415 | - | 2,814 |
| Ophthalmology Appeal | 6,958 | 15 | (319) | - | 6,654 |
| **Unrestricted Fund Total** | **139,827** | **122,535** | **(110,327)** | **(12,409)** | **139,626** |